

SPECIAL CASE TRANSFERENCE AND COUNTER- TRANSFERENCE IN THE TREATMENT OF DISSOCIATIVE DISORDERS

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ABSTRACT

While transference paradigms tend to be unique to each patient's situation, there are repetitive themes in the treatment of survivors of severe abuse which manifest themselves relentlessly. These over-arching exemplars describe the erotic and traumatic nature of abusive experiences. A thorough understanding of these situations is necessary to facilitate a positive outcome in the treatment of persons with dissociative disorders. Non-dynamic approaches to psychotherapy may be especially vulnerable to mistakes and missteps when erotic and traumatic transference themes are robustly present. The vicissitudes of the erotic and traumatic transferences are explored from a psychoanalytic perspective and a vignette is provided for explication of the theoretical material presented.

Psychotherapy may be thought of as that situation in which one person pays another to sit and listen to what he or she does not want to say, while the other person then feels obligated to sit and listen to what he or she does not want to hear. Psychotherapy is work. The work involved in the treatment of persons with dissociative disorders may be exhausting. Our patients may be quite ill, quite terrified, or numb, and every way in between. Special techniques such as hypnosis and EMDR (Eye Movement Desensitization and Reprocessing) are generally accepted as useful techniques when used judiciously as part of a broader therapeutic paradigm. Paradoxically, this acceptance of "needing to use something special" may already represent the "unmetabolized" projective identification of the patient's terror and the initiation of a transference enactment (Chused, 1991; McLaughlin, 1991) in which the therapist is a powerful helper who does things to rescue the victim. These are treatments of persons with intense affect to whom therapists react with their own intense affects. If this intensity is avoided by the

therapist, the patients feel the affective withdrawal of the therapist and will often believe that they are not interesting enough for the therapist to care to treat them (Gorkin, 1987). Special case transference-countertransference themes take root in the fertility of an intense, affect-laden womb.

In my experience, there are two regularly recurrent patterns of interaction in dissociative disorders: the erotic and the traumatic. Each is based on the sadly typical experiences of persons whose lives are replete with events which often exceed the definition of trauma for Criterion A of Post-traumatic Stress Disorder (American Psychiatric Association, 1994). These transference-countertransference patterns are viewed by this writer as co-created, interpersonally lived, inevitable aspects of an effective psychotherapy. In this forum, each of these two special case paradigms will be explored. Additionally, sub-themes of the traumatic countertransference, incompetence, and sadomasochistic are discussed.

TRANSFERENCE

The transference is not a pie that has been thrown on the therapist who then wipes it off with interpretation. It is the best attempt of the patient to have a relationship with the therapist. While there may be some misattribution of characteristics of past persons or situations onto the person of the therapist, it is my opinion that the patient is always correct, to some extent, in what he or she perceives. To deny this may be disastrous. The patient is the expert on what he or she feels. A feeling between the patient and therapist or perhaps just a kind of odd ambience to the therapy, may be the most outstanding quality represented in the transference, (e.g., anger, irritation, sleepiness, admiration or sadness). The transference needs to be safely cultivated by the therapist and eventually brought fully to consciousness if the treatment is to progress.

The Erotic Transference

Transference love is a term that precedes the more specific concept of erotic transference. It was first described by Freud as a positive transference (Freud, 1958a). These were friendly or affectionate feelings felt toward the therapist. Freud felt that they invariably rested on an erotic basis. In 1915, Freud tells how these conscious and unconscious erot-

ic feelings puts "the analyst into a painful and embarrassing position...to reassure [her] of her irresistibility, to destroy the physician's authority by bringing him down to the level of a lover" (1958b, p. 381).

We can further our discussion of the erotic transference by looking in the dictionary. It becomes apparent that we need to pay attention to the less overtly sexual part of Webster's notion of erotic, the part known as desire. Erotic may mean the tendency to arouse sexual love or desire. While some "erotic" behavior is indeed sexualized, the meaning of actions that refer to desire may be somewhat different.

Touch is a very important experience for human beings. Lichtenberg makes this point by including the sensual in his motivational schema, the sensual-sexual (Lichtenberg, 1989). I do not advocate touch as part of a psychoanalytically-informed psychotherapy, but I do favor talking about it when appropriate, and asking about it when it feels like it is a live but ignored issue in the room. But then, is the therapist who asks about the place of touching and being touched actually being seductive? What about the therapist who thinks about touch during a session, to reach out in a human way and reassure? Can the patient be that far away from what thoughts the therapist has?

In Martin Bergman's discussion of love he, too, is aware of an underlying desire in love but he links this to a call to action (Bergman, 1982). This may be inspired in the therapist by the patient. This call to action is important to remember when we consider the intensity with which the therapist experiences the patient's desire for something special. Bollas discusses this same issue and is clear that it is an error to think of the erotic only in terms which are associated with genital sexuality (Bollas, 1987).

Blum (1973) includes seductive behavior in his discussion of the erotic transference as it makes itself felt in the treatment room. Behavior such as giving gifts, financial advice, looking at art work together, meeting for meals, frequent and lengthy phone calls, and physical contact may represent aspects of an erotic transference. There are also certain qualities that may appear in the relationship between patient and therapist which herald the erotic. The therapist may feel coaxed, enticed, lured tempted, attracted, persuaded, charmed, corrupted or fascinated. When these qualities appear in the treatment room, there is an attempt underway by the unconscious of either the patient or the therapist to make the therapy into something non-therapeutic.

