Psychoanalysts would generally agree that the optimal treatment setting is one which would enable the patient to experience the full range of those intra-personal conflicts which have stunted his development as a person and have impaired his capacity for coping with the problems of living. There would also be general agreement that the analyst may be in the best position to help the patient resolve these conflicts when they are played out in the interpersonal field of the patient-analyst relationship so that the analyst becomes for the patient the primary object of his fantasies and the primary target of his feelings of love and hate. In short, concerning the therapeutic and maturational value of generating and resolving the patient's transferences and resistances toward the analyst, there is little argument.

Opinion varies, however, concerning the therapeutic and maturational value for the patient of those emotional reactions he typically induces in the analyst.

Positive feelings from the analyst are generally recommended as being beneficial to the patient, sometimes with something like moral force; “compassion, interest, warmth, all within limits, are vital for the working alliance.” (Greenson, 1967, p. 379); “a certain amount of compassion, friendliness, warmth, and respect for the patient's rights is indispensable.” (p. 391).

In such statements, it is strongly implied, but not explicitly stated, that it is therapeutically beneficial for the patient to experience positive feelings from the analyst. The subject of emotional communication as a therapeutic tool has always been an uncomfortable one for classical psychoanalysts, implying a departure from an objective analytic stance, acting-out, dilution of the transference, etc. The communication of negative feelings is generally felt to be incorrect or is, at best, mistrusted. However, the following statement by Greenson seems contradictory: "Bearing the hostile and humiliating outbursts of his patients without retaliation is as important as remaining unperturbed by their sexual provocations. This does not mean that the analyst should not have feelings and fantasies in response to the patient, but their quantity ought to be within limits that enables him to control his responses so that what comes into the open is only as much as the patient requires." (Italics mine, Greenson, p. 394). It is implied here that the patient may have some therapeutic need for some of the negative feelings he induces in his analyst.

I intend to explore the vicissitudes of those transactions involving the induction of hate and anger in the analyst by those patients who these days would be diagnosed as borderline character disorders. Specifically I shall examine the following topics:

1. The problem analysts have with the hate that such patients may induce;
2. The functional value that a hateful interpersonal matrix may have for such patients;
3. The special problems which a hate-inducing patient encounters vis-a-vis a therapist;
4. The damaging effects that may result from meeting the patient's hate with benign understanding or forbearance;
5. The maturational gains that may result should the patient receive from the analyst communications of neutralized objective hate.
There has been, in the thinking of some analysts, a marked shift away from an orientation to countertransference as "bad" and a hindrance, toward viewing the totality of the analyst's emotional reactions as having value for understanding the patient in the ongoing process of the treatment and for formulating interventions. Winnicott (1951), Racker (1968), Spotnitz (1976), Searles (1966), Levenson (1972), Kernberg (1975), Issacharoff (1976), Wolstein (1976) and Feiner (1977) all favor this view.

Winnicott, Spotnitz, and Searles have specifically indicated that the patient may have a therapeutic need for the analyst's hateful feelings when appropriate. In his paper, "Hate in the Countertransference" (1951), Winnicott was rather definite about this. After defining the subjective and idiosyncratic components of the countertransference, Winnicott writes:

> From these ... I distinguish the truly objective countertransference, or if this is difficult, the analyst's love and hate in reaction to the actual personality and behavior of the patient, based on objective observation.

Following this, he writes:

> I suggest that if an analyst is to analyze psychotics or antisocials he must be able to be so thoroughly aware of the countertransference that he can sort out and study his objective reactions to the patient. These will include hate. Countertransference phenomena will at times be the important things in the analysis.

Then:

> If the analyst is going to have crude feelings imputed to him he is best forewarned and so forearmed, for he must tolerate being placed in that position. Above all he must not deny hate that really exists in himself. Hate that is justified in the present setting has to be sorted out and kept in storage and available for eventual interpretation.

And:

> A main task of the analyst of any patient is to maintain objectivity in regard to all that the patient brings, and a special case of this is the analyst's need to be able to hate the patient objectively.

Later on he writes:

> I want to add that in certain stages of certain analyses the analyst's hate is actually sought by the patient, and what is then needed is hate that is objective. If the patient seeks objective or justified hate he must be able to reach it, else he cannot feel he can reach objective love.

