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Object Relations Family Therapy: Articulating the Inchoate¹

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In recent years there has been a renewed interest in psychodynamic ideas within the family therapy literature. While some authors have explored the usefulness of psychodynamic concepts in the systemic context (Byng-Hall, 1995; Flaskas, 1993, 1996; Luepnitz, 1988, 1997), others have argued that psychodynamic models of family therapy should be given more credence in systemic work with families (Guttman, 1991). This paper describes Object Relations Family Therapy (ORFT), a psychoanalytic model of family therapy, in plain English in order to minimise the obscurity of some of the existing terminology and to emphasise the utility of more contemporary formulations. ORFT addresses the interface between psychoanalytic and systemic theories. It offers a way of conceptualising complex family dynamics at both the interpersonal and intrapsychic levels. It also integrates an understanding of nonverbal, unstated and often implicit processes in its formulation of problem development. The unique contribution of ORFT is elaborated using a clinical example.

OBJECT RELATIONS THEORY

There is no single unified theory of object relations (Bacal, 1987; Bowlby, 1986). Fairbairn (1952; 1963) originally articulated the theory as a psychology of the individual based on the premise that the individual has a need to relate. Relating begins in utero and continues at birth within the matrix of the attachment to the mother or primary caretaker. Neo-Freudians and object relations theorists, in particular Bowlby (1969; 1973), Balint (1979), Bion (1970), Guntrip (1968), Klein (1946), and Winnicott (1977), have been interested in exploring the way in which early experiences with primary caretakers are absorbed by the infant/child and how this experience is organised in its internal world.

According to object relations theory *internal objects* represent unconscious memory traces of experience with someone (*the object*) who has or had significance for the person (Klein 1946). These internal symbolic representations act as a template. Templates

influence all future relationships. The infant's initial experience of the world is fluid, but slowly over time he/she builds up an internal working model of objects. Templates penetrate every level of psychological experience—the motivational, behavioural, cognitive, perceptual, experiential and affective.

Klein (1946) posits that the infant first communicates feeling states to the mother or caretaker through the process of projective identification. In the developmental context, projective identification is seen to be an adaptive defence mechanism because it enables the infant to communicate with its primary caretaker for the purpose of survival. The American school of object relations family therapists (e.g. Scharff and Scharff, 1987; Scharff, 1989; Slipp, 1988) have adopted Klein's concept of projective identification to move the theory of the individual's object relations into the interactive family context. We believe that this integrative model offers a multileveled understanding of the subjective and shared experience of family processes.

ORFT focuses on the conscious and unconscious processes that develop between people as a result of each person's internal object constellation. The model provides an understanding of family problems through analysis of the shared lives of family members within and beyond the awareness of family members, and through an understanding of the interactions between family and therapist. Despite this, ORFT lacks a prominent place in the family therapy literature (Guttman,

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1991). Indeed in Australia the object relations model has remained one of the least influential and least articulated schools of family therapy.

There are several reasons why this model is overlooked and even misunderstood. One difficulty is that ORFT is grounded in psychoanalytic theory, which has traditionally been associated with linear-historic thinking and with an individual, intrapsychic focus (Hoffman, 1981). This focus has been problematic for systemic therapists because it has been deemed to be reductionist and therefore inadequate in its comprehension of the family system. A trend in the articulation of systemic therapy is to polarise the systemic and the psychoanalytic (cf. Griffin, 1993). This has led to a vacuum where the possibilities for conceptual enrichment inherent in the interface have been lost.

A second difficulty is that ORFT has sometimes been confused with classical psychoanalysis and core Freudian concepts such as drive theory. However, this is a misunderstanding for a number of reasons. First, interpersonal object relations theorists (e.g. Fairbairn, 1952, 1963; Guntrip, 1968; Winnicott, 1977; Bion, 1970) reject the view that the individual is motivated solely by sexual and aggressive instincts. Instead their approach assigns more importance to the individual's need to relate and so is more focused on relationship dynamics. Although Freud did address intergenerational dynamics, his focus was primarily individual and intrapsychic. In contrast, the object relations model conceptualises intergenerational family dynamics at both the intrapsychic and interpersonal levels.

