The unbearable agony of being: Interpreting tormented states of mind in the psychoanalysis of sexually traumatized patients

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This article focuses on the clinical importance of the disturbing transference-countertransference matrix in the psychoanalysis of patients whose ego development was decisively influenced by early, traumatic sexual abuse. Dissociative defensive operations and "automatic" identifications are emphasized in accounting for the sadomasochistic and other characteristic features of the "traumatic" transference-countertransference ambience. Two clinical vignettes depict the analyst's need to take his or her own disturbing experience as an object of analytic examination, while illustrating how "here-and-now" transference cues are used to interpret the patient's efforts to cope with overwhelming, traumatized states of mind. (Bulletin of the Menninger Clinic, 61[4], 495-519)

What an abyss of uncertainty, whenever the mind feels itself overtaken by itself; when it, the seeker, is at the same time the dark region through which it must go seeking. (Proust, 1928/1970)

Early childhood sexual trauma creates the "abyss of uncertainty" described by Proust, while dramatically impacting the nature of the violated child's attachments, identity formation, and developing psychic functioning (Steele, 1994). Adults who were subject to such early

My title paraphrases Milan Kundera's (1984) pithy expression. Since originally choosing this title, I have learned that Stolorow and Arwood (1992) have coined a similar phrase, referring to "the unbearable embeddedness of being."

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maltreatment and who consequently carry a sense of an internal chasm are appearing more frequently in our psychoanalytic practices. This article is intended to draw upon and advance current thinking about the psychoanalytic treatment of severe early trauma. I will focus on the technical implications of the disturbing transference-countertransference situation in the psychoanalysis of these adult patients. Sado-masochistic and other characteristic features of the “traumatic” transference-countertransference reenactments that account for the disturbing tone of such treatment will be explicated, and I will present clinical material to convey the particular nature of the analyst’s struggles to gain perspective without becoming disengaged. Both the “tormenting” character of the analytic treatment and the special demands placed upon the analyst’s attitude and interpretive capacity are given prominence in order to advance analytic technique in the treatment of dissociative processes and their concomitant intrapsychic and intersubjective manifestations. I will begin, however, by briefly commenting on the controversial issue of the accuracy of memories of early childhood abuse.

Accuracy of memories of early childhood abuse

I will only briefly address the important and controversial issue pertaining to the veridicality of the memories that are reconstructed through the psychoanalytic process. The difficulties in distinguishing between memories and fantasies are well known both within the analytic and wider mental health communities (see Allen, 1995, for a cogent discussion of the spectrum of accurate traumatic memory recall). Analysts must be knowledgeable regarding current scientific understanding of memory functioning and the problems stemming from “false memory,” as well as aware of the possibilities for overt and covert suggestion on the therapeutist’s part. The burden falls upon the analyst to ensure that the retrieval environment created as part of the therapeutic setting does not increase the patient’s willingness to call nearly any mental experience a “memory.” The analytic process, then, is best managed when the analyst’s skepticism and credulity are tempered by a sound and balanced view, which entails that we, as Brenneis (1994) suggested, “believe skeptically and doubt empathically” (p. 1050). Allen (1995) accented this point succinctly when he argued that “clinicians and their patients will benefit from thinking in shades of gray rather than in terms of ‘true’ versus ‘false’ memories.” (p. 84).

I favor the position, along with many other analysts working in this area (e.g., Biglas, 1990; Brenneis, 1994; Davies & Frawley, 1994; Levine, 1990b; Shengold, 1989), that the analyst’s belief in the patient’s ability to partially reconstruct early trauma may be a crucial precondi-
tion for the emergence of valid memories and, subsequently, an important technical issue. Empirical findings emerging from cognitive neuroscience imply that there are fairly reliable ways of distinguishing between memories of actual abuse and more illusory, false memories (see Schacter’s, 1996, excellent synthesis of current work on memory). The nature of early memory, cognitive functioning, social influence, and the psychodynamics of fantasy, however, would preclude any conclusive statements about the historical accuracy of the details of any specific memories. Moreover, there is no research verifying the historical truth of the particulars of any traumatic memory recovered or reconstructed in therapy (Schacter, 1996). Memories, in fact, are always records of our experiencing of events, not replicas of the events themselves.

