Transference-countertransference repetitions of traumatic affects

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Some patients defend against all affective experiencing, which limits their ability to process feelings verbally. When they establish such defenses to cope with early traumatic experiences, they may need to repeat the affective tone of these experiences within the transference. Using case material, the author explores ways that therapists can utilize the transference-countertransference matrix—particularly their own affective responses in the hour—to help patients to know these experiences. (Bulletin of the Menninger Clinic, 77[2], 161–177)

Many writers, including Krystal (1988), J. Gedo (1996), and Modell (1996), have discussed the crucial role of affective processing problems in patients’ adaptive difficulties, and the contributions of affectively based dyadic communications to therapeutic action. They argue that certain persons keep from consciousness, or split off and disavow, intense affects or affect-laden wishes. These patients mobilize defenses to ward off affective experiences—such as murderous rage or intense lust—which would otherwise contradict their self-image or threaten them with an overwhelming sense of danger. When these defenses are erected to cope with early traumatic experiences, patients may need to repeat the affective tone of these experiences within the transference. They may need many accurate interpretations to “soften” the defenses. This process eventually facilitates a reexperiencing of the split-off affects in the transference-countertransference matrix. Such patients require considerable working through (Freud, 1914/1958) to integrate these novel affective experiences without traumatization, and to create new neural pathways that will ad-
dress their missing psychological skills—especially the ability to communicate affects via symbols—and allow regular access to these affects (J. Gedo, 2005).

When the pathogenic patterns originate in the primary attachment relationships, the patient cannot process them verbally. Hence, the therapist may need to use various noninterpretative interventions to address these archaic difficulties. Because the patient wards off affective experiencing, which threatens the archaic core of the self and the earliest sense of his or her objects, the affects may only “enter the conversation” (Ferenczi, 1912/1950) via dreams, parapraxes, somatic expression, or enactments within the transference. One powerful manner in which the therapist can come to know these affects is by experiencing them personally as countertransference. Our own affective responses provide clues to the patient’s archaic nonverbal or preverbal experience. We can then use our own capacity to tolerate (or “metabolize,” in Bion’s, 1962, sense) these feelings to help the patient to integrate experiences that were previously either beyond words or disavowed. This process can foster a powerful shared experience that makes the work real and vital to both participants, and that allows the dyad to translate hitherto unformulated experience (Stern, 1997) into discursive language, which in turn facilitates cortical control and contributes to ego mastery.

I consider this focus on such patients’ emotional experience, and the need to help them learn to experience and process their affects symbolically, central goals of their treatment. Their disconnect with their own emotional experience makes it impossible to tolerate closeness to others, because this closeness would evoke strong feelings that they find overwhelming. The inability of more severely disturbed patients to process their own feelings—particularly their murderous rage—creates risk for self-destructive and suicidal behaviors that simultaneously express (in action) and distance them from these emotions. In other words, these patients have little cortical control over their affective life and instead express feelings via earlier nonverbal modalities, such as somatization or action. The affective discomfort also disrupts these patients’ ability to form a therapeutic alliance or indeed to collaborate with anyone. This discomfort is often connected
to near-delusional fantasies of being an alien, inhuman, or toxic to others (P. Gedo, 2009). Thus, the affective system is related to patients’ attachments and to their thinking and judgment.

In general, more disturbed patients struggle with, and can evoke in the empathic therapist, the rawest, most painful, and most potentially disorganizing feelings. These patients have more difficulty modulating affect and are vulnerable to breakthroughs of volcanic rage, intense sadness, murderousness, despair, and overwhelming fear, which threaten their equilibrium and, at times, their lives. Yet they can only overcome their psychological gaps by experiencing the affects they so fear and therefore split off. Those of us who have worked in settings such as Chestnut Lodge Hospital have found that the patients offered an opportunity to know their intense, archaic, raw affects as we experienced them in the countertransference; this experience also offered us powerful, if sometimes frightening, occasion to encounter similar feelings in ourselves. In the following vignettes, drawn from a long, intensive psychotherapy, some of the intense affective moments are mostly the patient’s and some are mostly mine, but still others are much less differentiated; they belong to both of us, or to the “potential space” (Ogden, 1986) within the hour. Therapeutic progress is contingent on differentiating the therapist’s identification with the patient from reactions of the therapist’s permanent self.

