

# Countertransference Hate in the Treatment of Suicidal Patients

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**The countertransference hatred (feelings of malice and aversion) that suicidal patients arouse in the psychotherapist is a major obstacle in treatment; its management through full awareness and self-restraint is essential for successful results. The therapist's repression, turning against himself, reaction formation, projection, distortion, and denial of countertransference hatred increase the danger of suicide. Such antitherapeutic stances, their recognition, and the related potential for constructive or destructive action are the subject of this paper.**

Countertransference is inevitable in all psychotherapies. Taken in the broader sense of the term, it comprises the therapist's emotional response to his patient's way of relating to him, and to transference which the therapist may form in relation to his patient. Some of the therapist's countertransference response may specifically arise from the way the patient behaves in the specific therapeutic relationship, and some of it may stem from the disposition of the therapist to react in certain ways either to all patients or to patients of a certain type.<sup>1</sup>

When the countertransference is fully conscious it can stimulate introspection in the therapist, can usually be controlled, and can direct his attention to details of his patient's behavior the meaning of which might otherwise remain obscure. Otherwise, when unconscious, countertransference may generate well rationalized but destructive acting out by the therapist. These facts are well known to experienced therapists and various authors have described them in detail.<sup>2-21</sup>

While inevitable in all psychotherapies, countertransference is likely to be particularly intense in the

treatment of "borderline" and psychotic patients, especially those who are prone to suicide.<sup>18</sup> Repeated experience has taught that borderline and psychotic patients have great difficulty with aloneness, hostility, and sadism. Klein<sup>22</sup> has described the mechanism of projective identification encountered in such individuals, and Kernberg,<sup>23-25</sup> their personality organization and primitive defenses. Searles<sup>26</sup> has emphasized the cannibal instincts as well as the role of an attacking, raging posture as a defense against sadness. The contributions of Winnicott<sup>27</sup> and Guntrip<sup>28</sup> have helped better to understand the aloneness, separation, and fears of abandonment that torture such patients. While no review of this complex subject can be attempted here, we take it as understood that the transference hate manifested by borderline and psychotic suicidal patients relates to a deep sense of abandonment (or expectation thereof), an intense craving for yet horror of closeness (it threatens annihilation through engulfment), and various defensive operations that tend to alienate them from others.<sup>18</sup>

Transference hate disposes these patients to act in a variety of ways that will inevitably stir up countertransference hate. In this paper we will examine countertransference hate as it is experienced in working with them. We will describe the components of this hate—malice and aversion—along with the ways in which they are generated and how they may be usefully or deleteriously managed.

## Components of Countertransference Hate

Countertransference hate, like all hate, is a mixture of aversion and malice. The aversive component is the one fundamentally most dangerous to the patient and is often not clearly distinguished from the sadistic (malicious) aspects of countertransference hate. Sometimes the aversion is experienced more consciously while the malice is muted; this will give rise to a sense of inner fear and fore-

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boding, while the patient seems abominable. When aversion is mixed with malice in the form of disgust, the patient seems loathsome.

But whether the patient is the object of punishing, torturing impulses, or whether he is abominated or loathed, it is the aversive impulse that tempts the therapist to abandon the patient. The therapist's malicious impulses, on the other hand, imply a preservation of the relationship, for the exercise of cruelty requires an object; one cannot kill or abandon another and continue to torment him.

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. Suicidal crises are likely to arise when the torture is given up and withdrawal takes place. Undesirable and destructive as a sadomasochistic relationship may appear, it is better than no relationship at all.

To live out one's countertransference malice in relation to a patient is antitherapeutic and unacceptable. But even more undesirable is the living out of one's aversion, because then a suicide is likely to be precipitated. Paradoxically, most therapists find the component of lesser danger, malice, more painful to tolerate than the component with lethal potential, the dangerous urge to abandon. In fact, there is a temptation to resort to abandonment of the patient in order not to acknowledge, bear, and place in perspective the countertransference malice.<sup>21</sup> While the impulse to torment and torture will often be felt in some degree along with the impulse to abandon the relationship, in a great number of circumstances there is a reciprocal relationship between the intensity of the aversive impulse and the incapacity to tolerate conscious sadistic wishes.

### The Transference Onslaught

Transference hate operates against the therapist consciously, preconsciously, and unconsciously, and to support and justify it as well as to bear it, the patient employs a reciprocating system of provoking and projecting. Hate in itself, when intense, is difficult to bear. When felt toward a needed and cared for person, such as the therapist, it gives rise to a severe sense of worthlessness and primitive guilt (superego anxiety).<sup>29</sup> As to the unbearable quality of feeling hatred, Hendrick<sup>30</sup> long ago pointed out that there was an economic gain in the defense of projection. He speculated that projection accomplished a division of the mental representations of a hostile impulse, and that while the sum total of hostility in the experience "I hate him and he hates me" is the same as in the experience "I hate him," the hostility experienced as one's own is less. Put more simply one might say that the patient feels less id anxiety when, by projection, he can share the responsibility for his hatred with others. Projection also offers the advantage of reducing superego anxiety by means of the formula, "You hate me so my hate for you is justified."

