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Whose Bad Objects Are We Anyway?: Repetition and Our Elusive Love Affair with Evil

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do we come to hate that version of ourselves that emerges when we are with them? This paper explores these questions, examining the issues of repetition and repair with regard to our most toxic introjects—the patients' and our own.

Whereas Melanie Klein helped us to understand why we come to hate that which is good in others, this author explores the complementary question of how loving that which is bad in others keeps the self innocent, good, and sane. A fundamental dissociative split in two necessary but incompatible self-other organizations is posed. With reference to a detailed clinical example, the author investigates how the evocation of intensely shame-riddled bad self representations in both the patient and the analyst can perpetuate a need to provoke, find, and sustain that badness clearly in the psychic domain of the other, blocking entry into certain necessary therapeutic enactments that may therefore fail to occur. Both self-other organizations must occur, first in oscillating moments and ultimately in simultaneous awareness, in order for the analytic work to proceed.

Twas a thursday afternoon, the kind of day on which the coldness simply could not be stopped. Sweaters, space heaters, and the assorted accoutrements of winter were insufficient to the task. I had a sore throat and a terrible head cold. Achy and irritable, I was unsure how I was going to make it through my four remaining sessions that afternoon. I wanted only a pillow for my head, a warm comforter for the aches and pains, and a thermos full of hot tea and honey. To make it worse, Karen was coming next. At that moment I needed someone “easy”; someone who would be willing to cut me a little slack in my present condition. But that was not to be. One could simply never hide from Karen's keen and unrelenting eye. She was never easy!

We had been working together for almost three years, and though much of our analytic work had been productive, our relationship itself had remained tense and unpredictable, fraught with unexpected twists and turns, seemingly impossible demands, sudden disappointments, frustrations, and angry outbursts. There was little that was fluid and comfortable. As I came into the waiting room, Karen was hunched over inside an enormous down jacket. Her face was particularly stormy and brooding, even for her. My heart sank, and my spirits took a nosedive.

“You're still sick?” she asked, half complaint, half admonishment. “I can't believe you haven't shaken that thing yet.” I felt suddenly slow and stupid, my cold a matter of immunological ineptitude. She sat in the chair facing me, ensconced within her ballooning jacket. We were silent. From deep within her stare I detected a gleam ... a noticeable quantum leap in energy and excitement. In response, my stomach churned and my muscles stiffened. Even before words could explain, it seemed as if my body knew that *something* was coming, and my body told me it wasn't good. It must mean that we had occupied this place before ... that my muscles were remembering, before my mind could catch up, that something dangerous loomed ahead of us.

“I need an earlier session on Monday,” Karen proclaimed, her words piercing the air. “I have jury duty, and you know how essential a Monday session is for me.” I thought I saw steamy breath surrounding those words—the heat of her disowned rage penetrating the frigid environs surrounding us. Ah, yes, here it was: the impossible demand, the necessity of the moment that I simply could not provide. Why did Karen never ask me for things that I could give her? I braced myself for the struggle that I knew was coming. “I do know how important it is for you,” I responded, “and I so wish that I had a time. But you know how impossible my Monday morning schedule is, how inflexible it always is on Mondays when we need to change something. I'm afraid I can't unless I have a cancellation.” I finished my sentence and clung to the arms of my chair for strength and balance. Karen pursed her lips and narrowed her eyes, but behind the hungry pursed lips an unmistakably palpable smile of satisfaction; within the sad desolate eyes, a piercing stare and the steely glint of sadistic triumph. For Karen, it was a moment of profound desolation and abandonment but also a place of safe familiarity and comforting self-recognition.

But what of me? What of my complex reactions to this evocative, provocative moment, so reminiscent of many moments with Karen? “Who needs this?” I thought. “If I'm so awful, why doesn't she just quit? So many interesting referrals I'm not free to take, and I'm not helping her one iota ... uh-uh ... not one little bit.” In this moment, I struggled to evoke images of patients I thought that I was helping: patients who saw me as warmer, more caring, more therapeutically helpful than Karen did; patients who affirmed my own preferred vision of myself, patients who I thought saw me more “accurately.” Unknowingly, I dug my heels in as firmly as Karen. From the recesses of my mind came a small and unwanted voice: “You know you could come in an hour earlier if you don't do school drop-off. You could see her. You would do that, you know, for some of your other patients; you have done it on occasion. You don't like to disappoint the children, but you've done it before. It's Karen; you don't want to do it for Karen.” Now I was starting to feel really cranky. It had begun to feel as if even my own other self-states were conspiring against me. “But,” I answered my annoying little voice, “I'll do it for Karen and she won't even appreciate it. I'll disappoint the kids, and for what? In two days it will disappear down the black hole of borderline entitlement, and the next time she's frustrated with me she won't even remember how hard I've tried to accommodate her.” “Hmm ... a diagnosis,” retorted my voice, “borderline, no less? You really are angry. Who is this angry, petulant, withholding, unempathic Jody?” “Oh, shut up,” I countered. “This is old stuff, an old place, not an issue for me anymore. It's her; it's Karen. She has an uncanny ability to bring all of this stuff out of me.” “Sure,” came the inevitable reply. “And if she gets angry enough and goes away, then that part of you can skulk back into the cave marked Old News—Need No Longer Think About, and you can be safely self-satisfied again.” “That's right,” I said, by now consumed by oppositional but entirely self-righteous entrenchment. “Karen and I will never witness the coming of morning together!” My heels dug holes in the carpet. Karen and I glared at each other in silent rage: both of us from places we knew; both of us from places we hated within ourselves. In the lexicon of professional jargon, it was a moment we have come to think of as a therapeutic impasse, but a moment of profound mutuality and engagement as well.