My therapeutic technique with such persons focuses on affective experience; I try to help these patients to become aware of underlying affect, to tolerate this (often novel) encounter, and to process it in a modulated, verbally mediated manner. I try to draw the patients’ attention to their defenses against affect. I use affectively laden or evocative language, including puns, irony and paradox, metaphors (cf. Levin, 1981), voice inflection, and a touch of vocal drama, especially to highlight an underlying affect we can then process in discursive language. My intent is to amplify the patients’ underlying affect, as I experience this sitting with them. I attend to my countertransference or counteridentifications (Racker, 1968; Searles, 1979) as clues to the patients’ underlying affect, or to their subjective childhood experiences of their caretakers. I have found that occasionally articulating my
feelings can help patients to recognize and to articulate such pro-

Case discussion

History
When I met Ben Chow (a pseudonym), he was 12 years old and
a veteran of five years of therapeutic and pharmacological treat-
ment. He had been hospitalized at Chestnut Lodge following a
near-lethal suicide attempt. The Lodge was a private psychiat-
ric hospital, known for having adolescents and adults in long-
term psychoanalytic treatment. The adolescents attended an on-
grounds school, where they could continue their education and
treatment as outpatients after returning home. Therapists fol-
lowed their patients across the levels of care, and most patients
engaged in psychodynamic psychotherapy four times per week.

Ben was the only child of his white mother and his Asian fa-
ther. When the couple married, the father adopted Amy, his wife’s
daughter from a previous marriage. The mother was addicted to
painkillers but stopped using them when she became pregnant
with Ben. She relapsed after giving birth, then stopped using and
subsequently remained sober, although her struggle to overcome
the addiction preoccupied her and affected her mood for several
years. She was depressed before the pregnancy and remained se-
verely depressed for several years postpartum, before going on
medications that proved somewhat efficacious. Her husband sup-
ported her sobriety but was characterologically passive and aloof
both with her and with Ben.

When Ben was 5 years old, Amy became pubescent and began
a long period of belligerent defiance and substance abuse. This
was extremely agitating to his parents, and they and Amy en-
gaged in frequent, savage arguments. Ben was literally set on the
sidelines; his parents would have him wait in another room, from
which he recalled hearing vituperative screaming that seemed to
go on interminably. Ben was thus the passive witness to rage and
dyscontrol; no one was able to modulate feelings or communica-
tions; Ben learned that anger was dangerous. No one ever dis-
cussed his experience with Ben; as he reflected a decade later, he
had felt that “I was a midget in the land of giants.” Ben was usually unaware of his split-off rage, but occasionally he expressed it in action. The most dramatic such incidence was his writing a suicide note, which his first grade teacher found in his desk. It was years before Ben could recognize that he had in fact written the letter; he had repressed this awareness after the teacher discovered the note.

In adolescence, Ben became mired in a hostile-dependent enmeshment with his mother, which was most clear in her hovering anxiously in an attempt to ensure his safety, while he wordlessly conveyed the threat that he might kill himself any day. Suicide would express his hostility toward his parents. We eventually explored his grandiose identification with the avenging God of the Old Testament, who, in righteous anger, had unleashed a destructive flood to cleanse the world. Ben shared this God’s seeming low opinion of mankind and what humans had done to the world, as well as his penchant for the talon response. By killing himself, Ben would forestall unleashing his own torrents of rage, which, in a split-off grandiose fantasy, he considered capable of wreaking enormous havoc. Ben’s needless death would also constitute a devastating indictment of the caretakers, who he covertly felt had driven him to the brink.