Because projection is so useful in attenuating id and superego anxieties, patients attempt to validate it in whatever ways they can. While provocative behavior appears in the transference as a displacement of hate from

primary objects, it also serves to render the transference a credible here and now experience. Sometimes in order to obtain sufficient evidence the patient attempts to arouse hate in others through the seductive and inductive conduct known as provocation.<sup>19,20,31</sup> Provocations occur directly and indirectly, verbally, and in other behavior. Often they are highly inventive, persistent, and effective. Lying behind some emotionally neutral or even positive statement of the therapist the patient may claim to perceive evidence of concealed hate and contempt. If nothing of the doctor's verbal content lends itself to plausible misinterpretation, then the patient is likely to think he hears suppressed rage in the tone of voice, or sees it in some accident of posture or a casual gesture. Remarkable about human psychology is the fact that virtually nobody, including psychotherapists, subjected to sufficient provocation of this sort, can respond without some degree of irritation. For this the patient unconsciously waits so that he can prove his point. The irritation, once provoked and once detected, the patient will adduce as proof that he is hated by his therapist.

Provocation can take the form of direct verbal devaluation of the therapist. In one way or another the patient conveys through language his contempt for the therapist as a person. Often enough the therapist is openly discredited. If the patient can obtain some information about the therapist's personal life (perhaps there has been a divorce, or a child has suffered from emotional problems), it will be called forward as evidence that the doctor is personally destructive and too troubled himself to be a good psychiatrist. There may be a direct disparagement of his physical appearance (especially if there is some out of the way feature or another), of race ("kike," "nigger," "WASP"), of his taste of clothing, of his profession ("headshrinker"), of his education, training, or skill. Should the doctor have lost a previous patient through suicide, this fact will not escape the patient as an opportunity for devaluative sadistic incitement.

Provocations may take the form of direct action, sometimes involving physical assault on the person of the physician, or destruction of his personal property. We know of one case in which a patient, rationalizing her behavior on the grounds that she had "a right to know," broke into her psychiatrist's home and ransacked all his papers and personal correspondence in quest of case notes of her treatment. There may be frequent telephone calls at predictably inconvenient hours. We know of two instances in which different women patients telephoned suicide threats at the moment they correctly guessed their doctors would be sitting down to Christmas dinner. "Anonymous" telephone calls may be made, or the patient may tarry in the vicinity of the therapist's office or home, keeping all his doings under vigilant scrutiny. Such patients have been known to make suicide threats directly to the children of the therapist. Of course, such conduct requires limit setting, but the patient will try to find some hate in the doctor's manner.

Suicidal patients may also employ indirect means to provoke a countertransference hate to substantiate their projections. These indirect provocations, which often have other determinants as well, gradually tend to exhaust the

endurance of the therapist. An acrid example is the muteness of the patient who remains silent, hour after hour, possibly with a faint smile of hauteur on his face. Akin is the patient who reduces the therapeutic hour to a repetitive, ritual recital of material without affect in an unconscious effort to bore the doctor, or to reduce him to a state of impotent anger. Repeated hypochondriacal complaining can have as a part of its purpose to accuse the physician and to evoke his anger. Constant confounding and forgetting of such matters as appointment hours or fee payment may have the same unconscious purpose. When the smooth and uninterrupted progress of the psychotherapy is precious to the therapist, he will be likely to develop countertransference reactions of an angry nature to all these kinds of disruptive activity.

### **The Lethal Potential of the Transference Onslaught**

In neurotic patients there is a fundamental presumption of trust and relatedness. To be abandoned by all and to abandon all others are often entertained as fantasies, but are not real options for action. In borderline and psychotic cases, however, the circumstances are otherwise. Such patients express fundamental questions about the basic worth, integrity, and reliability of people. When suicidal, their faith in the worth, integrity, and reliability of others is so precarious that they must threaten to quit this world by physically removing themselves from it.

Only in suicidal and homicidal cases is *de facto* destruction of all relatedness, physical and mental, a stark possibility. The risks are real in fact; they are not imaginary. This aspect makes the treatment relationship far more than a transference investigation; it is a unique encounter on which everything, at least for the patient, may pivot. The reality outcome depends on the transference and its management. The risk to life and limb involved enormously heightens the importance and the burden of countertransference hate. The question is not only whether the therapist can influence the quality of the patient's future life, but whether there will be any future life at all. While we do not believe it is possible to treat any patient without countertransference, and, in the case of suicidal patients, without countertransference hate, clearly the discharge of countertransference hate in the therapeutic relationship is noxious and sometimes fatal for the patient.