What enables us to explain the repetitive cycles of self-destructive, self-defeating behavior that we all struggle to help patients overcome? What explains the malignancy that can infuse the transference-countertransference relationship, often suddenly and without warning? Why do some treatments blow apart under the strain of such mutually repetitive, negative, and intransigent processes?

Much has been written in psychoanalysis about the so-called “negative transferences,” about the importance of letting ourselves become “bad objects” for our patients and, in so doing, allow for the expression of their more aggressive, hateful, and malignant thoughts. It seems intrinsic to relational thinking that these “bad object relationships” not only will but must be reenacted in the transference-countertransference experience, that indeed such reenacted aggression, rage, and envy are endemic to psychoanalytic change within the relational perspective. In my own work on treating adult survivors of childhood sexual abuse, the patient's identification with her abuser and her tendency to reenact this abusive object relationship within the transference-countertransference process forms the crux of what is regarded as essential for psychoanalytic change. I am not alone in this belief. The works of Stephen Mitchell (1997), Irwin Hoffman (1998), Jessica Benjamin (1988), Philip Bromberg (1998), Stuart Pizer (1998), Barbara Pizer (2003), Lewis Aron (1996), Stephen Cooper (2000), Margaret Black (2003), and Darlene Ehrenberg (1992), to mention only a few, are replete with vivid descriptions of working through the difficult, rageful, envy-filled transference-countertransference reactions that occupy so much of good solid psychoanalytic process.

But one question with which many of us have struggled in our writing as well as in our clinical work is exactly how we can evoke and work with the patient's more intense negative transference reactions, as well as with the countertransference states that can be evoked in response, without witnessing the collapse of potential, self-reflective space into the inexorable vortex of meaningless traumatic reenactment. To evoke the bad object relationship without concretely becoming the bad object. To invite the reemergence of traumatic histories of affective intensity and pitch without being swallowed up and destroyed by them seems to be our most complex

therapeutic challenge. To dance the dance of then and now, past and present, abuser and victim, doer and done-to, we dance on the head of a pin, spinning dizzily amid these points, changing perspectives, shifting identifications, blurring boundaries, spinning a tapestry of meaning and nuance that has the potential for depth, subtlety, ambiguity, and a multiplicity of rich, self-other experience, but a dance that also holds the forbidding prospect of spinning out of control, of falling over the edge into a miasma of projective-introjective enmeshment, boundarylessness, and deadly negativity.

It is just such a space that Karen and I occupy on this frigid February afternoon. Leaning precipitously close to the edge of the head of this now claustrophobic pin, we each struggle frantically to regain some perspective on the meaning of our work together. We search desperately to remember some of the good times we have shared, to evoke positive images and more caring, nourishing self-states in which we can exist together, memories with which to halt a catastrophic fall into traumatic reenactment.

“You’re such a bitch,” Karen insists. “You’re cold and unfeeling and ungiving. You’ve never been there for me—not ever. I mean, sometimes you pretend, but it’s just skin deep. Down deep inside you where I can see ... it’s just ice. The least you could do is to admit it.”

I stare at Karen in stunned silence, overwhelmed by the intense hatred in her voice. I think of the emergency sessions, the extra phone calls, the many heroic attempts to “be there for her” that seem to disappear at times like this. I try to hold on to her hateful image of me, to work with it clinically, to understand its meaning and history. But parallel to my therapeutic self, I seethe at her description of me and I struggle against it. I am ashamed of the things I feel. There is something about the notion of “working through the negative transference” or “being a bad object” that seems somehow unequal to this moment—*too* in the past, *too* in the other, *too* defined by distortion to capture what is happening. For in this moment it is not simply that Karen hates me, or that I have reached a place where I hate her. What is most significant, I believe, is that we have reached a place together in which I hate the self that I have become with her. I AM the bitch she describes, and I am horrified and chilled by the ice that lies below the surface, hardening over the well of good intent and affection that at other times defines the more loving relationship we “also” have. As I stare into the opaque deadness of Karen’s relentless gaze, I know that she is hating herself as well: hating the entitled, demanding, raging self she has become in these moments with me—hating that self, and all the time deeply ashamed and frightened by its internal tyranny.

Our session draws to an end, and it has become quiet. Then, “You hate me,” says Karen—the “crunch” as Paul Russell (1973) termed it. “Mhmm,” I tell her. “Sometimes we hate each other, I think. Not always, not even usually, but sometimes we can get to this place together. I guess we’re gonna have to see where we can get to from here. Neither of us likes it much; it just is.” “Yeah,” said Karen, “It sucks.”

“Yeah, it does,” I answer. A comment takes shape in my mind. It buzzes around, and I struggle with whether or not to say it. It feels right, but it has appeared suddenly and I haven’t had time to think about it. I decide to hold the thought, not to share it at this moment with Karen. The thought that I consider sharing with Karen goes something like this: “You know, Karen, I might have said, it’s very hard and painful to hear when you feel like you hate me, and it’s very hard and painful to feel hatred for you, but what really really bugs me—the thing I think is the hardest thing to feel—is that sometimes when you and I are in a place like this I feel as if I’m starting to hate myself as well. And that just pushes me over the top and I feel that I simply can’t move.” But the moment passes. And the words are not said.