A third difficulty is terminology. Both systemic and psychoanalytic models have developed confusing terminology. Systems theory and object relations theory have developed their own set of concepts independently and this makes any integration of the two a challenge. Attempts to explicate ORFT have not succeeded in identifying with clarity the systemic-cybernetic family processes inherent in object relations family therapy (e.g. Scharff and Scharff, 1987; Scharff, 1989; Slipp, 1988). The fourth reason is more subtle and relates to the apparent familiarity of psychoanalytic terminology. Although it is used in everyday language the complexity of the concepts is often not understood because few have read the original works. Familiarity is confused with explanation.

The language of object relations theory presents a challenge even to therapists who are familiar with psychoanalytic theory. The same word can have different meanings depending on the theoretical orientation of the therapist. For example, the word 'object' may refer to one's *internalised* experience of significant others as well as to the *actual* other. More recently trained therapists may dislike language which is considered to be pathologising—'object', for example, may appear to objectify people. More recent attempts have been made to replace the word 'object' with 'other person', 'other people' or 'aspects of the significant other' (e.g. Klein, 1987; Emde, 1994: 47). The change in term-

inology however has not consistently been introduced into the object relations family therapy literature.

A further complication arises from the fact that object relations concepts may overlap with similar family therapy concepts, yet have significantly different meanings. For example, the term 'boundary' in structural family therapy refers to the rules that define membership of a system or sub-system. It also describes roles and functions of family members (Minuchin, 1974; Aponte and VanDeusen, 1981; James and MacKinnon, 1986). 'Boundary' in ORFT refers primarily to the psychological differentiation between self and other, individual and family. The therapy process focuses on the unconscious interpersonal dynamics that result from poorly differentiated ego boundaries. This significantly different use of the same term is confusing.

The Theoretical Basis of Object Relations Family Therapy

1. Developmental Needs of the Family: Intimacy vs. Autonomy

Families go through developmental stages, two of which are integral to object relations theory. The first is characterised by the need for close, intimate relationships and the second, which comes later, is the need to be separate within the context of a relationship. The ability to distinguish between self and other is made much of in psychoanalytic thinking. In the family this evolves into the need for another, to be with another while nevertheless sustaining a sense of self. It is elaborated in the vicissitudes of intimacy between parents, the autonomy seeking of children and intergenerational holding and letting go from the cradle to the grave.

2. Relationship Needs of Individuals: Attachment and the 'Good Enough Parent'

Object relations theory is based on the assumption that people throughout their lives strive for mutually satisfying, close, loving and acknowledging relationships with others. This striving occurs from birth and is adaptive. Attachment is a biological-social system which ensures the survival of the young and which regulates the child's interaction with the major caregiver especially in situations of threat. Attachment behaviour is expressed in age specific ways and there is a broad theoretical and empirical literature on the importance of the attachment processes throughout life (Bowlby, 1969, 1973; Winnicott, 1976; Brazelton and Cramer, 1991; Main, Caplan and Cassidy, 1985; Shaver and Clark, 1994). Attachment theory has also been increasingly recognised as a useful paradigm in the family therapy literature (Byng-Hall, 1995; Das Eiden, Teti and Corns, 1995; Marvin and Stewart, 1990; Pistole, 1994; Sinclair and McCluskey, 1996).

Object relations theory addresses the quality of the relationship between the infant and caregiver in terms of whether this relationship is 'good enough' (Winnicott, 1976). 'Good enough' refers to a constellation of qualities of care. It includes an awareness of

the psychological and physical needs of the infant and implies a consistent, reliable and predictable response to the infant's needs. 'Good enough' does not mean perfect. There will be occasions when the carer cannot meet the infant's needs (Winnicott, 1976, 1977).

3. The Development of a Secure Base: Holding

Winnicott's concept of *holding* (Winnicott, 1976) refers to the physical and psychological care provided to the infant by the primary carer(s). If the caregiver is able to appreciate the child's needs and feelings predictably and reliably, the child internalises this as a sense of security and safety. The internalising of this quality of care means that later on the child develops the same capacity within him/herself.