It is perhaps relevant here to cite the case of the child of the broken home, or the child without parents. Such a child spends his time unconsciously looking for his parents. It is notoriously inadequate to take such a child into one's home and to love him. What happens is that after a while a child so adopted gains hope, and then he starts to test out the environment he has found, and to seek proof of his guardians ability to hate objectively. It seems that he can believe in being loved only after reaching being hated.

Then he describes his treatment of a nine year old evacuated child during World War II whom he and his wife took into their home:

> The important thing for the purpose of this paper is the way in which the evolution of the boy's personality engendered hate in me, and what I did about it.

Did I hit him? The answer is no, I never hit. But I should have had to have done so if I had not known all about my hate and if I had not let him know about it too. At crises I would take him by bodily strength, without anger or blame, and put him outside the front door, whatever the weather or the time of day or night. There was a special bell he could ring, and he knew that if he rang it he would be readmitted and no word said about the past. He used this bell as soon as he had recovered from his maniacal attack.

> The important thing is that each time, just as I put him outside the door, I told him something; I said that what had happened had made me hate him. This was easy because it was so true.

I think these words were important from the point of view of his progress, but they were mainly important in enabling me to tolerate the situation without letting out, without losing my temper and without every now and again murdering him.
Spotnitz (1976) has also been explicit on the issue of the patient's need for the analyst's countertransference reactions.

It is in the interest of patients that the analyst remain free of emotional involvement with them. ... But what if the patient has a maturational need to experience feelings from his partner in the relationship? His need challenges the attitude of emotional detachment. And observation of the therapeutic effectiveness of certain countertransference reactions strengthened the challenge. (p. 48)

Spotnitz recommends that emotional confrontation be "carefully timed and graduated to prevent uncontrollable reactions."

He warns;

countertransference cannot be utilized with complete confidence unless it has been purged of its subjective element. These "foreign" influences have to be "analyzed out" of the objective countertransference before they contaminate the transference reaction.

Searles (1965) cites the example of a male patient who developed hallucinations of "contemptuous, taunting voices" which he would talk back to "in a furious, angry way." Searles came to view these hallucinations as a reflection of his own dissociated rage toward this particularly infuriating patient. He wrote that this dissociated rage was "presumably fostered by my labouring under so much discouragement and, still, threat of physical injury for so long. ... More than once I had felt lucky to get out of our sessions alive, but I had not realized that he could be looked upon as being fortunate in the same sense."

One way of describing what had happened is to say that my increasing recognition and acceptance, of my own feelings of contempt and rage toward him served to arm me sufficiently for me to be able to step in and interact with him at the furiously vitriolic level at which he had often 'interacted' with his hallucinations, previously, while I had sat by, paralyzed with anxiety at the extraordinarily intense rage and contempt which his behavior was arousing in me at an unconscious level. I had come to realize that it actually relieved me greatly when he shunted the most intense portion of his rage, for example, off to one side, towards an hallucinatory figure and disclaimed that he was having any such feelings toward me. But there came a certain memorable session in which I felt sufficiently furious about what was going on, and sure enough of my ability to meet both my own rage and his, to be able to step into the shoes, as it were, of the hallucinatory figure or figures at whom he was directing his greatest fury, and from that day on it was as though there were less and less 'need' for these hallucinatory figures in our interaction with one another. What I did, specifically in that crucial session was to insist, with unyielding fury—despite his enraged threats to assault me—that these vitriolic tirades, such as he had just now been ventilating while denying repeatedly that they were meant for me, were really directed towards me. (p. 204)

Despite Winnicott's widespread influence among analysts of different schools, the issue of the analyst's hate for his patient has received scant attention in the literature. Bird (1972) refers to the problem analysts have with the raw fact of human destructiveness:

Even our analytic language, which leans heavily on euphemisms, seems designed to ignore the reality of destruction. We tend to use words like "negative," "aggressive," and "hostile" in describing patient behavior that may have caused actual damage. Or we may speak of angry feelings, murder fantasies, castration wishes, and death wishes in respect to a patient's determined attempt to cause harm. To me, this language always seems at least once removed from what we are actually dealing with. (p. 289)

Bird then raises the question: why do analysts need to suppress the patient's destructive tendencies when they begin to emerge in the analysis? "Is it because we all sense the limited extent to which actual destructive tendencies can enter into the transference neurosis, and thus the limited extent of their analyzability?" (p. 289)

To my mind, this does not answer the question, raising instead, another question, namely, why do the destructive tendencies of the patient not enter into the transference neurosis? I would suggest that when such is the case the major reason is that the patient's hate and destructiveness as they emerge in the analysis, beget the analyst's hate and destructiveness and that for most analysts, it is their own hatred more than the patient's that is abhorrent.

