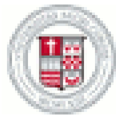

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CASE STUDY

A Case of "Loving Hate"

Michelle C. Loris

ABSTRACT. The case, "Loving Hate," clarifies the complicated dynamics of the eroticization of hate. These dynamics were forged for the adult sexual abuse survivor in the early abusive relationship where love was always accompanied by hate. In the therapeutic relationship, these dynamics are reenacted and experienced in the countertransference where the therapist feels the patient's unconscious pressure to turn this relationship into a kind of "hating mating." This case vignette is used to illustrate how the therapist's countertransference impasse impeded treatment. Explanation and analysis are offered in this case to suggest how by using the paradigm of Abuser, Victim, Bystander to understand countertransference reactions, the therapist might have offered more empathic responses to this patient and possibly circumvented the treatment impasse that ensued. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: getinfo@haworthpressinc.com]*

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INTRODUCTION

This case study describes the treatment impasse that developed from an eroticized transference-countertransference enactment with a patient who is an adult survivor of childhood sexual abuse. Because childhood sexual abuse or incest often fuses and confuses love and hate, affection and aggression, nurturance and eroticism for these patients, this childhood experience often emerges in the therapeutic relationship as an eroticized transference.

The following ideas help focus an understanding of the eroticized transference. In an enlightening paper discussing the eroticized maternal transference of an adult survivor of childhood sexual abuse, Saakvitne (1993) explained that early childhood incest confuses affectional needs with aggression and eroticism. The fusion of libidinal and aggressive wishes and internalized objects is recreated in the therapeutic transference where the wish for nurturance is often denied and given agency through aggressive or eroticized transformation, often with sadistic or masochistic overtones which then recreate the original trauma in which affectional needs were responded to with eroticized or aggressive behaviors by caretakers.

In an article describing a particularly malignant form of transference hate exhibited often by patients diagnosed with Borderline Personality Disorder, Gabbard (1991) explained that these patients are often identified with a cruel, sadistic, internal object. For such patients, attachment is concomitant with hatred. Gabbard (1996) explained that this malignant transference suggests a childhood pattern in which abusive figures have been in the role of caregivers. In fact, Gabbard (1996) reported that there is some empirical evidence which relates this pattern of malignant internal object relations and childhood abuse. Childhood abuse appears, then, to be one pathogenic pathway for the development of malignant hate which can then manifest itself in the therapeutic transference-countertransference (Gabbard, 1996).

Speaking to this point, Herman (1992) reported that in her investigations, 81% of patients diagnosed with Borderline Personality Disorder had histories of severe childhood trauma. Herman (1992) further explained that survivors of childhood sexual abuse are often misdiagnosed and that they are likely to receive a diagnosis of

Borderline Personality Disorder before the underlying problem of complex post-traumatic syndrome is recognized. Herman (1992) explained that these patients, usually women, who receive these diagnoses evoke unusually intense reactions in their caregivers: "Sometimes they are frankly hated" (Herman, 1992, p. 123). This transference-countertransference hate represents the confused love-hate internal world of the adult survivor of childhood abuse.

Davies and Frawley (1994) define this fused love-hate transference dynamic in adult survivors of childhood sexual abuse as a

> "malignant seduction" [which] is in essence an identification with the transgressing abusive . . . parent . . . reenacted in the transference-countertransference dyad. Its hallmarks are . . . relentless eroticized assaults, demands for actual gratification, and a countertransference response of needing to be ever vigilant to attempts at invasive transgressions of the therapeutic boundaries. (p. 232)

This malignant form of transference hate and the eroticized transference previously described by Saakvitne (1993), as well as the "malignant seduction" defined by Davies and Frawley (1994), can be further understood by Gabbard's (1991) explanation that "just as the eroticized transference may conceal enormous aggression towards the analyst, the hateful transference may conceal longings for love and acceptance" (p. 634). Bollas (1987) has coined the term "loving hate" (p. 118) to describe this fusion of love and hate. The present article presents a case study to illustrate Bollas' paradoxical term.

