"I Feel Stupid and Contagious:" Countertransference Reactions of Fledgling Clinicians to Patients Who Have Negative Therapeutic Reactions

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Patients who are prone to having negative therapeutic reactions seem to be increasingly common in clinical practice. These patients pose special problems for graduate students, psychoanalytic candidates, and other clinicians who struggle with anxiety regarding their new role and their feelings of incompetence and helplessness associated with the belief that their therapeutic efforts will result in treatment failure. The fledgling clinician thus provides fertile ground for this kind of patient to project her or his concerned, depressed, and guilty self-representation into the clinician. The fledgling clinician, owing to an incomplete integration in her or his own internal object world, is also capable of projecting dead or damaged and dying object-representations into this kind of patient, who sometimes responds by withdrawing from or leaving treatment. It is argued that although we must acknowledge the limitations of our therapeutic technique with this kind of patient, identification and interpretation of projective identification are essential to increase the likelihood of therapeutic success. Finally, rigorous education in severe psychopathology, exploration of one's intrapsychic conflicts, and participation in individual or peer clinical supervision, are recommended, as well as an interpretative emphasis on both the deeply buried love for the internal object world as well as its destruction.

INTRODUCTION

As a clinical supervisor over the past nine years I have watched clinical psychology graduate students become demoralized when patients get worse and drop out of treatment. Graduate students experience guilt and disillusionment, and wonder whether clinical psychology was indeed their

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calling after all. Teaching, nursing, and computer science all begin to look more appealing after that first patient suddenly leaves treatment, either having not improved or actually having become worse after the students worked so hard to keep their patients engaged in treatment. As a psychoanalytic candidate treating my first control case, I also fell victim to a disturbing sense of inadequacy when my patient failed to show signs of improvement. I want to propose that a certain kind of patient is prone to making fledgling clinicians feel demoralized. Graduate students, psychoanalytic candidates, and other inexperienced clinicians need to become aware of the existence of this kind of patient so that when they begin to feel depressed, hopeless, and unsure of their skills, they might use these signs as diagnostic indicators and apply therapeutic techniques that could keep this kind of patient engaged in treatment. I am referring to patients who flee treatment, not because the clinician has aroused their intolerable feelings of envy (a worthy subject in its own right), but because these patients in treatment experience intense unconscious guilt over both their aggression toward their loved internal objects and their failed attempts at reparation.

In 1936, the Kleinian psychoanalyst Joan Riviere wrote a groundbreaking paper, "A Contribution to the Analysis of the Negative Therapeutic Reaction." Extending Freud's 1923 observations of patients "who get worse during the treatment instead of getting better" and set themselves "against their recovery" (p. 49), Riviere further explored the meaning of the "negative therapeutic reaction" and the patients who experience it. Anyone wondering whether the passage of 66 years has eliminated these kinds of patients from our clinical purview or from society altogether need look no further than the song lyrics of some of today's most popular songwriters. In 1991 Kurt Cobain, considered by many to be the voice of his generation, and his band Nirvana released an album appropriately titled, *Nevermind.* On "Smells like Teen Spirit," the song that singularly defined the zeitgeist of the 1990's, Cobain's voice crescendos as he spews his despair and vulnerability, "I feel stupid and contagious." And on "Lithium" Cobain further expresses his feelings of alienation, self-loathing, and cynicism: "I'm so happy 'cause today I've found my friends—they're in my head—I'm so ugly, but that's okay 'cause so are you." The multiplatinum album touched a raw nerve and proved to be the rallying cry for Generation X and beyond. This self-doubting, detached, hopeless philosophy of that decade and beyond was poignantly summed up by Cobain: "Oh well, whatever, nevermind."

Whatever the sociocultural reasons behind the massive popularity of

this philosophy, greater numbers of disaffected youth seem to be showing up at our office, clinic, and hospital doorsteps. These patients (typically diagnosed with narcissistic, borderline, or antisocial personality disorders) pose special problems for fledgling clinicians. Because of their clinical inexperience, fledgling clinicians might be unable to see the contributions that these patients make to their own doubting perceptions of self-as-therapist and feelings of failure generated by these patients when they leave treatment.

BACKGROUND DISCUSSION

Briefly, Riviere's (1936) thesis is that many of these patients use primitive defense mechanisms—omnipotent denial, mania, projection, and splitting—to protect themselves from awareness of massive guilt and depression. These patients are unconsciously terrified of losing control, because losing control signifies for them the emergence of the guilt and depressive anxiety they are struggling to defend themselves against. Therapeutic change, therefore, becomes a danger, because it means relinquishing the status quo, of losing control of what unstable psychic equilibrium they have left. The patient prone to having a negative therapeutic reaction guards herself or himself against the dangers of the depressive position because through the treatment those dangers "may prove to be a reality, that that psychical reality in his mind may become real to him through the analysis" (p. 312).

