Technical Approaches to Transference Hate in the Analysis of Borderline Patients

Glen O. Gabbard

It does not matter much what a man hates provided he hates something, Samuel Butler

Freud (1915) once noted that the only truly significant obstacles likely to be encountered by the analyst are those involving the transference. Among the panoply of transference feelings directed at the analyst, intense hatred is perhaps the most difficult to endure. Analysts may be drawn to the field, at least in part, because the practice of analysis itself serves as a reaction formation against hatred, aggression, and sadism (McLaughlin, 1961; Menninger, 1957; Schafer, 1954). The experience of being hated day in and day out tends to erode one's carefully constructed defenses against hating one's patient. Moreover, the analyst's conscious altruistic wishes to help others are also thwarted by the hateful patient, occasionally leading the analyst to question whether the whole analytic endeavor in this particular instance is a waste of time and energy.

Transference hate, of course, is not a monolithic entity. It varies greatly in intensity, depending on the ego strength and internal object relations of the patient and on the phase of the analysis. An analogy may be drawn to Blatts (1973) distinction between erotic and erotized transference. Erotic transference is experienced as an ego-dystonic and perhaps shameful feeling of desire for the analyst, the gratification of which is viewed as unrealistic. In the erotized variety of transference, the patient's observing ego is nowhere in evidence. The longings for the analyst are not viewed as feelings to be analysed. On the contrary, they form the basis of an ego-syntonic demand for gratification of the wishes with the expectation that the analyst should reciprocate instead of interpret. (M.S. received April 1990)


HATE IN THE TRANSFERRENCE

The role of the aggressive drive is central to both rage and hatred, but the latter can be differentiated from the former by the fact that it requires an internal object-representation (Gabbard, 1987; 1989a). Whereas rage may be directed against any external object in the environment that is frustrating, hatred is much more specific. To hate is to hold on to an internal object in an unflagging way. There is no getting beyond the wish for vengeance, the wish to destroy the object. As Goldstein (1987) noted: 'The patient cannot get over it alone because hatred binds him to an object from the past in the grip of an ancient grudge that requires transference for its release' (p. 375). The analyst will soon be cast in the role of the one who has wronged the patient, and the patient's only hope of moving beyond bitterness and resentment is to resolve the feelings in the arena of the transference.

Gabbard (1987) points out that object constancy is a necessary developmental achievement for one to be able to hate safely. While this may indeed be true for the neurotically organized patient, the borderline patient, by definition, has not been able to integrate the loving and hateful representations of others into an ambivalently viewed whole object. In fact, there is a subtype of chronically hateful borderline patient under consideration here, who has established a dominant part-object relationship between a hated object-representation and a hating self-representation (Gabbard, 1989a). These patients often seem to be consumed with venenous contempt because the good, loving aspects of the self and the corresponding object-representations are buried deep within to prevent their destruction by the all-consuming hate. Alternatively, they may be projected into figures in their environment who are regarded as entirely good or totally loving (Boser, 1983; Giovuchich, 1975; Hamilton, 1986; Klein, 1946; Nearer, 1958). In this manner the lands of love and concern for others are further protected by safely storing them in others. This strategy may well backfire, however, because the perception that others are so saintly may produce profound envy. This development may lead the patient to project devalued and hated self-and-object-representations as a way of 'smeared' the saintly figure with undesirable aspects of the patient's internal world (Poggi & Gazzarri, 1983).

These patients appear to be stuck in the paranoid-schizoid position (Klein, 1946), where there is no mediating subject to make sense out of experience. This state of affairs creates extraordinary difficulties for the analyst because there has been a collapse of the potential space (Winnicott, 1971), or ‘analytic space’ (Ogden, 1986), so crucial for a therapeutic alliance with the analyst. In these patients, the transference hate is of the malignant variety because it lacks the ‘stand-in’ or ‘as-if’ quality typical of neurotic patients. The analyst is not viewed as a current-day repetition of a past figure based on projective processes, but rather is seen as the original object of hate. The ability to take reflective distance from experience as a result of a shift into the depressive position is an infrequently glimpsed event. Because of the inability to differentiate the perception of the analyst from the reality of the analyst, these transferences have been regarded as delusional or psychotic (Little, 1958).

