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Object Relations Theory: A Primer for Rehabilitation Psychologists

Kenneth R. Thomas. DEd[1]*, Kaiqi Zhou[2], David A. Rosenthal, PhD[3]

[1]Professor Emeritus, Rehabilitation Psychology, University of Wisconsin-Madison
[2]Ph.D Candidate, Rehabilitation Psychology, University of Wisconsin-Madison
[3]Professor, Rehabilitation Psychology, University of Wisconsin-Madison

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***Correspondence:**
*Dr. Kenneth R. Thomas, Professor Emeritus, Rehabilitation Psychology, University of Wisconsin-Madison;
Email: krtpsy@gmail.com.

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Abstract

Object Relations (OR) has been identified as one of the four major schools of psychoanalysis[1]. This article provides a comprehensive review of OR practice and theory in the context of rehabilitation psychology. Extensive data are presented on five of the most prominent pioneer object relations theorists, including Melanie Klein, W. R. D. Fairbairn, Michal Balint, Harry Guntrip, and D. W. Winnicott. All of these individuals have contributed significantly to object relations theory. Melanie Klein and W. R. D Fairbairn have been credited with founding the object relations perspective, Michael Balint has been touted as the leading object relations theorist, Harry Guntrip was analyzed by both Fairbairn and Winnicott, and D.W. Winnicott is probably the most creative and respected psychoanalytic theorist since Sigmund Freud. All five of these theorists brought a fresh, new perspective on psychoanalytic theory and practice, and their contributions may be used to better understand the personality development of persons with a disability and to inform the practice of rehabilitation psychology.

Introduction

The theoretical psychoanalytic perspective to be considered in this paper is object relations, one of the four major schools of psychoanalysis[1] as this perspective relates to the practice of rehabilitation psychology. Although several psychoanalysts have advanced significant discoveries in object relations, this paper will focus on the contributions of Melanie Klein[2-4]. W. R. D. Fairbairn[5, 6], Michael Balint[7, 8], Harry Guntrip[9-11], and D. W. Winnicott[12-21]. Other notable object relations theorists include Stephen Mitchell and Jay Greenberg[22], who co-authored the already classic *Object Relations in Psychoanalytic Theory*; Wilfred Bion[23], who applied object relations theory to clinical work with groups; Arnold Modell[24], the author of *Object Love and Reality: An Introduction to a Psychoanalytic Theory of Object Relations*; Otto Kernberg[25], the author of *Object Relations Theory and Clinical Psychoanalysis*; and Margaret Little[26], whose third analysis was conducted by D.W. Winnicott and who was an early contributor to object relations theory as well as a strong proponent of the usefulness of counter-transference.

The reader is directed, if possible, to secure a copy of Thomas and Garske's[27] article on the implications of object relations for the personality development and treatment of persons with disabilities. This article, which was published in a journal titled *Melanie Klein and Object Relations*, is difficult to access. Therefore, an attempt will be made in the present manuscript to present, often verbatim, the major points made in that article in relation to Klein, Fairbairn, and Winnicott as well as

object relations theory in terms of its relevance to persons with a disability. A separate and highly relevant article on D. W. Winnicott, authored by Thomas and McGinnis[28], was published in the *Journal of Rehabilitation* in 1991 and can be accessed in the PsycINFO database.

Melanie Klein

In any discussion of object relations, Melanie Klein is the logical person to discuss initially. Klein was born in Vienna in 1882. She aspired to become a physician but lacked the financial resources for a medical education. In addition, she experienced clinical depression as the result of four pregnancies and an unhappy marriage. She sought assistance with her emotional distress and entered analysis with Sandor Ferenczi in Budapest and later with Karl Abraham in Berlin. She considered both analysts to be great "teachers" who significantly impacted her psychological well-being and professional development. Klein's contributions to psychoanalysis, generally, and to object relations theory, specifically, were eventually monumental.

Adopting Freud's belief in drives, especially the death drive and transference, Klein differed from Freud in that she found aggression, not sex, to be the primary drive within mother-child relations. Attending particularly to the child's relationship to the mother's breast (i.e., nursing), Klein held that envy and guilt helped develop the superego before the phallic period. In this model, primary aggression, not the breast itself, triggers children's main defense mechanisms. These defense mechanisms are introjection, projection and splitting, and fantasy. For mothers nursing children with a disability, the child may develop an alternative association with the mother's breast due to a nonnormative sensory experience. Although it depends on the type of disability, a child with a disability may have difficulties in breastfeeding, thereby negatively affecting how the child relates to the mother's breast. This sensory experience suggests that the child would view the breast as a bad object, which is important to consider because a child's view of good or bad objects in their internal object world affects their self-esteem. In rehabilitation practice, psychologists should help clients identify their childhood object relations and how they contribute to current emotional and interpersonal issues. Discussion could focus on exploring ways to integrate the good and bad aspects of internal objects so the client could experience less internal conflict and a more authentic existence of self as well as see others more realistically.