### **Narcissism as a Special Target of the Transference Onslaught**

There are points of attack in all of us the striking of which is likely to evoke counterattack. Assaults upon self-esteem characteristically arouse ire, and in the day to day work with a suicidal patient, the therapist may expect many hits in that direction. The best attitude is one of expectant open waiting for the first manifestations of hate; one should assume he will feel provoked rather than to take it for granted that one is proof against taking such pricking personally.

The most common points of vulnerability at which the patient may shoot his arrows are those areas of unrealistic

narcissistic self-over-estimation (or overaspiration) that are to some extent universal among beginning psychotherapists.<sup>32</sup> Repeated strikes against these targets are sure to induce countertransference rage. At the beginning of the treatment, when the patient is full of magical hopes and expectations, the therapist will be idealized, as he may from time to time later. To the extent that the therapist is infected with lingering omnipotent attitudes, he will mistake the patient's wishes for realistic expectations and vainly imagine he has the obligation and the power to meet them. This, of course, he will be unable to do, and will before long find himself feeling helpless, guilty, and wishing himself far from his patient.

Chanticleer, Chaucer's learned and ambitious cock, was tempted to outsing his father by the treachery of Russell the Fox and in an effort to do so shut his eyes with the unfortunate result that he was carried off by the throat. The unwary psychotherapist may also be carried away if he believes his powers greater than they are because when the patient reproaches him for his failure, there will be a crisis of countertransference rage, and a danger of regressive anal and oral sadistic acting out.

As experienced therapists know, the three most common narcissistic snares are the aspirations to heal all, know all, and love all. Since such gifts are no more accessible to the contemporary psychotherapist than they were to Faust, unless such trends are worked out in the physician, he will be subject to a sense of Faustian helplessness and discouragement and tempted to solve his dilemma by resort to magical and destructive action.

There is no universal remedy, and though in all medical specialties the young physician is prone to expect of himself that he should be more helpful to the patient than he can, perhaps the psychiatrist is particularly prone to expect of himself that he should be all healing for two reasons. One of them is that in psychotherapy the means of "healing" is the person of the physician. His own personality is the therapeutic tool, and for this reason the means of treatment are more difficult to separate from the self than is the case in surgery or medicine, in which the means involve instruments and drugs. The psychiatrist is therefore prone to confuse the limitation of his professional capacity to heal with his sense of personal worth. Furthermore, the physician-patient relationship is more intense and the patient's expectations for therapeutic magic have a greater impact. In psychotherapy, change comes slowly in small increments, and the process is not only terribly slow from the patient's perspective but from the physician's as well. This adds to the frustration of those who are ardent to heal.

Suicidal patients are surprisingly quick to recognize in a therapist any lingering magical expectation that he personally should provide a panacea. If his self-respect depends on production a "cure," it is here that the patient will be likely to attack. The patient will be strongly motivated not to improve in order to convince the physician that he is worthless. The professional self-respect of any physician whether psychotherapy, surgery, or pediatrics is his calling, must depend on the best exercise of his skills according to the best knowledge available to him, and not according to "cures," if he is to feel happy and confident in

his work.

The initial period of work with a suicidal patient, especially if the patient is a woman and the therapist a man, may be marked by the patient's explicitly declaring in an erotic way that she is convinced that he only and nobody else can help, that she thinks he will understand what others have not. The patient expresses her hopes for the relationship in this way. If the therapist vaunts in himself similar omnipotent hopes—that he should be the panacea for depression and suicidal troubles—then both the patient and the therapist will soon be feeling hopeless, for the successful treatment of such patients requires the recognition of magical expectations as burdensome problems that lead to inevitable disappointments.

Patients commonly expect that the therapist should be able to "know" what is being thought and felt without being told. The expectation for omniscience is of course as magical as the expectation for panacea, but parallel self-expectations are found in some therapists who entertain magical attitudes about intuition and sensitivity. The mark of a skilled and experienced psychiatrist is that he does not "play his hunches" beyond a certain point and that his intuitions about a patient are constantly under examination in the context of the clinical data. Indeed, it is characteristic of a seasoned clinician that if asked to justify a "hunch," he will be able to do so at once by reference to the clinical data. In contrast to this is the tendency to play clairvoyant and to follow one's "emphatic sense" as to whether a patient is suicidal or not. To do so is to open the door to countertransference acting out of an omniscience fantasy in the name of empathy and intuition. The error can be fatal.