One of the true paradoxes characterizing these patients is that they repeatedly seek out treatment despite their thorough dissatisfaction with each treating. They often jump from analyst to analyst only to terminate prematurely each time with feelings of disappointment and resentment. They seem to seek out treatment because the very core of their being depends on having a lifelike relationship to attack (Rosenfeld, 1987). Kernberg (1984) noted that patients such as these, who are part of a larger group prone to negative therapeutic reactions, are often identified with a cruel sadistic internal object that can only give some semblance of love if it is accompanied by hatred and suffering. In other words, attachment always must come at the expense of hatred. The alternative is a state of non-existence.

It is helpful for analysts who are treating hateful patients to remind themselves periodically of the developmental value of hate. As Winnicott (1949) was fond of noting, love and hate are the yin and yang of early infantile experience. One cannot exist without the other. One is unable to reach a state of love if one has not also been able to hate. In addition, several authors (Rosenfeld, 1976, (Little, 1966; Pas, 1965) have observed that hate serves the function of organizing the ego. It may fend off feelings of disintegration. It may provide a reason to live and a sense of continuity from day to day.

The origin of the dominant part-object relationship may be in excessive frustration with parental figures, in an unusually aggressive constitutional temperament, or in a combination of both. Whatever the origins, however, once the constellation is firmly entrenched within the patient, the clinician will encounter enormous resistance to changing it. These patients with severe ego weaknesses will engage in a multiplicity of acting-out behaviors, including various forms of self-mutilation, bunt, and substance abuse, to name a few, and will often require psychotropic treatment in the context of extended hospitalization (Gabbard, 1989a). Those endowed with more durable egos may be amenable to analysis but will present formidable obstacles to the analyst.
CASE EXAMPLE

The technical challenges presented by these patients are best illustrated with clinical material drawn from several sessions stretched out over a period of years. Mr H, a 28-year-old divorced man, came to analysis after an abortive two-year attempt with another analyst. That treatment experience ended with the analyst's move to another city. (I often wondered if that were the analyst's way of extricating himself from the unpleasant experience of spending an hour a day with Mr H.) The most startling aspect of the opening phase of the analysis was the rapidity with which the transference hate and the conviction expressed by the patient that his perceptions were absolutely accurate. My overwhelming impression was of being fiercely accussed. I was, of course, accustomed to being the target of negative transference, but rarely of this intensity so early in the process. I took flight from the daily barrages by retreating into diagnostic speculation: 'Obviously a borderline feature,' I would think to myself.

His contempt was thoroughly justified, in his view, because of the structure of the analytic situation, which he perceived as unreasonable and inflexible. Mr H presented my fee, and he unabashedly expressed his feeling that he deserved to be treated for free. One comment he made in the first few weeks of the analysis, in response to my observation that he was verbally assaultive, nicely captured his point of view:

'I know you think I'm assaultive, but it's because of the way you treat me. You charge me, you even bill me when I choose to take vacations, you don't give me answers to any of my questions, and you rigidly enforce the end of the hour even if I'm in the middle of a thought. I see you as assaultive, so I react with hostility.'

All his feelings were the direct result of how I treated him, as though he had no role in recreating an object relationship from his past. His partially developed self had no sense of active agency connected with it—no sense of 'Iness' (Ogden, 1986). He was simply buffeted by malevolent forces in his environment. One of the most striking features during the early weeks of the analytic process was the absence of anger (or any other feelings, for that matter) directed towards his previous analyst. Working from the assumption that much of the venom directed towards me was a displacement and actually belonged with the memory of his last analyst, I occasionally would interpret this connection to him. He always reacted to my interpretations with scorn, suggesting that I was trying to 'pass the buck' to someone else for my own failings. In his own way, Mr H may have been tuning in to an attempt on my part to sidestep the heat of the transference by deflecting it elsewhere. When I was confronted with the absence of analytic space, with no gateway to forging a viable working relationship with the patient, I was tempted to develop an alliance by encouraging him to direct his wrath elsewhere. When H had succeeded, I could then have empathized with his hatred towards someone else and, in so doing, attempt to form an alliance around the shared anger towards an 'outside enemy.'