Klein's most valuable contributions include projective identification, the paranoid-schizoid position, and the depressive position. First, projective identification is when the child relates to him- or herself through their caregiver by inserting split-off bits of themselves into the caregiver. The caregiver becomes those parts in the child's view. The child is then at high risk of developing a mood or personality disorder such as a borderline personality disorder or organization. It is important to notice that projective identification does not only function as a defense, but also serves "as a mode of communication. Projective identification is a process by which feelings congruent with one's own are induced in another person, thereby creating a sense of being understood by or of being 'at one with' the other person. As a type of object relationship, projective identification constitutes a way of being with and relating to a partially separate object, and finally, as a pathway for psychological change; projective identification is a process by which feelings like those that one is struggling with are psychologically processed by another person and made available for re-internalization in an altered form." (Ogden[29], p.362). Secondly, the paranoid-schizoid position is the position of the infant when he or she has intense tormenting fears of the mother's breast. Finally, infants progress into the depressive position in which they fear they will lose the good object (i.e., the mother's nurturing breast). Unsuccessful working through the paranoid-schizoid position is likely to result in the infant developing severe psychosis. An inability to work through the depressive position puts the infant at risk for depressive illness, mania, or paranoia.

Klein's work was revolutionary for several reasons, especially her emphasis on the child's personality and emotional stability in the child's early relationship with the mother. Moreover, Klein held that the depressive position determines an individual's social relations in general. For example, Klein believed that working through the depressive position even had a clinical link to one's ability to process the Oedipus Complex.

Considering the specific contributions, abilities, and reactions of both the child and the mother is necessary for understanding how the mother-child relationship may affect the child's development. For instance, the child may have a disability that prevents him or her from nursing or bottle-feeding. The child might then face difficulties in relating positively to the good object and processing the depressive position. If the mother expresses anger at the impeded feeding process, the child may internalize this feeling and be tormented by the object. Children with a disability may be more likely to have an unhealthy relationship with their mother, which can affect the development of the child's personality structure, increase their risk of mental illness, and determine their approach to interpersonal relations throughout adulthood.

According to O.F. Kernberg et al[30], these issues could be treated psychoanalytically by improving the child's ability to "experience self and others as coherent, integrated, realistically perceived individuals, and reduce the need to use defenses that weaken ego structures by reducing the

repertoire of available responses" (p. 8). This treatment has the potential to increase the child's ability to influence their impulses, anxiety, affect, and instincts and to maintain stable interpersonal relationships, including those of love and intimacy.

Given the unique vantage point it offers on child development and disability, object relations theory could inform this treatment as well as others used in rehabilitation practice. Since object relations-informed psychotherapy and rehabilitation share common aims apart from personality restructuring, Klein's theory is appropriate for rehabilitation settings. If persons can better control their impulses and anxiety, they are expected to adapt more successfully to the demands of a given situation. For a rehabilitation client with a borderline personality organization, Thomas and Garske[27] explained how providers could tailor their interventions to the client's unique needs.

This intervention would include assessing the client's ability in reading and math before entering trade school. For job placement, the rehabilitation psychologist would determine which jobs, adaptive tools, and accommodations would best help the client to succeed. The psychologist would further remove any assessment tools that would make the clients think about themselves in a negative manner. For treatment plans that include personality restructuring, the psychologist would try to facilitate the client to have a corrective emotional experience (Alexander[31]) in a safe environment without criticism. This plan would include encouraging clients to reflect and share their fantasies about important people in their lives, including the provider, as well as explore various interpersonal roles. By helping clients work through real or imagined fears of being abused by a caregiver (in this case, the psychologist), they move past the depressive position. Since persons with a disability may need a caregiver at times or all the time, it is crucial that they have the capacity to form trusting relationships with their caregivers.

