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Treating the Untreatable - a Cautionary Tale about Love-Transference

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Abstract

In this work I shall describe the futile task of trying to establish and maintain a therapeutic alliance in the weekly psychotherapy of Tamar, a 32-year-old woman within the special setting of a public mental health clinic over 18 months. I shall place special emphasis on the issues of the therapeutic alliance, erotic transference, and perversion, as manifest in the transference-counter-transference paradigm relevant to this case.

Keywords

Borderline Personality Disorder, Erotic Transference, Perversion

"I would leave the question open to avoid the misfortune of an answer."

(Green, A. 1998; p. 663)

Fiction and Fact in Case Studies

As early as 1915, Freud (1915) suggested that the main difficulty faced by the therapist was the management of the transference situation. In his article about transference love, he outlined, perhaps overly simplistically by today's standards, the challenges the therapist has to face when dealing with the eruption of normal and perverted forms of love within the process. Since then, many authors have established that transference love is far from being simply the expression of resistance to the unveiling of suppressed sexual conflicts. While still being a form of resistance, it is also thought of as a testimony. The strict ethical injunction of avoiding any kind of acting-out and wish fulfilment holds still and at the same time, therapists are being told that they need to pay close attention to their subjective experiences in the process and not just repress their sexual counter-transference experience. The subject is still not discussed openly or often enough in psychotherapy training.

In his preface to the first edition of Studies on Hysteria, Breuer & Freud (1893) wrote: "It would be a grave breach of confidence to publish material of this kind, with the risk of the patients being recognized and their acquaintances becoming informed of facts which were confided only to the physician." (Breuer, J. & Freud, S., 1893; p. xxix)Despite this warning, Freud goes on and describes the case details, elegantly trying not to expose what he thought would be harmful to the patient. My contention is that the writing and publishing of clinical material is problematic for another reason. I believe that the therapist's attention should be focused solely upon the needs of the patient. Therefore, the mere possibility of publication of clinical material interferes with the kind of attention I believe the patient deserves. I am aware that any therapist who also writes has the desire to do so and therefore totally prohibiting writing about clinical cases will also adversely affect the therapist's attention towards the patient and might even result in hostility towards them. I therefore suggest a good-enough solution whereby I allow myself to write a case study which is fictionalized in the sense that it is not based upon any one of my patients, but rather upon my evolving and accumulative experience in the area I wish to write about. The patient I will describe shortly is a subjective and fictional portrayal of a patient. I would argue, based upon the writing of Felman (1977), Ogden (1997), Spence (1993), and others, that while writing "true" case studies, we are in fact fictionalizing them since we write our own perspective of the case. What I have written about in this case study is indeed both fiction and fact and represents a truthful account of my perception, as it has been developed and modified through intense supervision which always accompanies my clinical work.

Therapeutic Alliance

The term therapeutic alliance, or treatment alliance as Sandler (1992) calls it, refers to"…the patient's conscious and unconscious wish to co-operate, and his readiness to accept the therapist's aid in overcoming internal difficulties… an acceptance by the patient of the need to deal with internal problems and to do analytic

work in the face of internal resistance. (Sandler, J., 1992; p. 29). In this context, resistance to the therapeutic process expressed through erotic transference cannot be seen simply as the patient's attempt to sabotage the ongoing treatment, but rather as the manifestation of the unconscious at work. It can be viewed as the patient's reaction to the symbolic intimacy that is created when entering this special relationship with the therapist. Ogden (1986), used the term "matrix" to describe the "frame" that is needed when establishing a therapeutic alliance, and which allows the introspective and reflective subjective process that is part of psychotherapy to take place. The existence or partial absence of such a matrix would be indicative of the level of internalization of the maternal holding environment.