Blum goes on to say that the erotized transference is an extreme subspecies of the erotic: "...an intense, vivid, irrational, erotic preoccupation with the analyst, characterized by overt, seemingly ego-syntonic demands for love and sexual fulfillment from the analyst" (1973, p. 63). It is my opinion that an erotized transference does not simply refer to aspects that are sexual but may also refer to the patient who desires something special from the therapist. The therapist

often feels compelled to act because the patient has a special need. This is clearly expressed in the statement that the patient wants the therapist to prove to the patient that the therapist cares. It takes a prepared therapist to be able to reply that the evidence for the caring is already in the room. The feeling that the patient will be let down if there is no concrete demonstration of caring is an erotized countertransference response. It is irrational for the working therapist to believe that they do not demonstrate their caring to the patient each time they sit down with them to do the work of the therapy. But the patient demands that the therapist demonstrate the specialness of the attachment.

Specialness is a quality which makes its way into the consultation room in both subtle and powerful ways. Specialness is a feeling which is a basic component of that which is erotic. As such, it is a useful guide to ferreting out situations which might otherwise elude our observation. This is of particular value given that to be "special" has a less affectively consuming connotative value than to be "erotic." The erotic transference may be experienced as an intense, relentless demand to change the therapeutic relationship in response to the patient's special need. It is the degree to which the erotized transference remains unconscious, irrational and ego-syntonic that distinguishes it from the less intense erotic transference.

I would call particular attention to the erotic longings of child alters, and to the expression of hyper-sexual adult alters, in the treatment of DID. In the first instance, apparently innocent childhood longings for closeness may be part of a narrative being played out as the enactment of past accommodations to abusive persons (Summit, 1983). Child alters whose psychological purpose is to remain as children in the hope of one day being loved may also be insistent upon maintaining child-like postures and themes in relation to the therapist. For example, child-like speech is often characteristic of child-alterers as they emerge for the first times. Over time, these utterances tend to lose their child-like semantical contexts and sound much more like the adult person of whom they are part. Some therapists find that they talk to these "children" in language they would reserve for the "sing-song" natural language between parent and child in the first years of life. I am not recommending that therapists demand that child alters talk like adults. I am noting that if therapists persist in using language which confirms the delusion of "child-likeness" this may not be therapeutic. It is seductive behavior on the part of the therapist. It is tantamount to agreeing with the patient about the delusion of separateness: "I do not have that body, that is not mine, the slut!" Speaking with patients in compassionate tones acceptable to either an adult or a child and choosing clear language which either would understand, gives a message of expectation and knowledge about the patient's ability to relate in a non-regressive manner. Special adaptations of language, action, or play with child alters may mark an erotic transference enactment.

The hyper-sexual adult alter has little genuine interest in adult sexuality. Such an alter's interest is in meeting the expectations of their therapist. Power and control is where the action is. Proclamations which pronounce otherwise need to be analyzed along side other narcissistic and grandiose statements. Patients may be interested in creating dread or horror (Kumin, 1985) in their therapist as a way of controlling them or avoiding other issues. An example is the fear that if they do not seduce the therapist, then they will be anxiously awaiting the therapist's seduction of them (Loewenstein, 1957). The hyper-sexual adult alter may provide cover for dissociated affect. This often includes sadness, terror, loss, and the perversion of the otherwise genuine childhood wishes for cuddling, and safe sensual experiences (which healthy children absorb with pleasure). Interpretations of the patient's intensely expressed erotic longings as adult statements of an intent to seduce, with the therapist's harsh or anxious setting of boundaries, may be a misstep. Clarification of the possibility that adult sexual expressions may be a wish to protect from knowing about the feelings of longing for intimacy in childhood, which were never satisfied, can be an enormously helpful step. Interpretation of the likelihood that the expression of sexual interest is an attempt to protect the patient from uncertainty about the therapist's behavior may also be appropriate. However, the therapist cannot be too interested or too persuasive lest the patient anticipate a seduction, as if after gentle but insistent play. When an attractive patient makes a statement of his or her wish to be sexual with the therapist, the therapist must learn to tolerate his or her own potential arousal, and encourage the patient to understand the multiple meanings which are likely to be hidden in the patient's wish. Immediate dismissal of the patient's longings truncates an opportunity to thoughtfully explore the patient's sexual and sensual needs.

The erotic transference must be cultivated, not dismissed. The attributions of the patient must be appropriately worn (Lichtenberg, 1996). If this is to happen, then the clinician must be comfortable with his own egotism.

Erotic Countertransference

The therapist's unconscious contribution to the therapy is represented in the psychoanalytic concept of countertransference. It was in 1910 that Freud first spoke of the counter-transference "...which arises in the physician as a result of the patient's influence on his unconscious feelings, and have nearly come to the point of requiring the physician to recognize and overcome this countertransference in himself....No psychoanalyst goes further than his own complexities and internal resistances permit." (Freud, 1956, p. 289).

Sandler (1976) suggested that Freud meant to include in his view of countertransference not only the transference to the patient but also communications from the patient that touch inner unresolved problems of the therapist. Therapists

do have feelings about their patients, but it is clear that they can go unrecognized. Cohen (1952) explored the arousal of anxiety in the therapist as a signpost that could lead to the discovery that an unconscious countertransference reaction was present. Winnicott (1949) and Balint (1952) both wrote of the need for the analyst to know about their own love and hate for the patient. The therapist is called upon to have a feeling, tolerate it, and, lastly, hold it in the treatment room in a way that it can be communicated back to the patient. To deny one's hate or love for the patient is to suggest that the patient might model that denial.