W.R.D. Fairbairn

Another notable pioneer of object relations theory was Scottish psychoanalyst William Ronald Dodds Fairbairn (1889-1964), who took great inspiration from Klein's theory on the depressive and paranoid positions as well as her emphasis on internal objects[32]. Fairbairn was born in Edinburgh in 1889. Many psychoanalysts consider him the founder of object relations theory. Although he was intrigued by Klein, Fairbairn rejected many of Freud's major theoretical concepts, including the structure theory as well as his hypotheses about the libido theory. Interestingly, Fairbairn's physical location in Edinburgh, instead of London, facilitated his ability to think independently and to develop a perspective that deviated significantly from those individuals who were the intellectual leaders of psychoanalysis at the time.

Fairbairn made the novel claim that humans are not creatures motivated by sexual and aggressive drives. Instead, humans are foremost object-seeking. Later, he theorized that pleasure-seeking resulted from unsuccessful relationships with objects[5]. With strong attention to the role of satisfaction, Fairbairn contended that the child is born with an ego that is coherent, structured, and entirely operative. With this ego, the child is prepared to deploy defense mechanisms to protect him or herself against a non-satisfying object. Of non-satisfying (bad) and satisfying (good) objects, the child can only internalize the former because the child both desires the non-satisfying object and views it as bad. The child grows restless by the frustrating and desirable elements of the non-satisfying object. Thus, the object is split into two parts, an exciting object, and a frustrating object. The child represses both objects, thereby dividing the ego. Ultimately, psychopathology and internal conflict are the results of the interlinked roles of the ego and introjected objects.

Fairbairn's work can inform the rehabilitation and treatment of people adjusting to having a disability. First, similar to the discussed applications of Klein's theory, the pattern of the child-caregiver's relationship with the child and the environment in which it occurs significantly impact the child's personality development. Second, Fairbairn viewed humans as inherently social beings who attempt to find satisfying interpersonal relationships. The attention on the roles of caregiver, environment, and desire for satisfaction in one's social relations are all uniquely related to helping persons with a disability gain independence and trusting, positive attitudes toward caregivers. As such, the rehabilitation psychologist would aim to offer support to become a satisfying good object in the client's view. Achieving this aim may, however, be more complicated for psychologists working with clients with disabilities. A child with a disability, for instance, may have a difficult time nursing from their mother's breast and would be more likely to introject the mother as a non-satisfying object. This situation would increase the child's chance of later developing intrapsychic conflict or psychopathology. Fortunately, this difference between the personality development of people with and without disabilities is only expected to occur if a disability impacts the quality of the relationship between children and their primary caregiver. However, a disability may also impact the type of care or the caregiver's attitude toward the child with a disability.

For Fairbairn, creating a safe environment where the client feels loved and cared for is foundational to helping the client psychologically break away from the "bad object" and instead depend on real objects. In rehabilitation, a

clinician could interpret this idea to mean that meeting a client's needs is more clinically effective than treatment based solely on empathic listening. A study based on rehabilitation treatment by Reagles, Wright, & Thomas[33] focused on client satisfaction and found several significant statistical relationships between client satisfaction, the number of counselors in contact with the client, and how much money was spent by the state rehabilitation agency on the client. These findings implied that while empathic listening is crucial to the treatment process, it should not be the only technique rehabilitation psychologists use (Shlien[34]). Having someone listen with empathy may not only be a critical client need, it may also be the best way to identify other critical client needs such as financing vocational training, finding a job, having friends, or meeting a future mate. Empathic listening could be part of the environment that Fairbairn thought would be ideal for clients to depend on real rather than "bad objects."

In tandem with its implications for rehabilitation treatment, Fairbairn's work offers insights into the formation of a child's level of dependence. Also, as pointed out by one of the manuscript's reviewers like Freud and Klein, Fairbairn thought there was a deep internal object relations struggle and conflict between self and other that needed to be examined to be resolved. There was always the internal/external, the unconscious view of the object, and the interpersonal pattern of relating, which were intertwined and always influencing each other. Prior research from Eagle[35] has argued in favor of Fairbairn's notion of the developmental stages of the ego and their relevance in clinical settings. Fairbairn conceptualized the ego as having three stages: infantile dependence, the transition stage, and mature dependence. Developmental failures during any of these stages, particularly the earliest one, are the root of all psychopathologies, according to Eagle's[35] interpretation of Fairbairn. Children born with a disability or those who have had serious illnesses early in life are at greater risk of failing to move beyond the infantile dependence stage due to disability-related trauma or deprivation.