I have long been of the opinion that “becoming a bad object” for the patient, evoking the “negative transference,” represents no great therapeutic challenge. It is in fact a far easier task than most of us would choose to have it be, despite our awareness of its essential therapeutic function. But simply becoming a bad object for the patient does nothing to erode the analyst’s sense of sanity, boundaries, and internal therapeutic

intent. Indeed, the very language suggests that we are letting ourselves be used by the patient for some therapeutic function. The bad object we are becoming is the patient's bad object, projected onto or into us; residing there temporarily; a temporary tenant or interloper. We can "hold" such bad objects without losing our self-reflective capacities, our more tempered hold on the meanings of such transference-countertransference moments. We can think about who these objects are for the patient. We can examine our own countertransference for clues to such understanding. Our boundaries remain intact. Our thinking, though altered and affected, remains clear. Even when projective identification holds sway and we are snagged by a projection that takes root and flourishes within us, we understand that the experience is part of the therapeutic process, something painful but something which emanates from the patient, something that will leave us when the hour is over. In essence we feel ourselves to be doing good, difficult, but necessary therapeutic work, filled up by some kind of badness that belongs to the patient's past—to his or her internal object world. We stay focused. We feel therapeutic. We do not lose our minds.

What is not so easy, I would suggest, and what represents, to my way of thinking, a much greater therapeutic challenge is finding a way to evoke and manage the emergence of our most secret and shame-riddled "bad selves," our own and the patient's—those needy, greedy, envious, hateful, manipulative, entitled aspects of self who have grown up in relationship with our bad objects, in relationship with our parents' own dissociated and evacuated bad self-states. It is, I believe, these selves who tyrannize us internally; who fill us with shame, self-hate, and self-loathing; who fuel relentless repetitions and internally occupy moments of intolerable therapeutic impasse. In early work that I coauthored with Mary Gail Frawley O'Dea (Davies and Frawley, 1992, 1994) on the treatment of patients traumatized in childhood, we pointed out the clinical dilemma that occurs when the analyst, much like the parental perpetrator of childhood abuse, must be both the object of the patient's transference rage over abuse, abandonment, and betrayal, as well as the one who helps the patient contain, soothe, modulate, and ultimately come to terms with such experiences. We employed Winnicott's metaphor that every baby needs both an environmentmother and an objectmother, to suggest that each patient also requires an object and an environment analyst. And we cautioned about the particular countertransference pitfall in which the analyst comes to feel so guilty about evoking the patient's horrendous memories of early abuse and betrayal that he or she will attempt all forms of inappropriate heroic rescue, attempts that ultimately interfere with the patient's need to mourn lost idealized objects and the analyst's need to mourn the limits of his or her therapeutic omnipotence. In a recent paper, Bromberg (2000) strikes a similar theme, considering the possibility that the analyst's shame over being the one to evoke the patient's experiences of such profound pain may precipitate a dissociated state in the analyst, in which he or she becomes unable to resonate with the patient's experience of profound hopelessness and despair. For Bromberg, this failed communication between patient and analyst fuels much of the repetition in clinical work.

In the present paper, I focus not only on the guilt and shame evoked by the analyst's therapeutic and object functions, but on the fate of the analyst's primary areas of shame, guilt, and despair as well (see also Elkind, 1992). In this more specific sense, I have not simply evoked a negative transference or become a bad object for my patient. Instead, it is more accurate to state that, at such heightened moments of impasse, something about my current interaction with this patient forces me to become aware of that which is and always has been "bad" within myself, something that I know and have always known to reside squarely within the part of myself I choose to consistently avoid and disown. My point here is to suggest that it can become the passionate mission of such guilty, shame-riddled self states, (whether in patient or analyst) to predict, seek out, and provoke the very worst in the other, in order to literally extrude the badness—to locate and confirm that the badness lies comfortably outside the self. It is I believe in the countertransference push to extrude these self states of our own, to locate them in the other (in this case, the patient), that the boundary confusion and collapse of self-reflective functioning endemic to moments, of what Stuart Pizer (1998) has termed nonnegotiable therapeutic impasse, may take hold.

We relational analysts have always emphasized the patient's capacity to appreciate the multiplicity of self-other configurations and organizations of experience, the capacity to exist in a heightened moment of emotional and interpersonal engagement while sustaining the capacity to exist outside that moment as well, appreciating the specific self-other dyad of the moment as only one of many self-other configurations that define the experience of the self and of the particular relationship at hand. In my own work, I have termed the patient's capacity to appreciate the tension between one particularly heightened transference-countertransference experience against a backdrop of multiple other potential interactions as a "therapeutic dissociation" (Davies, 1996), and I have regarded the analyst's counterpart (i.e., the capacity to move fluidly from one particular transference-countertransference paradigm to another without becoming mired in the repetitive reenactment of any one configuration), as a relational redefinition of analytic neutrality. In a similar vein, Mitchell (1997) has spoken of "bootstrapping," Pizer (1998) of building bridges between dissociated self-other configurations, Hoffman (1998) of constructing a dialectic of positions, Bromberg (1998) of "standing in the spaces" between these states, and Benjamin (2004) of the patient's capacity and the analyst's capacity to establish and sustain a third position. Despite subtle differences, each of us has tried to capture in these writings the importance of being in the moment and out of it at the same time, of allowing for an intensity of psychic experience while sustaining the capacity to reflect on that experience, to balance emotional immediacy with an appreciation of alternative possibility.