A further pitfall in the omniscience department lies not in the belief that one does in fact "know," but in the expectation of oneself that if one were a good psychotherapist one *would* know, somehow, even without data, but by intuition. Just as the self-expectation that one should somehow help every patient at once by some magic can lead to a sense of helplessness when the patient reproaches one for providing no succor, so can the expectation that one should "know," even without being told.

The third trap is the expectation held by some therapists that they should love all, that they should respond lovingly to all aspects of the patient. It is, of course, true that psychiatrists care about their patients, and their caring is vital to treatment, especially when the patient is suicidal. Being a caring therapist is also appropriately a part of professional self-esteem. Without exception the transference of borderline and psychotic suicidal patients will involve denouncement of the therapist as a cold uncaring person. Reality testing sometimes fades sufficiently to convert these accusations into near delusional or actually delusional beliefs. Insignificant matters concerning the therapist's demeanor are seized upon, exaggerated, and distorted to prove that his disposition is harsh and selfish. The onslaught can promote outrage in the therapist. Since threat of suicide is intensified during this kind of transference, the therapist will also be frightened, and the imposition of fear further stimulates countertransference rage. The more experienced the therapist, the more he has taken pains to extend himself to the pa-

tient, the more liable he will be to this reaction.

With experience most psychiatrists gain perspective on their hopes to be all-loving, and their vulnerability to attacks on this aspect of their self-esteem is much reduced. However, certain therapists are heavily invested in an image of themselves as unfalterably all-encompassing in their love for the patient. The nature of their investment is narcissistic, and they may extend themselves remarkably, even frantically, to preserve it. They are in fact highly vulnerable to attacks on their disposition to lovingness. Once their defenses are breached by the onslaught, they are pervaded by a sense of helplessness and depression, closely followed by retaliatory malice and aversion.

#### **Defensive Postures Against Countertransference Hate**

The personality organization of the psychotherapist is usually such that the feelings involved in hate for a patient are most inconsistent with self-esteem. We conceive ourselves to be compassionate, caring, and nonjudgmental, and often predicate our professional self-respect on not being rejecting, punitive, sadistic, murderous, and disgusted with patients. An able therapist cannot permit himself to behave according to such feelings, but neither can he afford the illusion that he differs from other human beings and has no id. Perhaps the intolerance for hating patients accounts in part for the paucity of countertransference literature relating to treatment of suicidal patients. It would explain the tendency to treat these countertransference phenomena as unclean or bad when they are discussed. Enlightened acceptance of one's own hate reactions is not sufficient to ensure against acting on them to the patient's detriment. All therapists, seasoned and unseasoned, find hating a distressing experience, and all are inclined unconsciously to mobilize defenses against it. It might, therefore be helpful at this point to survey five defense postures, the function of which is to protect from full countertransference awareness.

**1. Repression of Countertransference Hate.**—The therapist who needs to remain unconscious of his feelings may find himself having difficulty in paying attention to what the patient is saying. There is a tendency to daydream about being somewhere else doing something else with someone else. Subjectively, the therapist may be aware of some anxiety and restlessness, or possibly he may find himself drowsy. He may feel bored. While this defense offers little scope for direct acting out of the unconscious or preconscious hostility, the therapist may well convey his aversion to the patient by yawning, glancing too often and too obviously at his clock, or by other signs of inattention, conveying nonverbally the message to his patient, "I do not want to be with you." When this defense is in play, the therapist is unable to weigh what the patient is doing to arouse his hostility, and to what extent his reaction is intruding in the work.

**2. Countertransference Hatred Turned Against the Self.**—This response is frequently encountered in the inexperienced or beginning psychotherapist but sometimes, too, in the more seasoned. He is filled with doubts as to his capacity to be helpful to the patient, wonders if he has the potential to become good at such work, and thinks perhaps he should give up psychiatry and apply for training in

neurology or another specialty. The therapist may wonder if he himself is not deeply sick, and he may experience ideas of self-punishment, degradation, or possibly suicide. Subjectively, there is a sense of inadequacy, helplessness, and hopelessness. While this state of affairs can lead to giving up the case because one feels incompetent, thereby expressing the underlying aversion through action, the patient more often will suffer because the therapist deals with his malice by taking a masochistic stance, allowing to pass unchallenged the patient's efforts to devalue and dismiss him as an uncaring and incompetent person unworthy of trust and confidence. The hateful transference is likely to remain uninterpreted. This is particularly true when the patient is unconsciously pouring out material the intent of which is to degrade both the therapist and himself, but which the therapist cannot recognize and interpret because he is warding off his own hostility. This is an avoidance device often employed by those who are guilty about their own hostilities, and tend to punish themselves for it. There is an unconscious tendency to turn the encounter with a hostile patient into a penance.