A well-trained clinician realizes from the controversy regarding false memories that “memories” of early sexual abuse cannot be taken as scientific evidence for the event’s occurrence. Still, the patient’s report of the abuse events may capture something important about his or her past that should not be dismissed. The broad contours of the patient’s early life vis-à-vis the occurrence of traumatic abuse may be fundamentally accurate. As we know from memory research, general-event knowledge is frequently retained, although event-specific knowledge may not be well recalled. Schacter (1996) reminds us that “memories do not exist in one of two states—either true or false—and ... the important task is to examine how and in what ways memory corresponds to reality” (p. 277).

I have combined my understanding of what contemporary science knows about memory, my readings of the relevant psychoanalytic literature on early trauma, and observations derived from my psychoanalytic practice in order to find a clinically useful middle ground to distinguish between accurate and illusory memories of early sexual abuse. I believe that there is a cluster of converging material that analysts might use to establish the likelihood of a history of real trauma in contrast to either libidinally based, fantasized trauma or the illusory, false memories of suggested trauma. I argue, moreover, that there is a growing consensus within the psychoanalytic community that certain observable evidence within an analysis tends to corroborate the “historical” or “material” reality, not just the “psychic” reality, of the reconstructed traumatic abuse (see Person and Klar, 1994, as well as Terr, 1994, for interesting clinical suggestions concerning ways to distinguish true and false recovered memories).

I conclude, therefore, that a meaningful convergence among 12 criteria generally does corroborate the “historical reality” of traumatic abuse without necessarily demonstrating the accuracy of any specific memory. This compilation, however, is not to be applied in a checklist
fashion. The applicability of these criteria fundamentally depends on the clinician's skill in both recognizing and establishing the appropriate "controls" in terms of the therapeutic retrieval environment. In this respect, the criteria are useful only to the extent that the analyst is informed about the role played by imagery, suggestion, rehearsal, undisciplined interpretations of implicit memory functions, and other risky memory retrieval techniques in the molding of a patient's recollective experience (cf. Schachter, 1996). The analyst must also be cognizant of the patient's susceptibility to postevent influences as well as of the evanescent nature of source memory in order to apply these criteria of accuracy to the reconstructed material (Schachter, 1996).

The twelve criteria, when applied under these circumstances, include (1) repetitive dreams initially barren of associations; (2) bodily-sensory, somatic, presymbolic enactments as well as regression to action and vegetative sensations for discharge; (3) quasi-delusions and auditory hallucinations during regressive periods in a context of a patient's generally sound sense of reality; (4) focal, disturbed affective states characterized by a tendency toward automatic anxiety rather than signal anxiety; (5) reconstructed childhood self-states indicative of traumatic pathogenesis, involving overwhelming affect, a faulty stimulus barrier, defensive dissociation, and preoedipal fantasy construction; (6) "recovered" memories with qualities of true recollections, reexperienced as isolated pictures or bodily sensations accompanied by intense feeling (van der Kolk, 1994), frequently with ultra-clear peripheral details (Shengold, 1989); (7) the frequent occurrence of posttraumatic stress symptoms accompanying "uncovered material"—namely, numbing oscillating with intrusive reexperiencing in addition to the appearance of patchy, incomplete memories indicative of partial amnesias (Harvey & Herman, 1994); (8) the uncovering of childhood trauma subsequent to a current, consensually validated traumatic syndrome (e.g., following a traumatic accident, childbirth experience, or assault), suggesting a causal link indicative of implicit memory (Schachter, 1996); (9) the general convergence of memories as the patient's "same story" becomes better elaborated without shifting; (10) a transference-countertransference reenactment wherein patient and analyst experience oscillating roles of "believer" and "denier," typically in the form of very real doubts and skepticism that volley back and forth (cf. Davies & Frawley, 1994); (11) the patient's growing sense of conviction in spite of massive efforts to deny; and (12) corroborating experiences and symptomatology during early childhood that reflect probable responses to early trauma (e.g., dissociative experiences and/or related psychopathologies, language and learning difficulties, sleep disorders, somatic distress).
I will next consider the broad impact of such early trauma on the patient and analyst.