In the context of family therapy, Byng-Hall (1995) describes how the therapist can help the family develop a more secure base, a base from which a network of care and support is provided to each family member. For the family to feel held the therapist must provide a frame in which conflictual issues can be explored with sensitivity and protection.

4. Separation and Individuation

A 'good enough' relationship also allows for separation and individuation to take place (Mahler, Pine and Bergman, 1975). This significant developmental phase describes the baby's growing awareness of separateness from its main carer. It is thought that the way in which separation and individuation is negotiated will constitute a blueprint for future distance regulation in close relationships. If attachment was experienced as safe and associated with close, loving contact, then it is more likely that this quality will inform future relationships. If the child has been unable to experience 'good enough' relationships, separation and individuation will most likely be compromised. It is the development of these experiences within the context of a 'good enough' caring which allows the child to develop a secure identity. This secure sense of self then facilitates the separation process. The adequate provision of care at the appropriate time in development promotes autonomy and intimacy.

5. Mental Representations of Experience: Templates

The question of how experience is stored is a critical one in object relations theory. Object relations theorists agree that experiences with significant others are 'taken in' or internalised. The end product is the *internal object* (Klein, 1926). This internal representation of experience has been variously described in the infant research literature as a mental image, shape, schema, internal object, psychological blueprint, prototype and internal working model (Beebe and Lachmann, 1988; Fonagy, 1994; Greenberg and Mitchell, 1983). More recent theorists (e.g. Stern, 1995) emphasise the interactive experience of being with another person and how that experience is subjectively processed at the level of the template. There is increasing evidence that there are neural underpinnings to these templates

(LeDoux, 1994). In exploring the development of cortical plasticity and cognitive representation in the light of temperamental differences Derryberry and Reed, (1994), for example, postulate that *use-dependent* processes and the function of certain neurochemical pathways lead to the stabilisation of a synapse and to specific neural networks. Thus, synapses that are not used tend to regress and those that are used frequently are strengthened.

In this paper, we shall use the term 'template' to refer to the internal mental representation of experience. We define 'template' as the subjective synthesis of aspects of lived experience, taking input from both the external and internal world. Experience is processed in age-specific cognitive ways, and includes the world of fantasy and wished-for reality. Templates are the result of complex simultaneous processing of experience, using every physical and psychological system, the behavioural, the conceptual, the emotional, the perceptual, the proprioceptive, movement, visual and auditory stimuli. The term template is a shorthand for higher-order cognitive and affective schemata that regulate behaviour over long periods of the life span, particularly in interpersonal relationships.

Templates do not necessarily reflect an objective reality. They are internal, subjective and idiosyncratic versions of reality. Templates represent oneself, others, oneself in relationship with others, interactions and also wished-for responses of significant others (Greenberg and Mitchell, 1983). Templates are part of the psychic structure of the person, part of the self. People may not be consciously aware of the templates they have internalised. Templates can be modified. For example, a negative template can be modified by consistent positive experiences. This in turn will alter the intrapsychic representations of a particular relationship experience.

Infant research suggests that the young child forms complex preverbal social-interactive schemata which are part of the template but which are not necessarily experienced consciously (Beebe and Lachmann, 1988). Object relations theory assumes that the earliest of human experiences during pregnancy, birth and infancy are significant. These preverbal experiences are internally represented in pre-symbolic form (Emde, 1994).

6. The Unconscious.

The *unconscious* has been conceptualised variously in cognitive psychology as implicit memory and non-declarative knowledge (Cohen and Squire, 1980; Jacoby, 1984; Jacoby and Witherspoon, 1982; Koler, 1975). The dynamic unconscious is the cornerstone of psychoanalytic theory. Healy et al. (1931: 24) define the unconscious as the 'quantity of mental life which either never was in consciousness, or, previously in consciousness, has been repressed'. Freud (1915) describes the unconscious in its most primitive form as a repository for emotions. It has no language of its own until meaning can be attached to its features through words, symbols or mental representations—at which time it becomes conscious. It has no sense of time, logic or place.