Identity diffusion
My work with Ben moved in fits and starts. I constantly had to bear the haunting feeling that Ben might kill himself some day, no matter what I tried to do. Certain moments of particular affective intensity, most of which we experienced together, seemed to represent nodal points in our attempt to collaborate. I want to focus on these in hopes of illuminating the role of affect in the alliance and therapeutic action, which began to alter Ben’s destructive course.

In the opening phase, Ben kept me at arm’s length. He willingly attended the four weekly hours and usually talked, but in the interest of parrying me. I was not surprised to learn that he loved to play chess and cards, and that in his family cheating was covertly sanctioned and admired as cleverness. Ben readily acknowledged his delight in confusing me and others, and we
explored his need for control. He employed omnipotent fantasies as defenses against his underlying sense of helplessness. He made it clear that he continued to wish that he had succeeded in killing himself; only his ongoing asylum in the hospital mitigated the despair, anxiety, and anger that I felt about him. At this point, however, these were not shared experiences; although Ben evoked these feelings in me, I seemed to be the only one feeling anything.

Early on, sessions with Ben often left me feeling befuddled. At about this time, Ben began alluding to his identity confusion. For instance, he referred to himself as Asian (i.e., the same race as his father) when he was actually biracial. We were able to discuss Ben’s fear that the therapy constituted a potential threat to his self-control; this was the first time I felt that I really existed for him, albeit as someone who might upset his fragile equilibrium. His treating me as a (dangerous) person was an enormous relief to me, because I no longer felt like his animate tool or a part of the “nonhuman environment” (Searles, 1960). In retrospect, in transference reaction to Ben, I had found his hostile denial of my humanness quite anxiety-provoking. Now, there was a palpable reduction in both my and his anxiety, as we began to know one another and to discuss a relationship between two people in the room.

Contemporaneously with this incident, Ben’s former therapist—whom I knew from another professional context—arranged to meet with me to hear something of Ben’s hospital course, but also to share some drawings he had done during family sessions. She arrived accompanied by a colleague, whom she introduced as Ben’s former medicating psychiatrist. As we talked, I found myself addressing most comments to the psychiatrist, who was also more active in asking questions and eliciting comments. Later, the therapist called and angrily told me that she felt I had focused my attention on the psychiatrist and had evinced little interest in the drawings while she had reacted by withdrawing. Her call “cured” my disavowal. Eventually, I realized that we had unwittingly re-enacted Ben’s subjective version of his family, in which his parents slighted his needs and failed to note his hurts because they had been distracted by their own or Amy’s needs. Like Ben, the outpatient therapist had reacted with a mute withdrawal, which
had exacerbated the misunderstanding. As he did, she harbored fantasies of assuaging her anger by severing our relationship. It was only when she undertook an active alternative and called me that the repetitive enactment was broken.

Ben was not yet able to afford his caretakers such an opportunity, although much later he did articulate these feelings to them. However, subsequent to my second meeting with the outpatient therapist, he indicated an increased connection to me and to our work. The healing of the split between myself and his outpatient therapist seemed to affect Ben’s tendency to split off aspects of himself in the therapy. As Stanton and Schwartz (1950) observed, even if patients do not observe the interpersonal split or its resolution, these milieu factors nevertheless affect their functioning. Ben’s more integrated presentation in turn revived his dependency, his rage, and his fearfulness, which we could then explore analytically. He told me that if he voiced his anger toward Chestnut Lodge, he would wind up in restraints. Just before I took a brief time off, he fled the hospital and ran home. He subsequently reported that my three days off had “felt like three weeks.” After I announced my summer vacation, he decompensated and threw a book at a staff member. While I was gone, he made a mild suicidal gesture; we later connected this to his having consciously experienced murderous rage toward his parents and toward me in the transference.

