The Problem of The Bad-Analyst-Feeling*

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I want to address a problem that I believe it is fair to say is shared by all psychoanalytic therapists. I refer to a complex of bad feelings that issues from a negative representation of the therapeutic self that inevitably and necessarily arises in our work with patients. This negative self-image and the feeling complex that issues from it I would call, respectively, the bad-analyst-image and the bad-analyst-feeling.

I have found problems with the bad-analyst-feeling to prevail among all problems presented to me by students and supervisees. I have found such problems to prevail as well in supervision groups that I attend with my colleagues, and I regularly experience such feelings myself *vis-a-vis* my patients and my supervisees. In the latter case the term the bad-supervisor-feeling would be more accurate.

The bad-analyst feeling arises most frequently in connection with what we are likely to experience as treatment impasses. That is, such feelings may lead us to conclude that the treatment is at an impasse. In actual fact the therapy may or may not be at an impasse. Typically in supervision the therapist who presents such a situation is most often convinced, or near being convinced, that with respect to the patient being presented, sometimes with respect to his or her entire practice, he or she is a bad analyst.

The quality of the bad-analyst-feeling will differ according to whether a given personality organization has been arrested at what

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Melanie Klein called the paranoid-schizoid level of development or whether the patient has reached what she called the depressive position, or what Winnicott has more aptly termed the capacity for concern. I shall limit my discussion to the countertransference problems we are likely to experience in relation to the first of these two categories of patients, those patients called difficult and, more specifically, these patients diagnosed as borderline.

Margaret Little has said that in working with borderline patients an analyst needs many psychoanalytic concepts. My own understanding has been illuminated by the contributions of Little (1951), Melanie Klein (1957), Racker (1957), Sullivan (1953), Winnicott (1949), Bion (1962), Searles (1965) and Spotnitz (1976, 1985). I have also found support for my understanding in recent publications of Robert Marshall (1982), Ogden (1982), and in the work of such modern analysts as Meadow (1977, 1978), Margolis (1978), Liegner (1980), Abrams (1976) and Ernsberger (1979).

I would like now to describe the behavior of those patients who are usually diagnosed as having a borderline personality organization as such behavior is manifested in the therapeutic interaction. Such patients usually seek treatment because their experience of living is dominated by feelings of chronic and intense dissatisfaction. Session after session is typically taken up with a barrage of repetitious complaints of being, in one way or another, mistreated, misunderstood, unappreciated, or neglected by the emotionally significant people in their lives.

They present massive resistances to what we think of as the normal give-and-take of the therapeutic interaction. Our efforts to engage their cooperation in making sense of their situations are met with impatience and with suspicion, especially at those times that our inquiry may touch upon their possible contributions to their interpersonal difficulties. Interpretations, more often than not, are experienced as inimical.

All interventions, in fact, are likely to be experienced as either bad, or as not good enough.

Sooner or later the therapy and the therapist become the target of the patient's dissatisfaction, which is expressed in one or more of the following ways. The patient may become angrily withholding, sometimes going so far as to affect a kind of mutism. The patient complains that he isn't getting anywhere, that we are too cold, or formal or uncaring. He denigrates our method, he talks about leaving treatment, about consulting a friend's therapist who is warm and caring, or he plans to try something different, like

hypnosis, gestalt therapy, or one of the brief therapies, or even drug therapy.

He may apply intense pressure on us to, in one way or another, extend the limits of the setting, demanding extra time, or insistently claiming that he has a right to information about our personal lives. He may frequently telephone us at home, apparently desperate, and most times end up feeling unhelped and rejected no matter how long we remain on the phone. If we frustrate his efforts to reach us directly he may harass us via our telephone answering machine, taking up our tape with long and/or frequent messages.

Because of our perceived deficiencies and the apparent ongoing failure of the treatment, we may be repeatedly insulted and abused or threatened with suicide.

Turning now to the countertransference, let me elaborate on what we shall typically experience as the inevitable counterpart of such behavior. We can expect the countertransference experience to be so emotionally confusing, turbulent and stressful as to make it very difficult to sustain our therapeutic stance or to regain it once we have lost it.