The knowledge of one's love or hate for the patient leads to tension as the thoughtful therapist might consider whether or not, and under what circumstances, disclosure of the countertransference would advance the work of the therapy. In the early 1950s, a number of analysts wrote about the reasoning behind whether or not therapists should reveal the countertransference or silently know about it (Heiman, 1950; Little, 1957; Thompson, 1956). Little made what I consider a critical point about the emergence of feeling in the countertransference. There is a very real fear of being flooded "...with feeling of any kind, rage, anxiety, love, etc. in relation to one's patient...being passive to it and at its mercy leads to an unconscious avoidance or denial" (Little, 1951, p. 38). I believe this consideration has great significance in the treatments of persons who have been severely abused. Not only is there an issue as to whether or not the therapist can maintain an empathic stance while listening to the patient's narrative, but, in this model, the therapist is not a passive listener. The therapist may be verbally active, but more importantly, the therapist is stirred by the patient. The therapist responds on many levels. The therapist is a hotbed of activity, not a passive listening-interpreting device. How does a person manage the affective response inherent in listening to horrific stories, offer therapeutic responses, start and stop sessions on time, and allow oneself to be stirred by the patient? When you sit with your own acutely suicidal dissociative patient, who waffles back and forth between threats to kill herself and refusals to acknowledge their dangerousness, would you consider saying: "I feel so sad about what is happening to you and the loss of all our hard work to help you heal if you would kill yourself, but I also know that if you did that I would hate you for it!" In these words there is a paradoxical statement of caring couched in the egotism of trauma, the specialness of hateful attachment. This illustrates what I call an "attachment," an attachment style which holds abusive patterns of past relating. The disclosure of the therapist's affect must be carefully considered (Maroda, 1994). It may be just as useful to know one's feelings, tolerate them, and just sit with them. The number of times where I have simply contained my feelings and then found that my patient picked up the affective theme is uncanny.

Patients with a history of sadistic abuse seem to place themselves masochistically in the hand of the therapist, ask-

ing to be treated as special, but believing they will likely be crushed. This expectation of harm by the therapist fuels the therapist's rescue fantasies and also constitutes a powerful hypothesis for the patient to test (Weiss, 1986). The therapist experiences the patient as "exposed" and "vulnerable," but demanding and controlling by presenting him or herself as so much at the mercy of the therapist. While the patient is presenting such a vulnerable self, the therapist faces an apparent choice – to satisfy the wish or disappoint the patient and face the consequences. The solution to this typical double bind is to acknowledge it. "If I satisfy your apparent wish for me to take care of you, then I will have betrayed you by taking you over. But if I do nothing about your request for help, then I will have colluded with all those persons in the past who ignored your needs. What's a good therapist to do?" The patient and the therapist can negotiate a middle ground after this is done.

Wrye and Welles propose four types of erotic countertransference responses: grandiose, anaclitic-depressive, horror-distancing, and gender mis-attribution (Wrye & Wells, 1994). Grandiosity is enacted in fantasies that the patient will be "completely made over or reborn through the treatment." The depressive response is in the analyst's unwillingness to "let go of the patient." There is a refusal to see what is vital and healthy in the patient. The patient responds with regression, an anaclitic-depressive "duet" (p. 65). This position holds the dynamic of fusion-abandonment which is so much a part of the borderline dilemma (Lewin, 1992). Horror-distancing describes the analyst's horror at the patient's erotic "messiness" and a disavowal and distancing from an exploration of the patient's erotic wishes and longings. Gender mis-attribution is the tendency in both male and female therapists to see themselves more as ideal figures based on their own gender than as someone who can be role responsive to a maternal erotic transference. Female therapists may be more comfortable as a "Mother Theresa" than a sexually seductive "Madonna," the singer. Male therapists prefer to see themselves as intellectually and sexually powerful rather than a gentle "Mister Rogers" (p. 66). In the view of Wrye and Welles, what the patient longs for is contact with the early mother's voluptuous body. Both patient and therapist may face the longing for, and terror of, being one in the same skin. Desire, longing, and tension over the wish to be special, or avoid being special, can be seen in this frame. In the treatment of persons who were severely abused, I believe there may be less of a wish for contact with a voluptuous body, and more of a wish to have what Bollas has called an experience of a transformational object. This is the object who meets the infant's needs as they arise, uncannily (Bollas, 1987).

It is my sense that most therapists are a priori vulnerable to the experience of the erotic transference, and that we must know that this is always true. The patient, or his need, is somehow special, and the therapist is prepared to respond

to the patient's particular needs. Is this not part of the anticipation of both patient and therapist in a psychotherapy setting? The therapist often feels "deskilled" at these moments, wondering how can these needs really be met. The therapist who tries to respond to the pressure of the patient's archaic needs will fail to be therapeutic, even if the archaic needs could somehow be satisfied. This is a high risk situation for the violation of boundaries.