When, on occasion, I was not regarded as the hated internal object, I would become idealized. This turn of events, however, led him to hate me all the more because of the emergence of his envy:

'I see all your books on these shelves, and I feel a sense of loathing towards you. I could never read that many books. I can't ever hope to have the amount of knowledge that you have. I feel like getting up and tearing down all your book shelves.'

As the patient railed against me, he would often lightly pound his fist on the wall adjacent to the couch. He would exorcise some control over the pounding so that it would stop just short of being a disturbance to the occupant of the office next to mine. I could never be certain, however, and his behaviour placed me in a disturbing dilemma. Did nothing about the pounding, was I colluding with his 'acting it' by allowing him to disturb my neighbour? If, on the other hand, I told him to stop the pounding, was I allowing myself to be manipulated by him into a non-analytic position where he then could rightly see me as attempting to control him? He would also set up other situations which created the feeling that I was diagram'd if I did and damned if I didn't. He would begin a session by asking if I would let him know when the session was half over because he had to leave early. When I pointed out to him that he was wearing a watch and would know when the time was up himself, he would become furious at me for refusing to help him.

Most of all, he would repeatedly try to manoeuvre me into a corner where I would unwittingly or unwittingly imply that I did indeed hate him. The barrage of contempt day in and day out took its toll on me, and I was not always able to contain adequately the patient's projected contents. I would occasionally make sarcastic, contemptuous, or countermanticking comments as I sought to survive in the lion's den that he had created in my office. On one particular day he was accusing me of not empathizing with his point of view. Responding by saying, 'You treat me with contempt and then expect me to empathize with you,' I wondered if this was part of a larger pattern of expecting others to love you and take your side without earning their regard? The patient responded with glee: 'So you do hate me. I knew I could get you to admit it.' On another occasion the following exchange occurred:

Patient: I don't understand why you give me no credit whatsoever for being able to hate you. Don't I get two points for expressing my anger?

Analyzer: What do you see as positive about that?

Patient: Because all my life I've suppressed my anger. Now I'm finally getting it off my chest.

Analyzer: You're speaking of a side of you that I have not seen. All I have seen is unrelenting hostility.

Patient: Then you must hate me! You can't handle me! I'm too tough! I get a thrill out of triumphing over you and being the only patient of yours that will not get better, that won't change in the way that you want me to.

Mr H, of course, had made a couple of good points. At times I felt I could not handle him, and at times I certainly did hate him. One of the most distressing aspects of the analysis was that Mr H appeared completely uninterested in receiving help from me. He confirmed the accuracy of this observation when I pointed out to him that he repeatedly defeated any effort on my part to help him understand himself. His response was explosive:

'I don't fucking want your help! I want you as a target! I attempt to provoke you! I have a fantasy of throwing up on your floor or sitting on your couch. I want to rid myself of all this. I hate it when I can't provoke you into taking my anger. Then I have to take it. I need a place to dump. I've been using you like a pay toilet.'

This outburst helped me to understand how Mr H conceptualized the analytic process. It was indeed a toilet. It was a place where he could evacuate the bad aspects of himself and his tormenting and hated internal objects. From his point of view, projection of these mental contents was a superior option to any other alternative. His behaviour in the hours made me feel coerced into accepting the role of the hated object that hated him back. I resolved to numerous defensive manoeuvres to avoid the role. At times I would withdraw and become more aloof, attempting to retreat into defensive isolation where I would be impervious to his attacks. At other times I would attempt to empathize with his need to hate as his way to survive emotionally. In still other instances I would shoo up my occupational reaction formation by attempting to feel loving concern for the poor wretch. When I would shift into this mode, Mr H would invariably experience me as less than genuine, not to mention patronizing.

My countermanticking loathing of Mr H reached a peak when I had a thorny scheduling problem, and I asked him if he could change the hour he saw me on Wednesdays. He replied that while he probably could switch the hour to accommodate my wish, he was choosing not to do so. He said that it was important: for him to assert his own rights rather than to allow others to 'walk over me.' He went on to say that it gave him tremendous pleasure to know that he could control me rather than having me always do the one in charge. His refusal to cooperate left me with resentment. I dreaded having to see him day after day, and I found myself wishing that he would quit. I even caught myself day-dreaming about what I might do to make him decide to quit.