**3. Reaction Formation, or, Turning Countertransference Hatred Into Its Opposite.**—The therapist under such circumstances is likely to find himself preoccupied with being very helpful to the patient, too solicitous about his welfare and comfort. The doctor's daydreams may involve somewhat omnipotent ideas of rescuing the patient, either from his illness or from influences and persons in life that the therapist believes, correctly or not, to be destructive. He feels an anxious urgency to cure and to help. The potential for action when this defense is employed has two vectors. The therapist will be prompted to intervene in other relationships on the patient's behalf; this is at best nontherapeutic (the patient is not respected sufficiently to be given responsibility to order his own life) and often it is antitherapeutic, since it heightens the omnipotent transference expectation that the therapist will act at all times on the patient's behalf like an indulgent mother. Such tampering may even destroy relationships without which the patient may be quite isolated. Reaction formation in the therapist may also lead him to fear suicide excessively even in circumstances where there is little realistic hazard. Excessive use of restrictions and hospitalization may then follow, again fostering omnipotent transference expectations for ever present care and protection even when these are not needed. A therapist dominated by reaction formation cannot take necessary reasonable risks and in general cannot help the patient with his rage at not being cared for and gratified as much as he would wish.

**4. Projection of Countertransference Hatred.**—Projected countertransference hostility is usually experienced as a dread that the patient will carry out a suicidal act. It operates according to the formula, "I do not wish to kill you, you wish to kill yourself." While reaction formation against hatred leads to a subjective sense of anxious solitude, projection is likely to be accompanied by dread. The therapist may become preoccupied with fantasies about his patient's potential for acting out even though there are no objective reasons for such concern. Often enough his worry will be limited to thoughts that the patient will

certainly commit suicide no matter what; there will usually be a tendency to take such a possibility "personally" and to feel helpless. This kind of preoccupation is usually accompanied by some degree of fear (the consequence of projected malice), and with a sense of aversion, ie, the patient seems abominable. Projection of the countertransference anger at this level is often difficult to recognize fully, especially when it is taking place where objectively the patient is giving indications that indeed suicide is an imminent possibility. At such times it may be difficult for the therapist to decide how much of his concern is coming from the objective possibilities in the clinical situation, and how much from his own hostile impulses. We have found that when the therapist's affect is intense, it is safest to assume that substantial countertransference is at work. Sometimes the fantasy will not involve thoughts of outright suicide, but others which imply final breaking off of the relationship, such as the patient's running away (the aversion impulse is projected). When projection is operating in this way, three paths for clinical error lie open. One of them is that the countertransference hostility will be acted out against the patient by the imposition of unnecessary external controls (possibly enforced hospitalization) that will indeed provoke the patient to suicidal acting out and lead to disruption of the therapeutic alliance. The therapist may also err by recognizing in himself a countertransference rage and closing his eyes to the objective need for protective measures for fear that to take them would only be "acting out" on his part. The third possibility for error is that the therapist will give up the case and reject the patient when in fact the situation is not really "hopeless."

Whereas it is unlikely that most therapists will form a complete countertransference projection leading to the conviction that the patient is preparing to attack him or murder him unless there are objective indications that this is so (and suicidal types sometimes do have homicidal potential), 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, and require a careful examination of the objective facts in the clinical data, not only for the sake of the therapist, but for the patient. In such circumstances the stage is set for the rupture of the relationship. Projection of this sort operates according to the formula, "I do not wish to kill you, you wish to kill me."

The suicidal patient who for long periods of time remains mute is particularly prone to become the target of projected countertransference hate. Quite correctly the physician may conclude that the patient's silence is an expression of hostility the purpose of which is to ward off a fearsome relationship and to set the therapist's efforts at naught. The hazard lies in "taking it personally." The patient's silence makes it impossible to know just what fantasies are being entertained, but more than one therapist, sitting in frustrated silence, has felt that the patient is making him a helpless prisoner and torturing him as the cat the mouse, or the spider the fly. In short, to sit for hours with a rejecting mute patient who continues to be suicidal is likely to evoke primitive sadistic countertransference fantasies. Particularly if the patient betrays

similar impulses (and usually he will), a situation exists in which the therapist's countertransference hate can be projected *and the projection perfectly validated by the clinical material*. Thus, a situation can arise in which ego boundaries are blurred, the patient projecting his hatred onto the therapist and the therapist his onto the patient, without either being conscious of what is going on. Each will be perfectly convinced that he is the undeserving victim of the hatefulness of the other, but only the patient will be correct. The therapist would be correct also were it not for the fact that he has chosen to bear what the relationship requires in electing to treat such a patient. The therapist is simply the object of the necessary and inevitable hate of his patient, but out of choice, and in that sense he is not in fact a victim.

Implicit in what has been said is that before countertransference acting out can take place, the therapist must first arrive at the position in which his hatred for the patient seems reasonable. Real countertransference action implies that the clinical facts are not in accord with the preparedness to act, and that for action to occur, some aspect of the real clinical situation must be out of perspective in the therapist's mind. Projection is one route to a loss of perspective. Distortion and denial are additional ways to the same end.

