This book is a complete rewrite and expansion to almost double the size of my previous book *The Treatment of the Borderline Patient: Applying Fairbairn's Object Relations Theory in the Clinical Setting*, which was first issued in 1993. Sixteen years have passed since the publication of that book, and in the ensuing years I have deepened my understanding and appreciation of W. R. D. Fairbairn’s psychoanalytic model. During that time, many new developments in the field of “relational psychoanalysis” have emerged, and many of these recent concepts are absent from the earlier text. This enlarged text offers the reader far greater detail in the analysis of Fairbairn’s papers, and includes for the first time his paper “On the Nature and Aims of Psychoanalytical Treatment” (1958), in which he described his radical vision of the process of psychoanalysis. There is an increased focus on interpretation of transference and a new emphasis on the development of a co-created narrative of the patient’s developmental history in his or her family of origin. The creation of this narrative, which is understood and interpreted in terms of Fairbairn’s metapsychology, is seen as central to the developing relationship between the therapist and the patient, and serves as the vehicle for reassessing the relational influences that originally formed the patient’s character. It is also within the context of the emerging narrative that transferences develop and are interpreted, again, within the context of Fairbairn’s metapsychology. The original text focused on the borderline personality, but this edition includes a chapter on applying Fairbairn’s model to the historically and clinically significant disorders of the histrionic and the obsessional personality disorders.

My clinical experience with Fairbairn’s model came from twenty-six years of full-time independent practice as a clinical psychologist specializing in the treatment of battered women and patients with borderline personality disorders or anorexia. As a clinician, I was struck by the fact that my patients were preoccupied (if not consumed) either by the rejection they were receiving from their “new”
relational objects or by past rejections they had received from their parents, and yet they were unable to separate from the people who were rejecting them. In many cases, their sole purpose in life was focused on winning the love of people who appeared to hurt them endlessly. From my perspective, my patients were being rejected by parents or new relational partners who, compared with them, were blatantly manipulative and intellectually inferior. Despite this, these individuals seemed to have an almost magical grip over my patients. The most common and most frustrating clinical event that I saw in my practice (and one largely ignored in the psychoanalytic literature) was the borderline patient's hope-filled, frantic return to the rejecting object, despite having been rejected dozens of times previously. It appeared that emotional fixation and the resulting primitive dependency on frustrating and rejecting object(s) was the very core of many characterological disorders. Many of my patients’ self-defeating and self-destructive behaviors were secondary consequences to intolerable frustration from long-term unmet dependency needs that were exclusively focused on the parental object(s) who failed the patients in their childhood. Despite endless discouragement, my patients returned again and again, filled with false (and sometimes almost delusional) hope that with enough effort on their part their parents (or their new relational objects) would somehow learn to appreciate them. In patients who had managed to separate from their original objects, their “new” objects proved to be as ungratifying, yet at other times as promising, as were their original objects.

My understanding of the borderline condition, as well as related characterological disorders, was advanced by the publication of Greenberg and Mitchell’s *Object Relations in Psychoanalytic Theory* (1983). My reaction to their chapter describing Fairbairn’s model was electric, as many of the clinical observations regarding the endless attachment to abusive objects that had puzzled me were addressed in their discussion of his model. I then immersed myself in Fairbairn’s one and only text, *Psychoanalytic Studies of the Personality* (1952), which is a collection of fourteen of his papers. These papers are notoriously difficult to read, but they offer the persistent reader a complete and complex psychoanalytic model that addresses the reasons behind the powerful allure that the parental objects have on their dependent children (and later adults), as well as the dissociative mechanisms that allow patients to blindly pursue endlessly frustrating objects. As I read his papers, I was amazed that this obscure Scottish analyst had observed in the slums and orphanages of Edinburgh in 1940 exactly what I was seeing in the United States forty years later. His model, based on the innate dependency needs of humans, tied together many of the unexplained clinical observations that had been glaring at me year after year.