As fate would have it, I was fortunate to begin a much needed two-week vacation at this point in the analysis. As the vacation neared its completion, I found myself dreading my return to work because I would have to face the unpleasant experience of a 90-minute hour with Mr H each day. On the night before I returned, I had the following dream:
Mr H and I were in an analytic session. I was growing increasingly anxious as Mr H continued to pound the wall next to the couch with ever-increasing intensity. Quite unexpectedly, he turned around and looked at me and then stood up from the couch and stared down at me with a defiant grinn. I felt frantic that I was unable to control him, and I unleashed my pent-up fury in the form of a lecture shouted at the top of my lungs: 'Analysis is for people who can control their impulses and channel them into words. If you can't do that here, if you can't cooperate with what I am trying to do, you should not be in analysis'.

End of dream.

In my associations to the dream, I thought of the many times during the sessions where Mr H would pound on the wall. I had often wanted to say just those words to him. The dream helped me to understand why I had not. For me to assert the customary expectations of the analytic setting carried with it a risk. Clearly, my unconscious concern was that my intense hatred of Mr H and my sadistic wishes to control him so evident in the dream would show through my efforts to clarify the nature of our task. I realized that my guilt related to these feelings was leading me to feel disempowered as an analyst. In this context I suddenly understood the meaning of my proposal of the hour change on Wednesdays as an option rather than as a decision that had already been made and with which he was expected to comply. At an unconscious level, the ordinary power and control inherent in the analytic role was equated with omnipotent control driven by enormous aggression. Hence, my presenting the change as a choice could be understood as a reaction formation against these powerful wishes within me.

Another insight gleaned from the dream was that the patient had been serving as a receptacle for that part of me that desperately needed to control him. I could disavow that part of me by thinking that it was Mr H who was driven by the wish to control—not me. My self-analytic work with the dream brought me in touch with the fact that my analytic 'work ego' (Fleming, 1961) was being eroded by the intensity of the patient's projections. I was starting to share his propensity to view action—not understanding—as the solution.

When we resumed the analysis after the break, it was clear that the break had done us both some good. The patient began by commenting that he had been worried ever since the end of our last session. 'I was afraid it would push you into a breakdown where you would destroy furniture and attack me. I try to beat you to take on my characteristics. I hate it when you're calm. Then I have to take it back in me. I feel like I want to explode. I want to rip up your office. If I can't be your best patient, maybe I can be your worst. But I'm afraid that I'll drive you crazy'.

I had seen occasional glimpses of movement into an analytic space where the capacity for self-observation was present, but always in the context of extra-analytic relationships where he feared that he would harm someone on whom he depended. I took advantage of this opening up of analytic space and made an interpretation: 'The feelings you have inside are unbearable, but if you dump them into me, you fear that you will get well at the expense of my going crazy. This worries you, because after all, feelings of hate are not the only feelings you have. The patient responded to my interpretation

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by making the following observation: 'If I don't hate you, I feel like a primordial soup that is waiting to be pulled together. I have no identity. I want you to care for me. I have a preference of being independent and self-sufficient, but underneath I'm incredibly dependent and needy. I don't feel comfortable having anyone take care of me. I feel diffuse, amorphous, like an amoeba. I feel like being narcistic with others when I start to feel uncomfortably close'.

Changes had occurred on both sides of the analytic-patient dyad. I had recognized my own countertransference need to take action to control an analytic situation that was getting out of hand. In part, I was responding to a projective identification of the patient, but I was also reacting to my own anxiety in the face of a situation where I had very little control and where I felt de-skilled as an analyst because of my guilt related to my feelings of hate. On the patient's side of the dyad, a reasserted object relationship involving a concerned self-representation (with the capacity to love) and a loved object-representation (with the capacity to be hurt) had surfaced. It is possible that the patient's perception of my anger and hatred at his refusal to change the appointment time prompted the emergence of the other side of him, accompanied by depressive anxieties as the hating and loving sides of him were juxtaposed. He was also able to acknowledge the organizing effect of hate on his own sense of identity. In its absence, he felt amorphous. My interpretive effort to connect the split-off aspects of himself further enhanced his capacity to look at himself in a way that lay beneath the hate.