I suggest that there are two opposing forces at work: the drive towards connecting with the therapist in an unconscious repetition of an unresolved conflict or an enactment of an early object relation, and the attempt to stay in touch with her rational resolve to be an active partner in the therapeutic relationship aimed towards bringing about internal change. The conflict between these two complementary forces is often staged within the therapeutic setting, itself possibly challenged as part of the process. If the symbolic nature of the intimacy of the therapeutic dyad is being challenged and subverted into acting-out, the alliance is in danger, requiring the therapist to continuously repair and sustain it . In his book The Dove that Returns, The Dove that Vanishes, Parsons (2000) likens this repairing and maintenance of the setting to the work of the farmer who mends his fences after the storm, knowing he will have to do so again and again as part of his agricultural tasks. The psychotherapist will do the same with care, bearing in mind that any attacks upon the setting are important expressions of the patient's vitality and engagement with the process. As Winnicott (1945) puts it: "The patient who is asking for help in regard to his primitive, pre-depressive relationship to objects… In such cases the end of the hour, the end of the analysis, the rules and regulations, these all come in as important expressions of hate." Winnicott, D.W., 1945, p. 137)

In the following pages, I will relate the story of an expression of erotic transference which often felt like the expression of hatred towards the therapy. The details are indeed fictionalized and therefore represent no one person but have all been gathered by me through the clinical work of over twenty years.

Her-story

The following background details were gathered over years of different treatments.

The patient I am portraying here is often referred to as having a Borderline Personality Disorder, based upon Kernberg's classification (1970). Having a fragmented sense of self, it is difficult to have a history which is not fragmented. Tamar revealed parts of her biography to me begrudgingly, as this was often perceived by her as a sign of weakness and of losing control, of admitting a particular position in the therapeutic setting which she found very threatening. As will be expanded upon later, it was a rare event during the course of treatment when Tamar was able or willing to refer back to her history as a narrative. I was often left with a longing to know more, to have a better access to the inner workings of the story.

Tamar was a single 33-year-old woman when she began therapy. Excluding very short periods, she has never left the parental home. She has been unemployed for most of her adulthood. She is the seventh of nine children, born within a twelve-year span. Tamar's older brothers and sisters were already in their late teens when she was born. Most of her siblings have left home and established families of their own. An older sister is also still residing in the parental home and according to Tamar, her emotional and mental state is worse than her own.

Tamar grew up in an environment of marital conflicts and deceptions. Her father conducted a long-term and stable extra-marital affair with a woman whom most of the family members have come across in various circumstances. Although this affair has never been formally acknowledged by the parents, it has gradually become common knowledge to the children and in a

sense integrated into their family view. Tamar held a very affectionate view of her father as being a kind and warm man. Tamar felt that her father showed her more love than he did towards the other children and felt more secure when he was around, which was not often. Tamar's mother exercised a discriminating style of parenting where some children were favored more than others. Tamar was one of the unloved children, who were often rebuked, and, at times ignored.

Tamar was a precocious child who suffered strong mood swings that often caused her trouble at school and at home. She managed to perform above average in her schooling until she was 14 years old when she had an emotional breakdown followed by anorexic symptoms which were "treated" within the family circle. She was later sent to her sister in America where she suffered a severe anxiety attack, also untreated, and was sent back home almost immediately.

When Tamar was 19 years old, she made her first serious suicide attempt after an intense fight with her mother. Her fear of her mother was so great that even after she woke up in hospital, having had her stomach pumped clean of the 40 odd tablets that could have killed her, she claimed that she had wanted to die because of unrequited love.

When applying for therapy, she specified that she wanted an experienced male therapist because she did not want to waste any time nor was she able to trust a woman therapist. When I first met her, she immediately began interrogating me about my experience and expressed some wonder as to whether I could be of any use to her as I looked too young. This took some time and when I commented upon the anxiety she might be feeling in the first encounter, she relaxed a little bit and spent some time looking at me and at the room with an intense and worried look on her face. She then took out of her handbag a list she prepared with all the issues she wanted to go over in her therapy. She began reading from it: she felt dissatisfied with the kind of relationships she had with men, she was dissatisfied with the job she had had in the past, she felt at a crossroads in her life, she wanted to live away from the parental home. She read the list quickly and mechanically. She then stopped and expressed a worry that I would get depressed if I listened to her anymore. With some encouragement, she continued telling me about what had brought her to therapy at this time, including her suicide attempt, her sense of having failed at what she had hoped to achieve in her life. She kept interrupting herself and asked whether I thought I could help her and whether she was not boring me. Her manner of speech was very fast, fragmented, highly associative, and excited. She was obviously having to control a lot of thoughts and feelings. Later, I came to understand that her recurrent queries regarding how I would be affected by her material was an indication of things to come. She was warning me of her use of primitive defenses but at that time I was still unaware of this and misinterpreted her remarks as showing some degree of self-awareness, therefore providing good indication for starting psychotherapy.