**5. Distortion and Denial of Reality for Validation of Countertransference Hatred.**—Usually this involves devaluation of the patient in some way. This frequently is suggested in a preparedness to see the patient as a hopeless or bad case or as a dangerous person. On the affective level the therapist may experience indifference, pity, or anger at the patient, but does not have a feeling of empathic understanding or basic respect. Under such circumstances the patient may well be sent away, either by premature interruption of psychotherapy, transfer to other psychiatrists or institutions, or by premature discharge from a protecting hospital environment.

When countertransference hate is projected and the projection validated, whether by distortion of clinical facts or selective inattention to the facts (denial is really another purposive form of reality distortion), the therapist is employing defenses like those of the patient. Just as the patient seeks to repudiate the relationship by projection, denial, and distortion, a similar pattern often can be seen operating in the therapist at moments of countertransference crisis. The patient unconsciously sets the stage so that the therapist may experience a subjective sense of being attacked if he is not on guard. Like the patient, the therapist feels in danger, perhaps as the patient once was in danger from his rejecting and unsatisfactory mother.

The various defenses and the associated fantasies, affects, and potentials for acting out are summarized in the Table.

#### The Regressive Response

Defensive reactions to countertransference hate are at best ways of easing the therapist's state of mind and at worst means of facilitating calamitous acting out. Malicious or sadistic behaviors constitute the first steps down

Economy of Countertransference Hate			
Defense	Therapist's Conscious Fantasy	Affect Experienced	Potential for Acting Out
None, exercise of caring, restraint	Murder, torture and rejection	Hate	Little
Repression of hate	Wish to be elsewhere, difficulty in concentrating on what patient says	Restlessness, anxiety, drowsiness; little affect experienced toward patient; empathically not in touch	Tendency to watch clock, be impatient, to convey indirectly a mild rejection
Turn hate against self	Impulse to give up; fantasies of self-devaluation, degradation, possibly of suicide	Sense of worthlessness and hopelessness; active sense of inadequacy	Refer patient elsewhere; accept devaluation from patient masochistically and without investigation
Turn hate into its opposite (reaction formation)	Wish to rescue the patient from his plight	Sense of anxious solicitude, an urgency to help and cure	Meddlesome intervention in the patient's affairs; too frequent enquiry into patient's suicidal impulses, plans
Projection of hate	The patient is about to kill himself; the patient will kill me	Fear, some hatred	Rejection of the patient; attempts to control suicidal behavior by imposing controls
Distortion and denial	The patient is beyond help	Indifference, pity, resignation to failure	Rejection of the patient
Sudden breakdown of defense	Death of patient and therapist, utter disaster	Intense fear, rage, and helplessness	Flight, immobilization

the regressive path of countertransference acting out and for that reason will be discussed first. Certainly this sort of activity is thoroughly antitherapeutic. But farther down the way are the deeper regressions that involve impulses not to torture and punish, but to destroy. Therein lie the great dangers for the patient. These more profound regressions will be taken up in their turn.

*Sadism*, a 19th century eponym, is less satisfactory a term than *bloodthirst*, a word current in English for 300 years. The more technical term does not so directly connote the appetite for injuring and hurting. The older word also refers the appetite to the oral cavity, so that it is fairly specific for those forms of cruelty originating from primitive impulses to bite, suck out to depletion, tear, chew up, and devour. A similar specific word for anal sa-

distic impulses seems to be lacking in our language. We have torment, tantalize, and tease, as well as smutch, domineer, and beat. But the essence of anal sadism—to render a person helpless and then to dirty and injure him and to enjoy his agony—is not captured in any word. Perhaps torture comes as close as any.

The tendency for sadomasochistic patients to give and seek pain is only an exaggerated expression of the universal potential for fascination and delight in suffering. Not only is it evident in war, in prison, in school, but also in the cinema of the ferocious. Audiences relish scenes of bloody mutilation juxtaposed with the most brutal sexual degradation. The same potential for ecstasy in agony lies in the psychotherapist, and a tendency to regress to the level of primitive struggle will be aroused in him when the patient makes him feel helpless or futile.<sup>20</sup> At such moments the patient is likely to become unconsciously equated in the therapist's mind with the adversary mother of his anal stage; he will be tempted into a fight to "show her who is boss." When the therapist is drawn into a fight, the patient plunges into a hating, panic-like frame of mind in which survival or annihilation seems to be the issue. To the extent that the therapist's struggle is on the level of who will control and administer a beating to whom, his regression is to the anal sadistic level. But because the patient is likely to see the contest in terms of annihilation through engulfment or abandonment, for him the threat is one of oral punishment.<sup>33</sup> His threats against the therapist are to destroy himself and abandon the therapist, and he fears bloodthirsty retaliation of a similar kind. In order to cast the patient in the role of a dirty witch adversary complementary to the anal sadistic excitement he experiences, the therapist will have to distort these clinical facts and cannot see his patient as a person in a psychotic or near psychotic panic, in dread of death. Instead he sees the patient as a nasty person spitefully intent on thwarting all of his plans and efforts. When both patient and therapist are drawn into a contest of wills, each devaluing the other by projection, the torture drive and the bloodthirst will dominate their relationship. The therapeutic battle will then be lost because the therapist has given up his own weapons, reason, clear thinking, and caring. He has changed sides, as it were, and joined the patient in destruction.