Depending on a given patient's capacity to tolerate an awareness of his anger and hate, the assaults he makes on our feelings of goodness and competence will be delivered from higher or lower levels of consciousness. The less conscious he is of his feelings, the more covert his attacks. In these circumstances, we may be unable to see any direct connection between the patient's behavior and communications and whatever internal disturbances we may be experiencing. We may, for instance, experience a scrambling of our cognitive processes. The patient may be talking of things that we think should merit our interest, but in spite of our best efforts to concentrate, we may be unable to assimilate what he is saying. Our mind wanders capriciously, we may have to struggle to keep our eyes from closing. Our thought processes feel empty and shallow. We generally feel a growing pressure to think of something meaningful and worthwhile to say, yet nothing of value occurs to us. There are times that our emotional reactions in response to the patient's suffering are not what we think they should be. They may be contrary to the point of seeming perverse. Instead of being moved to sympathy or compassion, we may feel a cold indifference, disgust, contempt; we may even have the unsettling experience of wishing even worse things on the patient.

If the patient is sitting up and looking at us rather than lying

down, we may often feel ourselves in danger of being caught dozing off or otherwise being distracted. Such lapses may cause us to feel anxious and guilty. We may find ourselves furtively glancing at our timepieces in order to find out how much longer we shall have to put up with the torture.

Should a patient be more aware of his anger and hate, both his assaults on our feelings of goodness and competence and his rejection of the limits of the setting are likely to be more overt and direct. Our reactions are likely to be clearer and more focused. And if we fully own all of the feelings that are induced in us by the patient's denigration and contempt and by his inappropriate demands and his intrusive behavior, we may find ourselves, at times, feeling an intense hatred either for the patient, ourselves, or for both. At times we may feel like urgently getting rid of the patient, or we may feel like leaving the field of psychoanalysis.

Until such time as the therapy successfully dissolves his defense-resistances to enable a given patient to emerge from his borderline ego state, the therapist can expect to experience himself as having nothing of value to offer. He will have to endure what can be fairly summed up as a bad-therapist-feeling. This feeling when not understood and accepted as the inevitable emotional accompaniment to the work, occasions feelings of shame and guilt and fraudulence for taking fees from patients to whom we are apparently being so unhelpful, and when under the sway of this feeling, we may feel reluctant to consult our colleagues concerning the problems we are having with such treatment situations.

Now I would like to offer my best understanding of the meaning of this negative transference/countertransference matrix.

It is, I believe, a consequence of the impact of the psychoanalytic situation on the borderline personality organization. All of the patient's resistant behaviors and our induced countertransference disturbances can be understood to be a reflection of the patient's best efforts to cope with and survive the annihilation anxieties that are evoked in the therapeutic interaction; and the severity of such transference/countertransference disturbances may be diminished or exacerbated depending on the analyst's management of what Sullivan called the patient's gradient of anxiety.

This transference/countertransference matrix signifies that we are involved with a person whose self/other boundaries are ill-defined and permeable, and whose ego has failed to develop the strength to bear disturbing and conflictual mental contents in con-

sciousness long enough to submit them to processes of thought or to what Bion has called reverie.

When a person with such an unstable and permeable personality organization enters a relationship with an emotionally significant other person who is more intact, stable and comfortable with himself, the impact is likely to be both intensely exciting and potentially disorganizing.

Because of his actual dependency on the analyst for therapeutic help, and because of his fantasies of the analyst's superior mental health and superior competence to live a satisfying life—fantasies which are both reality based and projected—the analytic situation is likely to be experienced as especially agitating and stressful. The patient's ego is immediately assailed by an upsurge of unbearably painful and violent mental contents.

Were he to be undefended *vis-à-vis* the perceived or fantasied superior goodness and competence of the therapist, the borderline patient would experience an intensification of feelings of badness, agonizing feelings of deficiency, excruciating envy, and a murderous hatred of either, or both, himself and the other.

Were the patient to be undefended, he would become aware of a terrifying helplessness to cope with his vulnerability to the intense abandonment anxieties that would be evoked by the very fact of the therapist's separate existence, of his power simply to be himself. The patient's defense resistances enable him to remain unaware of his actual dependency on the therapist's capability to do good-enough therapy. His dependent, clinging, intrusive and demanding behaviors are rarely accompanied by an experience of the terror of loss and abandonment. Such manipulative behaviors are powered by compensatory omnipotent strivings and grandiose fantasy, the aim of which is to negate any experience of the separateness and otherness of the analyst, and of the analyst as the object of his attachment needs. The experience of vulnerability to being failed by the analyst—as he was by his parents—is obliterated by the paradoxical belief that the nullified other can be emotionally dominated, controlled and coerced so as to yield favors and care-giving of one kind or another.

Our negative countertransference experiences can best be understood as the inevitable consequence and counterpart of the patient's primitive interactional defenses, namely externalization, splitting and projective identification, and what Bion has called primitive communication.

