

COUNTER- TRANSFERENCE AND THE SUICIDAL MPD PATIENT

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ABSTRACT

The threat of suicide from a patient can constitute an intense crisis. Intense feelings from the patient will elicit intense feelings from the therapist, feelings which can be processed and understood more thoroughly and peacefully when one understands countertransference as it pertains to the threat of suicide in particular. Using theoretical material from many sources, this paper will discuss countertransference in general, pathological relational patterns as they become replicated within the therapeutic matrix, and the potential communicative value of suicide threats and their translation into useful dynamic material using the therapist's response as a clue to the meaning the patient is attempting to convey.

"I have become a problem to myself." (1961, p. 223). St. Augustine stated the problem quite succinctly. This paper will present information concerning countertransference in general and countertransference with suicidal multiple personality disorder (MPD) and dissociative disorder (DD) patients in specific in order to sensitize therapists to avoid some of the many ways in which it is possible that we might become problems to ourselves in the course of our work with such patients.

INTRODUCTION

Even non-suicidal MPD/DD patients can be difficult to treat (Chu, 1988; Greaves, 1988; Kluft, 1990; Loewenstein, in press; Watkins & Watkins, 1984; Wilbur, 1986). Frances Tustin (1990) poignantly hinted at the depths to which this truth is known when she wrote:

Recently a psychiatrist came to see me about a patient, a physics teacher, who gave the appearance of functioning quite well in the outside world but who told this psychiatrist, "There are three of me, two are all right but the third one is sealed off and won't let anyone near. This part is leading me to destruction." The very experienced medical director of the clinic in which this psychiatrist worked said to his junior colleague, "You should never have taken on

such a patient. These patients break therapists' hearts." (p. 124)

"These patients" are frequently suicidal at some point during their treatment, a situation which gives rise to intense feelings within the therapist. Every emotion from the patient will elicit an emotion within the therapist, and the more intense the emotion the patient feels, the more intense may be the therapist reaction (Racker, 1968). All responses to an MPD patient are complicated by the often chaotic confusing inner life of the patient; there may be matching therapist confusion as many responses will be occurring in the therapist at one time (Chu, 1988; Greaves, 1988; Wilbur, 1985). As the therapist becomes familiar with countertransference patterns in general and with his or her own patterns in particular, suicidal crises will become more understandable with more predictable components. Therefore, they will not necessitate the therapist's spending inordinate emotional energy on his or her own process at the time the patient can least afford to lose the therapist. I will briefly discuss countertransference in general and then move to a more detailed discussion of countertransference in response to the suicidal dissociative disorder patient. I will discuss countertransference reactions as discrete consequences originating from one or more three separate sources: the therapist's personal psychic structure and experience, the patient's psychic structure and experience, and/or the interactions between the dissociative patient and the therapist.

Brief History of Thinking About Countertransference

Countertransference was defined by Freud in 1910 as the unconscious reaction of the therapist to patient's transference. This conceptualization of countertransference is referred to as the classical description of countertransference and is opposed by the newer more inclusive totalistic description of countertransference (Kernberg, 1965). Freud originally viewed countertransference as constituting a hindrance to treatment, something that must be first recognized and then overcome through analysis. However, his views about countertransference changed as his understanding evolved. By 1912 he was noting that the analyst must use his unconscious as a "telephone receiver" to receive and then convert back to consciousness the patient's unconscious communication so that the analyst could "reconstruct the unconscious" of the patient.

The totalistic description of countertransference was embraced and described by Racker (1948, 1957), Fromm-

Reichman (1950), and Winnicott (1949), among others, as referring to the entire emotional reaction of the analyst to the patient within the treatment setting. By including both conscious and unconscious therapist reactions as well as everything about the patient and about the treatment in this larger definition, countertransference could now be viewed as potentially helpful. Specific patients, notably psychotic, primitively organized, borderline, narcissistic and severely regressed patients, have been noted to elicit powerful countertransference reactions from the therapist (Giovacchini, 1989; Greenson, 1967; Langs, 1980, 1988; Ogden, 1989; Searles, 1960, 1986, 1990). Multiple personality disorder and dissociative disorder patients have been known to elicit strong countertransference reactions from the therapist (Chu, 1988; Greaves, 1988; Loewenstein, in press; Watkins & Watkins, 1984; Wilbur, 1986) and suicidal patients in general elicit powerful reactions within their therapists (Gorkin, 1987; Grotstein, 1990; Maltzberger & Buie, 1973; Winnicott, 1949).

Many clinician/therapists now posit that countertransference provides a positive opportunity to understand therapeutic relationship and the patient. Bion (1967/1984) wrote that countertransference can be a valuable source of information, even the only evidence on which to make an interpretation. Harold Searles (1968) agreed that, "the countertransference gives one one's most reliable approach to the understanding of patients of whatever diagnosis" (p. 190). Heimann (1950) perceived that countertransference arose from a clear underlying communication between patient and therapist and wrote, "Our basic assumption is that the analyst's unconscious understand that of his patient" (p. 820).