In my work with Karen and others like her, it is precisely this self-reflective space of multiple possibility and potential that feels most threatened. I often find myself feeling that I am engaged in some kind of life and death battle for my sanity and mental integrity. I often feel pressed into a position in which the only way to affirm a patient's sanity and experience of reality is to accept a vision of myself that is so toxic and malignant that it feels threatening to my own sense of stability and identity, and I begin to feel crazy myself. The presence of a psychotic parent—of one who forced the acceptance of an insane reality as the precondition for a loving relationship onto and into a vulnerable child—hovers around the consulting room, exuding a malignant and sulfurous stench, fueling the game of projective-introjective hot potato from which the patient and I struggle to emerge intact. There is a desperate frenzy to our struggle, as though we are playing the children's card game "Old Maid," in which the dark and foreboding queen of spades skulks around the table—inside one hand and then another, inside me and then you, popping up here and then there: "Not me; I don't want her. Get rid of her; pass her on to someone else. I don't want to be left holding the witch/queen." Perhaps the dilemma in dyadic relationships is simply this: if it is not me, then it must be you. And how do we allow for the presence of such toxicity if the queen lives in both of us and neither of us all at the same time? The specific dynamic I am referring to is an inherent feature of a range of doer-done-to complementarities that Benjamin (1988, 2004) and Frawley and I (Davies and Frawley, 1992, 1994) have all written about.

Karen's father died suddenly when she was nine years old, and I have often suspected that her mother struggled with bouts of depressive psychosis. Karen refers to her mother's "dark spells," times when mother would become withdrawn, despondent, and brooding; her depressions spilling over into bouts of intense jealousy, rage, and obsessive cleanliness; times when Karen was expected to "care for" her mother and to devote herself almost unceasingly to her mother's moods and whims of the moment. My most visceral sense of Karen's mother grows out of my interactions with Karen herself and with my own countertransferential states when Karen and I go through one of our own dark spells. I often feel as if something toxic and untrue, something malignant in a psychotic sense, is being forced inside me. "You are ice," Karen screams, "just admit it." Admit it, I think. Grant it admission; let it inside you. I know at such moments that if I accept the "truth" of what Karen wants me to own, she will calm down—she will be mollified; but I also know that I will feel two things. I will feel as if I have betrayed my therapeutic function by submitting to a psychotic process in Karen and allowing it to dominate our intersubjective space, untouched and unchallenged. And I also know that I will begin to feel crazy myself, as if I have surrendered my mind and my sanity for a few moments of bartered connection and relief.

What does a child do when a parent's reality is so vastly different from her own, when a parent's sense of that child's innermost core is so vastly different from the child's own felt experience? How far will a child go for love? How does she protect the integrity of her mind while sustaining, at the same time, her loving connection to the parent on whom she depends for survival? I feel with Karen as if I hold that child's questions within myself, within my experience when I am with her. To feel sane, I must recognize that this very significant other is insane. I have my mental integrity, but I am alone and unprotected in a hostile world; to feel safe and protected and cared for I must accept a psychotic reality and live within my mother's world, supporting and believing in it. In these moments with Karen, I understand that child's dilemma. I feel that I know what Karen has gone through, but I know it in my bones. To feel sane, I must forego love; and to feel loved, I must render myself insane. I believe the process I am describing here to be a very special form of what Philip Ringstrom (1998), in a more general sense, has termed a psychoanalytic double bind, or what Barbara Pizer (2003) has termed a "relational knot."

I have no doubt that we all have our "Karens." But there is also no doubt in my mind that my Karens are not necessarily your Karens. It is not any particular form of pathology in the patient, or any particularly malevolent introject in either patient or analyst that, to my way of thinking, creates impasse. It is, I believe, for patient and analyst alike, the particular quality of the individual's idiosyncratic interaction with his or her own parent that will influence both the quality and content of what I think of as a certain receptivity to projections, the capacity to temporarily accept a projection without becoming it or drowning in it. Was there something that my own parent absolutely could not metabolize and own? Was there something that I was forced to accept as being inside me in order to feel myself in some loving relation to that parent? How invasive, alien, and toxic did that something feel when I took it inside myself in order to be loved? How defining of my entire self did it come to be? Ultimately, the question I am posing is how might that which I felt forced on me dovetail and interact with that which any particular patient felt forced on her? What happens when something intolerable in the patient's parent touches on and interacts with something that was intolerable for the analyst's own parent?

Given the developmental universality of projective-introjective processes between parents and children, we might want to consider that the kind of interaction I am describing exists on a continuum from the more "normal" and fluid attribution of qualities to the more toxic, evacuated, and entrenched forms of projection. How toxic these processes will become developmentally, for the child, depends on the intersection of two dimensions: (1) how toxic and shame-inducing is that which is evacuated by the parent into the child, and (2) how complete, dissociated, and unremitting is the projection itself—essentially, the content and the dynamic of the projection. To what degree does the loving relation to the parent depend on the child's complete and total acceptance that she is the only one who holds these negative attributions, that such qualities are the patient's own unique, self-defining, and shame-ridden burden to bear, rather than being shared with the parent and being universal in human nature? In essence, the child accepts the projection but identifies as well with the parental belief that to possess such qualities threatens survival, that these qualities must be evacuated and located in others at any cost, in precisely the way the parent has evacuated them into the child.