My patients’ absolute inability to see the faults of the objects of their desire was explained by Fairbairn’s central concept of the splitting defense, which allows patients to dissociate painful parts of their experience and repress intolerable memories of past rejections in their unconscious. Often the most severe examples of splitting
would occur just before a patient was about to return to his or her rejecting object. Thus splitting appeared to be a defense that served the patients’ unmet dependency needs, allowing them to continue to hold out hope in the goodness of their objects and simultaneously ignore the innumerable memories of abandonment they had experienced during their developmental years. The reciprocal behavior also seemed to occur in borderline patients: they ignored, fled from, or misread the intentions of helpful individuals who offered them the support they ostensibly craved. Instead, they seemed to prefer the excitement and frustration inherent in the pursuit of an object that proved, repeatedly, unable to meet their needs.

Fairbairn’s model sees that unmet developmental needs within patients are the source of motivation that keeps them enslaved and attached to their original objects, or to similarly frustrating displaced objects. This hopeless, stubborn attachment was universally rationalized by my patients with the simplistic belief that massive work and effort on their part would cause the alluring but rejecting objects to ultimately love and accept them. I found it futile and counterproductive to attempt to prevent severely deprived patients from returning to their abusive objects, and so I learned to tolerate this self-destructive behavior while I worked toward the goal of offering my patients an attachment to an alternative object that eventually would replace their dependency on their rejecting objects.

Today Fairbairn’s work remains obscure for a number of reasons. First, he originally published during the psychoanalytic “war” between the followers of Anna Freud and of Melanie Klein (Rayner 1991). He had no students, nor did he attract enough followers to establish a school of thought that supported his work, and so he was ignored while seemingly larger issues between the two established schools were debated. Second, the field of psychoanalysis has tended to see Fairbairn’s work as a mere philosophical challenge to Freud’s model, one that eliminated instinct theory, which is the very core of classical psychoanalysis. Fairbairn’s replacement of drive theory with a theory of human attachment was simply unacceptable to the field of psychoanalysis in his time. He is often remembered as the originator of the simple phrase “libido is object seeking” rather than for producing a complex and complete model of human psychological functioning. It is as if Fairbairn had produced an exquisite, fully functional automobile that was mistaken for a clay model, placed in a museum, and promptly forgotten. Fairbairn’s greatest contribution is not his indirect influence on other “relational” models but the creation of a complex and unique metapsychology that can be used every day in the consulting room as a “nuts and bolts” model of psychopathology and psychotherapy. It is unexcelled in treating the borderline patient as well as a wide variety of character disorders. Careful reading of Fairbairn reveals him to have been a keen observer who precisely, and most perfectly, described and explained the dynamics and structure of the borderline personality, and yet today he is overshadowed by lesser theorists even in the area of his greatest strength.
This book is designed, first and foremost, to be used by clinicians in their daily practice with patients suffering from characterological disorders. It proposes a simple and straightforward theoretical strategy for clinicians to follow: that of separating borderline patients from their bad objects (both internal and external) and replacing those bad objects with introjects from the good-object therapist. Fairbairn recognized that personality disorders are based on an internal world founded on an attachment to destructive yet desperately needed objects. It is this problem the psychotherapist must address from the first clinical interview on with all characterological patients. The therapist’s focus on separating the patient from the bad objects never changes over time, even though the patient will move through various stages during the therapeutic process.

The chapters are organized in a manner designed to help clinicians grasp this fundamental therapeutic strategy. Chapter 1 offers the reader an overview of Fairbairn’s work and begins with a brief biography emphasizing the developmental events in his personal history that influenced the direction and contents of his model. This is followed by a review of his first three theoretical papers, focusing on aspects of his model that have the greatest clinical applicability. Many of Fairbairn’s discussions in these papers are rebuttals of Freudian doctrine, which, as mentioned, kept him locked in the category of a metapsychologist, and these debates have been largely omitted here. By selectively focusing on the clinically relevant aspects of these papers, I hope to illustrate how potent and complete Fairbairn’s model is as a clinical tool, and how it can be applied today, with very few modifications, to patients with a wide array character disorders.

