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Commentary on "Dissociative Processes and Transference–Countertransference Paradigms . . ." by Jody Messler Davies and Mary Gail Frawley

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ACCORDING TO LEGEND, Bion was once asked for his thoughts in the midst of an extraordinarily chaotic group relations conference involving heated conflicts between groups and individuals. His response to the question was that he did not find the circumstances conducive to thinking (Symington, 1990). In a similar vein, analysts who attempt to treat patients with dissociative disorders as a consequence of childhood sexual abuse find themselves in the eye of a veritable hurricane that erodes what Fleming (1973) referred to as the analyst's work ego. Rational thought and quiet, introspective reflection are severely compromised by the sheer forcefulness of the reenactment of the patient's internal object world. Davies and Frawley have captured these paradigms with vividness and clarity. I fully concur with their view that the transference-countertransference developments arising from the patient's internal object relations may serve as either a gateway to recovery or a trapdoor to a mine field of problematic countertransference enactments. As Lisman-Pieczanski (1990) notes: "Contact with these patients deeply affects the therapist's inner balance and capacity to understand and care. Thus, the analytic process frequently includes the analyst's cyclic attempts to rescue his or her analytic capacity" (p. 145).

The authors' eloquent essay is replete with sound clinical wisdom for those who rise to the challenge of treating incest survivors. While they

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provide much food for thought, I shall limit my discussion to two principal issues: (1) an elaboration of the countertransference pitfalls, with particular reference to Ferenczi, and (2) an additional object relations paradigm that I feel the authors have neglected.

Analyst as Lover and Abuser

I share the view of Davies and Frawley that analysts who treat adult patients who were sexually abused as children must participate in the shared relational field evoked by the dissociative states. I shall focus on some of the perils inherent in journeying on what the authors term " 'the royal road' to otherwise unavailable, split-off experience and memory." Those who enter the relational matrix of their patient's dissociative experiences do so at considerable risk. One risk is that the analyst will assume the role of a rescuer who will love the patient more completely than the parents did. This role is often a prelude to the transgression of professional boundaries and a reenactment of the role of abuser. We know that a significant percentage of patients involved in therapist-patient sexual relations have been incest victims as children (Smith, 1984, 1989; Gabbard, 1989a; Bigras and Biggs, 1990).

Before examining this transformation of lover to abuser in greater detail, I would like to take issue with the authors' conceptualization of the decision to enter into the relational matrix of the patient's dissociative states as a choice. In advocating this course of action, they contrast it with a more classical alternative in which the analyst interprets the dissociative states as a "dispassionate commentator." The dissociative states of these patients are such affectively powerful depictions of victimization that the analyst is coerced or "bullied" into the shared field of the patient's internal object relations. I frankly doubt whether the position of the "dispassionate commentator" is even a viable role under such conditions; at best, it may represent a defensive posture designed to deal with the enormous pressures toward enactment emanating from the patient. Moreover, as Kluft (1991) notes, the interpretation of material to one state of mind when that material is meaningful only to another state of mind is futile. The projective identification process set in motion by these poignant, altered states of consciousness is so compelling that it may be nigh impossible for the clinician to maintain an analytic posture in the

face of the patient's moving display. As Davies and Frawley point out, the most likely complementary response to the appearance of the child-victim is the assumption of the idealized rescuer role.

The most widely accepted contemporary psychoanalytic view of countertransference is that it is a joint creation between patient and analyst and contains derivatives of unconscious issues from the analyst's past as well as more "objective" responses evoked by the patient's behavior. In keeping with this widely accepted view of countertransference, we can assume that the role of rescuer represents both a coerced object response to the patient's presentation of self as well as an overdetermined need on the analyst's part to heal and repair others. As Davies and Frawley perceptively point out, the therapist's wish to cure may serve as an Achilles' heel in the treatment of incest victims.

The clinical diary of Ferenczi (DuPont, 1988), to which the authors refer, provides a revealing glimpse of how the projected contents of the patient and the internal needs of the therapist may function synergistically to produce formidable countertransference enactments. Bitter after his analytic experience with Freud, Ferenczi became convinced that the emphasis of analysis on the role of fantasy was seriously misplaced. He maintained that many patients had experienced actual sexual trauma as children. As a consequence, Ferenczi argued, the analyst needed to supply the love to the patient that the parents had failed to provide. This technique involved hugging and kissing the patient like "an affectionate mother" who "gives up all consideration of one's own convenience, and indulges the patient's wishes and impulses as far as in any way possible" (Grubrich-Simitis, 1986, p. 272).