Among others, Little (1981) and Money-Kryle, (1956) held the view that countertransference has a definite advantageous effect on treatment. "Greater therapeutic results are found when ... the therapist experiences intense feelings and profound disturbance ..." (Little, 1981, p. 42).

However, there are those who judge that the more all-encompassing attitude concerning countertransference is too permissive in that it places too much emphasis on the therapist's process and does not encourage a truly neutral concern for the patient. Langs (1980) retained the pejorative valuing of countertransference as a force that impeded the patient's progress and was always a sign, although an inevitable sign, of unresolved therapist pathology. He wrote, "No intervention is without some modicum of inappropriate and pathological expression from the therapist" (p. 383). To continue to clarify his position, he (1988) eventually abandoned the word "countertransference" and substituted the word "therapist madness."

The preceding paragraphs are merely intended to remind the reader that attitudes concerning countertransference have not remained unchanged and that the cognitive dimension through which one views a subject will have an impact on the affective manner in which the subject is experienced. The next section will address therapist understanding of patient and therapist attitude towards the subject of suicide and death as an essential portion of the foundation for understanding the present situation.

ATTITUDES CONCERNING SUICIDE

Both therapist and patient bring their own attitudes concerning suicide, death and available options to the suicidal crisis and these attitudes influence one another even if they are not consciously known. As Freud (1953) wrote, "It is a very remarkable thing that the Unc. of one human being can react upon that of another, without passing through the C's. This deserves closer investigation. . . but descriptively speaking the fact is incontestable" (p. 194). If the therapist consciously understands what he or she can, the task may be slightly simplified.

Patient Attitude Concerning Suicide

I will not discuss here the many motivations for suicide in the general psychiatric population, but will confine my remarks to those concerning MPD/DD patients. The thought of suicide seems to be an ego-syntonic feeling for many multiples, a feeling they have had often in their lives and a feeling they will have often in therapy until the issue is resolved. MPD patients' personalities speak as if they are unclear about the reality of death, they speak as if they (or parts of them) believe that one personality can kill another, that one personality can live while the others die or that a personality can simply go get another body if they kill this one. They often speak as if they view death as children do, without comprehending the final nature of their proposed choice.

They seem to evidence a rather cavalier approach to their own death, an attitude that may seem more reasonable when one remembers their own experiences. Each personality and each fragment of a personality has, at some time, actually had the experience of splitting off from the rest of the person. In addition, many, if not most, personalities have had other personalities or fragments of personalities split off from them. Prior to the splitting, the affect or conflict would have been unbearable for the whole of the person. They reached the limit of human endurance, the absolute end of the psychic ability to tolerate and, at that time, relinquished their hold on life as they were experiencing it. Therefore, many portions of the person know, on an experiential level, what it means to give up; consequently, they may think they know what it means to give up and die. The thought of suicide may be seen as a portion of a re-enactment or the unconscious replication of an actual previously-discovered defense mechanism.

Therapist Attitude About Suicide

The possibility of one's patient killing themselves brings forth many emotions which I shall discuss later. In this section, I will confine my remarks to the therapists' cognitive attitudes about suicide, their intellectual beliefs concerning the possibility of ever considering suicide as a desirable option for a patient. Gorkin (1987) clarified his feelings that although he did believe, at times, suicide might be the best alternative, he had never met a patient for whom he believed such to be the case. A therapist who believes in life after death and/or in reincarnation may have a different attitude about death than one who believes that nothing exists beyond

this lifetime. Every therapist stance carries with it treatment implications, implications which must be identified and included in the therapist's general thinking about the present situation. Gorkin (1987) wrote of some of the implications of therapist belief:

The danger of holding the view that suicide may be an appropriate course of action is that this view can become a self-fulfilling prophecy, especially if it becomes harnessed to the therapist's unconscious countertransference wishes to rid himself of the patient. On the other hand, when the therapist holds the opposite conviction—that suicide is never an appropriate course of action—he may find himself malignantly out of touch with the patient who is convinced that it is the right course for him. This is especially possible if this conviction is employed by the therapist as a shield against induced feelings of hopelessness and despair. (p. 135)

If the therapist has had personal experience with the thought of suicide as a real possibility or has attempted suicide, the countertransference complexity is increased. Racker (1953/1968) wrote that countertransference "is the expression of the analyst's identification with the internal objects of the analysand" (p. 129). The therapist who has seriously contemplated suicide may have a greater propensity to identify with or alternately to defend against identifying with the internal objects of the suicidal MPD/DD patient.

The patient may also identify with part objects of the therapist, as Searles (1990) describes in his discussion of patients' temptation to leave treatment. We can extend this to include the temptation to leave life should the therapist have unresolved part objects which also contemplate this option.