The erotic countertransference wards off the conscious experience of the narcissistic wounds of the therapist. When the therapist feels special, then part of his or her own narcissistic need is satisfied. The therapist unconsciously longs for repair of his or her wounds. The therapist privately wishes to be nurtured. The therapist is willing to suffer with the patient toward therapeutic goals, a professionally sanctioned stance, which unwittingly matches model scenes of the past for both patient and therapist. This is a special dance (see Baker, 1997). Hatred of the patient and his or her demands remains unconscious. This recapitulates the experience of the child (therapist) who attempts to repair the unreparable parent (patient), but can never acknowledge the rejection of his or her loving effort (Miller, 1981). In this context, psychotherapy is a staging of the repetition compulsion in therapists who try to finally repair their wounded parents. When there is an acceptance of demands to break treatment boundaries, this satisfies the therapist's need to be appreciated (loved) by a grateful patient (parent). To the extent that the therapist needs to be seen as special by the patient, there is increased vulnerability to an erotic countertransference boundary violation. When sexual acting out occurs in the treatment, the therapist betrays the patient's trust by a recreation of an abusive past. This sexuality is often expressed by the patient as what is needed, with agreement by the therapist (Pope, 1994).

The Erotic Transference-Countertransference Matrix

The erotic transference is a screen upon which sado-masochistic themes of love, hate, and suffering appear. Attachment is one of the unconscious goals of both patient and therapist. Suffering is the typical glue which holds the therapist and patient in an erotic transference-countertransference matrix. This is a special attachment relationship which one patient astutely described as being based on "enragement." The narcissistic wounds of both patient and therapist must be brought to consciousness in order to work through typical kinds of impasses the erotic transference creates. Both patient and therapist have special needs, but what must be most special is the therapist's willingness to tolerate knowing about the patient's needs without taking action to satisfy them at the expense of the patient. This includes Searles' (1967) warning about over-dedication to a treatment which leaves the patient unconsciously committed to being ill so that the "good therapist" can be the hero who repeatedly saves them. In other words, the therapist may uncon-

sciously need to keep the patient ill in order to be "loved" by the patient.

An overlooked key to the discovery of an erotic countertransference is in the therapist's use of the patient to enhance his or her own specialness. Additional themes of specialness are in the enactment of responses to the patient's special needs, or the intense avoidance of such a response. Themes in the erotic transference are closely related to the traumatic transference. A traumatic transference is often found in association with an erotic transference. This may be the patient's best attempt to create a "safe" frame for the treatment. To the extent that the erotic countertransference remains unconscious and irrational it may become an eroticized countertransference and lead to severe boundary violation. The erotic transference-countertransference matrix is a concept which holds the dynamics of the erotic and recognizes its link to the traumatic and sadistic. These themes are pervasive in survivors of trauma, and while discussing them as separate entities is helpful, just as with alter personalities, we should not fall prey to the delusion of separateness.

The Traumatic Transference

The traumatic transference is a given in the therapeutic situation of persons with post-traumatic disorders (Spiegel, 1986; Lowenstein, 1993; Kluft, 1994). The belief systems of both patient and therapist fuel a transference enactment. Its analysis is essential to the success of the therapy. The traumatic transference defines the conscious or unconscious expectations of the patient that he or she will be traumatized by the therapist. Patients' intense identifications with all aspects of their story leaves them alternately in the psychological spaces which correspond to victim, perpetrator, and rescuer. I will not focus on these established pieces of the traumatic transference paradigm.

The trauma-related literature tends to overlook the veracity of the ubiquitous complaints by patients about the controlling nature of the therapeutic milieu. The therapist's wish to be seen in a positive light fuels this error. Just as the countertransference is a joint creation of patient and therapist, so is the transference. The patient correctly perceives that within the therapist resides all those potentials for murderous rage, sadistic thought and action, collusive betrayal, and self-object devaluation which the patient knows too well from the past. The therapist's conscious or unconscious denial of these potentials is, in my experience, the most common source of impasse in the treatment of persons with post-traumatic disorders.

The therapeutic contract is filled with the hypothesis that the patient must give something to the therapist or the therapist will not sit with (i.e., will abandon) the patient. Summit (1983) suggests that survivors of childhood abuse learn to accommodate the unspoken requirements of their environments, without protest. Moreover, the patient correctly

perceives that the basis of the "holding environment" is designed, in part, to protect the therapist from harm, to control the patient's behavior, and to reward the therapist. The patient also will notice that the principle of "containment" is in part designed to protect the therapist from the "toxic" nature of the patient's being, his or her affect.

The "good therapist" has the belief that he or she is selfless, humanitarian, thoughtful, educated, sensitive to the needs of the patient, and saving the patient from a life of suffering by his or her effort and good works. These altruistic beliefs, combined with the patient's correct perceptions about the holding environment and containment, leave therapists with an obligation to be vigilant about there being a not so friendly setting for psychotherapy. Both the "good patient" and the "good therapist" may be in for a rough ride when everybody's goodness is energized by reaction formation to the horrors of the past.

The Traumatic Countertransference

The setting for this treatment is what R. J. Loewenstein called the "dissociative field" (Loewenstein, 1993). This concept hints at the presence in the therapist of not only hypnotic capacities of adaptation, but also of adaptive ego states activated by the therapeutic relationship. Empathic attunement with a hypnotized or dissociating patient may mean entering this intoxicating transitional space. Do therapists have ego states? Has any reader's spouse ever said that they were furious with them for sounding as they did in an argument: "You would never talk that way to one of your patients!" Being a therapist may, to some extent, mean entering a "therapist" state of mind. What does this state of mind include or exclude? If it excludes the feelings that go along with being obnoxious to one's spouse, then how easy would it be to know about these feelings toward a patient? In a dissociative field it might be very easy.