Every treatment requires the uncovering of depressive anxiety. Riviere asked why this uncovering often results in a negative therapeutic reaction and the breaking off of treatment in these particular patients. She contended that these patients live with the conviction that they have already destroyed all their internal objects. The treatment would reveal this truth to them, and it would mean psychic death. It would also spell the end of any shred of hope they have that the treatment could actually resuscitate their intrapsychic object world. The patient thus "clings to analysis, as a forlorn hope, in which at the same time he really has no faith" (p. 315). Finally, the patient fears that she or he will destroy the clinician just as she or he has destroyed all the internal objects. The patient will "add [the analyst] to the list of those [the patient] has despoiled and ruined. One of [the patient's] greatest unconscious anxieties is that the analyst will be deceived on this very point and will allow himself to be so misused. [The patient] warns us in a disguised way continually of his own dangerousness" (p. 317). In the mind of the patient, then, treatment becomes a danger to the clinician, who must be saved from the patient's aggression by the

patient's withdrawal from the therapeutic relationship or even by leaving treatment.

Riviere informed us that this kind of patient also often feels unworthy of treatment. "Why should I allow the clinician to cure me, when all my internal objects—objects *I* am responsible for damaging—remain damaged and in need of reparation?" The patient often feels indebted to cure the objects in the internal world, which are all so more deserving of cure than she or he is. Trying to convince the patient that she or he cannot repair these internal objects until she or he is first repaired ultimately fails because the patient treats this idea as an invitation to betray and abandon these internal objects, leaving them dead or damaged and dying. The manic omnipotent defensive structure convinces this kind of patient that she or he has the self-sufficient capacity to repair the internal object world without outside assistance. The solution to this predicament suggested by Riviere is to uncover the love and unconscious guilt associated with the imagined destruction and, ultimately, to integrate the love for these internal objects with the destructive, murderous hatred directed toward these same objects.

In the final two sentences of this paper Riviere alluded to the countertransference reaction stimulated by this kind of patient: "[The transference] tends to rouse strong depressive anxieties in ourselves. So the patient's falseness often enough meets with denial by us and remains unseen and unanalyzed by us too" (p. 320). As we clinicians become tuned into the underlying depression and guilt disguised by these patients, we begin to act like our patients and protect ourselves from experiencing these same emotions—until they leave treatment, when the emotions often hit us full force. It is the identification with these depressive anxieties—and the resulting unconscious denial of them—that graduate students, psychoanalytic candidates, and other fledgling clinicians are especially prone to experiencing when treating these patients. One might observe that the contemporary songwriters of this generation are more capable of using their intuitive artistic talents to empathize with the self-debasement, guilt, and depression unconsciously experienced by Generation X and their younger siblings.

In retrospect it is important to speculate why Riviere stopped short of discussing countertransference. In the first place it would be another 10 years before Melanie Klein (1946) would formulate the concept of projective identification in perhaps her most important paper, "Notes on Some Schizoid Mechanisms," which would later allow for a more penetrating understanding of countertransference by her students (Bion, 1959;

Heimann, 1950; Rosenfeld, 1952; Winnicott, 1950). This kind of patient is prone to engaging in projective identification with the clinician, making her or him feel inadequate, disillusioned, and hopeless. In the second place Riviere was probably writing about her own experience as a patient in psychoanalysis with Freud (First, 1999). During his analysis of Riviere, Freud used her as a translator, ostensibly to assist with her reparative processes. But as Riviere pointed out in her paper, "recognition and encouragement by the analyst of the patient's attempts at reparation (in real life) allay them merely by the omnipotent method of glossing over and denying the internal depressive reality—his feeling of failure" (p. 320). First suggested that Riviere must have conducted a self-analysis to arrive at the insights formulated in her paper. Because Riviere was probably writing about herself as the patient, it would have been difficult for her to conjecture what Freud might have been feeling toward her during the analysis. How terrifying it would be to speculate about the contents of the mind of your analyst—or your mother or father—that perhaps she or he might be feeling depressed, hopeless, or even despairing because of what you might be projecting into them! Perhaps for both these reasons Riviere stopped short of exploring the countertransference reactions stimulated by the kind of patient who is prone to having a negative therapeutic reaction.

If we apply Klein's concept of projective identification to Riviere's insights regarding the patient who is prone to having a negative therapeutic reaction, the results are particularly relevant to inexperienced clinicians already uncertain of their therapeutic talents and the value of the treatment they have to offer. Because of the debilitating psychic pain stimulated by the depressive anxieties associated with the belief that the internal object world is dead or damaged and dying, this kind of patient often projects into the clinician the concerned, depressed, guilty part of herself or himself for safekeeping, as it were. Otto Kernberg (1984) masterfully described this process:

> Because the analyst stands for the patient's weak, frail, submerged [I would add here concerned, depressed, and guilty] self, the patient may project his good or idealized self-representations onto the analyst, almost 'for safekeeping,' and yet need to attack them under the effects of aggression and envy, originally self-directed. Racker (1968) has stressed the high risk, in such circumstances, that the patient will successfully reinforce whatever masochistic traits the analyst may still retain (p. 269).