"The Agon, then"

A few weeks later, Tamar entered the room enraged about how she was spoken to by the secretary of the clinic. When I responded in a reassuring way, similar to my tone in the first meeting, she turned her rage towards me and accused me of being un-empathic, cruel, bastardly, too young, and in cahoots with the authorities. I was taken by surprise. I had thought that some trust had been established during the first sessions, but realized that it was built on very shaky grounds. I was reminded at that point of Goldberg's (1989) essay regarding the incongruence of frameworks. Later that day, when I was back home, I reread the article, thinking that it would help me to understand the way my words and gestures are felt and interpreted in a totally different way to what I intended. One passage in particular caught my attention:

"… The nature of the mental framework that is assumed in psychoanalysis (and ultimately in all cultural institutions), and the accompanying code used to construct meaning, is verbal-symbolic in character … but the patient might employ a quite different framework, built upon a more idiosyncratic code of transformation of experience, a more peculiarly personal mode of over-

coming chaos and securing the indispensable backdrop or frame of psychical existence… There exists in these cases not an imagined or fantasized antagonism but an actual interactive struggle over the way meaning is to be established and appropriated between therapist and patient… The task of establishing a common or consensual framework between therapist and patient would, from this perspective, necessarily take precedence over the uncovering of the unconscious or the analysis of the self, the ego defenses, or the transference and resistance. (Goldberg, P., 1989, p. 448)

It had taken me quite a long time to understand how poorly I was able to use the insight Goldberg offered.

When in a rage, it was as if she was alone, it was a blind narcissistic rage, directed towards a non-existent, or destroyed object. After I made my presence felt by my comments, she seemed to wake up from a stupor, take notice of me and was able for a very brief and lucid moment to acknowledge her desperation and frustration at getting so worked up and losing control. She showed what I mistook to be insight by telling me that she feels she uses sex as a way of relieving tension in herself but ultimately is unsatisfied. At this point I made a comment about how it must feel frustrating to want to connect with a man and feel that she could do this only through sex and her response was an angry denial which again plunged her into a mood similar to the one she came in with, that of being misunderstood, hurt and isolated. She then said that she thought that the therapy was not helping her at all and that she did not know whether she was going to come again.

Over the next few months, the nature of the internal environment Tamar lived in, where her deep narcissistic injury showed in her inability to conceive of an internal space for herself, came to the surface. She made multiple attempts to attack the setting of the treatment. She tried to cancel several sessions by ringing the clinic and saying she could not bring herself to attend as she was not feeling well. When I commented that it was just the reason to come for her sessions, she became coy and evasive and insisted that she wanted to have a break in a manner which was both pleading and threatening. It was almost as if she was begging me to let her stay away but at the same time insisting that I take good care not to forget her. I took this to be a sign that a therapeutic alliance had been formed, albeit in the fragmented sense she was capable of. When she did appear, she spent most of the time lashing out at me for various inadequacies in the way the clinic was being run, the way the room was decorated, my manner of greeting and more. These attacks were followed by apologetic telephone conversations she made to check that I was not angry with her. The problematic nature of these telephone conversations, which at first I thought constituted some attempts at reparation, became clear to me as they increased in frequency and seemed to constitute the bulk of the interaction over a period of several weeks when Tamar did not show up for her sessions offering various questionable excuses.

W.R. Bion (1959) wrote about the patient's rage at the therapist who provides him with containment for his worst and most difficult feelings and unconscious projections without being destroyed himself. I began to suspect that Tamar was unable to tolerate my containing presence in the room. I believed that for Tamar the experience of containment by me at that stage as an experience of annihilation against which she had to fight. She was only able to stop lashing out when back in the relative safety of her isolation at home, where she was occupied with the "evil" mother upon whom she had no problem of exercising her well-practiced denial and splitting mechanisms. It seemedt that the process had reached an impasse.