The aim of such projective processes is twofold: to urgently rid the psyche of the painful affects and unwanted self and object parts that would give rise to unbearable and potentially disorganizing experience, and to aggressively penetrate the analyst's insides and deposit there the evacuated, toxic mental contents. The purpose of this transfer of mental contents is to achieve an emotional domination and control of the analyst as the object of denied attachment needs, and to achieve, as well, within the unequal therapeutic dyad, a more equitable distribution and balance of goodness-and-badness and power-and-weakness.

Spotnitz says that in this way the patient attempts to make the analyst into a defective person, more like himself, and, therefore, a person more comfortable to be with. Spotnitz has termed this the patient's need for a negative narcissistic transference. I prefer negative self-object transference—a modification of Kohut's "self-object transference."

I should say something about the patient's use of primitive communication. Bion's theory of primitive communication is one of his most brilliant and useful contributions. It accounts for our otherwise unaccountable cognitive disturbances of concentration, attention, and sleepiness. According to Bion's theory, speech and language processes become primitivized so that they lose their primary function which is to communicate symbolic understanding. They become the instruments for the urgent evacuation and the transfer of unconcious accretions of psychic disturbances, and for the creation of impervious barriers to the communication of meaning, for the actual destruction of meaning.

Truth and understanding and meaning are dreaded because they would make the borderline patient conscious of unbearable experience. Thinking gives rise to meaning, and therefore, the borderline patient by means of primitive communication, attacks and successfully scrambles our thinking processes. At such times, when the patient is bombarding our minds with unconscious elements of psychic disturbances—which Bion termed Beta elements—the best we might be able to do to survive the situation is to fall back on the security operation that Sullivan called "somnolent detachment"—a psychobiological defense that we develop in early infancy to cope with the anxieties evoked by our mother's empathic failures.

As a simple matter of fact there is truly nothing that we can do to prevent ourselves from experiencing such cognitive disturbances unless we intervene in a way that interferes with the pa-

tient's primitive communication. This may, or may not, be a good thing to do.

For all of the foregoing reasons, until the patient has emerged from his primitive mental state, we cannot expect to enjoy the feeling of being a good analyst. The patient, because of his dread of meaning, because of his split-off destructive envy, and because he is haunted by feelings of badness—which are heightened and perpetuated by his nullifying destructive interactions—simply cannot allow us to enjoy feelings of goodness. The better he allows us to feel about ourself, the worse he would have to feel about himself. We have all had the experience of having friendly normal sessions with such patients only to have them turn the next session into a shambles, vitiating all feelings of mutuality and shared goodness.

In working with such patients we are in a paradoxical situation. We must learn how to function competently while feeling incompetent.

Our feelings of incompetence do not necessarily signify that the therapy is not progressing. The patient may not be able to afford to recognize progress because this would require him to acknowledge that the therapist might have had something to do with it. He might then be vulnerable to unbearable envy and to the terror of loss and abandonment.

The point is that neither the therapist's nor the patient's negative feelings should be taken at face value as valid indicators that the treatment is inadequate. Confidence in the treatment should be based on more objective criteria such as signs of improved functioning. For example:

- The patient functions better at work and in his outside interpersonal relationships.
- His symptoms diminish: somatic complaints, sleep disturbances are reported with decreasing frequency.
- Addictive behaviors diminish, such as alcohol and drug abuse and overeating. The patient gives up smoking.
- Complaints of outside suffering diminish in favor of complaints more focused on the therapy and the therapist.

We shall gradually be permitted to feel competent as the therapeutic process strengthens the patient's ego sufficiently to enable

him to bear unbearable experience—especially the upsurge of bad feeling which is stimulated in relation to the analyst—and as it enables him to formulate this experience on the level of language and to discharge it in meaningful speech, thereby rendering obsolescent his evacuative and projective defense-resistances.

I should like to present what I have found to be a therapeutically useful perspective on the relationship between borderline psychopathology and countertransference.

When Winnicott wrote of failures of adaptation, he was referring to an environmental failure to adapt to the maturational needs of the developing child. In keeping with this view I have differentiated two ways in which the human environment has typically failed those patients who present primitive mental states. I have termed these, respectively, the primary environmental failure of adaptation and the secondary environmental failure of adaptation. The primary environmental failure refers to those chronic and repetitive parental failures to meet the particular constellation of maturational needs which is presented by the patient in infancy and early childhood.