Wilson and Lindy (1994) appropriately emphasize the need to monitor "empathic strain" and to develop "empathic stretch." They see the countertransference in tension across two interacting dialectics: avoidance – over-identification, and subjective – objective. This dialectical model of countertransference is a reframing of the patient's inner experience of being trapped by the wish to merge with the powerful object and the fear of destruction-abandonment by that object. The patient pulls away with the wish for separateness and self-definition but finds fears of ego-disintegration.

It is not just the patient who suffers from the borderline dilemma noted above, tension between fears of abandonment and wishes for fusion. This dialectic is one of merger in tension with self-definition. The therapist feels pulled between these same poles (merger – self-definition) due to the objective countertransference; that is, what any competent therapist is likely to feel with a particular patient (Gorkin, 1987). This occurs as part of a process of routine trial identifications, an ongoing part of having empathy. The

therapist approaches the patient, contacts their affective cloud (temporary merger through empathy), and pulls back to clear the fog and see what has happened (self-definition). The therapists who are otherwise distracted by threats to their own stability will have a very difficult time making contact with their patients.

Recursive attempts of the therapist to approach the patient, to make contact and retreat to survey the results, confirm the patient's unconscious pathogenic belief in expected contact and rejection. The patient correctly perceives the need to be on guard while the therapist perceives an empathic disruption. These "mini" disruptions are a constant feature of work in the traumatic transference. However, it may confuse the therapist when his efforts to get to know the patient are perceived as teasing and/or attacking. Failure to intuit, or at least notice, this pattern of disruption will lead the therapist to perceive the patient as unresponsive to his good wishes and attempts to contact them. When therapists take on this variation of the rescuer position, they rule out consciousness for their threat to the patient. In these circumstances therapists perceive a negative therapeutic reaction (Valenstein, 1973). While clinicians are correct in their assessment of the patient's attachment to painful affect and dismissal of their "good" overtures in an empathic understanding of the patient, there is a misinterpretation of empathy as soothing. In fact, empathy may scare the patient. A patient said, "When you listen with such compassion to what I have told you about my childhood, I get frightened all of a sudden. It is as if your listening tells me that there is something which actually could be real about these things that I think of as dreamy stuff from the past. That frightens me to death."

The countertransference is a "joint creation" of the therapist's past conflicts and the patient's current projections (Gabbard & Wilkenson, 1994). But what about the therapist with a current conflict, like a divorce, or illness in the family? Gabbard and Wilkinson would be the first to note that this is an obvious problem being introduced into the treatment which would, of course, have an effect on its conduct. But I pause here to emphasize that as "healing persons" we routinely tend to ignore our own human needs, this writer being no exception. Our patients who dissociate also routinely ignore their own needs. The extent to which we, as healers, believe that because we know all about stress we can avoid being affected by it, is astonishing.

Competence in the treatment of post-traumatic disorders leads to referrals of difficult patients. In these harsh times of managed care and other efforts to limit the availability of mental health services, woe to the clinician who turns down referrals of difficult patients who can afford to be treated. It seems crass to write this, but being a psychotherapist means owning a business. Inattention to "business" issues and the management of a practice may contribute considerably to therapist distraction and mistake. It is in this context that

the fee for the session must be considered as part of the action of the treatment. Money is power. Control of money is at the core of feelings of power, self-worth, and a capacity to initiate change. This is true for patient and therapist. How many patients do you have in your practice who are not "full fee?" Does this affect your work with them? Does this affect the patient's behavior toward you? The factor of the fee for the treatment, and how it is paid, may be of central concern in expressions of unconscious issues of power and control in the traumatic transference and countertransference.

Countertransference vulnerability, especially in the traumatic countertransference, is also fueled by current conflicts, concerns, and problems in the therapist, and we dare not forget this. It is easy to dismiss this sentiment as a statement of concerns which all therapists know about. On the other hand, it is just as easy to believe in one's own omnipotence.

Countertransference Incompetence

One often overlooked feature of the traumatic transference-countertransference matrix is the feeling of incompetence. The patient feels incompetent to live his or her life. He or she was often told as a child or young adult that he or she was grossly incompetent. Patients also may have experienced their perpetrators as incompetent.

Incompetence is related to feelings of shame. In shame there is both the sense of having been a failure (not having lived up to the expectations of the ego ideal) and a sense of global responsibility for all misdeeds in one's life (that somehow, no matter what bad things have happened, I know I am responsible). Incompetence is an unconscious expectation which the patient has for their therapist.

The therapist who is new to the diagnosis of DID, or has no experience with switching phenomena or trance-like states, will often feel completely deskilled in a first meeting with a floridly dissociative patient. This is similar to the erotic countertransference experience of never being able to meet the patient's special needs. I have seen this "deskilling" occur in very senior clinicians who become so taken, both fascinated and/or frightened, with the patient's presentation that they forget the basics of psychotherapy. An intense sense of inadequacy may occur in the therapist. There may be a sense that one needs some special skill or knowledge in order to meet some minimum level of competence in the treatment. There is sometimes a rush to refer the patient for more competent treatment. The patient experiences this as a major rejection and abandonment, and this can throw the treatment into chaos. It does not occur to the clinician under the sway of countertransference incompetence that they could simply be a good observer and say to the patient: "You know, a moment ago you sounded like your usual self, but right now the way you sound is as if you have gone back in time and become the child you used to be. You sound sad and scared. Have you noticed that too?" Frankly, this is the kind of question I often gently ask in a diagnostic

interview for a person suspected of having a dissociative disorder.

