

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

by

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It was a Thursday afternoon; the kind of day on which the coldness could simply 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 out 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 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 so 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 I had been helping; patients who saw me as warmer, more caring, more therapeutically helpful; 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 it - to disappoint the children, but you've done it before. It's Karen. You don't want to do it for Karen." Here I was starting to feel reeeeeaaaalllly 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." "Hmmmmm.....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....its her...it's Karen.....she has this 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 my 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 our selves. In the lexicon of professional jargon, 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, oftentimes suddenly and without warning? Why do some treatments literally 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 to me intrinsic to relational thinking that these so called "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. In this belief however, I am not alone. The works of Stephen Mitchell, Irwin Hoffman, Jessica Benjamin, Philip Bromberg, Malcolm Slavin, Stuart Pizer, Barbara Pizer, Lewis Aron, Stephen Cooper, Margaret Black, 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 that many of us have struggled with 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 which 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 me 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 amidst 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 which 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 which Karen and I occupy on this frigid February afternoon. Leaning precipitously close to the edge of the head of this now claustrophobic pin we struggle frantically, each of us, 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 onto her hateful image of me; to work with it clinically; to understand it’s meaning and history. But parallel to my therapeutic self, I seethe at her description of me and I struggle against it. I feel 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 which 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 it’s internal tyranny.

Our session draws to an end, and it has become quiet. Then... “You hate me,” says Karen. The “crunch” as Paul Russell termed it. “MMhmmm.... 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 considered sharing with Karen goes something like this, "You know Karen, I might have said, it's very hard and painful to hear when I feel like you hate me, and it is 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 am 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 it's essential therapeutic function. But simply "becoming a bad object for the patient" does nothing to erode the analysts 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 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 coauthored with Mary Gail Frawley O’Dea, (1992,1994) on the treatment of patients traumatized in childhood, we pointed out the clinical dilemma that 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 “environment mother,” and an “object mother,” to suggest as well that each patient requires an object” and an “environment” analyst. And we caution, the particular countertransference pitfall, that the analyst can come to feel SO guilty about being the one to evoke and pull for the patient’s most horrendous memories of early abuse and betrayal, that 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 her own therapeutic omnipotence. In a recent paper, Bromberg (2000) strikes a similar theme, and considers the possibility that the analysts shame over being the one to evoke the patient’s experiences of such profound pain, may precipitate a dissociated state in the analyst himself, in which he becomes unable to resonate with the patient’s experience of profound hopelessness and despair. For Bromberg it is this failed communication between patient and analyst that fuels much of the repetition in clinical work.

In the present paper, I wish to 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, 1994). In this more specific sense, I have, as analyst, not simply evoked a “negative transference” or “become a bad object” for my patient. More accurately stated, 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 which I know and have always known to reside squarely within the part of myself I most choose to avoid and disown. My point here, is to suggest that it can become the passionate mission of such guilty, shame riddled self states, be they 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 ourselves. It is I believe in the countertransferential 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(199 ) has termed non negotiable 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 (199 ) 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 Aron and Benjamin (199 ), and then later Benjamin (19 ) 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 upon that experience, to balance emotional immediacy with an appreciation of alternative possibility.

In my work with Karen and patient's 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 loving relating 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 like 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 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 than 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(1987, 2004), 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 Karen's 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 she was expected to "care for" mother; to devote herself almost unceasingly to 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** “dark spells.” I often feel as if something toxic and untrue, something malignant in a psychotic sense is being literally 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 parents reality is so vastly different from her own? When a parents 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 upon 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 (2002) has termed a “relational knot.”

I have no doubt that we all have our “Karen’s.” 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 which, 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 their

own parent which 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 the analyst’s 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 to be 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: how might that which I felt forced upon me dovetail and interact with that which any particular patient felt forced upon her? What happens when something intolerable in the patient’s parent touches upon and interacts with something that was intolerable for our own?

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, it seems to me, on the intersection of two dimensions. How toxic and shame inducing is that which is evacuated by the parent into the child, and 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 upon the child’s complete and total acceptance that she is the ONLY one who holds these negative attributions, that rather than being shared with the parent, being universal in human nature, such qualities are the patient’s own unique, self defining, and shame ridden burden to bare? In essence the child accepts the projection but identifies as well with the parental belief that to possess such qualities threatens survival, that they must be evacuated and located in others at all 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 upon a particularly intractable dissociation and oscillation of self other configurations which 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 upon 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 care giver. 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." But Fairbairn was a "one-person" theorist. What is left out of his all important formulation is the "second person" dimension, i.e. that God loves a sinner; not only because sinners sustain God's goodness, but because it is so easy to love someone who owns their own "bad" qualities, not to mention your own, and who also appeals 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, hateful, etc. she also experiences more of the parents/analysts love and positive regard. The sacrifice in this self state is that the child/or 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.