Kernberg explained that the clinician is able to identify not only with the patient's projected object-representations, but also with her or his own

self-representations projected onto the patient, activated in the transference. With intrapsychic representations being projected both ways in the course of a treatment or even a session, it becomes exceedingly difficult to know which representations belong to whom. Betty Joseph (1987), a contemporary Kleinian, has further developed these ideas by characterizing projective identifications in these kinds of patients as primitive forms of communication and a potential mechanism of psychic development.

This task is especially hard for fledgling clinicians, who often are identified with pre-existing self-representations of incompetence, guilt over anticipated sins to be committed as a result of their incompetence, and depression over their inability to help the object in front of them. Graduate students, psychoanalytic candidates, and other inexperienced clinicians provide fertile ground for a projective identification from a patient who wants to expel her or his concern for her or himself and her or his damaged objects and the subsequent depression and guilt that accompany this concern. Fledgling clinicians can easily identify on an unconscious level with this projected self-representation coming from the patient. One common response I have noticed in clinical supervision is the clinician's construction of omnipotent denial to defend against these projected feelings: "The treatment is going fine. The patient is expressing anger toward me, so she must be connected to me and to the treatment. I feel great that she is able to do that." Or worse, the supervisee reports that the patient is cooperative with her or him in sessions, but is destroying relationships outside the treatment. In both cases the clinician could be defending against depressive anxieties stimulated by a projective identification on the part of the patient and identified with by the clinician. This omnipotent denial often takes the form of reassurance offered during sessions. Feldman (1997) observed that "patients often recognize such actions, that we all engage in, as expressions of the analyst's own anxieties and wishes, and they similarly increase the patient's uneasiness about the analyst's strength and capacity to contain his projections" (p. 337)—which could convince them to leave treatment.

Inexperienced clinicians with damaged internal objects are also at risk for projecting any of these self or object-representations into the patient. These clinicians therefore need to cure the patient as an external representative of an internalized object in the clinician's intrapsychic world. This phenomenon therefore clashes with the patient's need not to be cured first. The patient interprets the fledgling clinician's attempts to cure her or him as a betrayal of all those internalized objects, which so desperately

need help before her or him. The need to flee treatment intensifies. In both situations the treatment risks becoming imperiled because of the clinician's unconscious acceptance of the patient's projective identification, and manic defense against, the patient's projective identification into the clinician, and the clinician's projective identification into the patient.

Kernberg (1984) argued that clinical inexperience cannot be classified under the rubric of countertransference reactions, and dismissed its dynamic importance: "Errors owing to lack of experience or knowledge are just that, not countertransference" (p. 268). Although I agree with Kernberg that lack of experience is not synonymous with countertransference, I have argued, and will attempt to demonstrate, that lack of experience nonetheless makes a clinician vulnerable to accepting projective identifications that resonate with a currently active self-representation as incompetent, helpless, and guilty. Similarly, such a clinician is also vulnerable to projecting damaged self or object-representations into the patient, whom the clinician will then try to repair. Both situations can cause a reaction in the patient to leave the treatment prematurely. Thus, fledgling clinicians who are treating patients who are prone to having a negative therapeutic reaction are more likely to experience treatment failure than more experienced clinicians. The reason is that fledgling clinicians are more likely to be identified with an incompetent, helpless, guilty self-representation that proves to be fertile ground for the projective identification favored by this kind of patient. Kernberg (1987) described this phenomenon as resembling "a compromise formation that includes elements both from the patient and from one's own self" (p. 81).

Fledgling clinicians are also less aware of their own projective identifications of damaged internalized objects into their patients, who might experience the vigorous attempts at curing these objects as a betrayal of their own damaged objects and leave the treatment. Lack of experience can thus act as a catalyst for a negative therapeutic reaction to occur—even, as we shall see, in the work of a psychoanalytic candidate with considerable experience as a psychotherapist. Awareness of these mutually reinforcing processes on the part of both fledgling clinicians and clinical supervisors can serve to prevent some of these treatments from derailing. We must keep in mind, however, that the effectiveness of our therapeutic techniques in working with such patients is modest at best. We must neither omnipotently declare the unlimited potential of our craft, nor cynically join our patients in bemoaning the helplessness of their situation—or ours.