Unconscious masochistic trends may also be activated in the therapist as he attempts to deal with the primitive aggression of his patients. Under the guise of being loving and tolerant, he may allow the patient to attack and punish him in a way which frightens the patient and deepens his guilt. Often such masochistic acting out is also turned to the service of keeping malice out of mind.

It is hard for most student psychiatrists to appreciate that they cannot only seek out such punishment from patients, but also that they may actually invite it and provoke it. Sometimes such behavior is rationalized by the argument that the patient was never permitted the expression of anger as a child, and that almost unlimited hateful display should be tolerated because it is a necessary "abreaction." Under the spell of such an illusion some therapists have even permitted patients to smear them with feces for periods of time, quite unaware that they were satis-

fying their own craving for degradation, and further burdening a psychotic patient by inviting him to do the degrading. Much more frequent are those therapists who permit hour after hour of verbal threats and degradation in the "therapy session," making little effort to interrupt the stream of abuse and to direct the patient's attention to what he is doing and why. The therapist who too much needs to make himself an "innocent and loving victim" is likely to be insufficiently active when a patient launches a sadistic attack.

In some instances the therapist may suffer from a masochistic character attitude that leads him to select such patients in the first place to fulfill his need for suffering and abuse.

While sadistic acting out against a patient is sometimes relatively easy to rationalize, the therapist who is well able to tolerate the conscious and physical manifestations of angry and sadistic affect, ie, he who does not have to rely on isolation or other defenses to ward off such feelings, will be able to attend to his own state of emotional excitement. This means for most people a sense of muscular tightness and tension; especially the abdominal muscles may feel tense, and there may be a tendency rhythmically to tighten the musculature of the jaws, buttocks, and anal sphincter. Sometimes there are sensations of sexual arousal. There may be a sense of tingling in the buttocks or anus, and at the same time a sense of fullness in the chest and head. Subjectively, there may be a sense of righteous indignation. If the therapist can tolerate it he may experience lively impulses to attack the patient, beat him, cut him, or mutilate him where others would experience anxiety. Able psychotherapists monitor themselves even for slight degrees of such responses and use them as indicators that the patient is in danger of evoking an antitherapeutic response.

The kind of countertransference acting out that is more likely to result in suicide involves the therapist's unconscious impulses to kill the patient. These pertain not to the anal struggle for control but to the therapist's more archaic oral craving to be loved exclusively, and to the primitive rage that is aroused when that wish is frustrated.

As the suicidal patient's demands for total love and succor mount, the psychotherapist may worry more and more that his patient will commit suicide. This particularly occurs when the therapist has invited a rapid development of primitive transference from his patient by participating with him in the fantasy that the physician can provide what the patient so desperately craves, ie, the experience of being loved as a small infant is loved. No psychotherapist can be a Madonna, but many have aspired to be. If the physician unconsciously aspires to the impossibility of being all loving, all caring, all giving, he subtly may be drawn into a relationship in which he tries to provide what the patient seems so much to need. When the psychiatrist tries to meet his patient's longings to be mothered in such a way, usually he longs to be cared for in a similar way himself, and by becoming a Madonna, he enjoys vicariously the patient's experience of being a totally secure, totally loved infant. Just as the patient expects the psychiatrist to love him, so it may develop that the psychiatrist begins to yearn for a return of love and gratitude

from the patient for whom he attempts such understanding, care, and forbearance. Should the patient early in the relationship have been lavish in praise, or otherwise warmly responsive, the physician, like Chanticleer, may have been early lulled into the belief that his powers to heal and help were very superior indeed, and that he deserved the love that a little child might give its mother.

Dread of suicide increases as the patient's inevitable transference rage begins to appear; the therapist becomes an object of intense hatred. If the therapist has made promises for perfect mothering, tacitly or overtly, the danger of suicide indeed may be greater than it would be had the transference been correctly managed.