Fairbairn’s first theoretical paper, “Schizoid Factors in the Personality” (1940), is a relatively brief article that expands the concept of “schizoid” to include disorders that are based on splitting of the ego. Fairbairn saw the schizoid personality as a direct result of emotional deprivation and as characterized by three factors: omnipotence, detachment, and a focus on the interior world. A second significant consequence of emotional deprivation on the child’s emotional development is a loss of faith in whole-object relationships and a reliance on “partial” objects. The child’s turn toward part-objects is seen as a regressive retreat that protects the child from further disappointment in his objects, while salvaging some semblance of contact and gratification. The third significant contribution of this paper is Fairbairn’s counterintuitive observation that emotional deprivation is the source of increased attachment (developmental-emotional fixation without the concept of libido) to the rejecting object. Finally, he recognized that the child who experiences rejection assumes that his own love is worthless and that his hostility toward others is a reaction to feelings of inferiority and worthlessness. This paper begins the process...
of establishing Fairbairn’s model as one of the first two relational models in the field of psychoanalysis, as his work was developed independently and simultaneously with Sullivan’s model of Interpersonal Psychoanalysis in the United States.

Fairbairn’s second great theoretical paper, “A Revised Psychopathology of the Psychoses and Psychoneuroses” (1941), continues the development of his theory with the introduction of a clear but incomplete developmental sequence based on the child’s progressive differentiation from the object, with the child moving from a stage of complete identification with the object to a transitional stage, and ending up as a young adult completely differentiated from his or her objects. Fairbairn clearly stated that emotional support of the child by the objects was the engine of differentiation and, without it, the child would remain fixated and undifferentiated. He also continued to challenge Freud’s instinct theory, saying that libidinal pleasure was a “sign-post to the object” (1941:33) and thus demoting the pleasure principle and replacing it with the primacy of attachment to objects. The lack of emotional support for the child’s legitimate developmental needs not only prolongs the child’s dependency on his objects, but it also turns him toward “substitutive satisfactions” (1941:40), which in today’s world would translate into addictions of one type or another. The most surprising and bold clinical example in the paper is of a young female patient who thought of offering to sleep with her father, an “obvious” example of Freud’s Oedipal conflict. However, Fairbairn interprets this example strictly in terms of object relations and offers the reader a surprising and viable alternative to one of Freud’s central psychoanalytic constructs.

Fairbairn’s monumental third theoretical paper, “The Repression and the Return of Bad Objects (with Special Reference to the ‘War Neuroses’)” (1943), begins with his redefinition of the human unconscious, which up to this point had been the province of Freudian and Kleinian theory. Fairbairn’s unconscious contains no source of objectless energy equivalent to Freud’s Id; rather, it is populated by dissociated relational events that originally took place in the external world between the child and his objects. These relational events were too intolerable and disruptive for the child to integrate into his conscious, central ego, yet too powerful and structure producing to be permanently banished. Thus Fairbairn’s unconscious is filled with dissociated events from actual interpersonal interactions, and this unique “accrued” unconscious replaces the Freudian unconscious of inherited instinctual drives that are assumed to constantly pressure the ego for expression. Fairbairn’s unconscious had a different source, a very different set of internal structures (which were later described in his 1944 paper), and a different purpose compared with the unconscious in classical analytic theory. This bold act of proposing a unique unconscious that has absolutely no commonality with Freud’s inherited drives eliminated much of the support he might have had from the analytic community, as the models were mutually exclusive and his colleagues had to choose one model or the other. No one chose Fairbairn.
Fairbairn then turned to the issue of shame and recognized that neglected and abused children were ashamed of themselves for two separate reasons. First, because they felt demeaned by their parents, who behaved as if they were unworthy of being cared for, and, second, because they were identified with (undifferentiated) bad objects from whom they could not flee, and therefore they shared in the “badness” of their parents. From this, he developed his first major defense, “The Moral Defense Against Bad Objects,” which manifests itself by the rationalization often heard from abused children that their violent parents are actually “good” but they themselves are “bad” and therefore deserving of punishment. My discussion of this defense is extremely critical of Fairbairn’s analysis of the dynamics of this defense, and I offer the reader an alternative view. Fairbairn also noticed that the children who were keeping their parents “good” were quite eager to blame themselves. He recognized that by blaming themselves, the children kept the illusion alive that they lived in an orderly, predictable, and “good” world. Fairbairn recognized that it would have been devastating to the emotional equilibrium of these children to acknowledge that their objects were randomly hateful and eternally frustrating, as this would dash their hope for love and support in the future. The “Moral Defense”—that is, blaming the self for the failures of the object—is the fundamental cognitive defense that every therapist who works with this patient group must be prepared to encounter.