Time and again, one sees (or hears about in supervision) a patient who recurrently acts out by absenting himself from work, or who recurrently threatens to quit the therapy and get a job in some other part of the country. In one instance after another, I find evidence that the patient is unconsciously identifying here with part-aspects of the therapist—a therapist who is being perceived, unconsciously, as not really working, not really doing a job, or who is recurrently and unpredictably quitting his job during the session and going off God knows where into what we might call autistic reverie. In my own work with such patients, it is comparatively rare for me to feel that I am genuinely and consistently present and am doing a valid job here. Instead, I have powerful, submerged urges to chuck this whole difficult and—so often, I fear—basically undoable job and go off into some other field far away. Hence the patient who acts out in a fashion that jeopardizes our collaborative effort is almost certainly doing so partly on the basis of identification with my own largely submerged urges to escape all this. (Searles, 1990, p. 217)

TYPES OF COUNTERTRANSFERENCE

In their attempts to grasp the complexities of countertransference, many theoreticians/clinicians have attempted to separate and identify what they considered to be different types of countertransference. Glover (1927) postulated that countertransference could be understood as reflective of the analyst's psychosexual development although he realized that it may reflect the analyst's response to the patient's present level of psychosexual transference. He differentiated among countertransference as feelings originating in the analyst's oral, anal, and phallic stages as distinguished from counterresistance as a more mature analyst reaction originating from the analyst's oedipal stages (Slakter, 1987). This differentiation may have some utility in understanding some of our reactions to the crises with MPD patients, but as most of those patients seem clearly to be in oral, anal, or at best, phallic stages, the more "advanced" responses we experience with neurotic patients may not be relevant in many difficult situations. Ferenczi (1919) described *objective countertransference* as the resultant love and hate feelings of the analyst in response to the reality of the actual personality and behavior of the patient. Money-Kryle (1956) also viewed at least some of the countertransference responses as inevitable and normal response to the patient with the sympathetic nature of the countertransference arising from the analyst's tendency to see the patient as the child within himself (Slakter, 1987). It is important to realize among many components of this countertransference reaction, reality is one of those components.

Concordant/Complementary

Racker (1968) describes his observation of two different processes or identifications which occur in countertransference: concordant or homologous identification and complementary identification. Concordant identification is the resonance of the external (from the patient) with the internal (from the therapist), a process based on introjection and projection through which the analyst identifies with the matching aspects of the patient in a parallel manner. The degree to which the analyst is unable to do this smoothly for reasons of his or her own, intensifies the degree to which the complementary identification will be the primary therapist process—the one which will present more of a potential problem to the therapy process.

Complementary identification begins as the patient treats the analyst as an internal (projected) object. The analyst who, on an unconscious level, feels treated this way reacts by acting this way, and if the therapist does not recognize this, may continue to react to the projection rather than to identify with the projection. The extent to which the analyst has difficulty with an aspect of the patient reflecting an aspect of him or herself is the extent of the possible difficulty in the complementary identification rather than with the easier and smoother concordant identification which necessitates the therapist being somewhat accepting of his or her self.

Racker (1968) took into account both conscious and

unconscious countertransference forces, of the countertransference response to "the manifest and present transference... and the countertransference response to the latent and potential and repressed or blocked off transference" (p. 61).

Homogenous/Idiosyncratic

Giovacchini (1989) differentiates between *homogenous countertransferences*, universal emotional reactions which anyone would be expected to have to a particular situation, and *idiosyncratic countertransferences*, responses which arise from the individual psychic make-up or experience of the particular therapist. Winnicott (1949) refers to homogenous countertransference as objective countertransference.

Inevitable/Preponderant

Langs (1980) differentiates between "*inevitable countertransferences*, those relatively minor portions of countertransference inherent in the limitations of the therapist's own therapy and self-analysis and in his condition as a human being" (p. 318), and "*preponderant countertransferences* which exceed the fundamental minimum and become a major input into the bipersonal field and therapeutic interaction" (p. 318).

SOURCES OF COUNTERTRANSFERENCE

Many clinicians have attempted to identify or to isolate the source of countertransference within the therapist so that one might then be better equipped to understand it. Giovacchini (1989) and Ulman and Brothers (1988) postulated some specific areas of weakness or vulnerability within the therapist, some hypothesized structures within the therapist which, when disrupted, can cause considerable discomfort.

Self-Representations

Giovacchini (1989) postulates the existence of separate two variations of self-representations which are important for us to maintain in sturdy health and both of which could be threatened: a personal self-representation and a professional self-representation, both of which we have fabricated for ourselves. He described our *personal self-representation* as the totality of all we believe about ourselves. This can be threatened by stimuli which necessitate that the therapist alter his or her view of him or herself. Often the feeling of being threatened and the resultant discomfort takes place on an unconscious level which makes it more difficult for the therapist to notice emerging ego-dystonic feelings. The *professional self-representation* is the totality of all we believe about our profession and about ourselves as professionals. When a patient does not do well in a treatment which we believe should help, it may seem as if both the process we believe in and our skill in facilitating that process is being questioned. Freud's recommended evenly hovering attention is often the first (and hopefully the only) casualty of the suicidal crisis. The loss of a neutral emotional stance may cause a professional self-representation to totter before it

restabilizes. A threat to either one of these invisible but assumed psychic structures can be sufficiently disruptive that we will compensate against the perceived threat either internally or externally, consciously or unconsciously.