Despite such moments of increased connectedness, Ben generally continued to utilize his wit and sarcasm to relate to me while also maintaining distance. He was transferred to the on-grounds residential treatment center because he continued to be too suicidal to go home. Ben explored his fantasies that World War III would begin that year. He became enraged at his parents and refused passes for several weeks. While Ben could describe his overdose in a matter-of-fact tone, he remained unable to consider what had motivated this desperate act of rage. He continued to endorse suicide as a possible solution to his troubles, but in a provocative manner that seemed split off from his loneliness and despair.
The recovery of traumatic affects: Despair

One day Ben was uncharacteristically silent and withdrawn. He seemed spacey and out of touch. I too gradually became mute, preoccupied, and caught up in an altered state of consciousness. I experienced an increasing loss of connection with physical and temporal reality and an inability to discern meaning in Ben’s behaviors. A growing sense of passivity, helplessness, and dyscontrol overwhelmed me until I felt suspended in space, slightly aloof from a barely sensed yet intense experience of alienation, loss, and angst. I felt utterly alone but unable to touch the sadness and futility this experience might normally have evoked. I was unable to achieve any lexical or cognitive understanding of my lethargy, passivity, hopelessness, and pain. At one point, I did have the thought, which seemed to form out of nowhere, that “This is what it’s like to be dead.” I felt that I might lose my mind and go crazy. I could bear the awful intensity of this wordless experience, and maintain some small contact with reality, only by glancing periodically at my watch and calculating (with some difficulty) how much time remained. Yet it seemed crucial to endure this, not to use words to distract myself and reduce the intensity of the experience.

This shared ordeal seemed to afford me a painful, but direct and powerful, glimpse of Ben’s existential despair. In the grip of the experience, I felt too paralyzed to have thought through or managed any complex action. In considering the experience subsequently, I had the fantasy that if I had to bear such a state indefinitely, I might kill myself. I had experienced a dedifferentiation1 and became immersed in a subjective state that was almost unbearable. Yet this wordless experience also represented a moment of merged closeness, empathy, and identification with Ben. In rare circumstances such as this one, dissociation may serve the function of increasing subsequent understanding (P. Gedo, 2000a, 2000b). Ben and I eventually put many aspects of this experience into words, although this tended to make Ben anxious, and he then resorted to distancing defenses. These discussions

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1. The late Jaime Buenaventura, MD (personal communication, 1991), suggested this term to me.
did clarify that Ben realized that I knew some of his most painful feelings, and that I had felt one motivation for his suicidal despair in a very direct way. After this session, the therapy became much more intense and focused on Ben’s internal world; only after we experienced the dedifferentiated dead state together did our collaboration achieve a vital liveliness.

However, this did not mean that the work proceeded smoothly. I continued to feel that Ben might ultimately destroy himself; when I shared this feeling with him, he soberly agreed that it remained a real possibility. Once he accused me of not caring about him; when I pursued this, he blurted out, “I hate you! I don’t want you to care.” He angrily asserted that he did not need to be at Chestnut Lodge, then later opined that he would remain there “50 years, give or take a century.” He did become more open regarding his intense, chronic loneliness. He despaired of ever conveying his true feelings or needs to anyone; if he did so, he was certain that the other person would abandon him. On the other hand, he stated that if he ever met someone who really understood him, he would “marry them.” Ben recognized that he believed his rage and aggression would harm others unless he kept constant vigil and exerted maximum controls. He feared that he might “destroy the world.” When we explored his rage at his parents, he experienced suicidal ideation and fled from the school to the residential unit. We had not been able to contain his feelings in the office, but he used the milieu and the unit staff to remain safe, return to the therapy, and resume a secondary process discussion of his disorganizing feelings. Over many months, with the family therapist’s help, he confronted his parents regarding his disappointment and sense of abandonment. Home visits began to go better. Ben was a bit more active on the milieu. He reported periods in which he felt happy and envisioned a future. He had his first crush on a girl and endured her failure to reciprocate his feelings. He recognized that his parents keeping myriad pills accessible in their medicine cabinet was a sign of their ambivalence, and he told them to lock up those pills and his medications. After a year in residence, Ben was discharged home.
The recovery of traumatic affects: Rage and murderousness