Erotic Transference

I diligently but unsuccessfully tried to arrange meetings at Tamar's convenience, outside the therapy room and during the fifth month of therapy, after missing two sessions and ringing in numerous times she arrived at a scheduled meeting wearing very provocative clothes. She began relating detailed stories about her sexual activities which involved having sex with a few men she knew, one of which was her ex-boyfriend, now married to someone else. She took her time and lingered in her

descriptions, provocative in her choice of words. She also paused frequently, , pretending to be embarrassed. When I asked her if she was trying to see how easy it would be to embarrass me, she became very alert to my inquiry in a way I only understood later. As was often the case, my comments, be it a clarification, a question, or an interpretation, were met by a flat denial and at times by anger at being misunderstood. This time her denial was quick. I was indeed slightly embarrassed and not sure what path to follow. During this time, it had become clear that Tamar's sexual exploits were at best defenses against being emotionally intimate with men. An awkward silence followed. I felt as if anything I might say would be wrong and suggested to her, after inquiring what she was thinking about and encountering a flat rebuff, that she did not want me to say anything as this interrupted her fantasying. She seemed to be submerged in private thoughts. She said that the silences were uncomfortable for her and began expressing concern that she was being listened to by someone outside the room and even checked by looking out into the corridor. Yet, she kept silent and would not respond to my comments, which tried to focus on the embarrassment she might be feeling.

During the next session, after some of her characteristic explosive exclamations, she suddenly calmed down and proceeded to take out a box from her bag, opened it and took out a large vibrator from it, held it out in my direction and asked me to hold it. I was stunned. Eventually, I asked her what she expected me to do, and she replied that she wanted me to experience what she was entertaining herself with. She added, giggling, that she also wanted me to see her in her sexy underwear so that I could get "a true impression" of what she was really like. When I commented that the best thing we could do was discuss what she had hoped to achieve by such a proposal, she objected and claimed that I did not understand her.

H.F. Searles (1963) wrote about the importance of the therapist not defending themselves too strongly against the psychotic components of their patient's transference. I was swamped, trying to survive but getting a sense that I was not doing so well. An example of this was my response to her phone calls. In her phone calls Tamar invariably expressed vague sensations of distress and demanded that I give her extra sessions during the week. During the first couple of months, I replied to her calls emphatically, believing them to be signs of her neediness, and therefore responded from the position of wanting to provide holding. It took me a while to realize that what Tamar was trying to do, and to an extent accomplished, was to subtly change the terms of our dialogue so that it could be conducted over the telephone while she was ensconced in her bedroom. This became clear after a fortnight of missed sessions for which she offered various excuses, all the while trying to talk with me on the phone every day. When I made it clear that I was not going to respond to her telephone calls and that anything she wanted to say would have to be said within the hour, she appeared for the next session and told me in great length, with a triumphant smile on her face, about all the sex calls she had been engaging in at that time. It was clear that she was feeling victorious in having fooled me.

As much as I tried to resist her attacks upon me, I felt that I was being reduced to a position of incompetence and helplessness in regard to the treatment. I tried to share with her how scary it must have felt for her to be under attack, and Tamar responded with derision and denial. In my supervision, I expressed my sense that I was doing really badly as a therapist and perhaps should terminate the therapy.

The next few sessions were taken up by Tamar flooding the therapeutic space with her erotic fantasies about me. This took the shape of disjointed talking on her part interrupted by giggling and denials, interspersed with spells of anger directed to me, but mainly non-verbal communication, including her provocative outfits, gestures, posture etc. It was becoming clear that she had decided to go in "for the kill".

My attempts to interpret what was going on were met with either a flat denial or juvenile glee, as if she had succeeded in achieving her purpose, i.e., to incorporate me into her sexual fantasies. This often gave way to paranoid fear and she would be convinced that someone was listening in on the sessions.

Towards a resolution?

Just as I was ready to give up and inform Tamar that I was ending the therapy, she arrived in a quiet and serene mood and launched into a continuous monologue, leaving little space for me to do anything but listen, whereby she would relate her genuine anguish. That session revealed to me the depth and nature of her disposition. She told me of her horror of thunder. On a stormy night, she had lain in bed and listened to the thunder. Someone had told her that one could calculate the distance to the thunder by counting the seconds between the sound of thunder and the flash of lightning. Thus, she would both comfort and frighten herself by imagining the thunder getting closer and closer. When she could tolerate the pressure no longer, she would get up and go to her parents' bedroom and ask to be let in for comfort.