Our professional self-representation may be threatened when patients discuss our response to treatment dilemmas with other professionals when they are hospitalized or by their consulting with other professionals. Patients who interact with other patients of the same therapist in group are certain to discuss all manner of real and imagined incidents with each others, discussions which may threaten the professional self-representation of the therapist.

Archaic Narcissistic Fantasies

Ulman and Brothers (1988) offer a conceptual framework that includes remnants of two early fantasies, which they refer to as archaic narcissistic fantasies. These are: (1) *the fantasy of our own omnipotence*, and (2) *the fantasy of the possibility of total merger with another human being*. They perceive the traumatic meaning of any experience lies in its ability to impact on the sanctity or do irreparable harm to either one or both of those two universal archaic narcissistic fantasies we retain. The greater the stress on the fantasy, the greater the trauma from the incident.

The MPD patient threatens the therapist's omnipotence fantasies by not healing in response to the therapist's helping interventions and, therefore, making it quite clear that the therapist is not omnipotent, and the suicidal MPD/DD patient threatens the therapist's merger fantasy by threatening to abandon the therapist and die.

Identification with the Id

Little (1981) asserted that the origin of the countertransference or the "underlying mechanism for this [countertransference] may be identification with the patient's id" (p. 42). The combined id urges of the analyst and the patient work toward healing, but, at the same time, there is an unconscious identification on the part of the analyst with the patient's superego and with the prohibition against getting well, with the need to stay "sick." This identification may play comfortably into the analyst's reparative need, the need to make reparation to or to "fix" the patient (Racker, 1948). Thus, the analyst may have to make the patient sick again and again in order to make the patient well. A suicidal crisis presents an intense opportunity to cathartic intimacy, the discharge of tension accumulated in response to issues which presently cannot be or are not being addressed and are, therefore, avoided.

THERAPIST FEELINGS

In this next section, I will discuss some specific therapist feelings in response to a suicidal MPD/DD patient. Many therapists find themselves experiencing most, if not all, of these feelings at some time in response to some personality or patient.

Panic/Anxiety

Often the first emotion to be noticed by the therapist is panic. The therapist feels faced with a true crisis, a life and death situation in which it seems that an error could have disastrous consequences. And the immediate situation is confusing. It may be that the patient is not differentiating the past from the present and is re-enacting or beginning to remember suicidal feelings from the past without knowing it is the past. It may be that the patient who reports having made suicidal attempts such as overdosing or wrist-slashing is remembering something done and not actually doing something. Or it may be that the patient is talking about feelings and, because he or she is unable to differentiate between feelings and actions, cannot and does not clarify that these are feelings and not intentions.

If the therapist overestimates the patient's resources and does not take protective action, the patient may escalate the attempts in order to force the therapist to take him or her seriously. On the other hand, if the therapist over-responds to the crisis, the patient will not have the opportunity to resolve the issue and the situation will recur until it is resolved. The therapist must respond to the situation but, as Jung (1916) said, "taking it seriously does not necessarily mean taking it literally" (p. 88).

Many over-involved interventions have their origin in our earnest desire to avoid our panic/anxiety. The teddy bear, the guided imagery visualization, the long hours in session or on the telephone, the hug can all come from our very natural desire to avoid anxiety, to make it all better.

Although interventions such as these may calm the crisis at the time, they do not solve the problem. The suicidal feelings will return. If the therapist continues to attempt to avoid his or her own anxiety and make the patient better, the distance between the patient and the therapist will increase. The patient is voicing a desire to die, the therapist is advocating life. As the therapist more staunchly and more strongly speaks for life, therapist grandiosity as a defense may come into play. The therapist may experience him or herself in competition with death, with the abusive family, with organized groups of malevolent intent, with "evil" itself; a competition which may feel to the therapist as if the therapist is fighting to rescue the soul of the patient. The therapist who has strong feelings towards others involved in the patient's life is exhibiting "indirect countertransference" (Racker, 1953).

The therapist who functions as or even sees him or herself as the valiant warrior in the eternal struggle between good and evil, actually runs the risk of bringing the patient closer to acting out the desire to die. With the therapist advocating life and the patient advocating death, there may be an unconscious collusion between patient and therapist for the therapeutic dyad to externalize the conflict rather than for the therapist to contain his or her feelings enough to allow the patient to own his or her conflict. Therapists who become identified with one "pole" of the patient's internal struggle compromise the patient's ability to manage the conflict by usurping one of the patient's positions. The therapist who drives over to the patient's house and searches for the gun, the pills or the whatever is a therapist trying to

accomplish something externally that can only be accomplished internally. Overly aggressive rescue attempts cloud issues of responsibility for the patient and postpone the inevitable moment of choice. It can happen with an overly-persistent and overly-attentive therapist that the patient must go to incredible lengths to re-establish ownership of his or her own life, even to the point of suicide attempts in order to halt the over-dedicated therapist who is moving intrusively ever closer and closer into the patient's life. The therapist, relentlessly determined to "save" the patient through constant telephone calls, frequent appointments, and increasingly rigid behavioral contracts may, in fact, soon witness an iatrogenic suicide attempt.

A description of another conceptualization of the way in which an unconscious collusion to avoid or to externalize the patient's conflict occurs may be found in the discussion on projection.