EXAMPLE 1

I would like to illustrate these phenomena with three examples taken from the clinical experiences of three clinicians. The first two conducted psychoanalytic psychotherapy, and the third conducted his first control analysis. Although the first two examples underscore the feelings of incompetence of two clinicians early in their professional careers, the proneness to experiencing such feelings would equally apply to more experienced clinicians just beginning treatment of their first control cases in psychoanalytic training, as illustrated by the third example. The first clinician was a 32-year-old clinical psychologist. After his one-year psychology internship, he had taken two years off from clinical work to complete a research fellowship and had just begun a two-year clinical fellowship on an inpatient psychiatric unit specializing in the treatment of severe personality disorders. Dismissing the analogy of learning how to conduct psychotherapy to learning how to ride a bicycle, he was feeling incompetent and concerned about whether he could benefit the seriously emotionally disturbed patients he would be treating. Three months after beginning the fellowship, he was assigned a 21-year-old woman, "L.," with a history of 10 previous psychiatric hospitalizations and a history of self-destructive behavior that extended back to her early adolescence. The treatment regimen included three-times-per-week individual psychoanalytic psychotherapy conducted by the clinician, an intensive milieu program that included frequent psychotherapy groups, and a highly structured schedule of daily therapeutic activities. L.'s chief complaint stated the obvious: "I have a history of self-abusive and suicidal behavior. I have a borderline personality disorder. And I thought with the right information and willpower I could get better." These two sentences seem to reveal three things about L.: 1) she had assimilated the psychotherapeutic jargon used by her previous treatment providers with no obvious benefit; 2) she was denigrating her previous treatment providers by implying that they had not provided her with the "right information;" 3) she was still invested in an omnipotent manic effort to save her dead or damaged and dying internal world with "willpower."

L. estimated that during the previous three years she had cut herself over 30 times on the arms and legs. She preferred to use sharp objects to make deep cuts often requiring stitches. L. also admitted that she had lied to previous treatment providers about her perceived level of safety. In the initial sessions L. reported that her parents tended to minimize or deny her feelings, but in spite of this acknowledgment she denied having any angry

feelings toward them. The clinician constructed a dynamic formulation in which L. mutilated herself as a form of self-punishment for the unacceptable aggressive impulses L. probably experienced unconsciously toward her parents, while simultaneously gratifying aggressive wishes toward the parents. L. herself confirmed the idea of self-mutilation as both self-punishment and gratification of aggressive wishes toward her parents when she related that the sight of blood from her arm or leg meant that she had sufficiently punished herself for her sins. She also reported a dream in which her father took a hunting knife and cut himself on the chest.

The clinician, not wanting to take a passive, indecisive stance with this patient that would resonate with his own fears of incompetence and mounting helplessness, immediately began to interpret the obvious aggressive aspects of the previous behavior, which had hurt her, upset her parents, and sabotaged the attempts of previous treatment providers to help her. L. responded to this group of interpretations by denying any hostile feelings directed toward her parents or toward her previous clinicians. In subsequent sessions she became more withdrawn and combative as the clinician vainly attempted to interpret her resistance. The treatment seemed to come to a standstill.

L. then began to allude to a secret that she was keeping from the clinician. The therapeutic alliance seemed to be rupturing. Interpretations by the clinician that L. seemed to enjoy dangling a secret morsel of knowledge in front of the clinician only intensified L.'s sarcasm toward the clinician. The aggression had infiltrated the transference, but the clinician was experiencing difficulty knowing what to do with it. The nursing staff finally discovered that L. had scratched herself with a staple and a piece of her watch on her lower right leg, left ankle, and lower back. In subsequent sessions L. was confronted about her dishonesty toward the clinician, the nursing staff, and peers. The clinician also interpreted to L. that perhaps his previous interpretations regarding aggression directed toward her parents had made her feel guilty, which resulted in the self-punishing behavior. L. acknowledged that indeed, the previous interpretations had made her feel guilty, but refused to rule out future cutting incidents.

At this point our fledgling clinician, now clearly worried about L.'s safety, his capacity to help her, and his own reputation, observed that L. had become fixated on a female member of the nursing staff. L. now reported sadomasochistic fantasies in which this nurse would strip off L.'s clothes, pull her legs apart, and "repeatedly jam [a] metal tube up inside me, laughing evilly all the while." In other sessions L. simply nodded off to sleep. How could a patient, obsessed with sadomasochistic fantasies and

posing a chronic danger to her own safety, simply fall asleep in a psychotherapy session where she was supposed to be getting help? L. had successfully projected into the clinician her concerned, caring, guilty self-representation. What was left was her sadomasochistic, denying, indifferent self-representation. It is critical to point out that a clinician more experienced with this kind of patient might have become aware of the attempted projective identification, and interpreted L.'s need to rid herself of concern and love for her internal objects to avoid feeling guilty. Instead, this inexperienced clinician, concerned about his lack of clinical skills, defended against the awareness of this lack through over-active interpretation of aggression, neglecting the deeply buried love and concern L. also must have felt for her internal objects. Why punish herself if she were not so concerned about the effects that her aggression had produced on her internal world of loved objects? L. therefore found fertile ground in this clinician for this projective identification.

The results of this approach were devastating. Early one morning, the clinician was walking down the long hallway of the unit. Patients were sitting around, drinking their coffee as usual, but something was different. All eyes were focused on the clinician as he made his way into the nurses' station. A nurse quickly informed him that the night before, immediately after 15-minute checks had been completed, L. had unscrewed a light bulb from a lamp in the hallway, crawled into her wardrobe closet, broke the light bulb, and slit her throat from one end to the other. Fifteen minutes later, she was found scrunched up in the closet, profusely bleeding, a smile on her face. L. was rushed to a medical hospital, where she received 32 stitches. Within 24 hours L. was returned to the unit, and subsequently lobbied for a transfer to a state hospital, which was granted to her.