Ben was seeing me as an outpatient when I went on my summer vacation. Ben rode his bicycle to each appointment with his interim therapist. In their last session Ben reported, and seemed, to be feeling in control. Then, the last day of my vacation, he broke into the locked pill container and took a massive overdose. After being rehospitalized at Chestnut Lodge, he related that, as little as 30 minutes before impulsively ingesting the pills, he had had no awareness of his intense rage, feelings of abandonment, or suicidal intent. He seemed smug about his actions and their impact on others; he was only sorry that his parents had found the smashed box and had taken him to the emergency room. He denied that my vacation had been a factor in his act; he did this in a manner that left me feeling utterly dismissed and belittled. He wallowed in his deprecations, disdain, egocentrism, and passivity. He made no attempt to work in treatment and remained without privileges for over a month. He missed the first quarter of ninth grade because he could not leave the unit, even with an escort. He went on strike during his therapy hours. He rotted.

Ben was aware that he was expressing intense rage and entitlement by these behaviors. He knew that he was provoking his parents, and me; he professed that this pleased him. Of course, by remaining without privileges on a milieu he disliked, Ben was also “screwing [him]self,” but he said he did not care. Eventually, his parents became so angry and frustrated that (with the family therapist’s concurrence) they stayed away for a time. This helped Ben and me to articulate his underlying feeling that his parents owed him; he felt that they should compensate him for past deprivations by being instantly available and gratifying, regardless of how he treated them. When I interpreted his having experienced my vacation as an abandonment, he denied it but then associated to experiencing gnawing hunger.

Later I shared my feeling that Ben was treating me like a nonperson—his complete denial of my impact, and dismissal of my emotional responses, had the cumulative effect of denying my existence. (These experiences seem similar to archaic transferences that Searles, 1960, described in his work with regressed, psychotic patients.) In response, Ben associated to having been
shunted aside when his parents and sister had battled in the past. He became a bit livelier; the unit staff helped by making him write essays that compelled him to try to address his underlying feelings. After reexperiencing the traumatizing denial of his humanness in a “projective identification” (Klein, 1946/1975) with the staff and myself, he gradually resumed functioning. However, the full meaning of my countertransference feeling of being obliterated only became evident after he returned to school. During a family therapy session, his father revealed that, on the day of Ben’s attempted suicide, he (father) had found the smashed pill container but had done nothing for some time, until his wife had come home and he had revealed his discovery to her. She was also slow to react: She had called the Lodge, and only when the family therapist, alarmed, conveyed that this was an emergency, did she find Ben and take him to the emergency room. The meaning of this was not lost on Ben, who characterized it as an attempted murder. That is, father had literally tried to negate the child’s existence, albeit with Ben’s active collusion. It was the affects surrounding this incident that Ben reenacted with me; he took on the parental role of actively negating the other, which I had endured passively, as he had in the original incident. As we explored these feelings and Ben got in touch with some of his anger and despair, he was able to resume being an active participant in treatment. He was able to come to life and to strive for life again.

Ben was gradually becoming more open regarding his underlying sadism, rage, and murderous feelings. We explored ways he regarded and used his parents and Chestnut Lodge caretakers as need-gratifiers who fulfilled his anaclitic yearnings to be fed and soothed. Ben became aware of his wishes to hurt his parents, and he knew that his suicide would certainly wound them. For the first time, he stated that he hated his parents. He was often sullen and withdrawn in family therapy. He also became angrier at me and sometimes deprecated therapy or refused to collaborate in a manner I experienced as sadistic. I was (partially) aware of my increasing frustration and resentment.