For one thing, historically, analysts' have shared a self idealization which includes such values as a high degree of rationality, objectivity, and a highly developed capacity for controlling impulses and detaching themselves from personal feelings and needs, in the service of the analytic task. In other words, such a self idealization requires them to be, vis-a-vis their

immature and emotionally disturbed patients, something like a paragon of mature functioning.

Racker (1968) believes such self idealizations to be narcissistically invested infantile ideals that are passed on, unanalyzed, from one generation of analysts to the next:

*These deficiencies in the training analysis are in turn partly due to countertransference problems insufficiently resolved in the training analyst. ... Thus we are in a vicious circle: But we can see where the breach must be made. We must begin by revision of our feelings about our own countertransference and try to overcome our infantile ideals more thoroughly, accepting more fully the fact that we are still children and neurotics even when we are adults and analysts. Only in this way—by better overcoming our rejection of our countertransference—can we achieve the same results in candidates.* (p. 130).

Racker wrote this in 1953. Currently analysts may be considerably less narcissistically invested. We are generally much more accepting of aspects of our countertransference as valuable components in the therapy. I think, however, that our tolerance toward our own countertransference may desert us when that countertransference is dominated by intense hatred.

Leaving aside the issue of our narcissistically invested self idealization, we may subscribe to certain assumptions concerning the nutriments a patient may require from the therapist. At the very least we believe that the patient requires our respect. We may also believe that the patient requires "warm concern, " "unconditional positive regard, " "compassion" etc. It is difficult to reconcile our hatred for another person with any intention to respect him, no less offer him nutriments.

So, to my mind, if an analyst unwittingly suppresses the actual destructive tendencies of his patient it is not, as Bird suggests, because he sense the limited extent to which they can enter the transference neurosis, but rather, because of their power to destroy the analyst's capacities of sustaining, or recovering, his therapeutic intention toward the patient. And hatred induced in us by the patient may cause us to become our own object of hatred and contempt, and for this we might have to hate the patient all the more.¹

¹ The intensification of our own destructiveness may issue not only from the assaults on our analytic self idealization, but also from the awakening of a dormant cynicism (despair). (See Feiner, 1977)

There are patients, however, whose destructive tendencies are blatant and immediately beget reciprocal emotions in the analyst. This would be the kind of patient described by Winnicott and Searles in the references cited earlier. I would like to present my own experience with such a patient, whom I treated many years ago. The therapy, though successful in many respects, was conducted largely in ignorance of any substantial rationale for treating a patient of such character structure. In fact, the steady and significant improvement in the patient's functioning did not make much sense to me at the time since, from the beginning to the end of the treatment, she denigrated me, and her persisting estimation of the therapy was that it was totally useless.

She had been referred to me by a colleague, who, after two sessions, found her impossibly obnoxious and decided he couldn't work with her. Thinking of me as being generally a more tolerant person than himself, he felt I might be better able to work with her, or at least, to abide her. I accepted the referral, thinking that anyone who wanted therapy couldn't be all that bad.

In fact, when I first met the patient, whom I shall call Marcia, I couldn't imagine what my colleague found to be so terrible about her. I was expected some sort of demon. She seemed quite normal. She was conventionally dressed, in the style of an upper middle-class sixteen year old. Actually, she was twenty-two. Her figure was good, and her face was moderately attractive. Her hair was drawn back in a bun, giving her a somewhat prim and shy look.

Initially, she gave brief answers to my questions. She lived with her father in a private house in the suburbs, he was a haberdasher. He treated her very badly. He was critical and mean, and they didn't get along. Her mother died of cancer when she was eight years old. She had an older brother in law school. They didn't get along. She dropped out of an art college after two years, and in the two years since that time, she did little more than stay at home, watching a great deal of television. She had no friends. She got along badly with almost
everyone. She was anxious and generally unhappy about her life.

She was taken by surprise when Dr. P. told her that he didn’t want to work with her. She would have preferred to stay with him. She regretted having to come to me. She wanted to come to therapy twice a week. Her father would pay for treatment.

