Using Hate in the Countertransference to Mend the Fragments: A Sampling of a Patient's Treatment

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I work largely with "the unanalyzable" patients whose fragmented internal state and presentation puts them in danger of a completely disintegrated life. Because of the intensity of fragmentation, I have learned to embrace a radical use of my countertransference as a mutative element of the treatment.

The theoretical understanding of my work stems from Kernberg et al.'s (2015) clear conception of psychodynamics at play in their object relations based Transference Focused Psychotherapy (TFP). I make a fundamental distinction from the classical underpinnings of Kernberg, et al., however, by abandoning the notion of technical neutrality in favor of a deeply interpersonal conception, largely influenced by Relational theory (Aron, 2001) and most especially by Ehrenberg's notion of working on the "intimate edge" (2010).

In order to illustrate this understanding, I will provide a highly masked detail of a patient who most accurately illustrates this type of clinical work.

William

As brilliant as he was destructive, William came to treatment after attempting to kill himself while in his first year of graduate school. He was referred to my care in a hospital based treatment program.

William had a history of at least seven hospitalizations in which he attempted suicide and he demonstrated severe self-harming tendencies including: cutting; bingeing and purging; and severe alcohol and drug abuse. He presented in treatment as depressed and full of silently expressed rage.

Serving as his primary clinician, William proved extremely ambivalently attached. He frequently attempted to empty himself in my presence, yet would become disruptive and self-harming if I was away from the treatment for even the shortest amount of time.

After several weeks of treatment in which I had done my best to facilitate some kind of positive engagement only to be met with a frigid deathly stare, I intervened intensely with the full force of my countertransference. "I really hate you". I said. "Here I am giving you everything I can in order to try to help you progress, and you just sit here like a zombie". "Meanwhile", I continued, "when I take even a two day vacation, you immediately harm yourself." "You are clearly attached to me and our work, but you refuse to allow me to help you." As William remained defiantly silent, I ended the session twenty minutes early.

Winnicott's (1949) pivotal understanding of hate in the countertransference is central to the work with William. As Winnicott articulates, patients like William must be able to reach "a place of hate in the other" in order to be able to begin to transform this fragmented understanding of hate in themselves. Therefore, to not address these dissociated feelings, is to support the fundamental internalized unconscious belief that they must be expressed self-destructively.

William’s understanding of himself in this way emerged largely from an upbringing with a physically abusive narcissistic father and a masochistically depressive mother who was silently complicit with her husband’s ongoing attacks of physical and verbal abuse against the family. In order to soothe himself after these attacks, William learned to binge and purge as a way to offer a fragmented sense of comfort that he could then purge in self-loathing disgust. These rituals would take different avenues of self-harm, but continued throughout his young adulthood.

When discussing his symptom of bulimia, I first offered empathy. This sentiment, however, was immediately met with contemptuous disdain. I soon learned that my empathy for William’s distress was not only not comforting, but destabilizing. Consequently, to offer him comfort and support at this juncture only moved him closer to a need to defensively enact a destructive understanding of himself.

So, I changed my tack. William frequently described his sense of disgust for actions that kept him up all night as he secretly carted his vomit from a bucket to the bathroom. As he repeatedly described this ritual, it appeared he took pains to neither understand the meaning behind his destructive actions, much less allow me to help make changes.

Consequently, instead of offering what would have been a false sense of support in response to his rejection of my help, I allowed myself to be actively in touch with my feelings of anger, frustration, and disgust for his deliberately enacted self-destruction. Articulating this in session I asked, "Do you actually put your fingers down your throat?"

Shocked at my question, William nodded with the smallest hint of a smile. In response, I winced in exaggerated disgust and continued, "It is so gross to picture in my mind how you actually carry your vomit as it spills all over you!"

By purposely joining William in his understanding of himself as disgusting, sullied and filled with bad introjects, I entered his world as a familiar object. It was at this moment that he began to open up to our work in a more reflective manner.

William continued to work with me in my private practice after his discharge from the hospital. The outpatient treatment was part of his conditional reacceptance to school. Returning to the place that held such a promise for his advancement in life, it immediately became clear that William felt the stakes were high. Yet, rather than considering this interpretive understanding and attempting to work through the associated feelings related to his new advanced state, William began to withdraw from both treatment and his life. He started bingeing and purging with increased frequency and returned to a destructive pattern of abusing alcohol on a daily basis.