The case of M. explores the fusion of "loving hate" or what often, especially for adult survivors of childhood sexual abuse, may emerge in the therapeutic relationship as an eroticized transference-countertransference enactment. This case vignette also illustrates a lack of awareness of countertransference reactions, and shows that attempts at interpretation reveal what Gabbard (1991) describes as the therapist's "error to return the patient's projected self or object representation via interpretation. . . . Such patients are unable to integrate these self or object representations within themselves" (p. 631). Finally the analysis of this case intends to explain how the use of the object relations paradigm of Abuser, Victim, Non-Pro-

tecting Bystander/Uninvolved Mother (Davies & Frawley, 1994; Miller, 1994) might have avoided the therapeutic impasse and the therapeutic failure which ensued with this patient.

CASE STUDY

Demographics. M. is a 38-year-old white, Irish-Catholic, college-educated professional woman who came to therapy referred from another therapist. M. wanted a therapist who understood lesbian issues. At her first session, M. reported that she was having an affair with a woman who lived in another state and that she, M., was living these past 10 years with a female partner who was her partner in all ways but not romantically and sexually. M. stood about 5′5″ and was somewhat stocky. She wore her dark hair cut short, and she always wore pants, a shirt, sometimes a necktie, a blazer and various kinds of boots.

Family and social history. M. was the youngest of six children. One sister, the oldest of the six children, had left home at age 17 and never returned. M. never knew her father who had left the family before she was born. Her mother, now dead, had worked several jobs, and had been for M. the most important person in her life and "the only one I was ever in love with." M.'s mother had died of cancer 10 years earlier. M. described her brothers as "alcoholic motorcycle types" with whom she never associated. Growing up, M. did well in school, graduated college with a degree in engineering and worked in a managerial position at a local firm.

M. had never had a relationship with a man. Her first relationship with a woman, at age 18, lasted about a year. For the next 10 years, she had several two-to-three-year relationships with women. She described these relationships as "alcoholic, abusive, and violent." At about age 28, M. met L., the woman with whom she still lived. Throughout their 10 years, M. had been having several affairs but she described L. as the "stable anchor" in her life and as the woman who had "saved" her when her mother had died. At that time, M. had been in a very physically abusive relationship with a younger woman. It was around this time when her mother died and when this abusive relationship ended that M. was admitted inpatient to a local hospital for attempted suicide.

Psychiatric history. M.'s previous psychiatric history included this one inpatient admission for attempted suicide. She remained hospitalized for one month and refused medication. Following that hospitalization, she attended outpatient individual therapy with a female therapist for six months. In addition to her hospitalization and individual treatment, M. had been active in Alcoholics Anonymous, and in one brief couples therapy with L.

Presenting problem and course of treatment. M. attended individual, once-a-week therapy with the author for just over one year. At the first session, M. wanted to know if the therapist had experience with lesbian issues, alcoholics, and the 12-step program, and if she had a doctorate in psychology. The therapist answered all of her questions and asked M. about what had brought her to therapy.

M. discussed her then current situation which involved living with L. in a home that they both owned, and being involved in an affair with S. who lived in another state. M. described herself as someone who went to bed with someone first and asked questions later–when it was too late. The therapist observed during this first session that M. stared quite a bit at her and seemed to "posture" herself as they talked. The therapist began to feel somewhat uncomfortable at what she was experiencing as a subtle flirtation. Towards the end of that first session M. said "I have one last question to ask you. Are you flexible with your schedule and sessions?" An explanation was given about the importance of maintaining regularly scheduled, consistent sessions. M. responded, "So there's no room for flexibility." The therapist, feeling somewhat cornered, asked M. what she meant by flexible. She said, "Well, I am really in a hurry to do this therapeutic work and I work better with bigger blocks of time, so I'm wondering if we could, say, meet for lunch Sunday afternoon and just spend the afternoon talking?" The therapist was surprised and hesitated momentarily. M. quickly interjected, "Oh, I see you're the constricted, strictly-by-the-book kind of therapist with no room for invention or flexibility."

Feeling defensive, the therapist said that she was indeed surprised by M.'s request. The therapist then attempted to explain the boundaries of the therapeutic relationship. M. responded by saying she would see how it went with someone who could "only follow the book." An appointment was then made for the following week.