Alas, in the session that followed she denied, negated, ridiculed, and blew to smithereens all that seemed to have been said by her and by me. She seemed to truly convince herself, and nearly me too, of the worthlessness of the previous session, thus protecting herself from any possibility of future contact, with the attendant horror of possible rejection. I realized that Tamar needed to exhaust me in a sense before she allowed herself to share her concerns without feeling threatened.

When I had to write a report to the health authority to request that her treatment be continued, as is customary in public mental health settings, the difficulty of maintaining clearly defined settings, or what Goldberg (1989) termed as "the non-process" in order to allow for a discernable psychological process to emerge, became prominent. The continuation of her treatment was dependent upon the decision of an authority not present in the room. I felt I was in a double bind. On the one hand, her reliance upon another person for the continuation of her treatment was playing into her conscious and unconscious negation and castration, respectively, of the treatment and therapist. On the other hand, it was both part of the reality of working in a public clinic, as well as a clear representation of her inner world, which unfortunately was colliding with external reality. With some misgivings in my heart and after lengthy discussions with my supervisor and colleagues, I decided to try the impossible and continue with the present setting, that is, write the report while knowing that by doing so I was perpetuating a situation in which she had full scope to abuse the setting.

The next couple of months were dominated by turmoil. Only one of us could come out of this "alive". During this period Tamar got hold of the report in some way still unclear to me, tore it up in the room, complained to various people and agencies about me, including the head of the clinic, hurled very severe verbal abuse at me and on two occasions physically threw things at me in the room, left the room in a fury when my comments, or silence, were too much for her, harangued the secretarial team of the clinic with daily phone calls, becoming gradually but surely the most hated patient in the clinic, and on one occasion attempted to expose herself in the room. One thing she was not prepared to do was to discuss the contents of the letter. While I wrote it, I had anticipated that she would read it and was therefore prepared to explain and support what I had written. I even entertained the possibility it would help. She never let on that she read it nor allowed any mention of its content.

I was often left in the room to deal with the debris of her acting out and internal turmoil. Often, I felt quite paralysed, incompetent, and impotent. I felt exhausted by the internal work I had found myself conducting to contain my countertransference. It was hard to gain more and more insights into her mental constitution while being attacked. I was feeling increasingly frustrated at not being able to use any of my insights and felt very lonely during the sessions in my attempts to maintain an empathic position towards her. At times I felt the absurdity of the situation - there I was, trying to provide a facilitating and holding environment, yet getting nowhere. At the same time, I also knew beyond doubt that my attempts to hold the situation were essential - her last chance to approach some sense of recovery.

When the health authorities declined her request for further treatment, which meant she would have to pay for future sessions, her outburst of rage did not surprise me. She then became somewhat coy and for the first time confessed her worry that she would not be able to raise the necessary sum. When the day of reckoning was getting near, Tamar failed to appear for what would have been the last three sessions, ringing in and apologising in retrospect. My supervisor tried to reassure me that it would be unrealistic to expect a borderline personality to behave in any other way. Still, I was experiencing some disappointment. There had been something moving in her solitary and incessant attempts to make contact, however perverted. I knew that sometime during our meetings a seed of hope had been planted in her by the treatment.

Discussion

In Tamar's therapy I was confronted by a sense of failure. I was not able to help her deal with her inner turmoil. Her character and demeanor had demanded from me high levels of restraint, boundary watching and patience. I realized that I was dealing with a person whose ability to enter, engage in and maintain a working therapeutic alliance was very limited and my work was mostly confined to protecting the shell of the therapeutic setting. It appeared that the very offer of such a setting posed a threat and a challenge to the perverse manner Tamar had conducted her life; it seemed as though I was skidding on thin ice to protect her from the abyss of her internal turmoil and terrors. The bulk of the sessions was dedicated to a struggle between two forces. One was determined to perversely avoid dealing with the pain which was the manifest reason for the therapy and the other was attempting to construct a bypass that would possibly allow an appreciation of the abyss.