Soon I ran out of fact-oriented questions. She volunteered nothing. She sat stony-faced, never making eye-contact with me. As the session wore on, I felt her growing disdain, and the tension between us increased. She would answer no questions as to what she wanted from therapy. Nor would she tell me anything of what she was thinking or feeling. I felt totally impotent. Although she seemingly had agreed to be in therapy with me, I felt somewhat tentative about offering her a schedule of appointments. I more than half expected her to sneer at me for being foolish enough to presume that she would return for more sessions. She accepted the appointment schedule and left abruptly when I told her that the time was up.

In subsequent sessions, I attempted to deal with the impotence and frustration Marcia induced in me in the following way. I would remind myself that she was a woefully unhappy person, arrested in her emotional and psychosexual development, damaged and deprived by the early loss of her mother and by having been left with a cruel and insensitive father who preferred her high achieving brother. I would remind myself that her schizoid existence was barren of nutriments, and that her arrogant, queenly, rejecting behavior toward me was a narcissistic defense against feeling her own very poor self esteem.

In other words, I attempted to counter the actual feelings induced by this patient by creating a more sympathetic image of her in my mind. This enabled me to affect a posture of forebearance vis-a-vis her withholding, rejecting and contemptuous treatment of me.

Her behavior toward me was mostly non-verbal, but she would, from time to time, tell me with considerable disgust that I didn’t understand her at all. She reported that she was getting worse. She was becoming more withdrawn, and watched T.V. day and night. Her relationship with her father was deteriorating even further. He hardly spoke to her except to say something nasty and critical. He said he thought the therapy was a complete waste of money, and that she was a hopeless case. Her brother agreed.

This was the situation after the first six months of therapy. At that time, I consulted one of my analytic supervisors, who responded to my presentation with a single sentence: "Why don’t you use the voice of her father, but not his intention?" This statement was sufficient to dissipate the image I had created of my patient as a vulnerable, love-starved child. I now saw her as a nasty, withholding, contemptuous, uncooperative bitch, and I reacted to her accordingly. Having done with forebearance, what I now felt as anger and hate, I expressed as irritation. I challenged her stony silences, asking her how in hell she expected to make any progress in therapy if she refused to talk and provide me with material to respond to. When she exuded contempt, I identified it and testily asked her what it was all about. When she would maintain her silence over long intervals, I informed her, with annoyance, that I would be making no further effort to engage her, but that I would respond when she would resume talking.

With this change in my behavior, Marcia’s progress was rapid. Within the next six months, she sought and found a job, the first in her life, and one in which she could use her graphic skills. She found her own apartment. She never reported any of this as if she felt she was making progress, or that these changes amounted to anything that she truly wanted for herself. For instance, she never said she liked her job or having her own apartment. In fact, she didn’t like either. She apparently got along better with both her father and her brother. They helped her move into her apartment, and she no longer reported much in the way of friction with them, but didn’t acknowledge any change in her relationship with them.

Within a year, she began socializing with other people her own age, and she entered into what was to become a long-term, intimate relationship with a man. As her life became richer, she was less often silent and withholding. She had more to talk about and when she needed help with some problem she was having in one interpersonal relationship or another, she would, for the moment, seem to forget how useless I was and consult me. The affective tone of those consultative transactions was more or less neutral. It was as if she had decided to declare a truce which was, however, abruptly ended, sooner or later, as if by a malevolent transformation.
again became the wrong therapist for her, being an insensitive person, incapable of understanding her, and hardly worth talking to.

Over the course of the therapy the hate-free intervals lengthened, and the intensity of her denigration diminished. Yet, its reappearance would revive my doubts as to whether the therapy had anything to do with her progress. At the time of my work with her, it made little sense to me that a patient could progress with a therapist whom she hated so much and who often hated her back with at least equal force.

I always took her complaints about me quite seriously, and on several occasions, when she made a good-enough case for my being totally useless, I would ask her if she wanted a referral to a therapist she might like better, possibly a woman. She never took me up on this. One day, after about two and one-half years of therapy, she surprised me by suggesting, herself, that since she had never liked me and never expected to like me, perhaps she would be better off with another therapist, possibly an older, maternal type of woman. I knew of such a therapist, and referred Marcia to her.