As the analysis proceeded, the patient continued to operate predominantly in a paranoid-split-schematized mode. However, with each foray into depressive concerns, there was usually an associated opening of analytic space. At these moments, I would make interpretative connections for the patient that he could use to further his developing reflectiveness. When the time was right, for example, I was able to interpret that his reluctance to change the hour was connected with his fear that I would replace him with someone else. I suggested to him that he had therefore been hurt by my proposal of a schedule change. He responded with a fearful observation that he'd never heard me acknowledge his proneness to feel hurt. He went on to say that no one had recognized his pain in the past. Building on my observation that he feared being replaced, he told me that his worst fear was that after termination, I would not remember him. He imagined that he would call me on the phone many years after the analysis and I would not know who he was. This confession provided an opening for me to interpret the role of hate in maintaining connectedness and avoiding abandonment. As long as he continued to hate me, he knew that I would not see him as ready for termination.

The opening of analytic space in the process also allowed the patient to bring in genetic material that he had scrupulously avoided throughout the analysis. He spoke of his rage at his father for leaving him and his mother when the patient was only 2. He spoke of a wish to take revenge against his father and also the fear that he had driven him off with his hatred. He was soon able to link his attempts to coerce me into controlling him with an earlier wish that a father had been present to control his powerful oral-sexual longings towards his mother. He also had a firm conviction that his mother was indifferent to him. He recalled numerous instances where he would act up in the household as a way of trying to evoke a response from his mother. As an adolescent he would come home drunk at night and wake his mother up to be sure she was aware of his drinking. He felt that even such drastic efforts were often unsuccessful, and he went through life behaving in such a way that others could not avoid being affected by him.

At the time of his successful termination, the patient experienced a resurgence of hate towards me because I would not stop him from terminating. The only way he could experience coming from others, he realized, was through their efforts to control him. If I did not stop him from terminating, I obviously did not care about him. He came to see that his hatred served to mask feelings of grief at the prospect of losing me. He made numerous reparative efforts during the last months of the analysis, letting me know that he had been embarrassed about the things he had said to me and about the way he had treated me. He was also able to let me know that the analysis had allowed him to grow up and experience gratitude in addition to hatred.

**DISCUSSION**

In my work with Mr H, I often thought of a piece of advice I had once heard regarding what to do when one encounters an angry grizzly bear in the wilderness. According to wilderness lore, one should neither charge the bear in a counterattacking posture that is designed to drive him off nor run away from the bear out of fear. If one simply stands one's ground, the bear will usually drop his threat of attack and go elsewhere. While I have so far had the good fortune to avoid any situation in which I would have to test out the soundness of that advice, it seems to me that one can think about the technical problems of handling transference hate in an analogous way. One must yield neither to the temptation to counter-attack nor to the urge to withdraw and retreat into aloof disengagement. Rather, one must be a durable object that holds one's ground and attempts to contain and understand that which is being projected.

This strategy is difficult to sustain because our powerful, natural, impel one to action rather than reflection (Heilman, 1950). The action choices may include the use of interpretation as a weapon of counter-attack—an attempt to put the patient in his place or suppress his hostility. These interpretations are also frequently an attempt to undo the hateful self-object-representation projected into the analyst. However, it is usually an error of technique to return the projected parts of the patient prematurely via interpretation (Cargy, 1989); (Epstein, 1977); (1979); (Grothius, 1982); (Ogden, 1982); (Rosenfeld, 1987); (Sees, 1986); (Sherby, 1989). As in the case of Mr H, the patient needs to keep the hateful-object-self-representation in the analyst because he is unable to integrate it within himself. Moreover, if the analyst cannot tolerate the transference role to which he has been assigned because of the unpleasant nature of the projected introject, how can he expect the patient to tolerate it? Sees (1986) warned that when the analyst tries to force the introject back into the patient through premature interpretation, there is an implied denial of any basis in reality for the patient's transference perception of the analyst. As it is though the analyst is saying to the patient: 'Hate resides only in you, not in me'.