But the dread of suicide may also conceal the therapist's wish to kill his patient. This problem arises when the therapist has formed a narcissistic countertransference in which he has come to expect infantile loving regard from the patient. It is then that he is likely to experience his patient's abrupt eruption of transference hate as a deprivation of the love to which he has unwittingly become addicted. The therapist's dread of the patient's suicide is under such circumstances a countertransference dread of abandonment by *his* mother; he longs for her but hates her because of the way in which she treats him, as an unworthy child, rejecting him and all his best efforts, threatening to go away forever.

When the patient rejects the therapist and at the same time directs against him his cannibalistic rage, to the extent that the therapist regresses under the impact of the narcissistic shock, he will feel what the patient feels. Both will become bloodthirsty, both excited by the primitive sadism of the oral phase, and the temptation of the therapist will be to chew up the patient. An even greater danger exists in that the aversive element of primitive hate may at this juncture come into play. Whether originating in the bloodthirsty oral craving to kill and devour, or in the anal impulse to expel and reject a worthless object, the patient is in danger of actual abandonment. This is a moment of genuine suicide danger. Recognition of murderous impulses against the patient at the peak of suicidal threatening may forewarn the therapist that such a crisis is impending and enable him to avoid it. A breeding transference-countertransference storm can be recognized before the winds of rage begin to blow, however. 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. At this point, if the therapist can recognize the impossibility of such hopes both for himself and for the patient, gentle interpretation or clarification of the patient's impossible expectations and a more realistic demeanor in the therapist may make the coming disturbance easier to manage.

#### The Therapeutic Response

The best protection from antitherapeutic acting out is the ability to keep such impulses in consciousness. Full protection, however, requires that the therapist also gain comfort with his countertransference hate through the process of acknowledging it, bearing it, and putting it

into perspective. Guilt then has no place in his feelings, and the therapist is free to exert a conscious loving self-restraint, in which he places a higher value on the emotional growth of his patient than he does on his own tension discharge. At the proper time, the patient can be shown how his behavior leads to an attacking or rejecting response in others. In other words, the suicidal patient's repetition compulsion to involve others in relationships of malice and ultimately to be rejected is signalled in the therapist's countertransference hate. In time it can be interpreted and worked at, provided the therapist, by accepting, tolerating, and containing the countertransference, does not join the patient in repeating his past instead of remembering it.

#### The Result of the Contest

Very few patients are incapable of developing the trust and making the compromise necessary to set aside the attitude of hate and the option of suicide. These few may, under the intense impact of the transference rage, bring about a state of affairs in which the therapist has no choice but to give up the case. This may come about when the patient cannot confine his onslaughts to the target of the therapist's narcissism or other noncritical areas, but extends the attack to the physician's person by physical assault, or to his other relationships. Rarely the patient may be so determined to provoke a rejection that in fact he gives the psychiatrist the choice of withdrawing or being destroyed. To persist in the treatment of a patient where there are substantial risks of this order is to fall into the ultimate snare of one's own narcissism, namely, the unrealistic belief that one is physically invulnerable.

However, experience leads us to believe that optimism is appropriate for the treatment of by far the large majority of borderline and psychotic suicidal patients. The most important problem in treatment is the considerable emotional demand the undertaking from time to time places on the therapist. When the therapist has the motivation, skill, and strength to deal with the transference-countertransference burden such a patient stirs up, good results are most often obtained. When the onslaught of the transference is met not with narcissistic overweening and regressive acting out, when the therapist can maintain the relationship in an appropriately interested way, the patient has a chance to acknowledge his transference for what it is, to learn to bear the intensity of his craving and rage, and put them into perspective. The patient may exchange his impossible narcissistic dreams for real relationships once he finds their fulfillment is not necessary for survival. This exchange can come about as he internalizes his therapist as a good object, tried and tested through the fire of the treatment and found trustworthy. Increasingly, he uses the therapeutic relationship to grow and to accept life in the real world for what it is—something less than a narcissistic paradise but populated with other people who can reliably offer some love, if not total gratification.

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## Correction

**Table Corrected**—In the article, "Clinical Factors in Lithium Carbonate Prophylaxis Failure," published in the February ARCHIVES (30:229-233, 1974), errors occurred in Table 1 on page 231. The correct table is printed below:

Table 1.—Lithium Carbonate Prophylaxis Failures				
	Total No.	Clinically Well	Failure	% Failure
<b>Lithium Carbonate Treated</b>				
Rapid cyclers	11	2	9*	82
Nonrapid cyclers	44	26	18	41
<b>No Lithium Carbonate</b>				
Rapid cyclers				
Prelithium carbonate	1	0	1	100
Discontinuation, placebo	4	0	4	100
Nonrapid cyclers				
Prelithium carbonate	16	4	12	75
Discontinuation, placebo	10	1	9	90

\*  $\chi^2$  for this distribution of lithium carbonate failure patients was 4.37,  $P < .05$ .