In both the developmental and the therapeutic endeavor, then, the capacity to maintain relatedness, albeit a compromised one, becomes dependent on a particularly intractable dissociation and oscillation of self-other configurations that sustain and protect this projected status quo. In the first of these self-other configurations, the child/patient accepts the toxic projections, accepting herself as crazy, hateful, envious, icy, or dead depending on the particular content projected; but she guarantees herself loving protection under the now benign eye of her all-good parent, who is thus preserved as a loving, sane, and reliable caregiver. This is Fairbairn's (1943) "moral defense"; as he so succinctly puts it, "better to be a sinner in a world ruled by God, than to live in a world ruled by the Devil" (pp. 66-67). But Fairbairn was a one-person theorist. What is left out of his all-important formulation is the second-person dimension: the idea that God loves sinners, not only because sinners sustain God's goodness, but also because it is so easy to love those who own their own bad qualities

(not to mention your own) and who also appeal to us for help in overcoming these problems. The paradox of the first self-other configuration is, therefore, that while the child or patient believes herself to be bad, crazy, evil, or hateful, she also experiences more of the parent's or analyst's love and positive regard than she would if she failed to view the parent's negative qualities as her own. The sacrifice in this self-state is that the child/patient must blind herself to many of the negative aspects of the other, thus rendering herself "crazy" in terms of her capacity to judge reality.

It is my belief, however, that the child who internalizes and identifies with parental abusiveness in such a way must also maintain simultaneously and in dissociated form an accurate capacity to read the interpersonal emotional landscape with clarity and sensitivity to nuance. Her all-important reality-testing skills, indeed her very connection to certainty and sanity, are ensconced in a self-other relationship in which the dangerousness or potential abusiveness of the other is clearly perceived and held in mind while the innocence of the self is reestablished. When parental behaviors or projections are particularly toxic and relentless, however, such a state can only be established by an equally forceful and relentless counterprojection. The second significant self-other paradigm is therefore one in which badness is projectively evacuated into the other, and the self once again feels a sense of internal goodness, innocence, and sanity. The child is able to withstand parental projection and adequately perceive that all badness does not lie within herself—as long as she perceives no badness whatsoever in herself. The therapeutic dilemma in this self-state is that, although it allows the patient to experience her own internal sense of goodness and to rely more constructively on her internal sense of sanity, she can be projectively blinded to the significant aspects of her own participation that contribute to evoking these more negative interactions. The intensity of the counterprojection required by the patient to sustain her innocence requires that such an innocence be total and complete. The paradoxical aspect is that, although she believes herself to be more lovable, in this self-state she has experientially sacrificed the important state of feeling adequately loved by the other, because the "devil," once projectively constructed, is incapable of loving the other. The analyst buffeted by relentless malignant projections finds it quite difficult, sometimes impossible, to locate analytic love for the patient. Once again: to feel loved she must render herself insane; to feel sane she must forego feeling loved.

In her work on malignant envy, Melanie Klein made it possible to understand how one can hate what is good. She taught us how to integrate a hatred for the good object into our clinical work. She clarified how when the patient stands up and screams, "I hate you," she is often saying, "I hate that I love you. I hate that I need you. I hate that you can give me what I cannot give myself." In the present paper, I am grappling with the inverse unconscious paradigm: the ways in which we often seek to find, engage with, and love our most malignant objects (our patients' and our own); the ways in which provoking, seeking, and engaging with the worst that the other has to offer unconsciously secures our own internal sense of goodness, righteousness, and innocence. It is only by acknowledging that we often hate what is good in others and love what is most evil that we bring into conscious awareness the unconscious and dissociated complementarity that can fuel such repetitions and collapse self-reflective functioning.

To the extent that we see this split in our relationship to bad objects as universal, we must of course look at the analyst's experience of these oscillating states as well. Most of us now accept that the analyst comes to the therapeutic endeavor struggling with his or her own internal demons, striving to heal others, but in so doing, striving also to reaffirm and revitalize his or her own sense of internal goodness. Let me suggest the possibility that the analyst as child among his or her own bad objects struggled to feel sane amidst insanity; to preserve his or her sense of mental integrity by seeing more clearly the pathology of others. "To feel sane I must forego love." In later work with patients, the analyst is caught between the counterbalancing needs of continuing to locate pathology clearly in the other and not the self and also of curing the other, who is seen as sick, so that the analyst may be loved and nourished once again. Perhaps more than others, we analysts are subject to this particular vulnerability (Anthony Bass, 2001, personal communication).