M.'s attempts to invite the therapist to lunch or go for a ride "to spend longer periods of time on her therapy to accelerate the process" continued intermittently throughout the therapy and were responded to by continued efforts to hold and explore the boundaries. Most important, several attempts were made to get M. to discuss what this request was really about. But she refused to enter into this discussion. Also of note during the therapy, M. responded strongly and somewhat negatively the two times the therapist wore wool slacks, a sweater, and a blazer to the sessions. M. commented that she was surprised to see the therapist dressed so casually and that these clothes did not suit the therapist the way skirts did. She also commented when the therapist wore her hair pulled back saying that the therapist looked "severe" and that her hair down looked "softer and more feminine." The therapist tried to engage M. in conversation about such comments and to interpret these projections but M. always refused. A few times M. stated, "I'm not in your textbook so you'll have to work hard to figure me out."

Also, during the course of the therapy, M. reluctantly, in piecemeal fashion and with great resistance, related a history of childhood physical and sexual abuse perpetrated by two of her mother's boyfriends, her brothers and her brothers' friends. The abuse began when she was two (her first abuser was her mother's boyfriend) and it continued to age 14 when a brother's friend raped her. And, although M. had read enough popular books on therapy and childhood abuse, her consistent stance was not to talk about or think about her past. She insisted that she had done well (she had) and that she could go forward without doing trauma work.

Some of the therapy also focused on interpersonal issues between her and her boss, and between M. and the staff that she supervised. But much of the therapy focused on her affair with the other woman and her relationship with L., the woman with whom she lived. By around eight to nine months into the therapy, M. was terminating the affair with S. At about that time, M. came to the session with a kind of grin on her face. She said that the session was special and that she wanted to tell the therapist something.

M. reported that she had broken off the affair and that she wanted the therapist to know that she was now in love with someone else.

The therapist was not surprised to hear this declaration because she had been noticing M.'s waning interest in the woman, and she wasn't surprised that she already had an overlapping relationship, but no other name had been mentioned in therapy to date. The therapist asked about this new person. M. said that the woman was intelligent and attractive but shy and frightened to be herself. The therapist asked her how she had met this person and how was it that she had never mentioned that she had met someone new. M. smiled, then she grinned, and then she stared and looked somewhat angry. Finally she said: "You don't know who I'm even talking about, do you? That figures. You don't know anything about feelings. All you know is what the book tells you. Well, the book won't tell you that I'm in love with you."

The therapist felt taken off-guard by the patient's declaration. The remainder of the session was spent trying to get M. to discuss her feelings and what this attraction was all about. Attempts to interpret the meaning of the transference to M. were futile and wrong headed. By the end of the session no progress had been made except to alienate the client.

When M. returned the following week she was angry, "not in a mood for talking" and ready to quit therapy. The therapist said that it was important to discuss why M. felt it was time to stop treatment. M. said that the last week's session was a big eye opener for her. She professed her love and complained that the therapist did not understand her. The therapist responded, "Your feelings are important for us to discuss." M. quickly and angrily cut off the therapist's remarks and said that this discussion would relegate her feelings to a clinical matter, but that indeed her feelings were not a transference or a clinical issue. She said that the therapist could not really understand her. The session ended in an impasse. M. canceled the following two sessions and came in for the next session. The following text is a record of that session.

Text

TH: So, what's going on . . .

PT: (Smiles) Nothing . . . nothing . . .

TH: Mmmmm . . . (Silence) . . .

PT: Well, I guess I better get it over with and say this now. I was going to save it till the end.

TH: What is it?

PT: I've decided to stop coming here . . . or just come every other week . . . to put some distance here . . . That's it.

TH: I see. Well, this is quite an important decision . . . to put distance between us . . . Sounds like we need to talk about what this is all about.

PT: No! We don't need to talk about it! I've made up my mind! There's nothing to talk about! You know why! And we don't see eye to eye; that's it! (Very volatile, disputatious)

TH: I know why?

PT: Don't pretend you don't know–

TH: I want to be sure I understand.

PT: What's to understand? It's the same as I've been saying. It's about us.

TH: Us? Oh. You mean because of your feelings for me. You feel that your attraction to me is the reason you need to leave therapy or put some distance between us, instead of working that out here with me.

PT: No! That's not what I mean!

TH: Well, then, maybe you could explain it to me more so that I can understand it better.