Ferenczi's idea that the analyst must love the patient clearly grew out of his perception of the patient as a victim/child who missed out on parental love the first time around. His point of view, however, was also an outgrowth of his own desperate need to be loved. He grew up in a family with multiple siblings and parents who were so busy that they were relatively unavailable. Grubrich-Simitis (1986) points out that Ferenczi's mother was harsh and unable to supply her son with the nurturance he felt he needed. Hence, Ferenczi readily identified with his patients who had experienced real trauma at the hands of their parents, and he spent his life trying to give to patients what he himself did not receive as a child.

Ferenczi's example is instructive because it typifies a common unconscious determinant in the career choice of psychotherapists. Many

mental health professionals harbor an unconscious fantasy that love in and of itself is curative (Gabbard, in press). Often they have felt insufficiently loved as children, and they hope that providing love for their patients will result in their being idealized and loved in return. In this manner psychotherapists often hope to regulate their self-esteem through their work with patients. As is the case with many therapists who transgress professional boundaries with their patients, Ferenczi began to confuse his own needs with those of the patient.

This dynamic became most transparent in his diary entries on mutual analysis, a technique he tried with four American female patients. He would analyze the patient for an hour followed by a role reversal in which he allowed the patient to analyze him for an hour. These entries reveal how what began as an effort to heal patients developed into an effort to heal himself, as viewed in an entry on January 17, 1932, where he wrote, "Our psyche, too, is more or less fragmented and in pieces, and, especially expending so much libido without any libido-income, it needs such repayment now and again from well-disposed patients who are cured or on the point of being cured" (DuPont, 1988, p. 13).

Further evidence of Ferenczi's poignant efforts to work through his childhood difficulties with his mother via the practice of analysis can be found in his comments on his mutual analysis with a particular female patient known as R.N.: "In R.N. I find my mother again, namely the real one, who was hard and energetic and of whom I am afraid. R.N. knows this, and treats me with particular gentleness; the analysis even enables her to transform her own hardness into friendly softness" (DuPont, 1988, p. 45). In a later entry he acknowledged that his own childhood feelings of aggression and hatred toward his mother were often displaced onto his patients. Through a tremendous effort he was able to develop what he termed an "intellectual superkindness" (DuPont, 1988) in an attempt to overcome such feelings and be as loving as possible toward his patients. Despite his earnest attempt, R.N. nevertheless told Ferenczi that she experienced feelings of hate coming from him. In a diary entry on May 5, 1932, Ferenczi acknowledged the accuracy of the patient's perception: "The patient's demands to be loved corresponded to analogous demands on me by my mother. In actual fact and inwardly, therefore, I did hate the patient, in spite of all the friendliness I displayed" (DuPont, 1988, p. 99).

Hence, in Ferenczi's case we see a clear example of thoroughgoing confusion between the patient's needs and his own needs. His therapeu-

tic zeal that led him to boundary transgressions was only partially determined by his professed interest in providing patients the love they had missed in childhood. Of greater importance is that he was attempting to give them the love that he wished he had received first from his mother and later from his analysis with Freud. Moreover, just beneath the surface of the compulsive efforts to love his patients, he was struggling with feelings toward them of hatred and resentment stemming from longstanding bitterness toward his mother. One could speculate that Ferenczi's therapeutic efforts were, in part, designed to repair the damage he felt he had inflicted on his own mother.

Ferenczi is a figure of enormous historical importance in psychoanalysis, largely because of his early recognition of the clinical significance of real trauma of a sexual nature in the pathogenesis of neurosis. His recognition of the effects of sexual abuse on his patients, however, led him directly into the role of the idealized rescuer. In so doing, he provided a historical example of what Davies and Frawley refer to as the most common countertransference deadlock in the treatment of incest victims, that is, the rescuer-victim paradigm. Moreover, lurking behind his wish to provide a corrective emotional experience for the patient was hatred that he was unable to disguise. In addition, patients seemed to have served as containers for his own projected self-representation of the abused, unloved child within. In loving his patients, he hoped he would be loved himself. All these factors led to ill-advised physical contact with patients and the unfortunate practice of mutual analysis, which he abandoned after a few months.