However, even if the therapist can free herself from her own toxic self-states and from her need to evacuate them into the patient long enough to reflect on what is happening in the therapeutic relationship and to interpret that process; the therapeutic/interpretive dilemma remains problematic. For if I manage to offer my patient an interpretation that feels empathic and resonates with her own internal sense of our shared experience, the transference-countertransference complementarity shifts, and rather than feeling warmed and nourished by an empathic and meaningful comment that she can take in and use, the patient feels shamed and humiliated by my empathy (because it challenges and contradicts her projections). Here her own inner sense of goodness and sanity, a sense held in check by the evacuation of all that is bad into me, ricochets back against her and resurrects her own episodic and dissociated sense of internal badness. When the therapist is experienced as nurturing it fills the patient with shame and not warmth. The therapist is either bad and has nothing to give, or the therapist manages to touch and reach the patient, and in response the patient feels so hateful, shame-filled, and loathsome that she feels that she deserves nothing. It seems that something in the therapeutic stalemate must shift so that both badness and goodness can be jointly held and experienced together. It is not that the patient must give up seeing the bad object in the analyst, but that she must first give up seeing this badness as residing exclusively within herself. Then and only then can she believe in the analyst's actual rather than total and projected badness, and only then can she see the process of her own projection without blinding shame. Likewise, the analyst must come to see the ways in which she searches for pathology as the most acceptable derivative of badness in the patient, to accept her own projective resistances to allowing the patient to occupy both good and bad self-states simultaneously.

On Friday afternoon I am still sick, anticipating a weekend of soft blankets and hot liquids. I brace myself for Karen's entrance. She looks at me as if sizing up my physical state, my preparedness to engage in a battle worthy of our history together. But I notice, almost immediately, that something feels palpably different. The air feels warmer, her eyes look softer and more searching, and my own body seems to relax even before I can formulate the experience. The words follow. "You really do look lousy," she says, with an uncharacteristically warm and playful smile. "I feel lousy," I counter, smiling to let her know that my form of "lousy" is tolerable and manageable by me but seeing no point in attempting to deny the obvious. I am transfixed by this "other Karen," attempting to hold her there with my response, continuing to perpetuate this other form of relatedness by the words I choose and the kind of playfulness I might offer.

Karen reaches down into her book bag and pulls out a large silver thermos and mug. As she opens the thermos and begins to pour, the warm smells of honey, vanilla, and cinnamon fill my office. I am mesmerized as I watch Karen, intrigued with her swift and competent movements. "This will be good for you," she says. "My grandmother used to make it for me when I was sick. It is a combination of hot tea and hot milk with a lot of other wonderful stuff." She holds the mug out to me, an expression of intense pleasure and hopefulness suffusing her face. As I reach for the mug, our fingers touch for an instant, and I recall that my own grandmother brought a similar recipe with her from Russia, one that she would prepare for us when someone in the family was sick with a cold. There are now two more personas squeezing into our already overcrowded analytic space: Karen's grandmother and my own. The evocation of both of our alternate mothers seems not accidental.

I will myself to think, despite the feverish buzz in my head. My patient is attempting to feed me warm milk. There must be an incredible interpretation in this somewhere! Who was I at this moment in the transference? Was Karen afraid that I was going to die like her father? How did this relate to the unconscious fantasies she harbored about the reasons for her father's sudden death and about the role of her own aggressive and murderous thoughts? Should I interpret her outrage and horror at his abandonment, her sense of guilty responsibility for his death, her compulsive need to destroy and then feverishly resuscitate all that is good in her present relationships? Or was this interaction about a more loving, less ambivalently attached, more genuinely nurturing self who had somehow died along with her father? Had I unconsciously spoken in her

father's voice, exhibiting his demeanor—his unique affective array—in relation to her? In so doing, had I unknowingly resuscitated a ghostly self-organization that had existed only for him? Did I need to engage this emergent, unconscious aspect of Karen's self, talk to her, accept her offerings, actually drink her warm milk? Did I need to do so long enough for this fledgling wisp of self-experience to organize itself, to shape itself around my words and emotional response, to set down roots that would sustain it through the trials and tribulations of more traditional interpretation?

But maybe this wasn't about Karen's father at all. What of her mother? How enraged would Karen be if I allowed her to nurse and take care of me as she had always had to manage her mother's illnesses, if I drank her milk instead of offering her mine? How exploited might she feel? What of the omnipotent mother who lurked behind the sick one? What angry, competitive feelings existing between us would fail to get elaborated and contained in the analytic space if I was not able to interpret Karen's enactment and encourage her to reflect on her present behavior?

Ironically, all of these interpretive musings seem important; all things that Karen should understand. Most of them were interpretations that I would have to make at some point. But the maddening dilemma of such therapeutic moments is that they allow space for only one analytic response out of myriad possibilities. The therapeutic choice is not which interpretation is right and which is wrong, but rather, which comment out of all possible comments is the most important one for Karen to hear—and to hear at this particular moment of time and opportunity. For me—and, I believe, for many relational analysts—a full engagement with this question involves not simply a consideration of the content of any possible interpretation but a full analysis, as well, of the self-states of analyst and patient that occupy this interpretive moment. As I have stated the question in previous writing, we must ask ourselves, Who in the analyst will speak in this particular moment, and who in the patient will be listening and receiving that interpretation? (Davies, 1999, p. 193).