It is true that just like working with patients who have bipolar disorder or major depression, there is a set of knowledge which would be a prerequisite for competence. Clinical training too often leaves its trainees without this knowledge set for dissociative disorders. This contributes to the feeling of incompetence. But once that knowledge set is learned, the pressure in the transference regarding competence becomes visible. The clue is in the initial overwhelming and disproportionate intensity of the clinician's conviction regarding their incompetence. Remember Cohen's (1952) admonition about anxiety which arises in the therapist.

Countertransference Sadomasochism

The masochism of the "healer" may be unconsciously hidden in a professionally sanctioned knowledge that therapists do, at times, suffer in a treatment. The stoic wounded-healer (Chefetz, 1991), blind to his or her own wounds, and denying his own pain, "misses the boat." It sails away filled with clues to the non-verbalizable experience of the patient who has brought his or her transference suffering and special needs to the overwhelmed wounded healer who is in denial of his or her wounds. When the therapist is a "healer," a doer, rather than a guide for the patient looking for his own healing, the erotic and traumatic countertransference may be present and hiding in the unconscious need of the therapist to control through action. This is a sadistic countertransference position.

The sadism of the therapist may remain hidden in the unconscious need to keep the patient ill, the therapist "well," and the treatment submerged in mutual torture. It is this particular twist that can be found active in the fantasies of therapists who have sexual relationships with their patients. The therapists are often convinced that they had to do this for the patient's sake. The erotic debasement (Torras de Bea, 1987) remains hidden from the patient and the therapist as does the therapist's sadism.

Therapists must be comfortable with their own existential powerlessness. This resonates with Miller (1981) and Searles (1967), who both pointed out that the narcissistically injured therapist (child) may dedicate him or herself to healing. When the therapist needs to be "a healer" rather than simply helping the patient to find his or her own healing, the therapist is using the patient. The wounded-healer metaphor gives sanction to an equality in the treatment that acknowledges the therapist's vulnerability. This helps keep the therapist aware of his role as guide as opposed to the role of the rescuing hero, a paradoxically sadistic enactment.

Management of Erotic and Traumatic Countertransferences

The last identity a "helper" will consciously cultivate is the position of the sadist. The unconscious wish of the therapist to obtain "specialness" at the expense of the patient,

who must therefore remain ill, speaks to the presence of a sadistic variant of the traumatic countertransference underlying the erotic countertransference. In the treatment of survivors of abuse, countertransference missteps, mistakes, and egregious boundary violations are all at the expense of the patient. This is true regardless of the disproportion of one kind of error to another. The essence of the management of the erotic and traumatic countertransferences is in the therapist's acceptance of the typically denied parts of his or her conscious self, the counter-transferential sadomasochism and egotism. This sadism includes all that which satisfies the accumulation in the therapist of that which is of value, even temporarily – even a momentary good feeling – when it deprives the patient of what is rightfully his or hers. It also includes the therapist's willingness to suffer through the unreasonable demands of the patient. It is here that the erotic and traumatic transference often merge. Egotism includes the desire in the therapist to be special in relation to the patient. This desire to be special is not in the service of the patient's growth; it is the usually denied desire and need in the therapist for the patient to heal what is wounded in the therapist through the patient's admiration, affection, etc..

This management also includes a willingness to be used by the patient as a transference object, to tolerate the intense affect associated with this provision of a self-object experience for the patient, and to keep conscious knowledge about the tendency for interaction in the treatment of traumatized persons to fall into the realms of erotic and sadomasochistic enactment. The therapist's masochism is visible in the willingness to be tortured by "borderline" double binds about whether or not the patient will kill himself. I found myself saying to a patient not long ago: "You have been waffling back and forth between statements that you want to chop yourself up in little pieces, drug yourself into oblivion, and that you don't need to go in the hospital. Each of the parts who makes these statements seems totally out to lunch about what the other is saying, and now you tell me that you don't have parts! I'm glad to respond to your concerns, but not when other parts sit inside and let this kind of torture occur. I won't be toyed with. Those of you who know about what's going on that has led to so much distress need to own up, now. I won't be tortured. Either own up, or its 911." This patient was later clear that my refusal to try and control her years of cutting meant that I didn't care about her. Her torture of me was meant to clarify whether or not I was affectively engaged with her. Did I care enough to hospitalize her, or at least want to? The only way she knew how to ask was with action. This "sadomasochistic default" (Chefetz, 1996) is the tendency to experience life as being about power and control dynamics. It is a kind of "Murphy's Law of Negativity." Its power is legion (Olinick, 1964).

An Illustrative Case

A thirty-five year old woman with Dissociative Identity

Disorder (DID), had a long-standing transference theme of feeling that she must avoid doing the wrong thing and a chronic, intense, nagging sense that she had already done something punishably wrong. This fear had approached the proportion of terror during some periods of her treatment, but she had always been successful enough to contain the affect, first with switching phenomena, then with self-hypnosis, and finally with inter alter understanding and negotiation prior to a successful full integration experience.