Winnicott makes the point that when "for the immature child" the mother "becomes the target for excited experience backed by crude instinct tension," she "has to be found to survive instinct-driven episodes which have now acquired the full force of fantasies of oral sadism and other results of fusion" and that "to survive in this context means not to retaliate." (Winnicott, 1968)

I would translate this to mean that when the child induces bad feelings and/or feelings of badness in his care-givers, he needs them to contain and process these feelings in such a way as to enable them to respond without making the child a bad or no-good person in return, and without subjecting the child to the terror of being physically and/or emotionally destroyed or abandoned.

I would speculate that the borderline patient, as a child, was failed in this regard and that his ego's best efforts to cope with this primary parental failure resulted in the internalization of a strife-torn self-and-object-world that, for reasons that I have outlined above, he must thereafter externalize and project at some point in the course of all subsequent emotionally significant relationships.

Other persons in his life who become the target of such projective processes are typically impelled to react defensively and counterprojectively. Another way of putting this is that in ordinary interpersonal transactions, such transference projections typically

evoke responses which are strongly under the sway of raw, unprocessed countertransference reactions. The borderline patient's psychopathology begets the very kind of response in others which reenforces and perpetuates it. This failure of the human environment to respond in ways that might correct the intrapsychic warping that was laid down in response to the primary parental failure of adaptation I would term the secondary environmental failure of adaptation.

From this perspective, it can be seen that the negative countertransference experience generated by patients presenting primitive mental states becomes our main instrument of therapeutic leverage. If we can own this experience and inhibit our urges for riddance, retaliation, and counterprojection, if we can address this experience for its informational value, and if we can succeed in determining what the patient needs us to do with our negative feelings, we shall, in effect, be performing, over what Sullivan called the "long haul of therapy," a maturationally corrective, facilitating task which no previous care-giver in the patient's lifetime has either had the knowledge or the will or the capability to perform.

All of the internal work that the analyst does with his countertransference—inhibiting retaliatory impulses, holding the patient's evacuated mental contents in consciousness long enough to submit them to processes of reverie which cleanse them of their toxicity—is akin to the internal work that the good-enough mother does in both surviving and maintaining her connection to her baby during those episodes in which she "becomes the target for excited experience backed by crude instinct tension."

Gradually the patient comes to internalize the analyst's capability for impulse control and for containing and processing conflictual and dysphoric mental contents.

- I would discuss the unwitting ways in which we might either deny our bad-analyst-feelings or go into action to evacuate them.
- I would include a discussion of how certain preformed concepts of psychoanalytic theory and practice are unwittingly designed to perform the same functions of denial and evacuation in order to preserve the analyst's good-analyst-image and -feeling.
- I would like to discuss how recommendations for the treatment of difficult patients which are based on such preformed concepts

are likely to make treatment more difficult or even impossible for both analyst and patient. This would include the treatment recommendations of Kernberg, Masterson, Kohut and the self-psychologists.

- I should like to include a discussion of the main features of Spotnitz's treatment approach which I have found to be better adapted than any other that I know of to enable the therapist to function with consistent competence while feeling bad and incompetent.
- I should like to provide clinical examples illustrating the therapeutic leverage that can be gained when we are in the emotional position of a bad-analyst.

In conclusion, I want to address briefly what I believe to be an unconsciously based impediment to our living and working with the bad-analyst-feeling.

Any person who is made to feel bad or not-good-enough for the other person is likely to experience a threat to his self-esteem. For psychoanalysts, the bad-analyst-feeling presents a similar problem with, however, an additional feature, namely, that for most, if not all of us, the bad-analyst-feeling frustrates a core unconscious need that may have brought us into the field and which persists in requiring satisfaction. I am referring to our need to make reparation to our internal parental objects.

To the extent that we failed to be good-enough sons and daughters to cure our real parents of their mental pain and anguish so that they could have been more loving to us, we remain haunted by a sense of badness which we need to expiate by proving ourselves to be good-enough analysts to cure our patients.

As Racker has pointed out, the patient can be as much the object of the analyst's countertransference neurosis as is the analyst the object of the patient's transference neurosis.

The bad-analyst feeling may revive the unconscious despair of our child-self that it can ever be good enough for our parents. In this emotional situation our frustrated child-self eclipses our adult analytic-self. From this position we may be unable, and in all likelihood, unconsciously unwilling to do the hard work of functioning as a good analyst while feeling like a bad one, until we contact the full force of the hatred we feel for the patient as the bad parental object who is once again depriving us of our need to make reparation.

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