On more than one occasion I found myself wishing for the end of the therapy so as to put an end to the misery of being the target of so much abuse. Beyond the obvious informative function of such countertransference, I was also desperately grappling with existential questions as to whether it was at all feasible for someone suffering like this to stay in any relationship where so much anger and hatred were being evoked.

From the material Tamar presented through her words but more significantly through her actions, it can be said with some confidence that what she was enacting and repeating were early faults and holes in the maternal matrix. Often, it felt that immediately upon coming into contact with me, Tamar would "vomit" herself into the session, violent and venomous eruptions over which she had no control. It was as if the mere offer of contact threw her off key, as would often happen to her in her life, whereby any man she had a slight attraction to would soon be "flooded" with her inappropriate sexual innuendoes, therefore contaminating her own intentions.

D.W. Winnicott (1950) described normal emotional development:

"…We have to deal with separate expressions of the aggressive and erotic components, and to hold each separately for the patient who, in the transference, cannot achieve a fusion of the two. In severe disorders that involve failure at the point of fusion, we find the patient's relationship to the analyst aggressive and erotic in turn… the analyst is more likely to be turned by the former than by the latter type of partial relationship. (Winnicott, D.W., 1950, p. 214)

It seems that Tamar's behavior throughout her therapy can be described as acting out. While writing this, I find myself considering the treatment as a failed one. Acting out in the transference can be understood as a kind of remembering. What Tamar was evoking and bringing to life through her tempestuous and tantrum-like behaviour, was the failure of an early containment of her primary psychic life. I was being cast again and again into the role of the abusive, tantalizing, seductive and punitive mother. I felt desolate in my repetitive failure to support, maintain, and repair the containing setting of the therapy which Tamar felt compelled to ferociously attack. On the rare occasions she allowed herself a respite, the sessions when she related her deeply felt and seemingly psychotic fears, Tamar

seemed to use me as a paternal object, passive and weak, unable to penetrate the world of horror she was describing and feeling powerless to do anything but to acquiesce in her pattern of only feeling safe with a distant, non-sexual, uninvolved male.

Tamar's treatment was precariously ended by her, reflecting the pattern of all relationships she had been involved in. Whether or not she was nevertheless able to gain some insight as a result, or whether the therapy was just another link in a long chain of futile attempts at human interaction, is hard to say. What Tamar was able to do was let me in on her current incapacity to share without being destroyed. She was still arranged mentally around the notion of ruthlessness (Winnicott, 1962), a far cry from having any capacity for concern. Only the passage of time will tell whether this therapeutic trial has been a small step forward or, to use Bollas' (1995) rephrasing of the Freudian repetition compulsion, another representation of grossly traumatic dissonant attunements continuously enacted throughout her adulthood with other people as her accomplices.

Postscript

While writing the discussion of this essay, I read Green's (1998) article concerning the work of the negative and Bion (1959). I was struck by phrases which seemed appropriate to this case and to my sense of inadequacy in the treatment.

"The neurotic, after the interpretation has been given by the analyst, has the capacity to recognize the truth lying behind it even if resistance opposes this insight. The psychotic will not recognize it, as if it was somebody else's possession, which means that he does not recognize himself in a state of alienation. (Green, A., 1998, p. 652)

The issue of being able, or not, to contain this split through the work of projective identification, and projective counter-identification, became painfully clear to me one day when the hard disk of my computer crashed, allowing me no access to the file where I kept this work. I realized with horror that I had not made any other back-up copies and that in fact I was facing the annihilation of all my written effort (I had very nearly finished most of the work). This was not at all typical of me and I had to pay a fair amount of money to gain access to the material. The following day after I succeeded in retrieving the draft for this work, three months after she left therapy, Tamar rang the clinic and asked to be accepted back for treatment.

A. Green (1998) ends his article with a Vedas tale dedicated to Bion about the forbidden copulation between the goddess of Speech and the god of Sacrifice which, if consummated, would give birth to an omnipotent monster. The other gods intervene and cause one of them to slip into the goddess' womb and at the time of conception kill the awesome creature, giving birth to itself instead, and, most importantly, also tearing out the goddess' womb, thus preventing the possibility of a future birth. A. Green (1998) describes this as:

"The contained ripped off the container. Could this be the absolute truth that we can never reach?"

(Green, A., 1998, p. 663)

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