Fairbairn also offers the reader a clear and succinct definition of psychopathology in this paper, based on both the “badness” of the objects that the child internalized and the extent that the child identifies with these bad internalized objects. These are the internalizations that create the structures (self- and object-representations) in the Fairbairnian unconscious. The actual structures were not described in this paper but in his next paper, which followed one year later (1944). Another significant aspect of this major paper is Fairbairn’s discussion of the source of the power that the bad object has over the dependent child. He recognized that the more a parent rejected the child, the deeper the reservoir of residual need that would remain unsatisfied in the child and therefore the greater the child’s dependency and fixation on that object. Finally, Fairbairn (1943) used metaphors from his religious training to identify the major source of resistance to the derepression of unconscious memories of internalized bad objects, which was the fear of being overwhelmed by them: “When such bad object are released the world around the patient becomes peopled with devils which are too terrifying to face” (69).

Chapter 2 begins with a detailed review of Fairbairn’s paper “Endopsychic Structure Considered in Terms of Object Relationships” (1944), which compliments his 1943 paper and introduced his structural model. He solved the problem of the toxicity of the internalized bad objects with the introduction of the splitting defense and the resulting internal structures. The splitting defense uses dissociation to force intolerable material into the unconscious, and the resulting internal
structures “package” similar perceptions into a single vision of the self in relation to the object. Once dissociated, the structures protect the child’s conscious central ego from awareness of how badly his objects treated him during his development. Fairbairn described six ego-and-object structures, four comprising the unconscious and two remaining conscious. The four unconscious structures form two self-and-object pairs that remain dissociated from each other, and therefore safely isolate the bad objects in the child’s interior world. The two (mostly) unconscious self structures are the libidinal and antilibidinal egos that relate exclusively to the exciting or rejecting parts of the object, which have also been dissociated in the unconscious. The relational “bond” between the antilibidinal ego and the rejecting object is hate, with the antilibidinal ego hectoring the rejecting object in an attempt to force it to change and improve, while the rejecting object retaliates with uninhibited aggression and condemnation of the antilibidinal ego. Conversely, the libidinal ego knows nothing about the antilibidinal ego and sees another dissociated facet of the very same parental object as containing the promise of unlimited love. Fairbairn labeled this reciprocal part-object the “exciting object” because of the excitement engendered in the child’s libidinal ego by the hope of being loved. The libidinal ego allows the child to safely love his object and hold on to the hope that he will be cherished, thus preserving the attachment to the object who is, in reality, neglectful, even abusive. The libidinal ego’s love is uncontaminated by any feelings of hate, as the antilibidinal ego keeps the hate-filled relationship with the rejecting part-object sealed, separate, and apart from the libidinal ego–exciting object relationship. Thus Fairbairn’s structural model solves the problem of bad objects in the unconscious by keeping them dissociated and unaware of the opposite structures. My discussion of the structures expands the previously unexplored relationship between the conscious central ego and its ideal object, a relationship in which Fairbairn had little interest, as his focus was on psychopathology.