I would like to consider the functional value that a hateful interpersonal matrix may have for a person with a poorly integrated ego. Hateful transactions can provide a poorly integrated ego with a means of restoring its equilibrium. The feeling of hate can provide an ongoing sense of ego-identity. A person, like Marcia, can feel herself most definitely vis-a-vis a world of clearcut enemies. Counterattacks from others may not penetrate to have emotionally disturbing effects. They seem often to have a relaxing effect. Induced counterattacks may relieve guilt and gratify omnipotent needs (because of the power felt in being able to control the behavior of others). More importantly, they reinforce the boundaries of the self vis-a-vis the other by establishing appropriate, necessary distance. Thus, whenever the sense of self weakens and becomes diffused, it can be most easily recovered by provoking others to attack. It is likely that most of Marcia’s provocations came at moments when her ego-identity was becoming diffused through the danger of intimate merging.

Should she in unguarded moments engage in positive interpersonal transactions, her ego-equilibrium would become impaired. A person whose essential self-image is hateful, bad and worthless requires a reciprocal hateful view of the world. Positive interchanges are likely to lead toward confusion and feelings of inauthenticity. They may stimulate violent internal attacks from deeply entrenched unconscious parental introjects. Perhaps her hate was a means of not betraying an unconscious irrevocable vow to her dead mother never to love, or be loved by another. Or if betrayal was not the issue, perhaps it was the risk of loving and the unbearable pain of losing another love object. Hate might serve here to keep dormant a more profound and dreadful cynicism and despair.

Since hate typically begets hate, by being hateful and rejecting, such a person as Marcia generally exerts sufficient control over other people’s reactions to restore a failing sense of ego-identity. She is confronted with special problems, however, when she becomes a patient of a therapist.

Although surface cynicism may cause her to reject conventional viewpoints and expectations, she knows what they are. The conventional expectations of a therapist might include all or some of the following: That he is a person interested in other people, and that he is caring, loving, decent, reliable, skillful at healing others, that he is mature, intelligent and never wittingly destructive to others. The patient, then, who is by her own definition and the definition of others a hateful, bad and inferior person, is faced with the hideous prospect of a long term relationship with a person who is defined as, and might actually turn out to be, something like a paragon of moral excellence. This is an interpersonal situation which might seriously threaten her sense of ego-identity. The contrast between her badness and the therapist’s goodness is too great, and her feelings of inferiority and envy may become unbearably intensified. The first thing she must do is to reverse this imbalance, making the therapist a worse person than herself.

Her ego achieves this by a two-step process of splitting and projection, i.e., by dissociating and disowning what she hates in herself and depositing it in the therapist. Hence, according to my patient’s view of the two of us, I became the inferior and more worthless person; being stupid, insensitive, cold and unfeeling, and totally useless.

The success of the therapy, and the further maturational development of the patient will depend almost entirely on what the therapist does with the bad feelings and hateful impulses which the patient’s ego-splitting
and projective processes induce in him.

An imbalance most damaging to the patient is created when the therapist persists in behaving as if he were all good in the face of the patient's relentless efforts to blacken him. This may be the error therapists are most inclined to make vis-a-vis their most frustrating and destructive patients.\(^2\)

\(^2\) A. Isacharoff has suggested in a personal communication that a person like Marcia may have a special aversion to hypocrisy and therefore, may be highly sensitized to any hostility which is covered over by the benign accepting attitude which is required by the psychoanalyst's ego-ideal. Searles' hallucinating patient (p. 5-6) is a case in point. For such people the other person's love simply cannot be trusted until his hostility is out in the open.

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In order to maintain our sense of integrity as therapists with a hateful, hate-inducing person like Marcia, we might need to make believe that she is not as bad as we experience her to be. However hateful she is, we are committed to the theory that the patient needs us to be a so-called object of her transference neurosis and, therefore, the target of all her feelings. To protect her from our counter-hate, we fall back on the knowledge we may have of such a person's unhappy history, and understanding that such hateful behavior is somehow based on security needs, we attempt to imagine the deprived, damaged and vulnerable child-self behind the defensive facade.

By such means, then, we change the apparent reality into a construction of reality, and we no longer believe our sense data which informs us that we are confronted with a hateful, destructive and entirely frustrating person.

We shall be all the more moved to change our perception of our hate-inducing patient from "bad" to "good" if we also believe that all patients have a maturational need for our love and never for our "objective hate", as Winnicott has written. If such should be the case, our hate is likely to have been repressed, rather than suppressed, and once unconscious, may breed virulent, murderous wishes. It is at such times that the patient may become psychologically damaged because of his unconscious susceptibility to the therapist's unconscious hate as Searles (1965) has pointed out.\(^3\)

\(^3\) In another paper, "The Informational Value of the Supervisors Emotional Experiences", Searles observes that the therapist is likely to induce in his supervisor the unconscious frustration and aggression which his patient has induced in him. (1965).