Ferenczi's example sheds light on the dynamics involved in the transformation of the loving analyst into the sadistic abuser in the treatment of incest victims. As Davies and Frawley stress, the analyst who embarks on a campaign to provide such patients with the love they missed in childhood has hitched his wagon to a falling star. His efforts are doomed from the beginning because the patient's needs are insatiable. Driven by the conviction that she is entitled to unconditional love and attention as compensation for the abuses of her past, she torments the analyst endlessly with her demands for special treatment (Gabbard, 1986; Raphling, 1990). The analyst begins to glimpse the narcissistic triumph behind the victim role—the exception, who has won the oedipal prize denied to others. The analyst, however, may experience guilt connected with his growing hatred of the patient and may therefore bolster his professional reaction formation, as so vividly displayed in the

case of Ferenczi, to "run the extra mile" and meet the patient's needs (Gabbard, 1986). Davies and Frawley point out that this pattern leads to an externalization of an object relations paradigm within the patient, an externalization characterized by the analyst's assuming the masochistic role of victim while the patient becomes a sadistic abuser. What is often completely missed by the analyst who is driven to meet such a patient's insatiable demands is that the insistence on a concrete demonstration of love from the analyst (to prove that he really cares) is an outgrowth of the contempt with which the patient views the analyst's technique. While the analyst is doing more and more to demonstrate his caring to the patient, she is thwarting his therapeutic efforts while nevertheless demanding more of him.

In cases of severe boundary transgressions, such as therapist-patient sexual exploitation, therapists often resort to such extreme measures out of a sense of despair when their omnipotent strivings to heal the patient have been frustrated (Searles, 1979; Twemlow and Gabbard, 1989). The rage at the patient is thus buried beneath reaction formations involving professions of love and caring. In such tragic distortions of professional ethics, the analyst's attempts to love the patient result in a symbolic reenactment of incestuous sexual abuse. In terms of the object relations paradigm reflected in such behavior, the patient has reintrojected the role of victim while reprojecting the role of sadistic abuser into the therapist.

In the case of Ferenczi, it appears that his female patients served as the repositories for both the child-victim self-representation and the hated-mother object-representation. His efforts to heal the former were contaminated by his bitterness toward the latter. Davies and Frawley suggest that the publication of his diaries puts to rest once and for all the question of his sanity. Hoffer (1990), taking a different point of view, emphasizes that the diary can be just as persuasively construed as evidence that Ferenczi was psychotic as it can be used to defend his sanity. The real issue for purposes of discussion here, however, is not an assessment of Ferenczi's reality testing. Rather, the study of the dynamics that led him to become the rescuer of incest victims is useful in illuminating common unconscious issues in mental health professionals that lead them into the same countertransference hazards that lured Ferenczi.

In some cases of therapist-patient sex involving incest victims, what begins as therapeutic zeal is transformed into lovesickness (Twemlow and Gabbard, 1989), whereby the therapist is actually convinced that his

feelings are not countertransference but "true love." Blum (1973) has distinguished erotized from erotic transference by the patient's tenacious, ego-syntonic demand for sexual gratification from the therapist in the former variant. He notes that this variant of transference is often found in incest victims. Its counterpart can be found in the lovesick therapist—an erotized countertransference, in which the "as if" nature of the relationship is lost and the therapist views the feelings in the therapeutic dyad not as a reenactment, but as a case of "real" love.

The Uninvolved Mother

Davies and Frawley state, "The internal object world of this child-patient is organized around the representations of only three major players: a victim, an abuser, and an idealized, omnipotent rescuer." While I agree that these three characters in the intrapsychic drama are center stage much of the time, I submit that the authors have made one significant omission—the uninvolved mother. This internalized figure is protean in its manifestations. If one follows Fairbairn's (1940, 1944) observation that an object relationship, not simply an object, is internalized in the process of development, the appearance of the uninvolved mother may arise in various complementary pairings in the transference-countertransference constellation.

A common transference manifestation in the patient is the perception of the analyst's silence as evidence that the analyst is indifferent, unavailable, and rejecting. The patient may, in turn, experience a sense of nonbeing. Bigras and Biggs (1990) have termed this constellation "negative incest," a melancholic emptiness or deadness that is the legacy of an absent mother who made no effort to stop the father-daughter incest from occurring in her family. The sadomasochistic acting out of a defensive paternal transference often obscures this more primitive and disturbing object relations unit. The tenacity with which the patient holds on to the abuser-victim paradigm in the analytic setting, so well described by Davies and Frawley, may reflect the anxiety associated with losing the connectedness of the relationship with the abusing father and being set free in a void characterized by an uncaring, unavailable mother (Gabbard, 1986). An abusive object is better than no object at all (Gabbard, 1989b), and there is little doubt that the sadomasochistic

involvement with an abusive father serves an organizing function for girls who have been victims of paternal incest. Indeed, many adolescent girls become disorganized when their abusive fathers are jailed or banished from the home (Bigras and Biggs, 1990).