It could be argued that no fledgling clinician would have stood a chance of helping L. integrate her murderous and loving impulses, repair the massive damage caused to her internal object world, and diminish the overwhelming guilt feelings that drove her to self-mutilation. In the face of such intense self-destructive impulses we must acknowledge the limitations of our clinical skills and our therapeutic technique. Yet an awareness of the projective identification—and the clinician's corresponding self-representation as incompetent, helpless, and intensely concerned, which was already primed for activation in the transference—might have allowed the clinician to take more time to let the treatment unfold, interpret aggression in the context of the deeply buried love and concern for the internal object world, and metabolize the guilt feelings the patient was so motivated to ward off through her self-mutilation. This example illustrates how the

confluence of inexperience and projective identification can derail a treatment, leading to an abrupt termination, or in this case a serious suicide attempt.

EXAMPLE 2

The second clinician was a 24-year-old second-year graduate student in clinical psychology who was treating her first case. She too was feeling incompetent and concerned about whether she could benefit her first patient. In addition she had an emotionally disturbed brother five years younger on whom she had expended an enormous amount of emotional energy trying to help, and who figured prominently in her choice of career. The patient, "X.," was a 17-year-old boy who had lived in a therapeutic group home for four years. Sometime before his fourteenth birthday, X. was testing the limits of his alcoholic mother, staying out long past curfew, getting into arguments, and engaging in other behaviors that he refused to discuss. His mother had convinced the legal authorities to place a PINS petition (that removes the parent from culpability if the child does something illegal) on him. When this move did not have the intended effect, his mother placed him in a diagnostic treatment center for one month. The day he returned from the diagnostic treatment center, X. once again stayed out past curfew. The next day, his mother was hospitalized and died of cirrhosis of the liver precipitated by many years of drinking. In the absence of any relatives who wanted to take responsibility for him, X. was placed in a residential treatment center for a year and a half, then placed in a group home. During his approximately two years in this group home X. had received once-per-week individual psychotherapy from three previous graduate students. The clinician was X.'s fourth graduate-student clinician. The treatment regimen consisted of once-per-week individual psychoanalytic psychotherapy, which X. knew would end after one year, when he would be transferred to another graduate student.

X. appeared withdrawn and closed off about the circumstances surrounding his admission to the group home. He provided only cursory details about his mother, her alcoholism, his conflicts with her, and his father's multiple prison terms for drug-dealing. Instead, X. focused on his relationships at the group home and his interest in becoming an emergency medical technician (EMT). After the first couple of months of treatment X. withdrew from the clinician, who had made several interpretations regarding X.'s pushing away staff and peers at the group home. The clinician had good reason to make these interpretations. One evening past bedtime, X. was blasting his stereo in his room. Peers complained to the staff, who confronted him in his room. X. told them, "Whatever you do, you'd better

not touch my stereo!" Staff explained to him that he could turn down the stereo without their needing to touch it. He refused. Staff therefore turned down the stereo, and as a result X. needed to be restrained. X. constantly complained about the staff and his desire to be on his own.

As we observed from the previous clinical example, however, X.'s feelings of dependence on the staff, and the consequent feelings of vulnerability and concern, were omitted from the clinician's interpretations of aggression. These other feelings were clearly evident, however, in a later incident in which X. suffered a serious asthma attack while staying with a relative for the weekend. The relative called the group-home staff to alert them, then took X. to a hospital emergency room. After receiving treatment and being released, X. became enraged that the group-home staff never showed up—even though the relative appropriately took care of him without staff intervention.

As a result of clinical supervision the clinician stopped making these interpretations of the patient's aggression and worked harder on establishing a therapeutic alliance. X. began to bring into the treatment sessions music he liked to listen to or poems he had written. One of these poems considered the death of his mother. Written from the perspective of someone observing a patient in the intensive care unit, the poem described the heart monitor flatlining and the medical personnel coming into the room, trying to resuscitate her, and ultimately, covering her face with a sheet. X. became tearful in session for the first time after reading this poem. He could not—or would not—comment on what he had just read, or confirm whether the events were witnessed or only imagined.

In subsequent sessions X. began to complain about the treatment interfering with his other activities. For example, he wanted to take an EMT course that conflicted with his scheduled sessions. At the same time X. expressed a wish to drop out of the final semester of his senior year of high school. The clinician worried that she was losing the patient, and berated herself for saying and doing the wrong things. In particular she worried that she had said or done something during that pivotal session in which X. had shared the poem about the death of his mother. The clinician tried to explore with X. the meaning of that session. He refused. In one session he even called therapy "a waste of my life." Here again, we observe the clinician's becoming overly concerned and even worried about the fate of the treatment, while the patient is calmly talking about not caring about anything. In this example, however, it is possible that the clinician projected her own object-representation into the patient at a moment when the patient provided fertile ground for it and was able to identify with it.