I would like to consider more fully the damaging effects that may result from meeting the patients hate with benign understanding or forebearance.

Marcia, because of her ego-splitting processes and massive projective identifications, would be classified these days as a borderline character disorder. Had she reached a higher level of intra-psychic integration at the time she entered treatment, a benign response to her hatred might have confounded her essentially hostile view of the world, evoking some tolerable guilt,

followed by remorse and positive feelings toward the therapist. She might recognize him to be a person having essentially decent intentions toward her. We would then have the beginnings of an emotionally corrective experience.

Alexander (1946) cites the example from Victor Hugo's novel Les Miserables of the conversion of the ex-convict Jean Valjean, in his encounter with the kindly Bishop. When the Bishop responded lovingly and charitably to Jean Valjean after the latter had returned his hospitality by robbing him, Jean Valjean was moved to give up his criminal, callous attitude toward the world and to become a loving person, a man of honor and integrity. Although this is an essentially literary fabrication, depicting a highly idealized, romanticized conversion from evil to virtue, such a conversion might actually be possible for a person who had reached what Melanie Klein has called the depressive position and who had developed what Winnicott calls "the capacity for concern" (1965) before having been turned cold and hateful by the world's cruelty. The ego of such a person would have had to reach a high enough level of integration to enable him to tolerate the feelings of guilt and
remorse that would be evoked by the loving treatment of the person he had injured. Prior to his unjust imprisonment Jean Valjean was depicted as a decent man. In Marcia's case, should she receive love or tolerance in return for her hate, she would have to see the giver as either a fraud or a fool, as an object deserving of her contempt. Her capacity for loving either herself or others was either poorly developed or very deeply repressed. Therefore, there would be an insufficiency of good self-feelings to offset the guilt feelings that would follow upon her recognition that she was injuring a person who might be well intentioned and worthwhile. In other words, the more benign the treatment she receives in response to her destructive behavior, the worse she would have to feel about herself if she were to believe in the goodness of such treatment. To the extent that she may suspect that the treatment might be somewhat good and the given not all bad, she is in danger of becoming an object of her own hate. She would then have to annihilate any intimations of the other's goodness and to vilify and denigrate him all the more so that he remains in her view a worthless, unloving, stone-cold thing.

Yet nothing can be successfully warded off by processes of splitting and projection. The persistent efforts of the therapist to return love for the patient's hate sets up the following vicious cycle

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with escalating destructive effects: The patient is destructive; the therapist is kind and forebearing; the patient is in danger of recognizing the therapist as good and himself as bad; fearing devastation by guilt and self hatred, he hates the therapist all the more for provoking this dangerous situation. Increments of contempt for the therapist are gained from the enhancement of cherished images of a self having great powers of destruction, an enhancement generated by the perception of the therapist's goodness as weakness or phynyness.

The effect on the borderline patient, then, of the therapist responding to hate and contempt with benign "understanding" is to stress and weaken the patient's ego; feelings of badness and guilt intensify with each succeeding desperate effort to get rid of them by depositing them in the other person. Suicidal impulses gain in strength; paranoid anxieties mount; manic and schizoid defenses are called into play.

Something on the order of this ego weakening process was induced during the first phase of the therapy with Marcia when I was forging the kindness and patience which I thought was owed to the vulnerable and love-starved child I imagined her to be.

Such treatment is likely to be felt by the patient as rejecting. In fact, it is. The therapist, in order to like his patient more, and to feel less hateful toward him, denies his "badness", and makes the patient a "better" person, thereby turning him into an object of the therapist's fantasy. In this way, the therapist is being, to say the least, disrespectful to the self the patient feels himself to be. Behind such rejecting acceptance, there may even be unconscious murderous wishes.

At that phase of the therapy when my patient said that I didn't understand her, she was correct. My treatment clearly made her worse, causing her to become more withdrawn, to feel worse about herself, to become more anxious and depressed, all of which diminished her already limited capabilities for coping effectively with her problems of living.

There are some things I want to make clear at this point. I am in full agreement with the view that all of the analyst's affective

4 See Feiner (1970) for a discussion of various modes of inauthentic relatedness. The treatment I have been describing exemplifies "reflication", an act whereby one negates the other's autonomy and turns him into a thing. Also see Laing (1960).