As Karen leans toward me with the cup of tea, I am suddenly awed and humbled by the remarkable, almost incomprehensible complexity of psychoanalytic process and change. It is not simply that any analysis consists of an infinite number of such moments, but also that each moment contains a multitude of different interpretive channels and modalities: words, actions, facial expressions, body language. Do I chuckle when I say something; do my eyes express warmth, concern, playfulness or frustration? “You look lousy,” says Karen. “I feel lousy,” say I. But I smile. It is not premeditated, it just happens—the intersubjective meeting between my self-state of the engagement and hers. The smile honors Karen's recognition and sensitivity to my condition. She is noticed and appreciated in that moment. She has dared to enter my world, and she finds herself welcome there. How different “I feel lousy” would seem if it were accompanied by emotional flatness and withdrawal or by a sense of overwhelmed desperation akin to her mother's depressions.

I take Karen's mug in my own hands, breathing in its healing, aromatic warmth. I feel a moment of guilt as the intoxicating smells and moist heat penetrate and soothe. I grow aware of an insidious little burst of shame over how much I had hated Karen on the day before and had dreaded her session this afternoon. Perhaps I have been wrong about her. Perhaps I am the one who is cold and withholding and stuck. Perhaps I am undeserving of such kindness. I take passing note of the countertransference complementarity, as I take a long, deep, healing gulp of Karen's milk, not so much to be a good object for her as to acknowledge the hopeful plea for recognition of her goodness and generosity, a plea that is written all over her face: a plea to let her be a good self. “My milk is good and nourishing; it will heal you,” says Karen's gesture. “Yes, your milk is good and nourishing and healing,” responds my action. I think of Harold Searles's (1979) belief that the patient needs to feel capable of healing the analyst. I think also of Thomas Ogden's (1994) description of “interpretive action” as

the analyst's use of action to convey to the analysand specific aspects of the analyst's understanding of the transference-countertransference which cannot at that juncture in the analysis be conveyed by the semantic

content of words alone.... It accrues its specific symbolic meaning from the experiential context of the analytic intersubjectivity in which it is generated [p. 219].

I smile at Karen through the steam, and she smiles back. I not only like her again, but I like myself as well. I am also good—capable of being nourished, of accepting warmth. There is now such a warm, fragrant, milky goodness between us that it would be easy to hang on, to stay there, to let the “milkiness” of the moment drown out the opportunity rather than potentiate it. How can I sustain Karen's smile, her love of self, in this moment, while at the same time work to bring the events, experiences, and affect states of the day before, the self-other organizations of evacuated evil and envy, into conscious contact and coordination? Is there a way for each of us to hold and sustain the extruded malevolence that defined our therapeutic impasse of the day before with the loving goodness of the present moment? “I like it better in here today,” beams Karen. “Yes,” I respond, taking another gulp of Karen's milk, hoping that my “interpretive drinking action” will sustain Karen's present self-state and yet allow for the emergence of the other selves, hers and mine, for whom I now reach with interpretive words. “But what of those two other people who were in here yesterday?” I ask her. “They were pretty awful. What are you and I to make of them?” Will it be possible, I wonder, for word and action to move in two different directions, holding complementary self-other organizations in simultaneous awareness. Can I “drink in” our goodness while speaking of our enormous potential to hurt and shame each other?

“You hate that me,” declares Karen, her eyes becoming narrow and her face darkening. “Yeah sometimes,” I acknowledge, hoping that the enactment between us will sustain Karen's good self while I make use of the moment to verbally acknowledge my hatred for the other. I flash to the night before, to the interpretation I held at bay in order to reflect on it further. “But hating you isn't even the worst of it,” I counter. Karen's eyebrows are raised. The darkness is held at bay for a moment; it hovers, waiting. “The worst part of yesterday, of times like that between us, isn't that I start to hate you,” I tell her. “It's that I start to hate myself. I really hated myself last night more than anything, certainly more than I hated you.” The darkness dissipates for a brief moment. My patient's eyes seem to register curiosity. Karen giggles despite herself. Her giggle surprises me and catches me off guard. “Really?” Karen asks, “you really hated yourself more than me? I mean, you sometimes hate yourself?”

I think here of Emmanuel Ghent's (1992) notion of “object probing.” “I often hate myself,” I say, and before I become conscious of it, I find that I am laughing, too, giggling with Karen. For this very brief moment, we have become coconspirators, coconstructors of alternative selves too toxic to be owned independently but now held, sustained, even tentatively enjoyed as a moment of commonality between us. The shame that had filled our respective experiences of the night before is now rather tenuously held at bay by the strength we bring jointly to the endeavor. It begins to transform ever so slightly and to become tolerable.

“You wouldn't consider telling me what you hate about yourself, would you?” Karen asks. “I don't know, I might. Maybe we could take turns,” I answer. My eyebrows go up. I smile. We are playing with each other. “You are good, Karen,” say my eyebrows and my smile. “You can afford to be a bad self sometimes. You can be both.” In this manner, a kind of Bionian transformation occurs in which the analyst holds the patient's toxic projections, transforming them internally, and handing them back as not quite so horrendous or deadly. Of course, in these moments with Karen, I think of none of these things explicitly. It is not that I am aware of my eyebrows, my lips, or whether or not I drink or don't drink at a particular moment. Such movements are part of an unconscious psychoanalytic sensibility, controlled and coordinated by the fluid mix of transference-countertransference processes. But they speak along with our words. In many cases, they determine the nuances and textures of how our words are taken in, and of what our words come to signify for the patient. “Yes, I am bad like you. I have an evil self, too. And yet (unlike your parent) I can think of, even speak of, my evil self and survive. I can even smile. We can be bad together.” Here, the repetitive complementarities in the transference-countertransference (which I discussed earlier) begin to break down. Karen does not have to be

the only bad and crazy one in order to feel loved by me. Nor does she have to demonize me in order to feel sane. For me, a space has been created in which my own shameful self-states become tolerable. Aspects of my own behavior that may be touched with anger, envy, indifference, self-absorption, or self-interest can now be taken back into the self so that Karen can watch me survive the owning of them.