PT: What's the use of explaining it? We don't see it the same way. You see it as "Working it out." You hide behind your white coat, with your clinical bullshit so you can hide behind your wall. And I know it's not like that.

TH: What do you mean "My white coat and clinical bullshit?"

PT: You know what I mean . . . whatever you call it . . . your jargon . . . transference . . . You think it's that and I don't. I know I'm in love with you and have been since the start.

TH: As I've said before, your feelings *are* very important *and* real. That's why it's important for us to deal with them here in therapy.

PT: Bullshit! I'm not going to . . . what you call "work out my feelings." How I feel for you is not about "working it out" or about "transference." You hide because you're afraid. I understand that. At first I didn't. I thought you were just cold and distant. But then I realized that the real you hides behind her white coat. I understand. You're just a virgin. You've never had anyone like me before. So, I understand.

TH: So, I'm a virgin . . . What's that like for you . . .

PT: (Smiles) I don't mind teaching you. But I have had to do all the work by myself. You gave me the message from the get-go: "You're on your own, Don't lean on me. If you need a railing to lean on, it's not me." Fine, I learned to be strong on my own. That actually helped me a lot.

TH: So you must be pretty angry at me if you're feeling that I've not been able to be there for you.

PT: Angry? No. I'm not angry. I don't care. And you can't be there for me. You won't be, anyway, because you're too busy hiding behind your white coat . . . You march around guarding those boundaries so goddamn much, I've got calluses on my feet.

TH: So, my minding the boundaries is a way of saying "You can't count on me" or "I don't care about you." It makes you feel as if we can't be close.

PT: Well, you said it, not me. But go ahead . . . It's what you need to do to keep yourself safe. So go ahead. I can take the door slamming in my face.

TH: So every time I mind the boundary it feels as if I'm slamming a door and rejecting you.

PT: They're your boundaries, not mine.

TH: It must be terrifying to have someone try to keep you safe.

PT: Bullshit! Bullshit! That's why I'm getting out of here! You can't keep me safe. Nothing is ever safe. You're the one who is afraid, not me. You're the one who needs the boundaries. Not me. For me, there's nothing unsafe about having lunch . . . or even dinner with you . . . or giving you gifts. I know how I feel and how I feel means I have to get some distance. That's it. I'm not changing my mind.

TH: I understand how frightening these feelings must be . . .

PT: I don't feel afraid! I just told you. You're the one who is afraid. Not me.

TH: I see. I wonder if it ever feels confusing . . .

PT: What do you mean confusing?

TH: Well, I was wondering . . . you know . . . You've had people violate your boundaries and hurt you and tell you it was love and . . .

PT: Just stop right there. This has nothing to do with my past! I knew you were going to pull that. Well, I'm not listening to it. I told you I just need to put distance between us . . . (begins to gather coat to leave; session is not over yet). I've decided. There's nothing to talk about (begins to move forward to get up and leave).

TH: I understand how overwhelming these feelings are . . . (she sits back, still holding coat) . . . I do understand that it feels like maybe you won't have all of yourself if you stay here . . . (stares at me, still holding coat) . . . And while I encourage you to stay, I understand that you may need to leave or put some space . . . to put distance . . . I understand. I just want you to know that I am not leaving. I'll be here, right here for you . . .

PT: (Sits back; stays for remainder of session, but insists on coming every other week and leaves therapy within the next two months.)

ANALYSIS

The preceding text illustrates a treatment impasse, and finally, a treatment failure, because of countertransference turmoil. The countertransference turmoil included both the patient's projective identification as well as introjective identification which resonated the therapist's own internal object world. During this session the therapist had not been able to contain (i.e., tolerate, identify, analyze and reflect upon) her reactions to M., and M.'s self and object representations which were being played out in the treatment. The example here shows that M. has split off the "virgin/victim/vulnerable" part of herself which she had projected on to the therapist.

An analysis from the literature helps to explain the underlying dynamics that emerged in this interaction and that contributed to the impasse that ensued. Following this analysis will be an explanation of how using the paradigm of Abuser, Victim, and Bystander might have provided possible empathic responses to offer to the patient in order to facilitate treatment.