This possibility was discussed in supervision, and the clinician was able to acknowledge that X. reminded her of her own brother, whom she had been trying to save from childhood. The brother and X. were both roughly the same age, the same height (very short), and of stocky build. Both boys experienced depression and defiant behavior. And both boys also aroused in the clinician concern, worry, guilt, and a strong need to repair. The clinician became aware that X. had finally made himself vulnerable, sharing his experiences regarding his dying mother and feeling the obvious guilt he must have been unconsciously defending himself against because of his repeated disobedience, which in his mind eventuated in her ultimate death. Through the transference, X. had activated an internal object relationship in the clinician, who must have responded with increased worry, concern, and activity. These internal experiences took the shape of her brother, whose representation she then projected into X. X., however, unwilling to wear this mantle of dependence and concern because of his perceived supreme unworthiness of the clinician's love and concern, responded with omnipotent denial and narcissistic withdrawal and threatened to leave the treatment. How could he possibly be worthy of saving, when through his own aggressive wishes he murdered his own mother? He would rather forsake his own reparation, and instead go about the impossible task of resuscitating his mother on his own—perhaps through becoming an EMT and saving the lives of others.

EXAMPLE 3

I was the third clinician, a 42-year-old psychoanalytic candidate in a child-training program treating my first control case. In spite of having practiced child psychotherapy as a licensed clinical psychologist for 11 years, I was feeling ambivalent about beginning my first control case. It felt like starting something I knew little about, though I had read extensively about child analysis and had been practicing psychoanalytically-oriented child psychotherapy since my days as a graduate student. Psychoanalytic candidates seldom treat patients who have the potential to develop negative therapeutic reactions; these patients are often excluded from the control-case pool because they often pose the very challenges this article addresses, and often raise questions of analyzability. Because of the widespread paucity of child training cases and because changes in psychoanalytic training curricula now include courses that focus on severe psychopathology and its treatment; however, these exclusion criteria are often relaxed, and almost any child whose parent is willing to transport her or him to sessions four times per week now qualifies as a control case.

Thus, I was able to begin psychoanalysis with a child who would develop a negative therapeutic reaction.

The patient, M., was a six-year-old boy who was experiencing toilet-training difficulties. He had bowel movements during the day and night in his underwear and urinated at night in his underwear. These accidents occurred at school, on the school bus to and from school, and at home. M. could sit in his own waste products for hours and not seem uncomfortable. When a classmate asked him what the smell was, M. told him, "Just ignore it." He also experienced interpersonal difficulties. M. needed to control all his interactions with peers as well as with adults. Other children did not want to socialize with M. because the play had to take place on his terms, with his choice of activity and his rules. The parents and teacher reported that M. often refused to follow directions, particularly when he was asked to transition from one activity to another (e.g., watching television to going to bed, eating breakfast to leaving for school, playing with peers to sitting at circle time).

Most disturbing to his parents was M.'s aggression, which was directed toward his brother, who is 2 ½ years younger. When M.'s brother wanted to inspect one of M.'s toys, M. would hit him hard enough to make him cry. When M.'s mother changed his brother's diaper, M. would sometimes hit his mother. M.'s use of aggression was not limited to his brother or mother; he sometimes hit his school peers when they refused to play games by his rules. This aggression was not always reactive. In school M. once threw a live bunny against a wall for no apparent reason. When I asked M. about the incident in the following session, M. expressed anger because the teacher later refused to allow him to hold a baby chick. M. then demonstrated this sadistic impulse *in vivo* by gleefully knocking onto the floor a Russian *matryoshka* of cats, which he referred to as a mommy cat with her baby cats. He then took an action figure and got down on the floor to play with the cats. M. then narrated a fantasy story in which the baby cats got inside the mommy for protection from "the bad guy" action figure. The bad guy then overpowered the mommy, and the baby cats fell out and died. They returned to life, however, and battled against the bad guy, who then died. Then other bad guys came and "touched the insides" of the cats, who were filled with "boiling hot liquid soap." Each bad guy was scalded and died. Then the baby cats got inside the mommy again for protection, as before, from the original bad guy, who had returned to life. The bad guy then savagely attacked the mommy. She died along with her babies, who had fallen out of her. At the end of the session M. instructed me to clean up all the toys because "I like to order you around."

During other sessions M. demonstrated other aspects of himself. While playing Uno® or board games, M. would often upset the game board and fling all the pieces and the board itself all over the office without warning. He called this event "Hurricane Floyd." I later learned from the parents that at age 2 ½ M. and his parents had fled their home during Hurricane Floyd, which terrified him. When asked about this incident, M. reported that he remembered Hurricane Floyd and how loud the thunder and wind were. He also remembered his parents' looking "scared." He concluded with a statement that he immediately retracted: "God was trying to get me and my mommy." M.'s baby brother had been born only four months before the hurricane. Another intriguing aspect of M.'s personality centered on his making homemade greeting cards for his teacher and school peers. Some of them read, "I'll never hurt you again. Be my friend again." He also gave them stones he believed represented some value to them. I considered these behaviors to represent unsuccessful attempts at undoing and reflective of a sense of guilt over his mistreatment of them and his need to re-establish some sense of closeness to them.