At the conclusion of one otherwise routine session toward the end of the mid-phase of this four-year treatment, she voiced the feeling that she could not leave the room, that things were unresolved for her, and that she needed to stay for a few more minutes to reach a safe equilibrium. This inability to leave the session had occurred many times before, and had been discussed in detail, but with recurrence of the feeling for her. I had believed there was something in the transference about the repetition, but also that the patient was struggling with affect storms at these times and needed extra time to self-right. I also was aware that my analysis suggested something special, something "extra," and this signaled the presence of an erotic transference-countertransference enactment. However, I had not been able to figure out what specifically was going on, and neither had the patient, who was deeply troubled by her taking up additional time. She said that she knew I was not mad at her, but she worried I would get mad. I was aware of her chronic sense of having done something wrong and her fear that this would be confirmed as she delayed leaving. The session, in fact, ran over five minutes into the next session's time.

Even with all my understanding of the constellation of affects, on this day, as she left, when she asked if she should leave the door open or closed, I quickly replied: "Oh, you might as well leave it open. I have to tell the next person that I have a phone call to make and need to delay them more." I was horrified by what I had said, and the momentary shift in expression on her face told me that she had been wounded. Silently she left, while silently I cursed myself for my flip insensitivity. This was uncharacteristic of me, but not unknown, and while it troubled me, my attention was demanded elsewhere for the time being.

During the early morning, on the day of her next session, I dreamt that I was late for her session, had actually forgotten it, and rushed to the office, in clothing reminiscent of playing racquetball, with hair sweaty and plastered to my scalp, and missed her visit altogether. Affect in my dream included feelings of frustration, humiliation, shame, and dread at having to explain my lapse.

The session began later that morning with her statement that she was nervous. This felt unusual to her, but it reminded her how nervous she had been in group the week before (two days after the session reported above). She didn't know why it was that she felt nervous. I asked her if it might have anything to do with the remark I had made as she left the

last session. For a moment she didn't remember, but then with sudden recognition she did. She said she'd been upset, very upset. I recalled and restated my remark, and without waiting for her assessment, offered her my own reaction of regret and upset. My adherence to standard technique, to first be curious about what this might have meant to her, had always been experienced as baiting her, setting her up for attack, and drawing her out to discover her weaknesses. She looked relieved, then thanked me for remembering, saying that she had felt the sting of my remark, and then had forgotten about it. She said that she knew her difficulty leaving had created a problem, but she wondered why I had made my comment. "Didn't you know it would hurt me," she asked with a look of disgust? Her downcast eyes and physical agitation spoke of shame, anger, and fear. She thought I knew how much extending sessions troubled her and made her anxious. "How could you have been so mean," she asked. She went on to say that since her integration she no longer expected that I would physically abuse her, but that she still feared that if she did something wrong, then I would somehow make her pay. My parting comment in the last session had done nothing to convince her otherwise, and she had felt the familiarity of an out-of-body experience as she had left the room.

Associating to what she said, I openly hypothesized that she was talking not only about abuse by her father, but about betrayal, as with her mother. I also said that I knew she must be conscious that she controlled the length of the session in these situations and could anticipate the crisis each time. It reminded me of the theme of seduction of the aggressor (Loewenstein, 1957) which she had played out so often in her childhood. Was she trying to seduce me into the behavior I engaged in? What was her unconscious hypothesis? It must have been that I would hurt her, but we both had believed that she would know better at this point in the therapy.

Our effort to understand the situation seemed to be going nowhere in particular, and she was still clearly nervous. I asked her if she could make anything out of the idea that in her delay of the session, she hoped to provoke me into a behavior. She too picked up the old theme of seduction of the aggressor, but this did not produce a shift in affect. She was still nervous.

At that moment, I recalled my dream of that morning. Not only was there a fear of my doing something wrong, a match with the patient's established transference fear, but there was a hidden wish to disappoint or hurt her, payback for her making a mess of my schedule repeatedly. I began to think of how repugnant that wish to hurt her was to me, and realized that I was denying my potential unconscious wish to hurt her in retaliation for her behavior. I sat with this knowledge for a while, as the patient continued with her agitation. I elected to report my dream to her, without interpretation. She listened without difficulty. She thought about

potential meaning, but was stumped. She knew that the pieces did fit together, but she was not sure how. Encouraged, I offered that there was a potential interpretation of my dream, which I did not like, but it still might be useful to help us understand what had happened. I repeated what I had said to her about her dreams, that dream material often contains both a wish and a fear. I noted that if that applied to her, then it applied to me, too. I cautiously said that this meant that in my dream, and in my unconscious hurtful parting comment, I may have wished to hurt her. My language was cautious, but my voice was committed to the idea. She unreservedly said that it felt that way to her. It then occurred to me that her father, mother, brothers, had all clearly wanted to hurt her, and she knew it, but it was never acknowledged. As I said this last thought out loud, I watched as her eyes filled quickly with tears and overflowed while she wept and shook with relief and fear. In a halting, breathless gasp she managed to get say, "I knew they wanted to hurt me, they wanted me to suffer, they enjoyed it. I could see it in the dark look in my father's eyes."

My admission of a wish to hurt her had opened the flood gates. She recalled scenes of abuse which we both knew well at that point in her therapy, but the difference was now evident in her recognition of the horror of knowing how much her pain was enjoyed by her father and the rest of the family. In particular, his fine tuning of her humiliations was salient in her descriptions. We came to believe that it had meant everything to him that she would know her defeat at his hands, her inadequacy to resist his will or defend herself. "If I passed out from the pain, then he would slap me until I woke up. He wanted to see that I knew I was helpless." The abuse had been bad enough, but it was the humiliation of her will that had finished her off.