Expanding on this idea, Eagle[35] theorized psychopathology to be one of two types. One is the schizoid type of "to love or not love," which is characterized by an individual's struggle of how to love without loving to the point of destroying the object. The other is the depressive type of "to love or to hate," which is characterized by destroying the needed object with hate. Both types develop as a result of ego splitting during the infantile dependence stage. For two additional definitions of the paranoid-schizoid and depressive positions, the reader is referred to Moore & Fine[36] p.110 and pp. 107-108; and Laplanche & Pontalis[37] pp. 298-299 and pp. 114-116. Clinicians could benefit by considering these ideas when trying to improve a client's relationship with objects as the relationship pertains to dependence.

Fairbairn's work, like that of Winnicott (e.g., see Thomas & McGinnis[28]), implies that dependence in some form is necessary for treatment and effective adult adjustment. The level of dependence must be carefully considered to fulfill a client's needs without enabling over-dependence. This balance is extremely important to consider for clients with a disability because they frequently need to depend more on various external supports than clients without disabilities. A client's development toward independence will be largely determined by the client's abilities, the clinician's skills and available social resources. In sum, dependence is not inherently negative but must be kept in a healthy balance with the client's independence during the treatment process. For example, an individual with a spinal cord injury may be isolated due to mobility issues. On the one hand, it is crucial to provide resources and social support that this individual could depend on in order to address psychosocial issues. On the other hand, the individual should also be educated about self-management and adaptive coping skills to foster independence.

The last most revolutionary aspect of Fairbairn's work is his positing of mental internalization, such as splits in the object or the ego, as the primary defense mechanism (Eagle[35]). These mechanisms are an individual's reaction to an external object rejecting or depriving them, thus protecting the individual from bad objects in a given context. In a clinical context, Fairbairn advocated for the dispossession of the client's internalized bad objects and subsequent supplementation with good objects. It is critical that clinicians try to adapt to each client's needs and create an accepting environment for them, whether in a short- or long-term treatment plan. In line with the general goals of rehabilitation, therapeutic environments have great potential to help an individual achieve psychological growth and greater independence by providing a satisfying and accepting space for the client.

Michael Balint

Michael Balint has made a huge contribution to psychoanalysis and its application to psychotherapy and general medicine (Ornstein[38]). Because of his father, Balint became interested in primary healthcare and began his study of medicine. Balint had his first contact with psychoanalysis due to his wife, Alice Szekely-Kovacs, whose mother was a psychoanalyst. Both of them began studying psychoanalysis seriously with Sandor Ferenczi and Hans Sachs during the late 1910s to early 1920s. Although Balint's professional identity shifted from general practice to psychoanalysis in 1926, he still believed that psychoanalysis had much to offer the practicing physician (Johnson et al[39]). Thus, he started organizing lectures and seminars for general

practitioners to study the psychotherapeutic possibilities and potentialities in their practices, evolving into the later Balint Groups in London. Balint's forty-year of study in psychoanalysis mainly focused on the development of object relations and the application of psychoanalysis, specifically in the medical field. Based on his observation of special changes that occur in a therapeutic relationship, he built a unique interpretation of object relations theory (Balint[7]). His bold and innovative ideas have led the revolutionary developments in object relations theories.

Balint[7] proposed a new way to conceptualize the psychodynamic structure involving three areas or levels. The first is the oedipal or genital level, where conflicts are centered around a three-party relationship. Anything that happens at this level, whether related to the pre-oedipal or oedipal phase, involves at least two relevant objects (the parents) in addition to the subject (the child; Balint[7]). Another key characteristic of the oedipal level is that all the issues faced at this level are related to conflicts in relationships among the three parties (i.e., the child and parents). This conflict could be handled adequately in psychotherapy because "adult language" used to interpret these conflicts has the same meanings for both the analyst and analysand (Mendez et al[40]).

The second level, the basic fault level, has a marked distinction from the oedipal level in terms of the usefulness of language (Mendez et al[40]). "Adult language" loses its conventional meaning when being used to describe events that happen at this level. Analysands perceive the interpretation of the analyst as meaningless. Events at this level are based on a two-party mother-child relationship, which constructs a more rare and primitive object relation. The dynamics that drive the individual do not exist in the format of either instincts or conflict. Rather, from Balint's perspective, it comes from a form of lacking, which derives from the gaps between biological and psychological needs and the care and love received during early development phases (Balint[7]).