In my early work with M. I tried to contain his chaotic, hurricane-like feelings of anxiety and rage by empathizing with him. I made nonthreatening interventions such as "Gee, that hurricane must have been really scary—you weren't feeling protected." M. responded to this containment by becoming more organized in his play; the "Hurricane Floyds" eventually disappeared. M.'s accidents, however, continued unabated. Both parents expressed impatience and frustration by the lack of immediate results; they needed the accidents to stop as soon as possible. During a collateral session, M.'s mother clearly articulated the emotional impact of this symptom on her: "I want to kill him!" Simultaneously with my treatment, M.'s mother decided to take M. to a series of experts: an "encopresis specialist," a gastrointestinal specialist, a neurologist for an EEG (which was negative) and psychostimulant medication (which was prescribed), a neuropsychologist, a school psychologist, a urologist, and a nutritionist. M.'s mother also mentioned that the neurologist suggested that M. had Asperger's Disorder and therefore needed a different kind of treatment. She conducted some Internet research and had drawn the same conclusion as the neurologist. In the session that followed, M. was preoccupied with saying "bye-bye" over and over again. I told M.'s mother that although I am not a neurologist, I did not believe that the psychostimulant medication would be helpful. She snapped back, "Well, nothing else seems to be helping!" I tried to empathize with her frustration and impatience—how humiliating and frustrating it must be to be changing

M.'s underwear at age six. I calmly explained why I felt M. did not have Asperger's Disorder. I sat down alongside her and reviewed the diagnostic criteria in the *DSM–IV* (American Psychiatric Association, 1994) and discussed them with her one by one. By the end of the collateral session she agreed that M. did not have Asperger's Disorder.

In this example we observe what might be labeled a "vicarious negative therapeutic reaction." M. demonstrates some improvement in psychic organization during sessions, but the primary symptom remains unaffected. M.'s mother responds to the lack of improvement in the symptom for which she sought treatment for her son by parading in front of me the symbols of her lack of confidence in me and the therapy—a cadre of other professionals who she expects will provide the "magic bullet" that will immediately cure M. of his accidents. The negative therapeutic reaction was going on inside the mind of the mother—and its effects were being felt acutely by me. Was I failing in the treatment of my first control case of a highly intelligent boy from a middle-income, intact family? Should I be making more confrontational interpretations of M.'s sadism, his need to get rid of his brother, and his desire to punish his mother for betraying his love for her by having a second baby? Should I be telling him that he was also punishing himself for these aggressive impulses by sitting in his own cold, wet, smelly waste products for hours? This is exactly what I did. And the result was dramatic: M. began to withdraw in sessions, playing with Lego™ by himself or working on construction-paper projects without my help. Self-sufficiency replaced a genuine interaction with me.

I was feeling intense pressure from this exasperated mother to solve the problem of the accidents quickly; otherwise, she would surely end the treatment, as M. was suspecting ("bye-bye"). I responded by stepping up my interpretation of the aggression I felt certain was unconsciously responsible for this boy's refusal to be toilet-trained. M. responded by withdrawing from me—a kind of iatrogenic negative therapeutic reaction. I fell victim to the mother's projective identification of her own feelings of incompetence, inadequacy, and disillusionment partly because I was experiencing those very feelings as a fledgling analyst prior to the beginning of the analysis. My vulnerability was exploited by the mother's projection into me of unwanted aspects of her own parental representation. Through my own training analysis I gained insight into these dynamics. I was also 2 ½ years old when my sister was born, and according to my parents, my adjustment to her existence was difficult. I was often told the story that soon after she was born, I bit her toe because she was "making too much noise." My father sent me to my room with no dinner—only one example

of his inability to tolerate angry feelings, much less understand them, in me. M.'s mother exerted pressure on me to identify with those aspects of my representation of my father and project my own self-representation of the resentful, spiteful brother onto M. The unconscious purpose of the confrontational interpretations was to coerce M. to start behaving properly rather than to help him to understand himself. M.'s mother and I were sending him to his room with no dinner. Fortunately, M.'s desire to come to sessions never wavered; instead, he protected himself during sessions through withdrawal.