There are other compelling reasons to avoid premature interpretation of projected aspects of the patient. Unless the analyst has sat with the projected material and subjected it to the met abolizing, deontologizing process of containment (Bion, 1962), the analyst will be returning it in the same form in which it was delivered. In its most extreme form, this variant of
countertransference acting out may be as dramatic as the case of the young therapist described by Alschul (1979), who gave up his professional life at the borderline patient that he screamed 'I hate you' over the telephone. While such eruptions of countertransference psychosis by a psychotherapist may seem unusual, I have observed them with some regularity among hospital staff engaged in the inpatient treatment of borderline patients. In these cases, the therapist has been taken over by the patient's projection, and the patient's inability to integrate good and bad elements of self and object are re-created in the clinician (Alschul, 1979). In the moment of countertransference acting out, the analyst, like the patient, sees action—extinction or destruction of the 'bad object'—as the only solution to the intolerable feelings of hatred within.

My hatred of Mr H and my wish that he would quit the analysis prior to the two-week break was a re-creation of the patient's part-object world within my own mind. Getting rid of the patient seemed to be the only solution to my tormented internal state. My interventions were not particularly effective at that point in the analysis, and there was a kernel of reality in the patient's perception that I hated him and was having difficulty handling him. As Gorney (1979) has noted, when the patient's entire effort is to transmute the analyst into a bad object, there may be a real erosion of the analyst's technical competence as he reacts in a re-active manner by becoming bad in his choice of interventions and treatment. Both the analytic work ego (Fleming, 1961) and the necessary split between the observing and experiencing aspects of the analyst's ego (Kris, 1958) are compromised by the powerful projective identification process that accompanies the malignant form of transference hate. Fortunately, my self-analytic work and the actual break in the analysis gave me the necessary distance to get back on track with Mr H.

These considerations lead us to two crucial points in this discussion. First it is not only the patient who fluctuates between the paranoid-schizoid and depressive positions. In the theory of projective identification, the analyst himself is prone to lose his own sense of analytic space as he finds itself collapsing into a paranoid-schizoid mode of experience in which ill-advised action seems to be the only way of surviving. The second point is that interpretative work will only be effective when both patient and analyst are coexisting in an analytic space, i.e., both are functioning in a mode in which reflective distance, therapeutic alliance, and the creation of a psychic reality independent of the perception of external events are possible. It follows from these two critical points that the analysis of malignant transference hate in borderline patients involves prolonged periods of containment that gradually allow for interpretation at a frequency determined by the convergence of analytic space in both patient and analyst. The case of Mr H can be used to illustrate how the analyst's role varies according to whether his activities are principally interpretative or containing in nature.

CONTAINMENT

Numerous authors (Boyer, 1986; (1989); (1982); (1977); (1979); (1989a); (1989b); (1975); (1982); (1966); (1986); (1989); (1989)) have focused on the centrality of containment in the treatment of the borderline patient. There is a broad consensus among these authors that in verbal interpretations will fall on deaf ears when the borderline patient is harbouring intense negative feelings towards the analyst, (2) a new set of experiences with a new object is necessary before the borderline patient can accept interpretive interventions, and (3) the traditional role of the analyst as a neutral observer who delivers occasional interpretations from a position of equally suspended attention is not an adequate characterization of the requirements for the analytic treatment of borderline patients.

It would be erroneous to view containment as inferior to interpretation in terms of its therapeutic potential. It is a critically important ingredient in projective identification, which is the main mode of communication in the paranoid-schizoid mode and the principal method by which self- and object-representations are modified (Gabbard, 1989a); (Grotstein, 1981); (1988). In the process of containment, the patient's projections are modified and transformed in such a way that the patient can more readily re-project them. As a modified internal object is reprojected by the patient, the corresponding self-representation is similarly modified in keeping with the changes in the internal object.

Containment should not be equated with a kind of passive inaction (Rosenfeld, 1987). Nor should it be understood as a masochistic enduring of the patient's contemptuous attacks (Ogden, 1982). It involves silent processing, but it also entails verbal clarifications of what is going on inside the patient and what is transpiring in the patient-analyst dyad. In addition, containment implies a number of other processes (Gabbard, 1989b), including the identification of feeling states within the analyst, the diagnosis of the patient's internal object relations based on how they are played out in the analytic dyad through projective identification, an ongoing self-analytic process that seeks to delineate the analyst's own contributions to the struggles with the patient, the associative search for linkages between the disparate projected aspects of the patient, and the silent interpretation of what is going on inside the patient in preparation for verbal interpretation.