Herman (1992) stated that the eroticized transference-countertransference is one of the most complex dynamics to occur with adult survivors in the therapeutic relationship. Herman (1992) also explained that the reenactment with the perpetrator is most evident in this transference where the patient may even demand gratification in the sexualized dynamic. In this enactment, the patient takes on the role of sadistic abuser and places the therapist in the role of victim or bystander. In this interaction with the patient, M. became the Abuser and the therapist took on the role of Victim and Non-Protecting Bystander.

Saakvitne (1993) explained that this transference-countertransference reflects a projection of the patient's hatred for her own vulnerable self which the patient projects onto the therapist whom she abuses. M.'s love for the therapist which was fused with her aggressive drive to violate the boundaries of the therapeutic relationship reflects M.'s childhood sexual abuse wherein, as Saakvitne (1993) explained, "the fusion and confusion of wishes for nurturance with arousal and violation" occurred. The patient's need to be "male identified" is tied to the "experience of . . . associating femaleness with vulnerability or a victimized female child with

little power" (Saakvitne, 1993, p. 5). Here, too, M.'s "male stance" places her in the role of Abuser and attempts to place the therapist in the "female" role of Victim.

Saakvitne (1993) also explained that the countertransference responses to this eroticized maternal transference are informed by the taboos inherent in the transference, by the intense affects and defenses in the therapeutic relationship, and by the therapist's conflicts about gender and sex. The therapist's countertransference turmoil reflects some of these issues raised by Saakvitne (1993). First, the taboo inherent in the transference triggered the need to emphasize the boundaries of the relationship. But, as Saakvitne (1993) explained, by focusing on the erotic aspect of the relationship and by emphasizing boundaries in the therapeutic relationship, the therapist can shut off the transference and reinforce a patient's experience of herself as unmotherable and unlovable.

Second, the intensity of M.'s affects drove the therapist back into her own intellectual defenses, and toward a desire or need to distance from M. M.'s volatile rage and contempt probably frightened and angered the therapist. M.'s seductive overtures may have evoked guilt and confusion. Her attempts to belittle the therapist's competence as a therapist also evoked a subsequent need to be a perfect protector while at the same time they provoked feelings of failure. As already stated, M.'s "male-identified" posture and her projection onto the therapist as the victim/virgin may certainly have collided with the therapist's own gender issues and experience of the female as powerless. In all, the therapist retreated from the fear, frustration, anger and hate behind an intellectualizing and rationalizing defense.

What might have facilitated treatment with this patient would have been a therapeutic stance that oscillated between both a concordant and a complementary identification. Tansey and Burke (1989) explained that such an identification is appropriate as illustrated by the masochistic [victim] patient who assumes the sadistic [abuser] role while the therapist's temporary masochistic identification, awakened by the pressure of the therapeutic interaction, is both complementary with the patient's immediate sadistic self-representation and concordant with the patient's long-standing experience of self as victim.

To summarize, then, M.'s projection placed her in the role of the aggressive Abuser and the therapist in the role of the Victim. Her projection of virgin collided with the therapist's need to defend her own internal, vulnerable "female" self. The therapist's defense was to intellectualize and distance ("well, maybe you could explain it more so I can understand it better" or "what do you mean . . . ") rather than to offer empathic responses. These distancing and defensive responses place the therapist in the role of the Non-Protecting Bystander/Uninvolved Mother. Indeed M. is correct when she says "I had to do all the work by myself."

Appropriate Empathic Response in Therapy

An immediate concordant empathic response might have let M. know that the therapist could contain all her feelings: "Tell me all about your feelings." Other empathic responses might have included statements like: "I understand how overwhelming (or overpowering) these feelings are for you. Could you tell me more? Could we talk more about these feelings? I want to know how you feel." Or, "It must be frustrating to be in a relationship where you cannot get your needs met. Can we talk about that?" These responses offer her the possibility of an empathic concordant container where she can pour out all her feelings of love, lust, power, fear, rage, or hate.

Empathic responses might also have been offered from a complementary role. That is, since her aggressive and sexualized posture placed the therapist in the role of either Victim or Non-Protecting Bystander, instead of the therapist projecting her fear, anger, and hate back onto M., empathic responses might include the therapist acknowledging her experience of frustration, confusion, and helplessness to M.: "Yes, sometimes I do feel somewhat frustrated, helpless, even angry when I feel that I can't both protect our boundaries and keep us close." Or, another version of that same experience: "Yes, sometimes I don't know what to say to let you know that I want us to be both close and safe within our boundaries."