Some aspects of our experience, communication and interaction occur unintentionally and beyond conscious awareness. They can profoundly influence how we relate to others. They can either facilitate or constrain social interaction. Our experience with families has shown that implicit dynamics derived from non-facilitating relationships can constrain both parents and children alike. For example, in a family where one or both parents have experienced significant deprivation in the form of physical, emotional or sexual abuse, then there is a greater likelihood that the relational template will act to constrain healthy relating. Problematic aspects of the template re-emerge in new relationships. Families may seek help when the effects of these processes lead to symptom formation in the child.

7. When Ownership of Experience Becomes Confused: Projective Identification

The defence mechanism of *projective identification* is the cornerstone of object relations family therapy. Klein (1926, 1946, 1952) first used the term projective identification to describe processes that occurred between the infant and maternal carer in the first few months of life. Post-Kleinians (e.g. Bion, 1957, 1959; Segal, 1957) have extended the concept, and object relations family therapists have found it pivotal to the understanding of unconscious processes in interaction between family members (Scharff and Scharff, 1992; Slipp, 1988). Although the psychoanalytic literature reflects a general consensus as to the core meaning of the concept there are differing emphases on the interpersonal aspects (Grotstein, 1981; Kernberg, 1975; Meissner, 1980; Ogden, 1982; Sandler, 1987, 1994), and disagreement as to whether it refers only to the projection of unwanted parts of the self, or also to the projection of positive parts of the self (Likierman, 1988; Grotstein, 1981).

We understand projective identification as a reciprocal process occurring between family members where one person (the 'projector') attributes unwittingly an aspect of themselves to another family member. The recipient of the projection can be parent or child. The recipient is then induced into feeling and behaving according to the projected aspect, believing that it is part of him or herself, and thus 'identifying' with this aspect. That behaviour in turn verifies the projector's fantasy. The projector needs to establish an ongoing relationship with the recipient in order to maintain the reciprocal feedback loop. This loop involves a blurring of the self-other boundaries. Although the projector experiences a temporary self-other 'boundary', this perceived boundary is in fact very fragile, needing ongoing interaction with the recipient. Projective identification when used in this sense is defensive because it involves the disavowal of unwanted aspects of the self. It nevertheless provides short-term relief in maintaining the fantasy that these unwanted aspects are 'in' someone else. The confusion of feelings between parent and child, parent and parent or therapist and family may lead one person to behave in a way that is actually generated by the feelings of another.

In our work with families a common experience is that the child is more vulnerable to receiving a projection because it is dependent on its caregiver to construct reality. Most importantly, the process of identity development can be significantly distorted if the main caregiver perceives the child only in narrow, negative ways. Often the child commences to re-enact the behaviours that have received the parent's projected attention, thus identifying with the projection. As soon as the child's behaviour corresponds to the parental fears, the parent becomes overly focused physically and psychologically on this particular behaviour. Total attention focused on the behaviour by the parent will reinforce this behaviour in the child. This has the effect of creating a cycle of interaction in which a broader range of possible behaviours is unlikely to develop.

Projective identification of unwanted qualities results in ongoing tension between family members, with a spiralling of conflict. The original attempt to be free of internal distress and conflict is difficult to resolve, as the recipient is confronted by the same issues played out repetitively in the interpersonal space. In family therapy our aim is to determine what projections the child identifies with and which ones the child repudiates. A key task of therapy is to facilitate the disentangling of mutually reinforcing problematic behaviour and emotions between family members.

The Therapist-Family Relationship: A Meeting of Internal Worlds

In ORFT the therapist-family relationship is central. ORFT addresses the dynamic processes that occur between family and therapist. This is achieved through use of the transference-countertransference paradigm. *Transference* can be defined as an unconscious process by which aspects of a client's previous relationship (attitudes, feelings) are re-experienced in a current relationship. In ORFT, the term describes the way the family members, individually or as a group, generalise past and present relational experiences to each other or to the therapist. The concept of a group unconscious was elaborated by Bion (1961) and by other group analytically-oriented therapists. It follows that the family as a group forms its own unconscious and can generalise past and present relational experiences to the therapeutic relationship.