The third level, the area of creativity, is a one-party phenomenon characterized by the fact that no external object is present (Balint[7]). Balint[7] believed that it is the level where an individual's creative process occurs, such as math, philosophy, and epiphany. Similar to the basic fault level, it cannot be expressed by conventionally understood means because of the primitive nature and the disorganized "pre-objects" at this level (Mendez et al[40])

Unlike Freud, who believed that no object exists before the beginning of extrauterine life, Balint[8] assumes an immediate, primary object-relatedness based on clinical observations. Based on this perspective, Balint[8] introduced the notion of "primary love" to discuss things that happen at a deep level. This concept refers to the withdrawal of libido from a frustrating environment to reestablish internal harmony and rediscover early care and support (Mendez et al[40]). Before birth, the infant and the uterine environment are intertwined, creating an undifferentiated early relationship with endless materials and harmony. However, birth destroys this balance which becomes a trauma, forcing the infant to start a new adaptation mode of interacting with the environment and objects.

Balint[7] believed that the effectiveness of psychotherapy depends on the analysand's ability to regress to the basic fault level and the analyst's ability to create a safe environment for that regression. Regression to the basic fault level is the return to the primary status before the development of the issue and is a way to find a more appropriate and mature object relation. In other words, it aims to seek a new start for clients to relearn caring and love. Balint's emphasis on the environment in achieving positive outcomes in psychotherapy aligns with the theoretical foundation of rehabilitation psychology. The complex interaction between the individual and the environment needs to be considered in every step of rehabilitation services. Also, his conceptualization of primary love seems to provide a new perspective on understanding the psychosocial adaptation process of disabilities. More importantly, the idea of regression could potentially be applied in relevant adjustment counseling practices. For instance, after acquiring a disability, the individual may overgeneralize the impact of disability and hold false assumptions regarding his or her capabilities to achieve a successful life. In order to get out of this basic fault zone, rehabilitation practitioners could create a safe environment and help the client regress into the past to re-establish primary love and uncover basic fault.

Harry Guntrip

The next object relations theorist to be discussed is Harry Guntrip. His role was unique to object relations. He made dramatic contributions in regards to the coordination, synthesis, and expansion of other object-relations theorists' theoretical essences into a broad, workable model. Guntrip, a former Congregational minister, interacted with psychoanalysis as a patient for the first time and soon started immersing himself in practices and theoretical studies. During his membership in the British Independent Group, Fairbairn and Winnicott strongly impacted Guntrip's work regarding interactions between self and object. Instead of emphasizing the Oedipal complex during the Phallic stage of development as other Freud's followers, Guntrip shifted attention to infancy and infantile dependency (Mendez et al[40]). He believed the initial dependence on a stronger partner finally results in a sense of meaningful independence. Rather than directing and borrowing Klein's "essential contributions" of object splitting and the unconscious as an inner world, Guntrip

(1968) modified her conceptualization and suggested that object splitting and aggression derive from perceived failures and disruptions in nurturing.

Guntrip's most important contribution to psychoanalytic theory and practice is his study of regressed ego. Individuals with schizoid personality have experienced insufficient mothering and provisions in early childhood, resulting in an empathic failure in infancy and a certain amount of splitting and withdrawal (Ehrlich, 2009[41]). Guntrip[10] believed that retreating into an inner world of fantasy becomes the only way for infants to retain their ties to objects and avoid this emotional threat. However, the connections with objects in fantasies could be viewed as victimized or persecuted, making one feel anxious and further splitting the ego to withdraw and avoid anxiety (Ehrlich, 2009[41]. The final withdrawal represents a regression "into what is probably an unconscious hallucinated reproduction of the intrauterine condition" (Guntrip[10]). This regressed ego leaves the infant with an unrealized part of self and would influence relationship building in adulthood.

For Guntrip, the power differential in the holding situation forces the infant to seek dependence and validation from others. However, insufficient mothering inevitably directs it to the inner world for safety. Thus, the requirements of validation by others and psychic survival were also processed as a conflict, leading to a separation between the self and environment (Ehrlich[41]). Regression then serves as a defensive mechanism against anxiety and emotional threats by developing a less open self to establishing new connections with others.

Thus, in order to achieve positive therapeutic outcomes, Guntrip[11] argued that the therapeutic process should create an environment that provides clients with a sense of safety and allows the ego to regrow the unrealized part. Psychological contact is created between a congruent psychoanalyst and an incongruent analysand who experiences anxiety and regression.

By revisiting his psychoanalytic experiences with Fairbairn and Winnicott, Guntrip[11] concluded that analysts should fill in the emptiness of a non-relating parent in infancy. In therapy, the psychoanalyst functions as an attending parent, compensating for the empathic failure experienced in the past. This process provides a foundation for the client to regrow the unrealized part of self and develop a more integrated self.