By this time, Ben had again transferred to the residential treatment center, which I directed; one of my supervisees served as his clinical administrator. One day we held a unit meeting that
focused on another patient’s struggles with suicidal ideation. Ben, who was usually quiet in unit meetings, spoke up and derided her suicidality as a sham and a manipulative act designed to gain the staff and peers’ attention. I became irritated and confronted Ben: I was surprised that he of all people would dismiss the peer’s feelings because after all, “You killed yourself twice.” In retrospect, Ben’s failure of empathy enacted his parents’ typical attitude, and I responded as he was wont to do. On another level, the girl represented him; he was deprecating his own suicidality and I was defending his integrity by speaking up for her. I identified with him (via the girl he attacked) and his parents (by condemning his expression of hostility). He identified with me (interpreting the girl’s behavior and telling her to stop) and also his parents (condemning himself via the girl) and the girl herself. My embarrassment at having publicly chastised him and having called him dead also seemed to represent an identification with Ben. In the interwoven aggression, failures of empathy, and shame, our roles and feelings became intertwined. However, my sense of aggression facilitated my describing his hostility toward the peer. This subsequently allowed us to explore his ongoing delusional fear that his hostile wishes might literally harm others (P. Gedo, 2009). We resumed a more dyadic collaboration and began to explore Ben’s frightening, overwhelming loneliness.

Loneliness and attachment
I had always been aware of Ben’s loneliness and had often felt lonely in his presence. Ben had alluded to feeling isolated, both within and outside his family. Now he began describing this in more detail. For most of his life, Ben had felt that he had no friends at all. He described an inner world of imaginary friends and fantasies that had bordered on delusions, with which he had tried to fill the emptiness; he had not given up the imaginary friends until age 11 (the year before his first suicide attempt). During this phase of therapy, Ben became aware of warding off more positive, affiliative feelings for me, certain other staff, and some peers. He agreed that these affects were more difficult for him to tolerate than the intense rage he had felt earlier (which had
served partly to obscure these loving feelings). He also articulated a sense of guilt: He felt that he should have been able to stop the family fights that he had witnessed passively. As we explored this, I interpreted that these grandiose fantasies were a defense against a sense of powerlessness that had fueled his rage.

A month later, I announced a paternity leave. In the hours preceding the leave, Ben seemed distant and reported feeling more sad and disorganized. He felt that he was less important than my children. Throughout the spring and summer, Ben was increasingly able to be aware of, and to reflect upon, his feelings. He was less depressed but increasingly conscious of his rage and fantasies of assault, inside and outside the hours. I experienced this material as a relief because it represented such a direct verbal communication of the underlying state that I had sensed all along. In part, Ben was angrier at his peers because he actually cared about them and was thus more affected by them; he resented them and castigated himself because he felt connected. In family therapy, he tearfully told his parents about his chronic rage. Ben worried about getting close to anyone because “they always leave me.” Nevertheless, he found that he had developed several friendships with male peers. Their moods often seemed to covary, and sometimes he became enmeshed with them. However, there were also moments of more mature mutuality. Ben and I explored his fear that others would recognize that he cared for them and that he was capable of loving feelings. He dreamed about a man covered with bees, who had to keep still lest he get stung. We connected this to his characteristic passivity and underlying sense of vulnerability, and to fears of hurting others and being hurt by them. He recognized that he could arouse others’ vulnerabilities via hatred or love, and that he was capable of both. Now, when he occasionally became depressed and withdrawn, I felt loneliness and confusion; this seemed to be a muted echo of Ben’s childhood states. I tended to share these countertransference feelings with him, and this facilitated dyadic exploration of his isolation and sense of yearning. To my surprise, Ben told me that he would miss me during my summer vacation, and that he anticipated having a more difficult time in my absence. Our interactions had taken on an unprecedented fullness and liveliness. For the first time, I
began to feel Ben might survive and eventually have a reasonably fulfilling life.