The final paper reviewed in this chapter is Fairbairn’s “On the Nature and Aims of Psycho-Analytical Treatment” (1958), in which he challenged every aspect of classical psychoanalysis, from using the couch to providing a “real” relationship for the patient outside the transference relationship that was designed to reactivate the patient’s stalled development. Fairbairn’s concepts put him outside the boundaries of nearly every important assumption of classical analysis, and this paper ensured that his contemporaries would ignore his work. He boldly redefined “analysis” as “synthesis,” which follows from his model of dissociated selves populating the unconscious. Fairbairn saw the recovery of mental health as synonymous with the concept of integration. The therapist’s task is to help the patient integrate the memories encased in his antilibidinal ego into his central ego and accept the reality that he was poorly treated as a child. Conversely, the patient must also accept that his fantasies of unlimited love residing in his libidinal ego’s view of the exciting
object are only a compensatory attempt to keep himself attached to his object, which is necessary to prevent his collapse into depression and despair. Unfortunately, integration of these substructures into the realm of the central ego meets resistance from the patient’s inner world, which Fairbairn (1958) termed a “closed system” that tries to “press-gang” (335) the therapist into appearing to be a familiar object equivalent to the objects in the patient’s unconscious.

Chapter 3, the first to address the “application” of Fairbairn’s concepts, offers a detailed “user-manual” for the therapist with regard to the characteristics of the four unconscious structures. The chapter is designed to help the clinician understand the patient’s productions in the clinical interview. When using this model, therapists must know which of the partially dissociated structures is dominant so that they understand “to whom” they are speaking. The four, mostly dissociated structures are the antilibidinal ego, which is in a fiercely competitive and aggressive relationship with the internalized rejecting object, and the libidinal ego, which longs for and hopes for love from the exciting aspect of the object. The two ego structures know nothing about each other or the other’s associated object; thus the therapist can expect extreme shifts in behavior when one of these subegos is dissociated and replaced by the other. This split ego structure prevents ambivalence, as both internal and external objects are seen as all-exciting or completely rejecting, and this allows the child (or later the adult) to pour out his love toward an apparently loving object while his hate attacks a completely rejecting object. Premature, or forced, integration of these two opposing realities will create extreme ambivalence that can destroy the needed attachment and invite a psychological collapse. The developmentally fixated patient cannot afford to integrate the opposite facets of the object, because the rejecting aspects of the object would completely overwhelm the smaller fantasy-enhanced loving aspects, and the patient would see that he was dependent on an intolerably unloving, hostile, or indifferent object.

The antilibidinal ego was originally part of the central ego, but it must be dissociated because it has experienced intolerably rejecting aspects of the neglectful and abusive parental object. It is filled with impotent rage toward the rejecting object and can be accusatory, self-righteous, and filled with a desire for revenge. Because the antilibidinal ego is fixated at an earlier age owing to the lack of developmental support, it is enormously impressed with the power and importance of the rejecting object, even though the rejecting object is often (in reality) a failed, impotent, and unsuccessful person. The rejecting internalized object is composed of the intolerable aspects of the parent that could not be tolerated by the central ego and thus had to be dissociated. It attacks and demeans the child’s self (antilibidinal ego) with impunity. At times, the individual with a powerful internal rejecting object can identify with that ego structure and will play out the role of the abuser with others who appear to be weaker, just as he was abused in childhood.
The libidinal ego is a dissociated ego structure that contains all the hope and unmet need for love that results from a deprived emotional history. The child’s need for a loving attentive object is satisfied by the promise from the exciting part of the parental object that did occasionally meet the child’s needs. The amplification of these rare relational events, along with pure fantasy, saves the child from facing an intolerably bleak reality. The exciting object creates excitement in the child, because it promises the libidinal ego that love is just around the corner.