Therapists who become over-involved with their patients during suicidal crises have encouragement from the patient. The patient may, in fact, be expressing her fervent hope, desire and intent that the therapist will/can/ought to take care of her and love her as she would have liked to be loved. These feelings are expressed indirectly through disguised representational communications or directly verbally. They act as if they believe:

The idea that they suffer from a deficiency disorder and that the analyst must supply them with the loving care of which they were cheated is often and despairingly proclaimed by these patients. If only the deficiency can be supplied to them, they will be happy. In truth, the patient not only wants his deficiency made up to him, but also wants the analyst to roll back the calendar and "fix" everything "bad" that happened to him. Even then he would bear a grudge that things did not work out perfectly the first time. (Krystal, 1988, p. 192)

If the therapist has bought into the model that the therapist could/should make up the deficiencies from which the patient suffered, the stage is set for the next phase of the pattern. The patient's anger at the therapist for not being willing (as the patient sees it) or able (as the therapist sees it) to give more love or better love, to "fix" them crashes into the therapist's own sense of inadequacy and helplessness, and finds an ally there.

For the analyst *believes* the patient when the latter unconsciously attributes badness to him: that is to say, he believes himself to be as bad as the patient's introjected objects which have been projected upon him and which account for the patient's main resistances. And he believes him because the patient has a powerful ally within the analyst's own personality—the latter's own bad introjected objects which hate him and which he hates. (Racker, 1968, p. 121)

Now the therapist must do something to recover from this and taking more control does not seem to help. Another possible "out" or temptation for the therapist is to begin to distance from the whole tangled mess.

Impatience/Tolerance/Anger

The repetitive aspect of the suicidal thinking in addition to the seeming intractability of the desire to die can result in impatience, in intolerance, and anger when the therapist collides once again with another version of the same theme. Although therapists may be intellectually clear that recurring issues are important as actual themes or as resistances, however,

The resistances sometimes provoke annoyance and even intense hatred; this will be the greater, the more helpless the analyst feels about the problem confronting him. (Racker, 1968, p. 121)

The fact of therapists' anger is not the problem. It is the possible expression of the anger that may be the problem. The therapist who becomes angry or annoyed at the patient's resisting progress through suicidal desires may cause us to, "behave (if only internally, like a doctor who is annoyed by a physical disease and . . . gets angry with the patient when he feels that his medical skill is not sufficient" (Racker, 1968, p. 121).

The analyst's irritation is thus, partly, of an infantile nature. It cannot be completely avoided, but it is important to know its origin, so that the child within the psychologist should not disturb him more than can be helped and so that the two children—the one inside the analyst and the one inside the patient—should not come to blows. (Racker, 1968, p. 122)

Guilt

Most therapists are aware of their own internal processes and recognize that they have become angry. They may know they may have communicated this anger in some way to the patient and feel badly about this. The anger is real, the expression is real, the guilt is real; and the interactive aspect of the interchange is also real.

If the countertransference has developed along the lines of concordant countertransference (Racker, 1948/1968) or countertransference in which internal aspects of the therapist have identified themselves with internal aspects of the personality (in the case of anger, with internal aggressors or internal persecutors), the therapist may be relating both to his or her own feelings and to the patient's in the interactive matrix of the therapeutic dyad. If the therapist has not satisfactorily accepted his or her own aggressive/persecutory aspects, the countertransference will veer off or regress into a complementary countertransference in which the therapist is acting out or defending against the patient's internal aggressors or persecutors rather than being available to help the patient understand. The therapist may now feel

guilty for aggressive impulses or expressions.

This identification with the aggressor or persecutor causes a feeling of guilt; probably it always does so, although awareness of the guilt may be repressed. For what happens is, on a small scale, a process of melancholia, just as Freud described it: the object has to some degree abandoned us; we identify ourselves with the lost object; and then we accuse the introjected 'bad' object—in other words we have guilt feelings. (Racker, 1968, pp. 139-140)

These do not have to be extreme expressions. They may be no more than a little edge to a voice as the therapist reminds the patient that she is feeling suicidal now because she refused to deal with her feelings in session that day, or a slight or not-so-slight angry feeling of righteous justification and punitive aggression as the therapist insists the patient go to the hospital if she cannot keep herself safe, stop cutting herself, or threatening to kill or cut herself.

Hate

Winnicott (1949) and Maltzberger and Buie (1973) have discussed countertransference hate, "a mixture of aversion and malice" (Maltzberger & Buie, 1973, p. 625). Maltzberger and Buie believe countertransference hate is inevitable in the treatment of suicidal patients. They posit that "suicidal patients tend to evoke the sadism of others; often they can only maintain object ties in the sadomasochistic mode, and these they usually tolerate reasonably well and for long periods of time" (p. 626).

Maltzberger and Buie wrote that, "Without exception the transference of borderline and psychotic suicidal patients will involve denouncement of the therapist as a cold, uncaring person" (p. 628).

These statements/accusations of the therapist as a cold and uncaring person are triggers for the therapist which may result in the activation of those old introjected parts of the therapist who deep down believe that the therapist is, in fact, "bad."