That spring, Ben managed better. He moved to a group home, a less intense level of care that allowed him longer passes home. He and his family handled these well, although Ben continued to have trouble taking the initiative. In the sessions, Ben described fundamental changes in outlook and attitude, which I thought alluded to structural change. Most important was his awareness of his chronic irritability and anger, and his growing ability to put this into words. His rage was no longer split off and therefore unavailable for cortical control. Although Ben felt that he still might resort to suicide one day, he now regarded this as unlikely. He talked of a future. He was discharged home in June. Although this was warranted given his clinical status, it meant that he would again be home while I was away. This time, however, he managed adaptively. He enjoyed beating his interim therapist in chess, then gave her a chess book so that she might hone her game. He hung out, worked as little as possible, and went to the movies and bowling. He helped plan the first family vacation in years and returned to report that, while some of the sites had been a bit disappointing and his mother had dragged him to the art museum, basically they all had a pretty good time. Over the summer, he was often irritable, occasionally dysphoric, but also enjoyed some good times and did not act impulsively. He reflected on the impact of his relationships at Chestnut Lodge; people had hung in there with him, gotten to know him, accepted him; this gave him the feeling that people cared about him, liked him; he saw this as vital help his treatment had provided and that meant he might now have a life. He explicitly included me as one such caretaker.

Discussion

Ben suffered neglect in early childhood that overwhelmed his nascent coping capacities. His mother struggled with addiction and severe depression during his first years, while his father was often withdrawn. Ben’s oedipal period was dominated by his adolescent sister’s acting out and her screaming fights with their par-
ents, which sometimes involved physical altercations. Traumatized, Ben split off his despair, sadness, and intense rage, because experiencing these affects would have felt too dangerous. He occasionally expressed these split-off feelings—as when he wrote a suicide note in first grade—but these breakthroughs were subsequently disavowed or repressed. Usually unaware of his deep depression and loneliness, he maintained imaginary friendships until age 11. With the onset of puberty, he decompensated and made a near-lethal suicide attempt, leading to his hospitalization at Chestnut Lodge.

I have highlighted several episodes in which Ben and I shared intense affective experiences. These encounters went beyond words and are difficult to convey in words. It often took us considerable time to overcome the vertical splits in Ben’s mind (Freud, 1940/1964) and then to process these events in discursive language. Our experiencing shared affective moments, and my voicing my own emotional reactions seemed to help address Ben’s split-off affects and helped integrate events into the dyadic process. Discussing these moments together represented part of Ben’s “after-education” (Freud, 1916–1917/1963, p. 451) in the adaptive advantages of knowing and naming affects and the benefits of collaboration. Learning from my experience, Ben was able to integrate aspects of his experience that had only been episodically available to him previously (P. Gedo, 2000b). Several of the nodal points seemed to fit Klein’s (1946/1975) notion of projective identification, but others did not. Instead, they involved shared, rather than defensively projected, affects; they existed in the therapeutic “potential space” (Ogden, 1986) and we both felt them.

The subsequent therapeutic course demonstrated that these shared experiences represented crucial change markers regarding the level of mutuality and collaboration we were generally able to sustain thereafter. They often seemed to alter Ben’s sense of me, from an animate tool to another (often fallible) person in the room. Over time, this facilitated his experiencing fear, hatred, and finally affiliative yearnings toward me. These exchanges in turn deepened my appreciation of both Ben’s and my own previously warded-off affects. These incidents led me—usually without my conscious intention—to experience intense affect in a way
that was initially destabilizing, surprising, and difficult to tolerate. In each instance, my own internal and externally discernible reactions took me by surprise. That is, I too had been warding off a raw, archaic affect state; these episodes—which often involved some action or enactment—forced me to acknowledge, and then to integrate, my own underlying experience.

Although I, like some other therapists, often experienced these affects in an intense manner, such depth of feeling is not a universal. However, I am arguing that a transference-countertransference reexperiencing of the traumatic events and their associated affects is a necessary treatment phase for patients who disavowed these experiences in childhood. Eventually, with Ben, I translated our affective reexperiencing into discursive language. I believe that this represented a way of teaching Ben similar skills, and this allowed him to practice previously underdeveloped capacities in identifying, “owning,” modulating, and thus detoxifying his affects. He previously had feared them as potentially poisonous and had split them off, so that they had become disorganizing and even life threatening. Our shared affective experiences seemed to be markers of developing psychic structure, which might allow Ben to resume an adaptive developmental course.

References