Each of these ego structures can dominate the patient’s central ego and become the executive ego, which then misperceives the therapist in predictable ways. The four transference possibilities include the patient operating out of his antilibidinal ego misperceiving the therapist as a rejecting object, as well as the reciprocal relational scenario of the patient relating to the therapist as a rejecting object with the therapist pressured into the antilibidinal ego role. On the other side of the split, the patient can relate to the therapist from the perspective of the libidinal ego and assume that he or she has been promised love in the future, or the reciprocal relational scenario in which the patient presents himself as an exciting object and tempts the therapist into the libidinal ego position. Fairbairn’s structural theory offers therapists an enormously powerful model of the inner world of their patients that can be used in the consulting room as a guide when making transference interpretations.

The next section of chapter 3 focuses on the sudden and dramatic derepression of dissociated material from patients’ dreams that had been contained in their antilibidinal egos. Several examples are presented and appropriate therapeutic responses are recommended that buffer the shock of this material, while not allowing the material to be dissociated once again. Again, Fairbairn saw the goal of treatment as helping patients integrate material that had been split off and held in their unconscious back into the conscious central ego. As more of this material is assimilated into the central ego, the subegos lose their potency and the central ego expands into “territories” previously under dissociation. The final section of the chapter looks at the negative therapeutic reaction, which is an extended transference where the therapist is perceived as a rejecting object and the patient tries to thwart progress to both directly frustrate the therapist and prevent the therapist from taking any satisfaction in his work.

Chapter 4, which continues the theme of intervention, begins with the concept of “narrative truth,” which sees psychoanalytic truth as not absolute but as relative to the model from which it comes. The co-creation of a narrative between the therapist and the patient, based on Fairbairn’s metapsychology, is the fundamental relational matrix that is used to explain the processes of Fairbairnian analysis. The primary goal of this narrative is to review the patient’s life story and apply Fairbairn’s model to the events that are then interpreted in terms of attachment to bad objects. This process is facilitated by the maintenance of a tight and private
framework. Despite the therapist’s best efforts, his good intentions will be distorted by the patient’s unconscious, which will see the therapist as identical to one of the structures in the patient’s inner world (rejecting object, exciting object, antilibidinal ego, or libidinal ego). The therapist must repeatedly interpret his way out of the negative transformations until he is perceived as the person he really is—a good object. I offer a number of examples of transference interpretations using Fairbairn’s metapsychology. Transference interpretations are an essential part of treatment, particularly with borderline patients who often split the therapist from an exciting to a rejecting object in the very first session.

The co-created narrative is a vehicle for interaction, and during the process small bits of dissociated material will emerge. This material is seldom as dramatic as derepressed material from dreams, discussed in chapter 3, but the process is the same. The therapist must identify and keep the dissociated material in the narrative while helping the patient integrate what was once intolerable into his conscious central ego, without causing panic of abandonment. Fairbairn (1943) noted that the therapy was contingent on the patient facing an “unwantonly good object” (69), though I repeatedly remind the reader that Fairbairn (paradoxically) never believed that good objects were internalized. The fundamental mutative factor in my revision of his model is an emphasis on the internalization of a new good object, which allows the patient to relinquish attachments to the internalized exciting and rejecting objects. Not only is the therapist internalized as a good object, but his or her ways of thinking, organizing, problem solving, and understanding the world are internalized as well.

Fairbairn noted that the “real” (non-transference) relationship with the patient is part of its mutative power, a position firmly rejected by the field of psychoanalysis. He saw patients as developmentally stunted and fixated at an earlier age, and one of the therapist’s tasks is to restart the patient’s developmental progress through the therapist’s emotional support of the patient’s real efforts in the world. Supporting and strengthening the patient’s central ego is critical to reducing the illusory power of the bad objects, and a number of examples of this process are offered. Also playing a role in enhancing the patient’s ego is “positive projective identification,” in which the therapist projects his love onto the patient and the patient, in turn, is influenced by the projection.

Chapter 4 ends with the patient’s achievement of mature grief, as the divided aspects of his unconscious become integrated into his central ego. No longer can the patient hide from the reality that his objects were limited, and disinterested, and that he was an overlooked, even discarded, child. This once unacceptable perception, which was fragmented and dissociated, now becomes a core aspect of the patient’s central ego. The therapist’s role, once again, is to support the patient’s perceptions. Fairbairn (1943) noted that soldiers in the field would break down with “war neuroses” when their dissociated memories emerged raw, because they were
completely unable to cope with the frightening and overwhelming material without the support of a relationship with a good object.