From Guntrip's perspective, human development involves not only the expression of self but also the dependence on the acceptance and support of significant others. This perspective stresses the importance of interaction between analyst and analysand. Guntrip[11] stated that it is crucial to allow the analysand to relate with a genuine "good object" in one's analyst. This perspective is in line with the psychologist-client/patient relationship in rehabilitation psychology. The rehabilitation psychologist must develop a valuable therapeutic relationship and create a safe ambiance in which the psychologist could fill in feelings of emptiness resulting from empathic failure and create a sense of "ego-relatedness" (Guntrip[10]). For example, negative societal attitudes could result in internalized stigma among individuals with disabilities, leading to low self-esteem and distrust in social relationships. Having a genuine therapeutic relationship could help the client relate with the good object in the rehabilitation practitioner and address trust-related interpersonal issues.

D.W. Winnicott

Lastly, no discussion of the role of object relations theory in rehabilitation would be complete without mention of D. W. Winnicott's foundational work on how children develop and come to relate to the external world. Winnicott was born in Plymouth, England, in 1896. He was both a pediatrician and a psychoanalyst. His contributions to psychoanalysis and child development greatly exceeded any name recognition he might have had in the general psychology literature. He was probably the most notable of the members of the "Independent" group of the British Psychoanalytic Society. The two other most notable members of the Society were Anna Freud and Melanie Klein. Among Winnicott's most famous publications are *The Child, the Family and the Outside World*[14]; *Playing and Reality*[16]*; The Maturation Processes and the Facilitating Environment; Collected Papers*[15]*; Through Paediatrics to Psycho-Analysis*[12]; *Holding and Interpretation: Fragment of an Analysis*[19]*; The Piggle: An Account of the Psychoanalytical Treatment of a Little Girl*[18]*; Therapeutic Consultations in Child Psychiatry*[17]*; Babies and their Mothers*[20]; *and Psychoanalytic* Exploration[21]*.* He was also famous for his extraordinary ability to simplify complex issues with pithy phrases and sentences.

With such an expansive career, it is no surprise that Winnicott's body of work has numerous implications for conceptualizing and helping people adjust to having a disability (Thomas & McGinnis[28]). The most relevant ideas from Winnicott's work on this topic include the "holding environment," the "good enough" mothering, the true and false self, transitional objects, hate in the countertransference, and environmental impingement.

One of the most vital aspects of helping a client adjust to having a disability is ensuring the client's needs are met, which, as Winnicott (1958,[12]) proposed, is linked to their sense of self. Winnicott claimed that a child begins his or her life psychologically in a state of undisturbed isolation, being unfettered. Children will psychologically adjust if the environment and their caretakers meet their needs. If not, the child's sense of self will collapse,

which they will attempt to reclaim by self-isolating. In response, psychologists should aim to provide a "holding environment," otherwise called a "good enough" psychological environment, in which the psychologist can adapt to the client's needs. This environment should enable the client to develop more autonomously by increasing their confidence and independence as well as rectifying their developmental discrepancies. In a social model of disability, which understands disability as the product of environmental limitations (Thomas & McGinnis, 1991,[28]), a holding environment could help the client adjust to these limitations.

According to Thomas and McGinnis (1991[28]), two factors determine the success of a holding environment in helping a client with a disability adapt to any environmental limitations. The first is the client's adaptive and coping abilities, and the second is the facilitating characteristics of the environment. This approach must be conceptualized as a flexible process during which medications can be made available depending on the client's type of disability and related needs. For instance, clients with spinal cord injuries may be uncomfortable sitting down in particular chairs or couches, or a client with impaired vision may need Braille or audio versions of texts. Beyond sensory and physical impairments, psychologists should think carefully about how to modify psychoanalytic psychotherapy for clients with intellectual impairments and consider if the client is likely to benefit from such treatment.