My clinical supervisor was helpful to me. He noticed the frequent interpretations of aggression and the corresponding shift in M.'s behavior during sessions. He suggested that I focus on M.'s need for connection, his desire to feel close to me, and his enthusiasm for coming to the sessions. My supervisor observed that M.'s desire for love was not being noticed. From this point of view M.'s accidents were unsuccessful attempts at regaining his mother's love, now perceived by M. as lost to his brother. If he could just act like his brother, his mother would lovingly clean up his accidents, too. Empathizing with his mother's frustration, impatience, and devaluation of me and the treatment, without acting on the pressure she exerted on me to change my method of working with M., became my primary challenge. Since changing my emphasis to M. and his mother, M. has begun to interact with me once again and reveal his internal world to me, and his mother seems to be experiencing less frustration and impatience. This example illustrates how the feelings of incompetence and inadequacy engendered by the circumstances of beginning one's first control case can interact with other dynamic factors such as the psychoanalytic candidate's personal childhood experiences and the parent's vicarious negative therapeutic reaction to create a stagnating treatment in which the patient withdraws in the interest of self-protection, thus producing an iatrogenic negative therapeutic reaction.

CONCLUSION

Patients who are prone to having negative therapeutic reactions seem to be increasingly common in clinical practice. These patients pose special problems for fledgling clinicians in two ways. First, projective identifications from the patient are more likely to find fertile ground in the psyche of these clinicians, already primed to doubt themselves, their skills, and their capacity to help their patients. Lack of awareness of this defensive process can result in premature termination of the treatment. Second, fledgling clinicians, themselves less likely to be aware of their own intrapsychic conflicts, are prone to use projective identification in their clinical

work. Lack of awareness of one's own conflicts, and their influence on the patient, can also result in premature termination. Finally, I have argued that these phenomena are most likely to become activated in work with this kind of patient in treatment with an inexperienced clinician.

What can a fledgling clinician do to help protect the treatment of these patients? First, she or he can acquire an education about severely disturbed patients, specifically, a theoretical understanding of these patients' personality organization and cognitive, affective, and behavioral dysregulation, as well as techniques of structural assessment and diagnosis and clinical treatment. Over the past 20 years psychoanalytic training programs have expanded their curricula to include courses that focus on severe psychopathology and its treatment. Second, she or he can enter—or re-enter—analysis to uncover blind spots—the fertile ground for patients' projective identifications. Inadequate or malignant self-representations can be uncovered, and the circumstances under which they could be activated in one's analysis of this kind of patient could be identified and understood.

Third, she or he can find a clinical supervisor familiar with the processes of projective identification who can aid in their identification and interpretation. Kernberg (2003) suggested that excellent clinical supervision is the single most important aspect of psychoanalytic training. Clinical supervision can be helpful not just to inexperienced clinicians but to clinicians who work with these patients at all levels of training—from graduate students and psychoanalytic candidates to senior training analysts. The Kleinian psychoanalyst Ronald Baker (1989) recommends peer supervision with such cases: "The analyst who has the opportunity to share such material with his colleagues has, in my view, a distinct advantage over those who work more or less in isolation with these difficult patients. In the private sector there is some evidence that analysts who work under such duress for one or another reason lose or drop patients when the countertransference becomes unmanageable. The presence of a support group potentially militates against countertransference identifications, normal and pathological, with analyst and patient, which fluctuate quite remarkably at different times" (p. 39). In these settings the patient's projective identification, through the person of the clinician, has the opportunity of acting on the group members, who are then able to share their vicarious experiences of the patient with each other and thus be more likely to become aware of the psychic impact and meaning of the patient's defensive processes.

It must be noted that the outcome of the patient in Example 3 was more positive than the other two outcomes perhaps because psychoana-

lytic candidates, unlike most graduate students and postdoctoral fellows, have all three of these resources—a rigorous education in severe psychopathology, a personal analytic experience, and an intensive, self-reflective supervision—at their clinical disposal, along with greater clinical experience to rely upon as a holding environment of sorts whenever countertransference dilemmas arise. In addition to obtaining the assistance of these three resources for the purpose of becoming aware of and interpreting the experience of projective identification and its effects on both clinician and patient, what else can fledgling clinicians do to retain this kind of patient in treatment? In all three clinical examples reported, the clinician attempted to interpret the aggression toward the object world without simultaneously emphasizing the deeply buried concern and love, depression, guilt, and attempts at reparation that coexisted in exquisite tension with the aggression. Interpretations of aggression are not incorrect, but simply incomplete.

Albert Mason (Grotstein & Mason, 1995), a Kleinian psychoanalyst who worked with Melanie Klein and was analyzed by Wilfred Bion, remarked that "if the patient threw shit in [Klein's] face, she would first compliment [the patient] on his aim." Aggression never exists in a vacuum. We ignore this great psychological truth at our peril when we treat the patient who suffers from the conviction that she or he has destroyed the entirety of the internal object world—the loved ones whom she or he is killing herself or himself desperately trying to save. We must offer the hope of integration of bad and good objects, murderous and loving impulses, if we are to bring relief to the patient who is prone to having a negative therapeutic reaction. We must recognize in this kind of patient the wish to love and to be loved, as well as the wish to destroy and to be destroyed Karen Finley (1990) poignantly reminds us in her poem, "The Black Sheep": "Sometimes Black Sheep are chosen to be sick/so families can finally come together and say/I love you. Sometimes some Black Sheep are chosen to die/so loved ones and families can finally say—Your life was worth living/Your life meant something to me!" (p. 143).

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