The *countertransference* can be conceptualised as the therapist's experience of the therapeutic relationship(s). Sandler, Holder and Dare (1970) define the countertransference as the therapist's specific responses aroused by certain qualities in the patient. The concept has been elaborated further (see Hinshelwood, 1989) and in the context of ORFT, is seen as an important therapeutic tool. The countertransference draws on the therapist's past and present experiences and helps him/her understand processes in the family of which neither family nor therapist are immediately aware. Countertransference experiences include mental images, emotional responses and associations that

emerge in the therapist as a result of being with the family. Understanding countertransference therapeutically requires the therapist to be sufficiently self-aware so that he/she can receive the verbal and non-verbal communications expressed in contact with the family (Skynner, 1986). This allows the therapist to identify experiences which are not generated from his or her own unconscious processes. In ORFT it is assumed that the therapist has a willingness and a capacity for self-reflection, a sense of his or her own internal strengths and weaknesses, and training in how to make use of the countertransference.

CASE ILLUSTRATION

This first assessment interview with a single parent family is presented to demonstrate core concepts of object relations theory and practice in a clinical context. The case illustrates some of the family dynamics that result from unmet relationship needs. The resulting difficulties in separating and individuating show how critical the process of projective identification is in the re-enactment of unconscious templates and demonstrates how the therapist uses transference and countertransference to generate hypotheses about family dynamics.

The Campbell Family

The Campbell family consisted of Karen (21), Jason (5) and Jenny (2). The maternal grandmother Helen (52), closely involved in looking after Jason and Jenny, had asked to attend the first interview. Karen was in a de-facto relationship with Peter (25) until Jenny was born. At the time of referral Peter was in gaol serving a sentence for assault.

Jason was referred to the Department of Psychological Medicine at the Royal Alexandra Hospital for Children, Sydney, by a paediatrician concerned about Jason's violent outbursts of anger and aggression, head-banging and nightmares.

The therapist had been notified of the clients' arrival but was unable to find the family in the waiting room. Karen was chasing Jason up the stairwell, yelling at him to come back. Jason was screaming 'No'. Helen had followed Karen and between them they managed to drag Jason downstairs. Jason was now crying. Jenny sat with an anxious facial expression on a toy car near the stairwell and when she heard Jason crying she started crying as well.

When the family and therapist finally entered the interview room Karen demanded to know what was wrong with Jason. It was difficult to proceed with the interview because of the level of noise and chaos. Jason yelled non-stop. Karen reprimanded him repeatedly but ineffectively. Helen intervened; but her approach was to comfort rather than to discipline. Jenny registered the distress and continued crying. Jason attempted to leave the room and had to be physically restrained.

The family expressed concern about Jason's aggression towards himself and others. He would scream, tantrum and head-bang when he could not get his own way. He was a restless sleeper and had nightmares. The kindergarten teacher seemed to be able to manage his behaviour

but his social skills were lacking and he had concentration difficulties. Karen said at times she felt like strangling him and she was worried that she would lose control.

The adults made several attempts to stop Jason throwing toys around the room. Helen said to Jason 'Come here', inviting him to sit on her lap with a hand gesture. When Jason did not respond she did not persevere. Karen shouted at him and dragged him roughly away from the door. The grandmother expressed some warmth in her tone and gesture. All of Karen's communications to Jason had the same harsh, abrupt and hostile quality, to which Jason responded with escalating defiance.

Jason had difficulty responding to the therapist's questions. He gave vague answers and preferred to play with the toy animals. At times his play was aggressive. When Jason started to play quietly Karen interrupted his play with a negative comment. Jenny was sitting and exploring the toys and occasionally trying to sit on Karen's lap. There was physical contact at these times between Jenny and Karen but with minimal emotional response from Karen, who, preoccupied with Jason, seemed not to notice Jenny's presence.