People born with a congenital disability may be less likely to have difficulties in their relationship with caregiving and personality development due to the presence of the disability if psychologists apply a Winnicottian lens. If a child, for example, is socially distant or withdrawn due to the nature of the disability, such as autism, this characteristic will affect the caregiver's capacity to adapt to the child's needs. Such children are apt to develop a "false self," as Winnicott (1960[13]) called it. A child with a "true self" is a child who has sufficiently adapted to her or his needs; the child with a false self is marked by inauthenticity, which results in the child being overwhelmed by the environment and the caregivers' demands. The child's true self is hidden and cannot properly form due to the child's attempt to meet the expectations of others. While children with a disability may be more prone to developing a false self, certainly not every child with a disability will develop one. Specific conditions will, however, increase the chances of it happening. These include, first, when a caregiver cannot satisfactorily adapt to the child's disability. Second, when a caregiver has a negative attitude or reaction toward the child because of the child's disability. And third, when a child, due to the disability, cannot successfully convert an insufficient adaption into a good enough adaptation. Being aware of these potential disruptions to a child with a disability developing a "true self" can inform psychologists in creating the best treatment plans for persons with disabilities.

People who develop or acquire disabilities later in life (i.e., adventitious disabilities) could still face psychological effects from the conditions of the environment that would ultimately hide their true selves. As such, psychologists should design treatment plans similarly for clients with adventitious disabilities, no matter what their relationship has been with early caregivers.

Perhaps Winnicott's most famous concept that has bearings for the treatment of persons with a disability is called transitional objects. These objects refer to literal objects (e.g., a teddy bear) that come to symbolize the mother and her breast. These objects are transitional in that they help the child complete the process of separating from the mother and becoming an individual (Mahler[42], Mahler, Pine, & Bergman[43]). Depending on the impairment, children with disabilities may have difficulty forming bonds with transitional objects due to the nature of the object (e.g., unsafe or inaccessible). With these objects, the child is likely to have struggles in achieving a coherent sense of self and /or developmental deficits. The child's separation-individualization process could be further disrupted by an overprotective caretaker who does not give the child enough independence or, later in adulthood, persons with disabilities may have separation-individualization struggles deriving from reawakened dependence-independence conflicts (Thomas[46]). In either scenario, the client could regain independence in a therapeutic holding environment that makes the client feel safe and has the appropriate ego supports.

Also relevant for helping clients with disabilities is the concept of "hate in the countertransference," which is a child client's capacity to process and accept the occasional hate they receive from caregivers, including their clinical providers and caregivers. Without accepting hatred from objects, it is thought that the child or client cannot accept love from an object either. This is not to say that caregivers and providers are quick to hate those in their care, but rather it is normal and healthy for them to express a range of affects during the caregiving or treatment process. Since children and clients with disabilities have alternative needs and behaviors from those without disabilities, they are more prone to receive negative reactions and affects, such as hate and disgust, from other people, including providers and caregivers. As a result, if the child or client is unable to accept this hate, they may have difficulty or be unable to love, which would affect their ability to develop positive, supporting relationships.

Readers aware of Carl Rogers may see some similarities between his work and that of Fairbairn and Winnicott.

It is important to emphasize that there are significant differences between Rogers's person-centered approach and Fairbairn and Winnicott's approaches, despite the importance of empathy to all three therapists. Specifically, Rogers[44,45] promoted the point of view that the caregiver should provide a facilitating environment characterized by empathy, unconditional positive regard, and genuineness, which would allow the child or client to develop congruence between self and experience. Fairbairn and Winnicott, however, seem to require that the caregiver provide a more active role in meeting the child or client's needs that go beyond just listening and responding empathically. Moreover, as pointed out by one of the manuscript's reviewer, Fairbairn and Winnicott also advocated a more active exploration of the internal conflicts and object relational struggles that are acted out interpersonally and externally, often through projective identification.

Summary and Recommendations

Five prominent object relations theorists were discussed in this manuscript: Melanie Klein, W. R. D. Fairbairn, Michael Balint, Harry Guntrip, and D. W. Winnicott. Melanie Klein is known primarily for her work with children, and her theories, while relatively complex, can be used to understand both normal and pathological personality development. Klein adopted Freud's belief in drives, especially the death drive, and the importance of transference. Much of her theory concerns the relationship of the child to the mother's breast, and this relationship may be especially significant clinically in the case of a child with a physical disability. Two other notable beliefs of Klein's were that the superego was helped to develop by envy and guilt prior to the phallic period and the primacy of four defense mechanisms: introjection, projection, splitting and fantasy. Klein's most important theoretical contributions were projective identification and the paranoid-schizoid, and depressive positions. Rehabilitation psychologists working with clients with more severe psychiatric disorders such as borderline or narcissistic personality disorders need to be on the alert for their clients' use of these defense mechanisms. Projective identification is an especially troublesome defense mechanism. When clients use this defense mechanism, a bad part of the client is projected into the therapist, and the therapist may begin to act accordingly. According to Kernberg et al.[30], these issues could be treated by improving the client's ability to experience self and others as coherent, integrated, realistic perceived human beings and reduce the need to use defenses that weaken ego structures by reducing the repertoire of available responses. Since object relations psychotherapy and rehabilitation share common goals, except typically for personality restructuring, Melanie Klein's object relations theory would probably be apt for use in many rehabilitation settings.