In patients who have been sexually abused, the maternal deprivation has often been so extreme that the infant's developing sense of self is severely compromised. The mother may not have provided soothing sensory experiences to help the infant establish a feeling of sensory boundedness. Hence, some of the dissociative states that are witnessed in analytic treatment involve primitive states of psychological deadness in which there is a cessation or paralysis of the process of attributing meaning to experience. Ogden (1989) has described this mode of generating experience as the autistic contiguous position. A patient imprisoned in such a state seems completely unreachable by the analyst, and the patient's anxiety, stemming from being deprived of close sensory experiences with the mother, manifests itself in concerns about lack of body integrity. The self-mutilation so common in patients with dissociative disorders can be understood as a way of reestablishing boundedness at the skin border to deal with such anxiety.

States of emptiness or deadness in the patient may evoke complementary feelings of despair and helplessness in the analyst. When the analyst is feeling overwhelmed and unable to intervene in any effective manner, the ineffectual and distant mother may be reactivated in the analytic dyad. Intense feelings of disbelief and skepticism in response to dissociative states may also parallel the mother's reactions when her daughter tried to communicate to her about the paternal abuse. At other times in the process, the patient may maintain a distant, uninvolved, aloof attitude that evokes corresponding responses of deadness in the analyst (Levine, 1990; Lisman-Pieczanski, 1990). These countertransference responses often reflect an empathic identification with the nonbeing at the core of the patient's self in response to the distant maternal identification in the patient. Finally, there often comes a time in the treatment of incest victims when the demandingness of the patient is so intense that the analyst finds himself wishing that the patient would disappear or get her needs met elsewhere. In these countertransference reactions, it is easy to detect an identification with the patient's mother, and the analyst must be careful that this does not lead to unconscious collusions with suicide attempts.

The influence of maternal deprivation in the pathogenesis of dissocia-

tive states has implications for technique as well. While Bigras and Biggs (1990) suggest that analysis of the defensive function of sadomasochistic enactments paves the way for analytic work with the narcissistic vulnerability associated with maternal deprivation, other clinicians (Bernstein, 1990; Burland and Raskin, 1990) believe otherwise. They argue that until the uninvolved mother is addressed, a durable working alliance that can withstand the recovery of painful memories of the incest trauma will be difficult to establish. Bernstein (1990) even states that the recovery of traumatic incest memories will be impeded unless the analyst is introjected as a caring maternal figure. The ego deficits so common in adult patients who were sexually abused as children can be repaired, in Bernstein's view, only if the consequences and conflicts secondary to maternal deprivation are thoroughly analyzed. Working exclusively with the details of the incest per se may not be sufficient to heal the wounds inflicted to the patient's nascent ego.

The introject of the uninvolved mother appears to be linked exclusively to situations of paternal incest. Mother-son incest produces much greater feelings of specialness in its victims. Margolis (1977) described a patient who had intercourse with his mother as having a feeling of being "King of the World." If there is lack of involvement on the part of the father, it is usually of less concern to the sons of incestuous mothers. The narcissistic inflation associated with the oedipal triumph appears to overshadow the longing for a more involved father figure.

Concluding Comments

Davies and Frawley have done the mental health professions a service in providing such a vivid and detailed description of the vicissitudes of transference and countertransference in the treatment of dissociative states. As the authors imply, much of the analytic work involves surviving in the eye of the tempest produced by the activation of the patient's internal object relations. The analyst must contain, process, and self-analyze the kaleidoscopic array of self- and object-representations that are projected and reintrojected. Resistances to integration on the part of the patient's varied self-representations can be formidable, and at times the analyst must be willing to settle for more limited goals, such as less antagonism between the diverse aspects of the personality and an improvement in overall adaptation.

In many ways the psychoanalytic treatment of these patients is still in its infancy, despite the fact that 100 years ago Freud cut his analytic teeth on patients with similar pathological manifestations. As Simon (1990) has observed, now that psychoanalysis as a profession has acknowledged the pervasiveness of incest as reality rather than fantasy, the next challenge is to evolve a therapeutic technique that addresses both the role of fantasy and the role of real trauma.

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