One of the manifestations of the patient's anger of/hatred towards/acting out or projecting patterns of anger and hatred from childhood towards the therapist can be found in a pattern, "the analyst as unwanted child" (Searles, 1986). The patient replicates within the therapy relationship old family patterns with the attitude of the patient's mother adopted towards the therapist. This is an attitude of blaming and reproaching with the message that everything bad is the child's fault, that had the child only not been born, mother's life would have been at least a paradise of personal fulfillment and that the patient's life would have been much better had only the therapist never entered the patient's life, only never messed things up, only never made it worse, etc. Past rage directed at the child is now present rage directed at the therapist.

Therapists who defend against recognizing their hate for the patient may become overly solicitous of the patient to compensate for their dysphoric perceptions of their own

inadequacy. Racker (1968) wrote, "The guilt feelings over his own lack of love... that the analyst feels with some patients may also lead him to masochistic submissiveness" (p. 123). Understanding this as replicating some of the patient's internal or external experiences, recognition of masochistic submission can be useful for the treatment.

Closely Connected Feelings: Hurt and Helplessness

Hurt and helplessness have caused great difficulty for therapists of suicidal MPD patients. Variations of these feelings, feelings which may date back to infant feelings, are powerful.

A suicidal MPD/DD patient usually also has the capacity to be a homicidal MPD/DD patient. We are beginning to appreciate the rage MPD/DD patients have. Terr (1991) wrote about children with words that surely apply also to adult patients: "The rage of the repeatedly abused child cannot safely be underestimated" (p. 17).

These patients never learned to express anger in a way that did not hurt someone, and as they begin to express their feelings, they begin in familiar (to them) ways. Some patients remain in an acting out pattern for a long time during which they discharge their energy and their discomfort by hurting themselves or someone close to them. As the feelings intensify, their sense of their need to hurt someone also may intensify. Transference patterns have demonstrated that patients find it easier to transfer their anger from the real sources of their past pain to a "stand-in" for a time. It is at that time some MPD patients have threatened and/or actually attempted to harm their therapist either personally or professionally.

Maltsberger and Buie (1973) observed that "fantasies that the patient poses a threat to one's safety or reputation can give a clue to homicidal impulses being awakened in the therapist" (p. 629), but these do not always remain fantasies.

Hurt

Therapists believe in their work and in their patients. Most therapists make emotional commitments to their patients and although the relationship is clearly based upon a contractual agreement, therapists do care about their patients and work hard to do what they can to help the patients heal. When the patient is threatening to kill herself, therapists may experience this as a narcissistic injury, perhaps in addition to personal sadness and hurt, hurt that the patient would give up the chance to heal. It is only as the therapist can sit with his or her hurt, that the patient can do the same.

Helplessness

Few feelings are more difficult to tolerate than helplessness (Krystal, 1988). Our patients, helpless as children, make us feel helpless now. Our helplessness feels more intense and possibly overwhelming with the extent of their helplessness as so total and so overwhelming. In order for them to make their peace with helplessness as from hurt, we must make our peace with our helplessness; not run from it, not compensate for it, not deny it—but to learn to hold it, to feel it, to endure it. Little describes her view of the change

or necessary shift in the therapist's stance from active to acknowledgement and acceptance of helplessness as treatment with a suicidal patient continues:

For a longer or a shorter time the analyst (or some psychic extension of him) is all that stands between the patient and death, and at some moment he has to stand aside and allow the patient to take his life into his own hands, ...integrating with himself and becoming either a living person or a corpse. The analyst can do nothing but be there, a whole and separate person, with his own unity which he has made available to the patient. (Little, 1981, p. 119)

It is essential for the therapist to accept helplessness, his or her own as well as the patient's, and yet to see life as potentially rewarding. Bollas (1990) wrote that patients who rely heavily on primitive defenses, as MPD/DD patients do,

...sponsor the regressions in the analyst, rather than within themselves, analysts will endure regressive episodes from which they recover through time, patience, and reflective work. When this is so, analytic insight and interpretation are in the first place curative for the analyst, who gets better first. Psychic change, in this instance, begins within the analyst. Only gradually, through interpretation, holding and the passing of time, does the patient get better. (p. 352)

Tower (1956) taught that the patient's resolution depends significantly on the analyst's resolution of the countertransference syndrome. Little (1951) conceptualized the entire process as an interactive process with analysis being a dual process in which analyst and analysand regress together and do their most important work on an unconscious level. (Slakter, 1987)

Therapist Despair and Disillusionment

Despair, a part of each suicidal patient's deepest reservoir of feelings, is an unavoidable therapist response at times. As one hears how people have treated each other for generations and then discovers yet another layer of personalities espousing yet deeper commitments to torture and death, the impact reverberates. There is no easy answer. There is no emotional stance that can avoid the very real pain of very real situations. There is no way to face childhood abuse without facing the despair, the grief, the mourning. Michael Gorkin (1987), when faced with despair, responded in this manner.