Chapter 5 continues with the application of Fairbairn’s model to patients with a borderline personality disorder and to battered women. Rich in clinical examples, the chapter focuses on issues of technique and the management of characterological patients. It begins with a Fairbairnian twist on Sullivan’s concept of the “detailed inquiry.” In my view, the most significant factors to explore when using Fairbairn’s metapsychology are the various manifestations of the patient’s dependency on external objects or, equally important, on internal objects. As the therapist works with the patient to co-create a developmental narrative, the issue of patient “badness” and guilt is often central to the discussion. As the narrative is interpreted and understood in terms of Fairbairn’s model, new possibilities once thought unimaginable are introduced into the discussion regarding who was actually “bad” during the patient’s development. Clinical suggestions are offered with respect to managing the patient’s guilt regarding separating from his needy but abusive object. This is followed by a description of techniques that strengthen the patient’s central ego, particularly in regard to helping the patient protect himself from further humiliation or even outright abuse. As the patient’s central ego develops a stronger relationship with the therapist as an ideal object, the abuser’s motives and techniques can be interpreted, further strengthening the patient’s central ego. This allows the patient to learn, and to predict, the bad object’s next interpersonal “move,” and this process helps the patient reevaluate the strength and importance of the rejecting object. Over time, this process reduces the patient’s antilibidinal ego’s respect for the power and importance of the rejecting object. The discussion then moves to a related topic—guidelines for the therapist on how to support patients as rejecting objects actively attempt to re-intimidate or manipulate them back to their previously submissive interpersonal stance.

Chapter 5 continues with an examination of topics that Fairbairn wrote about that relate specifically to the borderline patient, as well as significant issues that I have repeatedly found in my work with this diagnostic group. Notably, many of Fairbairn’s descriptions of typical “schizoid” psychopathology eventuate as resistance to the therapist’s interventions. The first, and most obvious, is the schizoid’s excessive focus on the inner world, which allows the apparently desperately dependent borderline patient to remain serenely uninfluenced by the therapist, who is still outside the “closed loop” of the patient’s internal world. A second source of resistance comes from the borderline patient’s ruthless unmet dependency needs that demand satisfaction in relationships with others. Many borderline patients display little regard for the (partial) objects with whom they relate and have even less regard for the therapist’s effort and investment, as they see no immediate gratification of their needs in the relationship. There follows an extended example of the clinical manifestation of the core issue that Fairbairn cites repeatedly: “the
obstinate attachment to the bad object.” This attachment to bad external objects is a formidable source of resistance to the therapist’s best efforts. The patient’s self-destructive behavior in returning to the bad object simply cannot be prevented until the therapist has become firmly internalized as an alternative to the bad object in the patient’s inner world. One dramatic example cited is that of a young patient who, in his efforts to differentiate from his objects, joined an organized cross-country bicycle trip with a group of other young people, but, on returning home, bought a house right next door to his parents’ home! Fairbairn frequently spoke of “identification” with the object, and this, too, is a source of resistance; the undifferentiated patient cannot give up his objects for they are part of him, and, without them, he fears he will perish. I then offer a detailed clinical example of the effects of extreme dissociation, in which the contents of the antilibidinal ego and its relationship to the rejecting object were completely unavailable to the patient’s central ego. The therapist’s fundamental position—that the patient must separate from the bad object—made absolutely no sense to this patient, who had dissociated and repressed all the relational events that would have informed a normal integrated individual that his object was indeed bad.