Karen abruptly dismissed Helen's contributions whenever Helen tried to soften Karen's harsh attitude towards Jason. Helen would then sit there looking helpless. The therapist's attempt to obtain a family history was met with hostility. Karen rejected the idea that the family background was in any way relevant. Helen disagreed saying 'Don't you think Peter's violence has something to do with Jason's behaviour?' When Helen mentioned Peter, Karen shouted 'I want to forget about him, I don't want Jason to have anything to do with him. It's bad enough that he has his father's genes. You wouldn't want to know the things he did to me.' At this point Helen commented that Karen was frequently abused by Peter and that he had been charged with assault.

Discussion: An Understanding of Family Processes Based on the First Interview

The therapist's first unprocessed experience

In her initial countertransference response the therapist felt she was in a whirlwind of scattered emotions, screaming chaos and threatening anger, and she felt the need to remove herself from the immediacy of the emotional experience in order to think about what up to now had been unprocessed. She describes the experience in the following jumbled way:

The anger is outrageous. How can I rescue my own skin, my own boundary? I could easily be attacked physically or verbally. This is exhausting. There are moments where there are contradictions, hope, longing in the child's eye.

I must get a feel for a pattern, to make sense of it. There must be something more to know. Being in the middle of chaos is dangerous but there is some hope. There are attempts to think by Helen. Jason can play quietly in the corner at times but he gets disturbed. Why is Karen so angry with Jason and why is she dismissive of Helen? But why is Helen still in this family anyway? I feel Jason needs protection. I want to help him calm down.

What is the therapist's processed experience of this family at the observational level?

1. Angry Tension without Warmth

The tension in the Campbell family is unbearable. Conflicts between Karen and Jason are particularly intense. Their relationship lacks mutuality, warmth and effective communication. The level of anger is extreme.

2. Ineffectual Care and Failure to Elicit Care

Helen appears to have some concern about the level of anger and potential violence in the family but her attempts to contain the anger are ineffective. There seems to be tension between Karen and Helen. Because Karen is so preoccupied with Jason, Jenny remains largely unnoticed.

3. Unreflective Confusion of Negative Emotions

Jason is out of control and there is no consistent parenting. Karen is angry, and refuses to respond to Jason's needs. Karen's abrupt response to Jason's demands leads to further escalation of conflict. When he becomes quieter, Karen triggers another outburst with her criticism. The cycle is reactive, Karen and Jason react to one another. Karen does not seem to have capacity to think about what is happening.

4. Struggle in Parenting and Lack of Containment.

Helen and Karen are ineffective in meeting Jason's need for containment. Karen undermines Helen's attempts to grandparent, as well as Helen's attempts to think about what is happening in the midst of the chaos. Although there are patterns of interaction there is no containment.

5. The Desire for Something Better

There are brief moments of longing in Jason's eyes as if he has not given up hope of being positively connected with Karen. Jenny seeks closeness in a more passive way and Karen does not reject her. Finally Helen seems to have some capacity to reflect on what might be causing the level of distress in the family.

What is the therapist's synthesis of the family dynamics from an object relations perspective?

1. Redefining the behaviours in terms of inner need

In object relations terms Jason's aggression could be understood as care-eliciting, being both a reaction to the stressful current relationship with his mother and a plea for the kind of attention that will enable him to feel contained. At this point the therapist knows little about Jason's father or the nature of Jason's relationship with him. Since he is in gaol, it is Karen who plays a crucial role in conveying what it means to be male. Therefore, Karen's world view is pivotal to understanding the dynamics in this family.

2. Redefining the present need as an unmet past need

One hypothesis is that Karen has unmet needs in all significant relationships, with her mother, with her

father, and with Jason's father. She has felt unsafe and vulnerable as a dependent infant and child and has reacted to her mother's perceived softness with anger and hostility. Anger protects her from getting in touch with the softer, vulnerable, needy side of herself, which she equates with weakness. Because she devalues softness she forms a relationship with a man whom she perceives as strong, who becomes violent.