However, it is my belief, 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, lie ensconced in a self/other relationship in which the dangerousness and 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 counter-projection. 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 while it allows

the patient to experience her own internal sense of goodness and to rely more constructively on her own internal sense of sanity, she can be projectively blinded to the significant aspects of her own participation which contribute to the evocation of these more negative interactions. The intensity of the counter projection 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 loveable, she has, experientially, sacrificed the all important state of feeling adequately loved by the other. For 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 could hate what was 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 attempting to grapple with the inverse unconscious paradigm; the ways in which we often seek to find, engage with and love our most malignant objects; the patient’s and our own. The ways in which provoking, seeking out and engaging with the worst that the other has to offer, unconsciously secures our own internal sense of goodness, righteousness and innocence. It is, I believe, only by acknowledging that we oftentimes 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 in large measure, fuel such repetitions and collapse self reflective functioning.

To the extent that we come to 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. We have now, most of us, grown to accept that the analyst comes to the therapeutic endeavor struggling with her own internal demons, striving to heal others, but in so doing, striving also to reaffirm and revitalize her own sense of internal goodness. Let me suggest the possibility that the analyst as child among her own bad objects struggled to

feel sane amidst insanity; to preserve 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 to continue to locate pathology clearly within the other and not the self, but also to cure the other who is seen as sick, so that the analyst might be loved and nourished once again. Perhaps more than others, we analysts are subject to this particular vulnerability (Anthony Bass, personal comm.).

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 upon what is happening in the therapeutic relationship and 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, ricochet’s 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 I believe 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 then 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, 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, and somewhat 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 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 try to 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? About the role of her own aggressive and murderous fantasies? 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, on the other hand, is this interaction about a more loving, less ambivalently attached, more genuinely nurturing self who had somehow died along with father. Had I unconsciously spoken in father's voice, exhibited his demeanor his unique affective array in relation to her? In so doing, had I unknowingly resuscitated a ghostly self organization, who 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 this 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 the patient's mother? How enraged would Karen be if I allowed her to nurse and take care of me, as she had always had to "manage" 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 within the analytic space if I was not able to "interpret" Karen's enactment and encourage her to reflect upon her present behavior?

Ironically, all of these interpretive musings seem important. All of them things that Karen should understand. Most of them interpretations that I would, at some point, have to make. 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 one is wrong, but rather, which comment out of all of the 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 which 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, 2000).

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 that each moment itself contains a multitude of different interpretive channels and modalities; word, action, facial expression, body language. Do I chuckle when I say something, do my eyes express warmth, concern, playfulness or frustration? “You look lousy,” Karen says. “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 was accompanied by emotional flatness and withdrawal, or by a sense of overwhelmed desperation akin to mother’s depressions.

I take Karen’s mug in my own hands, breathing in it’s 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 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, but to acknowledge the hopeful plea for recognition of her goodness and generosity, a plea that is written all over her face. 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 (1979) belief that the patient needs to feel that she is capable of healing the analyst. I think also, of Thomas Ogden’s (1994) description of “interpretive action,”

...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

junction 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 (19 ) 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 co-conspirators; co constructors 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 which filled each of our experience of the night before is now rather tenuously held at bay by the strength we bring jointly to the endeavor. It begins ever so slightly to transform and become tolerable.

“You wouldn’t consider telling me what you hate about yourself would you?” Karen asks. “I don’t know, I might,” I answer. “Maybe we could take turns.” 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, whether or not I drink or don’t drink at a particular moment. They 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 nuance and texture of how our words are taken in, 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, that 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 my part, a space has been created in

which my own shameful self states become tolerable. Aspects of my own behavior which may be touched with anger, envy, indifference, self-absorption or self interest can be taken back into the self, so that Karen can watch me survive the owning of them.

I tell Karen a little something of the icy bitchy self I had to struggle with when we fought in our last session; of 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 over parts of myself. She was uncharacteristically quiet and reflective. "I hate myself most of the time," she tells me almost in a whisper. "Deep inside I am evil. You will say that's not true. But it IS true. I am 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 feel 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." I would disagree. I suspect there is little that I am telling Karen about myself in these moments 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 at the same time that the aggression and it's 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 within 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. Here 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 her rejection of a patient's unconscious communication. Here, the analyst struggles not just to hold a bad object representation for the patient, but to fend off an intolerable, shame riddled self representation of her

own; as part of her formidable effort to co construct 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 analysts 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 would like to conclude by relaying to you a dream that Karen reported to me several months into the process I have just described, during the time when she and I were actively involved in the exploration of her more shame filled and loathsome self states.

"I am walking out on a long pier that reaches out into an enormous body of water. I am 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 a creature....extraterrestrial or something. It is made of steel and metal with a stick like 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 towards 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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