The final section of chapter 5 is based on my previous book The Illusion of Love: Why the Battered Woman Returns to Her Abuser (1994). In that book, I applied Fairbairn’s structural analysis to the three-stage “Cycle Theory of Violence” proposed by Walker (1979) and found that the shift from one stage to the next was based on a shift in dominance from one previously dissociated ego state to another in one or both of the participants. Fairbairn’s model is the best explanation for the extreme shifts in perception that can be observed in both participants engaged in the battering scenario, which careen within minutes from maniacal rage to an opposite state, one of love and longing. Fairbairn’s model of alternating attachments based on a need for love that is dissociated and replaced by vindictive hate and revenge offers the clinician the best model for working with these patients, particularly compared with the “failure to flee” model that has been used in the past.

Chapter 6, the final clinical chapter, looks at the two “classical” personality disorders: the hysterical and the obsessional. Both disorders are examined from a structural point of view, and in each Fairbairn’s model offers new insights into these well-known personality styles.

The typical family constellation that produces obsessional disorders is one dominated by parents who are highly verbal and aggressive toward their children. Careful examination of these families reveals that the child’s central ego is damaged by punitive and contradictory parental behavior that confuses the child about when the rules he is trying to follow apply. Winckler (1995) describes the effect on the child as “mystification,” in that the child cannot tell when he will be attacked by his self-righteous parents for violating a rule he was unaware of or one that was suddenly replaced by another, opposite, but equally potent rule. The result is guilt
and confusion, as the child cannot comprehend how or why he is condemned as bad when he is trying to be so good. These extremely intolerable relational events are dissociated, and the young obsessional develops an antilibidinal ego that is suffused with fear and defensiveness while his internalized rejecting object mimics his real parents as it attacks his antilibidinal ego’s every move. Another feature of this family style is that the children are required to excel in the outside world at the same time that their emotional needs are ignored at home. As an adult, the obsessive individual is dependent and cynical in relating to others, and his frequent, and inappropriate, passive-aggressive behavior toward others originates in his engorged antilibidinal ego. His romantic partners are seen either as rejecting objects or, conversely, if the individual identifies with his internalized rejecting object, as devalued and worthless. The constant criticism of his choices by his parental object makes the obsessive wary of decision making in adulthood, and he seeks refuge in science, test reports, and recommendations from higher authorities. A Fairbairnian structural analysis sees the obsessive as suffused with a defensive and hypersensitive antilibidinal ego that is cowed by the bombastic, moralistic rejecting object, and, surprisingly, there is very little evidence of libidinal ego or exciting object in his inner world. His original object(s) gave him too little hope on which he could build libidinal ego fantasies. Finally, ritualistic symptoms can be understood as a dialogue between the two powerful structures in his inner world (the antilibidinal ego and the rejecting object), while the central ego looks on haplessly, unable to control the larger and more potent structures.

A structural approach to the hysterical reveals a different inner relational world formed by different family dynamics, such as a depressed, often uninvolved mother and a seductive father who trades what little attention he offers his daughter for premature and inappropriate sexualized behaviors on her part. The child, desperately needy for emotional support, complies and must dissociate the intolerable aspects of the sexualized relationship between her and her father, as these memories of such events cannot be integrated into her central ego. Her unmet emotional needs create a libidinal ego that sees her paternal object (and later all men) as an exciting object, as he offers some nurturance that is exaggerated by fantasy and hope, while her mother is ignored by both her and her father. The relational pattern she internalizes is projected onto all new relationships, and, from the perspective of her libidinal ego, men are approached as exciting objects. The hysterical’s eager, sexualized approach to men is based on her hope for nurturance, and her sexualized behaviors are dissociated so that she approaches each new relationship in a state of “innocence.” The male object often responds to the hysterical’s displays with a sexual proposal, which outrages the hysterical; she immediately represses her libidinal ego, replacing it with her antilibidinal ego, and all the bitter antilibidinal disappointment in men emerges with force. This analysis offers new insight into the “castration scene” well known in the analytic literature.
Chapter 7, the final chapter in the book, looks at the legacy of Fairbairn’s work in the larger world of psychoanalysis, both in terms of the acceptance of his ideas into concepts shared by other models and in regard to the number of specific texts that focus on the application of his model to the treatment process.