I realized then that probably the only way I could help W. was to sit it out with him. And so I did, feeling in part of my ego quite as impotent with him as he felt with his own life. In the other part of my ego, the observing or analyzing part, I knew that I could not give up on him; I could neither withdraw from him nor abandon him. In other words, I needed to manage his despair and my own. What I did

during this period, then, was not to talk of my despair or his despair, but our despair. I told him, "We are stuck, and we have not yet figured a suitable or manly way for you to go on with life." And I added, "The rifle will always be there to blow your brains out, but if you can tolerate the pain, try to hang on and let us see if there is some way to live." I do not think it was my hopefulness alone that helped, but the willingness to look for hope after having entered the position (to which he had brought me) of helplessness and despair. (p. 150)

Disillusionment

This feeling often accompanies later treatment when suicide threats do not come from unrecognized abreactions or from "new" personalities, but rather from the depths of the patient's belief that life is not as good as it "ought" to be, not worth struggling to continue. Therapist disillusionment may match the part of the patient that feels such disillusionment, may present another opportunity for the therapist to manage his or her own feelings so that they can "give them back" to their rightful owners.

This is not to say that the therapist might not have real disillusionment of his or her own. In the early days of treating MPD when we conceptualized the dissociative defenses as the problem, complete healing seemed more plausible. Now that many MPD/DD patients have progressed in therapy so that they no longer use dissociative defenses as their primary defenses and no longer fulfill diagnostic criteria for MPD or even DD, the effects of their traumatic pasts linger and create difficulties. In addition, it has become more obvious that some MPD patients choose to remain in lifestyles that seem abhorrent to the therapist.

Desire to Distance

A therapist may distance from that patient or personality in any one of many different ways. Asking to talk to someone else who can help or to someone who feels better may be useful to gather additional information or as a crisis intervention, but will not resolve the issue. Therapist intervention may externally distance both therapist and patient from the suicidal conflict and the therapist may also distance internally from the patient. Numbness, boredom, or sleepiness on the part of the therapist are all forms of emotional withdrawal from the patient, from the therapist's own feelings or from the material the patient is discussing. Ralph Greenson (1967) wrote, "Boredom, no matter what else it may mean, is a defense against fantasies" (p. 68), the patient's fantasies or the therapist's fantasies in response to the patient or of his own.

Therapist emotional withdrawal and disconnection from the patient is perhaps the most ominous and most dangerous countertransference reaction (Gorkin, 1987; Maltzberger & Buie, 1973; Ogden, 1979) and also one of the easiest ones to overlook. One rarely thinks of what one is not thinking of. If the therapist withdraws emotional energy from the patient at the same time the patient is withdrawing energy from life itself, it can result in increased isolation for the

patient, perhaps another re-enactment, and the life thread might be more easily broken.

INTERACTIVE ASPECTS OF COUNTERTRANSFERENCE

Little (1951) was one of the first advocates of viewing countertransference as an interactive process between therapist and patient. McDougall (1979) pointed out that patients who have endured trauma before they can communicate verbally must communicate such experiences other than verbally, in such a way that the therapist must receive the communication through countertransference. These communications occur through projective identification, projection, and parallel processing, defensive or communicative mechanisms common to all primitively organized patients. In addition, MPD/DD patients send out simultaneous, complex contradictory communications by different aspects of the patient which engender simultaneous different emotional responses from the therapist.

Projective Identification

Projective identification, a term first introduced by Melanie Klein (1946), is a process through which the patient splits off a feeling, an idea or an aspect of self from himself, attributes it to or attempts to lodge it in another person, someone to whom the patient is intimately bound. Then the patient can continue to relate to the feeling or attribute without owning it himself. Projective identification is an early form of projection (Kernberg, 1965) and occurs in all long-term therapy. A patient and the therapist may be involved in a projective identification when the therapist is invited or enticed into acting out the part of the parent.

One of my patients was angry and felt that I was not taking care of her sufficiently. She told me of her anger that I had not done what she had wanted me to do, and instead of continuing to focus on her feelings and associations, I asked her why she thought I ought to have done it. She had answered, "Because you're my therapist." In an instant countertransference regression, I retorted, "Yes, I'm your therapist. I'm not your mother."

Later, I realized that actually I had sounded a great deal more like her mother than I had sounded like her therapist. The intensity of this interaction, of her projection and my response might be understood as the result of her traumatic infant experiences during which she had been subjected to violent projective identification by her parents (Grinberg, 1962).

Projection

Projection, a more advanced defense than projective identification, is a process in which the person projects beliefs, attributes, or feelings of one's own onto or into another, and then proceeds to relate to the externalized contents as if they were separate. One such projection from MPD/DD

patients is the projection from personalities who are accustomed to and only feel safe with a feeling of internal deadness or total numbness, in fact, only feel safe with that feeling. Having developed the ability to numb feelings, first against the potentially overwhelming effects of traumatically engendered feelings and then against all feelings, parts of the patient are frightened to abandon that defense. Those parts perceive any feeling as an unendurable threat. The patient or personality may "put out" (Searles, 1960), or project the feeling of internal deadness and emptiness towards the therapist who may not consciously recognize what is occurring. As the therapist unconsciously begins to respond to this projection, the therapist may refuse to accept the projection, and may, in fact, actively though still unconsciously, be attempting to prevent emotionally fusing with the patient.