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reactions to his patient should be internally treated and neutralized so that they are fully under the control of his ego before any intervention is made. When hate is induced, the patient's interest is safeguarded if the analyst processes his feelings as follows; he should observe the full emotional impact the patient is having on him; be fully aware of counter-destructive impulses and wishes; reduce the intensity of his feelings without attempting to eliminate them lest they become dissociated and, therefore virulent; discover whether the main source is subjective or objective; determine what the patient needs in the way of an intervention; and finally, observe carefully the effects of the intervention.
Not all patients are benefited by receiving some return of the hateful feelings they induce. Some are benefited more if the analyst contains his feelings and conducts the analysis silently. Patients with masochistic aims are gratified, but not therapeutically benefited, if they are attacked with the hate they provoke.

I have found that hate can be safely communicated after I have succeeded in reducing its intensity to a level at which I am able to experience it as irritation or frustration.

When such communications of neutralized objective hate turn out to be therapeutically and maturationally beneficial for the patient, I think it might be due to some of the following reasons:

1. The establishment of a credible emotional matrix:
   When the analyst responds to hateful denigrating treatment in an emotionally appropriate way, the patient feels sufficiently at home to trust the reality of the interpersonal situation. It feels real because it makes emotional sense. This is what I inferred from my supervisor's suggestion that I use the voice of the patient's father but not his intention.

2. The patient is reassured of his interpersonal impact:
   By responding with feelings that the patient induces, the analyst reassures him of his power to have a reasonably predictable impact on significant figures in his life. This might relieve him of what could otherwise develop into an escalating desperation to make impact, leading to destructive behavior.

3. It helps the patient achieve a more tolerable distribution of badness:
   When the analyst responds to the patient's attacks with reciprocal emotion he rescues the patient from the maddening predicament of feeling himself to be an all-bad person vis-a-vis an all-good one. The analyst, in not behaving like a paragon of forbearance

becomes somewhat bad in the patient's eyes. And this makes the patient feel more comfortable.5

4. The patient is protected from the consequences of his destructiveness:
   When he initially attacks the analyst, it may be out of a need to feel his interpersonal impact, or out of a need to maintain or restore a failing sense of ego-identity, to separate himself, to keep things in their place, or to achieve a more tolerable distribution of badness. If the attacks do not persist, the patient may need nothing more from the analyst than a feeling of acceptance and respect for the self-other boundaries that the patient needs to maintain.

   The situation becomes dangerous for the patient when he is driven to penetrate the analyst's boundaries and attack his insides. This might be due to his ego's need to split off and project excessive portions of badness—possibly under the pressure of destructive envy. If such attacks persist and the out-pourings of hate are intensified, it may signify that the patient is caught in a vicious cycle of destructive impulses, unconscious (unbearable) guilt, paranoid anxiety (fear of retaliation), more hate etc. It is as if he had struck his victim with an axe and hating and fearing the sight of the bleeding and the mutilation, he hacks the dreaded object again and again.

   If the patient's attacks are unanswered by the analyst, the patient may leave the session as if it were the scene of a crime, having no idea of how much damage he has done to the analyst's insides. At the level of his unconscious fantasy, he may have left the analyst with the analyst's insides fatally maimed or poisoned. In between the sessions, then, the patient might be highly vulnerable to the ravages of unconscious guilt and paranoid anxiety.

   Since he is incapable of breaking such a vicious cycle by himself, he requires the analyst to do it for him. And it isn't any hating-back that he is in need of at such times so much as a strong enough response from the analyst to interfere with what is a self-perpetuating destructive and psychotic process.6 The analyst, in standing-up to the patient is, in effect, jarring him awake from a solipsistic nightmare. In presenting a surface hard-enough for the patient to feel, he reestablishes the self-other boundaries which
tend to be obliterated by the patient's attack, and reemerges separate, alive and well.

The following vignette portrays the relief a patient experienced when she was reassured by the object of her destructiveness (in this case, not the analyst) of his survival in good health.

A forty year old female patient, who feared nothing more than that she might destroy those she loved, became, over the course of the therapy, increasingly tolerant of the hateful wishes and impulses she sometimes had toward people she was close to and increasingly confident that she could contain and control them without destructive consequences. Previously self-attacking and somatizing and, in her interpersonal relationships, passive-aggressive and masochistic, she became asymptomatic and more spontaneously self-assertive. On one occasion, her husband, through extreme provocation, enraged her to the point that she uncontrollably spewed forth intense hatred, and heaped obscenities on him, she ordered him out of the house, declaring she could no longer bear to live with such a vile, destructive person.