Another prominent object relations theorist was W. R. D. Fairbairn, who is considered by some to be the father of object relations. Fairbairn made the novel claim that humans are not motivated by sexual and aggressive drives; instead, humans are object-seeking. Later, he hypothesized that pleasure-seeking resulted from unsuccessful relationships with objects. He also gave strong attention to the role of satisfaction and contended that the child is born with an ego that is coherent, structured, and entirely operative. The child grows restless by the frustrating and desirable aspects of the non-satisfying object. Thus, the object is split into two parts, an exciting object, and a frustrating object. The child represses both objects, thus dividing the ego, which may ultimately result in psychopathology and internal conflict.

Despite its complexity, Fairbairn's theory can inform the treatment of persons with a disability. Specifically, it is critically important that the rehabilitation psychologist strives to become the satisfying, good object in the client's mind. The attention on the roles of caregiver, environment, and desire for satisfaction in one's social relations are all uniquely related to helping a person with a disability gain independence and trusting, positive attitudes toward caregivers. Also, for Fairbairn, creating a safe environment where the client feels loved and cared for is foundational to helping the client break away from the bad object and instead depend on real objects. Fairbairn's work, like Winnicott's, implies that some type of dependence is necessary for treatment and adult adjustment.

Finally, it is critical that rehabilitation psychologists try to adapt to their clients' needs and create an accepting environment for their clients regardless of whether the treatment situation is short-term or long-term. As Balint advocated for positive therapeutic outcomes, psychologists are responsible for creating a harmonious and safe environment because this environment could allow clients to regress to the basic fault level and have a new start to relearn caring and love, which they lack (Balint[7]). In order to allow this process to happen, as Guntrip mentioned, the development of therapeutic relationships should be based on the needs of clients. The psychologist should serve as a genuine "good object" who can fill in the emptiness in clients due to empathic failure, leading to a sense of "ego-relatedness" (Guntrip[10]).

The final psychoanalytic approach discussed in this paper is the one developed by D.W. Winnicott. Winnicott was without question one of the most thoughtful, brilliant, prolific, and until recently least appreciated of the major theorists in psychoanalysis. His contributions to psychoanalytic literature were both theoretically and clinically groundbreaking. Many of these contributions have implications for helping persons adjust to their disability. The most relevant concepts from Winnicott's

writings that could be used to help persons with a disability include "the holding environment," "good enough mothering," "the true and false self," "transitional objects," "hate in the countertransference," and "environmental impingements." One of the most vital aspects of helping a person adapt to a disability is ensuring that the person's needs are met. Winnicott[12] proposed that having a person's needs met is closely linked to their sense of self. Thus, it is the rehabilitation psychologist's job is to facilitate the client being able to meet as many of the client's needs as possible. If not, the client's sense of self will collapse, which the client will attempt to reclaim by self-isolating. In response, psychologists should try to provide a "holding environment," which is otherwise called a "good enough" psychological environment in which the psychologist can adapt to the client's needs.

According to Thomas and McGinnis[28], two factors determine the success of the holding environment in helping a client adapt to any environmental limitation. The first is the client's adaptive and coping skills, and the second is the facilitating characteristics of the environment. When treating children Winnicott used play as his primary therapy technique. In fact, he believed that play was the only way to work psychoanalytically with children. Two of the games he played with his child patients were Squiggle and Spatula. Rehabilitation therapists could use these same or other games with their patients if they were properly trained. One of Winnicott's most famous books is titled Playing and Reality. Moreover, several books are available to facilitate playing Squiggle. Rehabilitation therapists could adopt Winnicott's theories and techniques to advance their own therapy goals, especially when working with early-aged patients. Such activities would clearly facilitate the creation of a holding environment and meeting the child's need for attention.

People who develop or acquire a disability later in life could still face psychological effects from the conditions of the environment that would ultimately hide their true selves. In these situations, rehabilitation psychologists should design treatment programs that serve to adapt to their client's needs regardless of the client's age. As pointed out previously, several other of Winnicott's ideas and techniques have relevance in rehabilitation settings, including "transitional objects" and "hate in the countertransference."

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