The therapist may then attempt to alter the patient's feelings rather than to accept the projection. The therapist may begin to talk about hope or to try to give the patient a feeling of enjoying being alive, the very feeling the patient would find most threatening. This attempt is, understandably enough, unconsciously or consciously, perceived by the patient as an abandonment and is intolerably frightening for the personality who associates feeling with overwhelming terror. The patient may then escalate his or her efforts to retain the safe, "dead" feeling. Some of the self-mutilating activity or suicidal desires could be understood in this paradigm as the person seeks to use pain to quickly dissociate, replicating their early discovery of dissociative numbing.

Part Responses

Little (1981) hypothesized identification with a part of the patient as the model for understanding the countertransference process in general and with MPD patients who elicit a variety of partial responses which may match one or another of their personality stances, this is even more possible. Our patients, abused and hated as children, introjected aspects of their abusive caretakers and developed a variety of complementary and contradictory responsive patterns. Because we are emotionally connected to our patients, we will find ourselves drawn into replicating both parental and internal stances. We must expect uncomfortable feelings as we enter their worlds and experience feelings from within their worlds, feelings which may not be familiar for us; an inclination towards physical violence, towards humiliation, towards any strong punitive feeling.

Although I usually felt concern and warmth for a particular patient, one day as she was discussing suicide as her decision about the solution to her dilemma, I was filled with feelings of utter disgust and loathing. Her face, her body, her smell repulsed me. As I studied my feelings in amazement, I remembered one particular personality who insisted she was Mother and viewed the patient as mother had. I asked if this personality was around and indeed, she was, railing at the patient from inside. As soon as I identified her activity, my abhorrence abated

and she proceeded to grapple with the issues she had been avoiding.

Parallel Processing

Dissociative patients process their feelings in a dissociative manner and there is a possibility that the therapist will be inadvertently co-opted into that same process in a form of parallel processing.

A patient (L.) had purchased a gun with which she intended to kill herself. She had done similar things before preceding the retrieval of painful memories concerning her mother. When I spoke with her briefly on the telephone between patients, she said she was not sure she could keep herself safe, a statement she had made before. I suggested she might be on the verge of another memory about her mother and she said she felt as if I was not listening to her, not taking her seriously. There may have been some truth to that as I was between patients, and I told her that I also thought she might be offering us a clue as to what feeling might be expected to occur in her upcoming abreaction.

Abruptly, L. said she knew I was busy and hung up. I thought that she might go for a walk in the park, something she enjoyed doing and had done before in tense times. I went in and sat down to begin the session with my next patient. As I began to attend to the patient, I suddenly thought, "What am I doing? L. just told me she has a shotgun, that she is not sure she can keep herself safe, that she does not feel as if I am listening to her, and here I am calmly sitting here as if nothing had happened while L. is sitting there with her shotgun." I had dissociated myself in a manner parallel to the manner in which she had handled her feelings.

THERAPISTS' SHARING FEELINGS WITH THE PATIENT

The question of whether or not the therapist will share his or her feelings concerning the suicidal crises or other therapeutic situations is beyond the scope of this paper. There has been much written with some clinicians advocating for the sharing of the therapist's feelings and even of the sharing of the unconscious precipitants (e.g., Ferenczi, 1919; Little, 1951), and others (e.g., Heimann, 1950), advocating against any such revelation to a patient. There are complications either way. The therapist who chooses to share his or her feelings with the patient may be replicating the patient's narcissistic parent whose own needs always took priority over the needs of the child. The patient will be certain to focus much attention on the therapist, partly out of concern for the future of the relationship, and partly because it is easier than focusing on the patient's own issues. Margaret Little (1981) points to the patient pattern that often develops as a resistance once the therapist has begun to share his or her feelings as "the dangerous blood sport of analyzing the ana-

lyst' " (p. 47).

On the other hand, the therapist who does not share his or her feelings, particularly when these feelings have caused disruption in the therapy, risks replicating the pathologically withdrawn parent who had no emotional connection to or concern for the feelings of the patient.

SUMMARY

In summary, countertransference is inevitable. Because much of the countertransference activity takes place on an unconscious level, it is difficult to be certain whether or not one is acting out some aspect of a countertransference pattern. However, there are some clues.

A breeding transference-countertransference storm can be recognized before the winds of rage begin to blow.... Efforts by the patient to cast the therapist into the role of a succoring Madonna and a warm, nostalgic response in the therapist, are as sure a signal as a dropping barometer and a calm sea are to a sailor. (Maltsberger & Buie, 1973, p. 632)

The more intense the emotional atmosphere, the more intense the probability of intense countertransference. (Racker, 1968) observed that intense therapist reaction arose from situations in which the patient had the greatest probability of acting out. Therefore, it is a wise therapist who will do what he or she can to understand his or her general and individual transference and countertransference patterns so that conscious feelings, projections, somatic clues, fantasies, dreams, and comments from friends can help alert the therapist to a possible disruptive countertransference response. ■

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