She said that she knew that my deep intention was not to humiliate her, but she knew that there were times where my remarks did so anyhow, and that I was human. We looked at the series of times during our work where we had become aware of how I had said or done something which led to her experiencing humiliation. We went over these scenes, and we talked about other relationships where the underlying intent and respect of the Other was clearly not supportive. She felt able to distinguish between the two. Her nervousness stopped.

With the session at an end, she stood and offered her hand for the routine handshake which had been part of a ritual since the beginning of our work. In the mid-phase of treatment we had discovered that the handshake was a counterphobic effort to undo the anxiety associated with walks she had taken with her father as a small child. They would leave the house holding hands, and as they walked, his grip would tighten to a crushing, painful clamping. He would then abuse her sexually. Today she hesitated, noting that she had a cold and not wanting to give it to me. I slowly reached for her extended hand and she gripped my hand

enthusiastically and laughed with delight.

In this vignette, my unconscious wish to retaliate for my patient's repetitive delays of the start of the next session led to an accumulation of emotion which waited for the right moment to complete enactment of the patient's fear, that I would want to hurt her for doing something wrong. It was only after I disclosed my shame-laden dream and my unconscious wish to hurt her that she had access to the terror, and then sadness, associated with what she knew of her family's sadistic pleasure in hurting her. The therapeutic alliance could tolerate the honesty of my disclosure in the service of understanding the interaction. It made visible what she and I unconsciously knew but each feared to say. It prefaced later work in painfully acknowledging her own sadistic wishes. My wish to be a "good therapist," and not provoke a crisis of abandonment, or one of power and control, led to an enactment of the transference. In my attempt to avoid hurting my patient, there was an omnipotent escape from the inevitability of being simply human and betraying her, albeit in lesser ways than in the past. This disavowal of my potential destructiveness was associated with the dream scenario of shame, failure, and a dread of owning up to it. I had owned my vulnerability, restated the limits of my competence, and was able to re-attach with the patient as the real therapist, not the omnipotent therapist who would do no wrong and make no errors.

My knowing that I made "special" accommodations for this patient was a clue to a transference enactment which did not advance the therapy. Indeed, specialness was a focal point of the enactment, but it was the destruction and humiliation of specialness that was the main feature. Erotic and traumatic themes were merged. Desire for attachment (a visible need) makes one vulnerable to humiliation. In that session the patient's unanalyzed wish to hurt me was likely as much the source of her nervousness as was my unacknowledged wish to hurt her.

My omnipotence was a defense against my own irritations and ill will. If I had been a better manager of my practice, then I might not have planned an important phone conversation after the session with this particular patient, whom I knew from long experience might not be able to finish the session on my schedule. The fact that this "slipped my mind" facilitated the enactment. My years' long refusal to be anything but thoughtful and understanding to this patient for her chronic inability to end the session on time was an unconscious refusal of anger, hatred, and finally a wish to hurt and humiliate my patient.

Even in writing these words, there was a point after I earlier described her anger with me when I nearly wrote of feelings of humiliation, but I stopped. I recognized that to write, at that place, of humiliation, would sound like a wish to also humiliate myself to the reader. Is this a parallel process? As a teacher of psychotherapy, class discussion about countertransference always, at some point, focuses on the motiva-

tions of the writer in being revealing of self. It seems inevitable that such questions will come up. Well, the best I can say, if you have such questions, is to enjoy your fantasies. There is still a profound need in our profession to write about what is unspeakable.

The erotic, traumatic, and sadistic countertransference positions are visible in this vignette. While in this situation there was a countertransference disclosure, that is not typical of my tendency, unless the treatment is threatened with a disruption, and there appears to be no further recourse. The use of disclosure here was based on the knowledge of a strong therapeutic alliance and an old transference theme, chronically unresolvable for years.

My willingness to disclose my sadism gave the patient permission to know about and eventually disclose hers. Fantasies of retaliation had been unknown to her until the mid-phase of her treatment, and even then they were brief and vague. The transferential meaning of this lack of fantasy was held in her sense that she herself could not know about her opposition to her abuse or it would have further enraged her father and brothers. It was her job to be "used like a doll so that they could do anything they wanted to do with me." Her father would work hard to discover any sense of refusal on her part to surrender and submit to his will. My refusal to acknowledge my ill will matched his dissociation of knowledge of abusing the patient.

SUMMARY

The special case transference-countertransference situations of the erotic and traumatic variety require vigilance on the part of the therapist. Awareness of the basic bias of the clinical setting, the relation of specialness and the erotic, the difference between the sensual and the sexual, the prevalence of power and control issues in the holding environment, containment, and the sadomasochistic default can prepare a clinician for management of the inevitable transference enactments in therapies with persons who have dissociative disorders. The lines of thinking presented here are an attempt to add nuance and color to a set of schemas which are often thought of as difficult to work through, but clearly set out and easily definable. All aspects of the relationship between patient and therapist are subject to these perturbations of experience. There is no escape; there cannot be. For to escape these crises is to not do the work of the therapy.

Our patients bring to us not only their suffering but their creative attempts to heal themselves. As blind as they are at times to their own issues, they are often keen sighted about their therapists and other patients. The idea of the healthy well adjusted therapist curing the patient is a myth. The therapist must be candid enough and human enough to treat the patient, as a fellow traveler in life, not all that different from the therapist. To paraphrase Theodore Reik (1983),

what is different between the patient and the therapist is the therapist's willingness to look inward and have the courage to describe what is seen. ■

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