She reported, "I felt horrible immediately after I said all this because at the moment I said it, I truly meant every word. He ignored my command to leave, but took account of my feelings by staying out of the way, and by performing the chores he had agreed to do for me before provoking me. I felt so good, so relieved. I didn't understand this feeling until later when I realized I had done my worst to him, and I hadn't killed him. He helped me by not pulling his usual number on me. He didn't get that depressed, hang-dog look he used to get when I would displease him in the slightest way, making me feel like a terrible person. My parents used to get a look of pain on their faces when I was bad. When I used to see that look, I hated myself so much, I wanted to die."

I would like to consider the further course of the therapy with the hateful borderline patient and the eventual humanization of the therapeutic relationship.

Winnicott (1965) makes the point that the child needs his mother to perform two functions: "It is helpful to postulate the existence for the immature child of two mothers—shall I call them the object-mother and the environment-mother? ... it is the object-mother who becomes the target for excited experience backed by crude instinct-tension ... the object-mother has to be found to survive the instinct-driven episodes, which have now acquired the full-force of fantasies of oral-sadism and other results of fusion."

It is the environment-mother who "wards off the unpredictable and who actively provides care in handling and in general management. ... Also the environment-mother has a special function, which is to continue to be herself, to be empathic toward her infant, to be there to receive the spontaneous gesture and to be pleased." (p. 75-76)

When the analyst responds to the patient's penetrating destructive attacks in a way that restores the integrity of the two-person situation, he is functioning as the object-mother. In being available for, and responsive to the patient's need to exercise his constructive tendencies he is functioning as the environment mother.

As the therapy progresses, the patient comes to rely on the analyst as something like a good-enough mother, as the best person with whom to work through hate-ridden internalized intra-personal relationships. Consequently, hateful impulses come to be delayed until they can be released in the therapeutic setting. I would speculate that such transactions work something like a purgative, relieving the patient of hate and badness, allowing the ego to relax its security operations—especially splitting and projection—freeing appetites and energies for more constructive living. The patient can face the world more as a good-enough person to partake of its satisfactions and to risk interpersonal relationships, and with some greater sense of a self worth caring for.

In the work with hateful borderline patients the bad and good intra-personal relationships may be played out in a discontinuous way, as in the case of Marcia. For one or more sessions, we were a hateful couple. This would be followed by sessions in which we were neither loving nor hating; we were, I would say, in good-enough rapport to be able to address ourselves seriously to her problems in living. At a certain point in the hate-free session, or at the very outset of the next session, the hateful sector of her-self would erupt without apparent provocation, and we were once again imbedded in a malevolent emotional matrix.

As the therapy progresses with such patients, the hateful transactions decrease in intensity and frequency.

6 See the example of Searles hallucinating patient above (p. 5-6).

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reflecting a diminution of malevolence in the internal relationships between self and other parts. The eruptions of hate then seem less capricious or generalized and more clearly connected with some reality determined experience of feeling let down by the therapist. This suggests that the self and the object world is more integrated.

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and no longer split between good and bad internalized self-other intra-personal relationships: between bad-self parts and bad introjects on the one hand, and not-bad-self parts and not-bad introjects on the other. There is a more continuous experience of a good-and-bad self vis-a-vis a good-and-bad analyst. The relationship becomes progressively reality-oriented, humanized, and invested with more love than hate.

In the case of Marcia the integration of good and bad self- and other-parts did not develop to the point that the relationship became humanized. I would speculate that when she said she saw no prospect of ever developing good feelings for me, it was a reflection of my own confusion concerning my role in her therapy. I did not fully understand that the intensely hateful emotional matrix that she established with me was necessary and desirable for the working through of intensely malevolent intra-personal relationships. I suspected that her gains were in some way connected with my reacting to her in an emotionally appropriate way; but within myself I could not help agreeing with her persisting opinion that I was not the right therapist for her, and I was still doubtful that therapy could be accomplished in this atmosphere.

My subsequent experience in working with, and in supervising the work of other therapists with hate-inducing borderline patients has led me to conclude that the humanization of the patient-therapist relationship—which is a function of the extent to which the patient's ego becomes integrated over the course of the therapy—will depend on the therapist's confidence in the potential therapeutic value of his countertransference hate and on his recognition of those instances when the patient needs to receive it.

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