3. Identifying the maladaptive template

Underlying Karen's hostility there may be considerable despair about her own needs being met. In her relationship with Jason's father she has managed to re-enact an earlier scenario of vulnerability and lack of safety in a relationship where she yearns to be safe. The difference this time is that she is unsafe because of violence. If she denigrates her own mother's attempt to parent and has no respect for her, it is very hard for Karen either to earn respect from her children or to be respectful of them. By the attention she gives it, she seems to be unconsciously reinforcing the behaviour in Jason that parallels her own anger and hostility. She seems to be projecting different aspects of herself into him, particularly her own anger. He responds by unconsciously receiving the projection of these feelings and enacting them, and one can see projective identification in action.

4. Putting forward a developmental hypothesis

It could be hypothesised that either a traumatic incident or the quality of early care rendered Karen's experience of being nurtured 'not good enough', that is, insufficient for her to feel confident in her maternal role. It would be important for the therapist to explore Karen's experience of containment, or lack thereof, by taking a family and developmental history. The impression at this point is that Karen seems not to have experienced sufficient containment from either of her parents.

The clinical hypothesis is that Karen's rage is her protection against feeling vulnerable and despairing. In choosing a violent partner she unconsciously recreates a situation in which her fears about being unsafe are confirmed. This unconscious process now continues in her anxiously intrusive relationship with Jason, who is perceived as 'having his father's genes'.

5. Testing the hypothesis therapeutically

These hypotheses need to be explored in subsequent interviews. If they are correct it will be the task of the therapist to be strong in a non-threatening way, in order to show Karen another way of relating. The therapist will need to reframe problematic family dynamics in a way that reaches some of the needs of every member. In particular, it will be important to engage Karen's trust so that she can experience positively relating to and being relaxed with another. Once Karen feels sufficiently contained and she can acknowledge the source of her own distress, her templates of parenting will gradually change. This change will lead to a different perception of Jason, and Karen will be able to attend to

the needs of her two children with more joy and energy. Karen may accept her mother as a grandmotherly figure who can provide external support. The engagement of Karen therefore will be pivotal for work with other family members.

Jason also needs to experience a relationship in which he is empathically responded to and in which he can develop as himself rather than with negative projections. His internal world will then have an opportunity to change. If the family therapist were male, Jason would also have the direct benefit of a non-aggressive and reliable male model which over time could become part of Jason's relationship template. However, regardless of gender, the family therapist can help Jason indirectly by helping Karen and perhaps Helen understand their previous relationships from an object relations point of view. Karen's anger at Peter, contained by the therapist, can gradually be explored and understood. This in turn will help Jason to understand that Karen's anger is specifically directed at Peter and not at males in general. Engaging Jason in play can act as a way of connecting with Jason therapeutically and in later sessions play can be the medium for parent-child interactional work.

We see Jason's symptoms as a function of frustration and distress and these symptoms should decrease once the internal sources of the family's relationship conflict become clear. However, as Scharff and Scharff (1987) stress, ORFT can also make use of more directive techniques to protect a family member from damaging symptoms such as head banging.

CONCLUSION

We believe object relations theory offers a number of unique perspectives to aid in the understanding of family process. Applied by family therapists, it extends the narrative paradigm by recognising the importance of preverbal, presymbolic aspects of human experience in the formation of unconscious templates. The model gives primacy to the emotional relationship needs and in doing so provides an understanding of motivational forces and feelings in families. ORFT thus fills an experiential gap in the current practice of systemic therapy.

The use of the transference-countertransference paradigm demands that the therapist learn to use his/her feeling and thinking self as the instrument by which knowledge and information about the family's emotional field is gained. This is achieved by self-observation and through the ability to tolerate anxiety and ambiguity in the face of conflict. This experiential role may not appeal to all family therapists. Nevertheless, ORFT provides a means of translating the unprocessed family experience into well-defined and familiar themes, and demonstrates how themes relate to one another in a particular family dynamic. It therefore captures not only the uniqueness of each family but also the commonalities of experience. It forms the inchoate—the preverbal and the unprocessed—into words. It is this process that allows the family to understand and work through problematic modes of relating.

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Notes

1. **Inchoate:** Lacking organisation; unformed (Macquarie Dictionary, 1992). In this paper we are using 'inchoate' in the sense 'difficult to articulate' 'not yet formed into words and language'.

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