I tell Karen a little something about the icy, bitchy self I had to struggle with when we fought in our last session, about how painful and shameful it was to feel that part of myself in my work with her. She was amazed that I could feel shame about parts of myself and was uncharacteristically quiet and reflective. "I hate myself most of the time," she tells me almost in a whisper. "Deep inside, I'm evil. You'll say that's not true, but it is true. I'm evil. The only time I feel good is when I find the evil parts of other people ... like with you. It makes me feel less alone." Something is clearly happening here to the experience of shame. I can speak with Karen about feeling vulnerable: how it feels for me to be vulnerable with her, how it feels for her to be vulnerable with me, the different ways in which one can respond to the vulnerability of a loved other. Some people would call the things I share with Karen as we reflect together on our more hated characteristics, "self-disclosures," but I disagree. I suspect that, in those moments, I tell Karen little about myself that she has not already discerned for herself from our interactions. Rather, I like to think that the message here is in the process: that shame is tolerable, that it won't necessarily destroy, that it can be met with love and recognition and self-acceptance even though the aggression and its effect on others must be taken seriously.

As analysts, I believe that we must be able to fully occupy the countertransference as it is constructed in the enactment with any given patient. My point has been to emphasize that particularly toxic impasses can occur when something in the patient's history of extruded self-states engages with something in the analyst's history of extruded self-states. In such instances, the boundary between self and other collapses in the mutual spitfire projections and counterprojections that ensue. The analyst's space for self-reflective processes becomes compromised and potentially shut down when overwhelming shame contributes to his or her rejection of a patient's unconscious communication. The analyst struggles not just to hold a bad object representation for the patient, but also to fend off an intolerable, shame-riddled self-representation of his or her own as part of the formidable effort to coconstruct with the patient a space in which each can feel loved and sane in the same moment.

In this context, I have come to think of certain impasses in psychoanalytic work not as enactments one can't get out of, but rather as nascent enactments that one can't fully enter and get into, because occupation of the countertransference component of the enactment is blocked by the analyst's dissociated, shame-riddled self-states. If the experience of self evoked by the enactment is too shame-filled and toxic to be held and experienced by the analyst, then the therapeutic couple can get caught in a state of perpetually resisting entry into the very enactment that they must enter in order to occupy a particular transference-countertransference state long enough to understand it from the inside and together create something different.

I conclude by relaying a dream that Karen reported to me several months after the sessions described here, during the time when she and I were actively involved in exploring her more shame-filled and loathsome self-states. Karen reports

I am walking out on a long pier that reaches out into an enormous body of water. I'm surrounded by water on three sides and must balance on this somewhat old and rickety dock. At the end of the dock, in the water, I see something, some kind of creature ... extraterrestrial or something. It is made of steel and metal, with a sticklike body and a cube for a head. It has a face and two enormous eyes. It seems to be drowning in the water, gasping for breath and going under, then coming up and gasping again. It reaches an arm out toward me, and in this unbelievably awful, inhuman, synthesized voice it sort of whistles, "Help me." It wants me to reach out and grab its hand, but I can't. I am repulsed and revolted by the very idea. The thought of touching the thing makes me feel ill. I notice that the creature has something in one of its eyes. It looks like a foreign body, like oil

on water. The eye is irritated and painful, and the creature keeps blinking, to try and clear it out. But it doesn't work. It keeps repeating, "Help me, help me." And so finally I take a deep breath and reach out for its hand. As our hands touch, I feel cold metal, and I am overwhelmed by nausea and dizziness. I close my eyes, because the feel of the creature sickens me and I think I will throw up. But when that feeling passes and I open my eyes, I see that the creature is crying, from both eyes, not because it has something foreign in its eyes but because it is grieving. They are sad tears. And I notice, also, that the creature is beginning to grow skin. It is becoming human. ... extraterrestrial or something. It is made of steel and metal, with a sticklike body and a cube for a head. It has a face and two enormous eyes. It seems to be drowning in the water, gasping for breath and going under, then coming up and gasping again. It reaches an arm out toward me, and in this unbelievably awful, inhuman, synthesized voice it sort of whistles, "Help me." It wants me to reach out and grab its hand, but I can't. I am repulsed and revolted by the very idea. The thought of touching the thing makes me feel ill. I notice that the creature has something in one of its eyes. It looks like a foreign body, like oil on water. The eye is irritated and painful, and the creature keeps blinking, to try and clear it out. But it doesn't work. It keeps repeating, "Help me, help me." And so finally I take a deep breath and reach out for its hand. As our hands touch, I feel cold metal, and I am overwhelmed by nausea and dizziness. I close my eyes, because the feel of the creature sickens me and I think I will throw up. But when that feeling passes and I open my eyes, I see that the creature is crying, from both eyes, not because it has something foreign in its eyes but because it is grieving. They are sad tears. And I notice, also, that the creature is beginning to grow skin. It is becoming human.

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