A more direct empathic expression of countertransference hate from both a complementary and a concordant position might have been: "I do hate it when I feel like a trapped and helpless virgin/victim. I wonder if you ever felt this way when you were abused as a

child." Distancing from and defending against M.'s sexualized aggression was an acting out of countertransference rage or even hate, rather than processing and using that emotion to provide an empathic understanding of the patient.

It is with this type of eroticized transference that often the therapist's most negative countertransference reactions, even countertransference hate of the patient, can become empathic. To be empathic, however, the therapist must know the patient's experience, and if that experience is hatred, the therapist must allow her/himself to feel from within that experience of the patient's hatred. First, if in a complementary identification, the therapist experiences the abuser's hatred, then the therapist has first-hand knowledge of the hatred that the patient received and internalized as a child victim. From this position, the therapist can also infer the feelings of hate the child may have felt, in turn, as the object of hatred. Second, if, in the concordant-complementary identification, the patient abuses the therapist, the therapist feels the experience of the abused child. It is this attunement to the patient's internal experience that determines the empathic position, and it is from this position that the therapist can respond empathically to the patient.

Countertransference hate is a disturbing, albeit necessary part of the treatment of adult survivors of childhood sexual abuse. Yet, through the careful exploration of those hate feelings in the countertransference, the therapist can gain a greater empathic understanding of the patient's internal world and early abuse experiences. However, being unable to contain and analyze the countertransference reactions led the therapist to interpretation instead of empathy, which turned out to be a therapeutic error.

M.'s transference fused and confused love with hate, as is often the case with patients in this kind of transference. The longings for the analyst are not viewed as feelings to be analyzed. On the contrary, they form the basis of a demand for gratification with the expectation that the therapist should reciprocate instead of interpret (Gabbard, 1991). With such patients, interpretation, too soon, impairs treatment. As Saakvitne (1993) discussed, the therapist can miss the developmental need these patients have for an idealized object. Also, as Saakvitne (1993) explained it, this transference forces the therapist to understand the event of childhood sexual

abuse, and its context and developmental implications. Davies and Frawley (1994) explained that it is all too common, and unfortunate, that in this transference-countertransference dynamic the therapist "identifies the patient to the demands of the sadistic introject, thus assuming a sadistically withholding retaliatory and overly interpretive stance" (p. 233).

Further, it is essential to keep in mind that these patients, because of childhood sexual abuse, depend upon having a libidinal object to attack (Gabbard, 1991). Premature interpretation forces this projected hated introject back onto the patient who is unable to integrate these self and object representations within herself. Winnicott (1949) explained that these patients could only learn to tolerate their own hate if the therapist could tolerate or hold that hate within him or herself in the therapeutic relationship. As Winnicott further explained, one cannot reach a state of love if one has not also been able to hate.

As a defense against M.'s "loving hate," the therapist offered interpretation rather than the understanding of empathy. Unable to contain and empathize with the experience of M.'s hate, the therapist failed to gain and hold her love. In this example, countertransference turmoil ended in a treatment failure.

CONCLUSION

Patients like M., because of the childhood experience of sexual abuse, often bring to the therapeutic relationship the intense, complex, and difficult-to-manage eroticized transference which fuses and confuses love with hate, nurturance with eroticism, longing and dependency with aggression and violation which these patients have experienced and internalized in the childhood relationship of sexual abuse. These patients have grown up in an abusive relational context where the only way they could feel alive and connected was in a passionate negative relationship with that caretaker. The childhood experience emerges in this patient's transference within the therapeutic relationship. In turn, the therapist's countertransference, triggered by such intense affects and complex dynamics, will itself fuse and confuse strong reactions of fear, guilt, shame, or even hate. In these countertransference reactions the therapist will often rapid-

ly take on the various concordant and complementary roles of Abuser, Victimizer, and Non-Protecting Bystander/Uninvolved Mother with this patient. It is through the careful containment and analysis of these countertransference reactions and roles that the therapist can gain a deeper understanding of the patient's internal world and early abuse experience, and thereby offer the patient empathic responses that may facilitate treatment.

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