As a representation of Mr H's part of the patient's task is to trace his own defensive maneuvers as he seeks to avoid hating the patient. Hate in the patient evokes hate in the analyst (Eisler, 1977), but it also tends to produce denial of hate. As Winnicott (1949) stressed, the analyst must not deny that hate actually exists within himself and that he actually hates the patient. The patient will only be able to tolerate his own hate if the analyst can hate him. In this regard my confused confrontations of Mr H, which I viewed as countertransference-related 'stomps', may have been useful in some way to the patient. In clinical discussions, it is often asked if an analyst can control a patient's hate. Is the analyst can treat a patient who does not hate. Epstein (1977) noted the great frequency error it is for the analyst to react to projections of hatred by attempting to be 'all good'. This deprives the patient of his primary defensive mode of projectively disavowing hatred and seeing it in the analyst instead of in himself.

Another defensive tendency that should come under scrutiny during the containment process is the tendency to collude with the patient's splitting by focusing only on the good or bad aspects of the patient (Kernberg, 1984). As described in the treatment of Mr H, one variant in this defensive posture is to encourage the displacement of hate onto an extratransference figure so the analyst can develop a therapeutic alliance through the expression of hate and badness from the analyst-patient relationship.

A crucial turning point in the analysis of Mr H was my discovery that his perception of one as a punitive figure invested in asserting omnipotent control over him was not entirely his own distortion. On the contrary, it resonated with actual wishes to control that I was harboring within. Another defensive operation requiring monitoring during the containment process is the tendency of the patient to act as if the patient's perception is entirely a distortion, leading to a disregard of all responsibility and a projection into the patient of qualities that actually reside in the analyst as well. In this content, Seales (1986) made the following observation:

It is essential that the analyst acknowledge to himself that even the patient's most severe psychopathology has some counterpart, perhaps relatively small by comparison but by no means insignificant, in his own real personality functioning. We cannot help the borderline patient, for example, to become well if we are trying unwittingly to use him as the receptacle for our own deeply unwanted personality components, and trying essentially to require him to bear the burden of all the severe psychopathology, in the interpersonal relationship (p. 22).

The analyst must walk a fine line between blasting the patient with his own hatred and denying it very existence. After hatred and anger are processed and metabolized through the containment process, they can be more constructively expressed in a way that is useful to the patient (Eisler, 1977); (1986); (1989). Moreover, the tolerating of intense feelings in and of itself may produce change in the patient (Carpy, 1989).

During the months prior to the two-week break in the analysis of Mr H, the patient bore witness to my numerous struggles to maintain an analytic posture in the content of his using me as a target for his unacceptable parts. My struggles were manifest in my partial acting out by making sarcastic comments periodically, by withdrawing into absences, by my gall-bladder's reluctance to enforce the schedule change I proposed for fear that it would betray my aggressive feelings, and by attempting to transmute my hatred by assuming a similar position vis-à-vis the patient. As Carpy (1989) noted, the patient's observation of this analyst's attempts to deal with feelings regarded as intolerable by the patient makes these feelings somewhat more tolerable and accessible for re-projection. Projective identification begins as an attempt to destroy links between the patient and his feelings because the feelings are unbearable. Observing the analyst's capacity to bear some of these feelings resolves the frictions. Mr H, for example, began to bear some of the feelings that he observed in me with his comfort that I had to take on my characterizations. I hate it when you're calm—then I have to take it back in me.

One other aspect of containment is the message conveyed to the patient that the analyst is a durable, persistent object that is not destroyed by the patient's attacks. Winnicott (1968) felt that the analyst's survival of the borderline patient's destructive attacks is a crucial element in helping the patient to make use of the analyst as a truly external figure outside the patient's omnipotent control. He drew a developmental analogy in this regard by noting that the mother must survive the primitive attacks of the infant for the child to proceed with development and maturation. Winnicott stressed that in both situations survival means avoiding retaliation, and he specifically cautioned against using interpretation in the midst of
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SUMMARY

Transference hate presents a major obstacle to effective analytic work with borderline patients. In a subgroup of these patients, the analyst is hated relentlessly in a manner that seems unresponsive to interpretation. The persistent projective identification of hated aspects of the patient's internal world may erode the analyst's ability to maintain his analytic posture and lead to various forms of countertransference acting out. A prolonged period of containment is required for both patient and analyst before they are likely to converge in an 'analytic space' where interpretation will be effective.

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