Without coincidence, these destructive behaviors always intensified after he had allowed himself to be close to me in a session. One such occasion occurred after he successfully completed the first half of his first semester. After I tentatively attempted to praise his success, William arrived to the next session drunk. He discussed how he had spent the evening with a former patient of mine whom he had befriended in the hospital treatment program. He noted, with a smug smile, how they "spent the night experimenting with heroin together".

Dumbfounded, I interpreted William’s actions as not only an expression of rage, but as a direct

response to treatment. I noted both his discomfort with a positive conception of himself, but most especially with my intention to offer him care. William sat in silence, staring with disgust. After refusing to speak for nearly half the session, I told him to leave and not return until he was sober.

William returned to the session the next day sober and in AA with a sponsor. He was able to reflect on his fears of allowing himself to progress in his career. He then wept as he stated: "I thought I would be dead by now; it's like I can't even conceive of how to live life". Finally, he noted how my matched level of anger and disgust was not only containing, but mutative.

Drawing a theoretical line from Ferenczi (1926) to modern interpersonal analytic thinkers, I draw on two-person understanding of treatment in which both transference and countertransference are joint creations that are unable to be interpreted in isolation (Aron, 2001). Furthermore, like Ehrenberg (2010), it is my understanding that enactments with the patient - especially with the most fragmented individuals - are not only unavoidable, but also inevitable. If survived by both participants, it is exactly this enactment that helps to facilitate change.

Survival, however, can prove treacherous. William started to make significant progress in his return to school. Yet, precisely because of this progress, he simultaneously regressed into aggressive states. This aggression was demonstrated most poignantly after a particularly vulnerable session in which William began to consciously draw connections between his attacks on himself and the history of physical torture he experienced with his father. Leaving the session crying through an expression of gratitude for progress he was making, William spent the weekend binge drinking and complaining to childhood friends about me.

I soon learned that one of these friends, an individual whom I have never met, took it upon herself to write a scathing review of me on an online rating site for mental health professionals. Upon discovering this review, I questioned William, who reluctantly admitted he had endorsed it. I angrily informed him that his actions and condoning attitude of such behavior was a direct assault on my livelihood, "All because I have had audacity to dedicate myself to trying to help you have a life for yourself".

I insisted the review be immediately removed.

Contrite, William complied with my request and reflected on the ways in which he has attempted to induce an angry response as a way to feel contained and understood in a manner that felt concordant to his internal understanding. He noted that my direct expression of anger allowed him to be in touch with the sadistic aspects of his personality that had not allowed him to benefit from treatment or move forward with his life.

This scenario illustrates the way in which the 'lived experience' between William and I - rather than simply an interpretation alone - allowed for the opportunity to experience not only a rupture, but also a consequent reparation of the split off and extremely fragmented internal state that has caused him so much difficulty in his life (Ehrenberg, 2010).

I not only interpreted the ways in which William refused to mourn the unavailable and sadistic aspects of the significant people in his life, but I joined him in his rage. It is this expression which, ironically, helped to restore a sense of equilibrium: one in which the boundaries between the self vis-à-vis the other could be reestablished in a way that was not possible with his abusive father and depressed

mother.

This situation came to a head as William approached the ending of his last term in school; and, consequently, the end of his time in which he was mandated to treatment. Although I made it very clear I hoped we would continue our work after the end of the semester, William insisted I was abandoning him and was not fully invested in continuing treatment.

As he progressed to graduation with an offer to work in a top position in his field, his drinking and self-harming behavior escalated to a fever pitch. After exhausting all options at an intervention, I succumbed to William's destruction. I stated I would only be able to resume our work when he stopped. William elected to end treatment two days before he would successfully walk across the stage for graduation.

I did not hear from William for several months. Then, suddenly, he called to say he had stopped drinking and was actively involved in AA - he asked to return. As we progress in the present, William continues to struggle with self-harming behavior and has great difficulty allowing for intimacy in his life. However, there is a new integrated flexibility in our work that allows for a more nimble maneuvering of the intense mood states that continue to threaten his equilibrium.

Recently finding ourselves in the familiar dynamic where he emptied himself in order to avoid the vulnerability of the pain of his traumatic history, he said: "Don't worry, you don't have to go all asshole on me and kick me out early; I'm just trying to gain the courage to tolerate how much you are actually helping me live".

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