**Repetition and the transference-countertransference field**

The existence of the incest element complicates the analytic situation, as Jung (1946/1959) described it, “like an octopus’ tentacles twining themselves through the transference, around doctor and patient” (p. 179). Perhaps the most characteristic feature of analytic treatment with patients who suffered such early trauma is the quality of the transference experience, which often goes beyond the usual intensity of a transference neurosis. The power of the compulsion to repeat tends to obliterate the line between fantasy and reality, frequently leading to the disappearance of the more transitional space in which the play of the transference neurosis usually unfolds. There are enormous pressures to relive the sexual abuse, and the transferences that develop in the course of these cases are often more akin to transference psychoses (Levine, 1990b).

The hallmark of the working-through process in psychoanalysis was first described by Breuer and Freud (1893/1955). Long before the structural effects of childhood sexual abuse were known and the transference was understood to be the significant vehicle for therapeutic mastery, they appreciated the necessity for what we now term transference-countertransference “reenactments” arising in the treatment of patients who could not symbolize the experience when it first occurred. In their words, “The psychical process which originally took place must be repeated as vividly as possible; it must be brought back to its status nascendi and then given verbal utterance” (Breuer & Freud, 1893/1955, p. 6).

Freud (1914/1955) soon appreciated that the “perpetual struggle” (p. 153) between analyst and patient asserts itself in the transference field and is based largely on the endeavor to direct or discharge psychical processes in the motoric rather than the psychical sphere. As I will argue, this struggle is experienced more concretely with abused patients, for whom the transitional “playground” of the transference neurosis tends to collapse under the sway of the intensity of the repetition-compulsion enactment. To account for this, I begin by considering the nature of early childhood trauma.

**Early childhood trauma**

Trauma is characterized by the inability to respond adequately to an excessive influx of excitation stemming from both the external world and intrapsychically generated stimulation. Trauma typically occurs
when there is a combination of too much stimulation and too little protective shielding. Traumatic overstimulation is a "shattering experience" that causes acute upheaval and lasting mental effects. The ego is overwhelmed and rendered inactive by sudden, unexpected excitation. In contrast to the signal anxiety generated by active ego functioning, the automaticity of the more biologically based traumatic anxiety produces a dread of ego collapse and annihilation (Freud, 1926/1959; Shengold, 1989).

This terrifying preverbal state of shock, helplessness, and "primary anxiety" is phenomenologically tied to fears of falling apart, dissolving, collapsing, suffocating, disappearing, and breaking down or going crazy. As one patient of mine described it, she was terrified of "coming apart," and thus relied on "going off into the darkness" in order to hold her "dissolving" sense of self together.

Owing to the immature condition of the psychic functions in early childhood, trauma is much more devastating if it occurs when the ego is largely undeveloped and the mental apparatus is fundamentally undifferentiated. Children must rely on attuned caretakers to serve as stimulus barriers protecting them from such traumatic overstimulation. Children deprived of this sense of being "blessed" (Grotstein, 1993) undergo a veritable "soul murder" (Shengold, 1989). The sexually abused child consequently suffers many losses, not the least of which is the loss of a normal incubation period of innocence and tenderness, precluded by the premature introduction into a more "predator"-like world.* This is complicated by the fact that incestuous trauma involves reality and fantasy meeting "in more ways than one" as the overwhelming effects of the childhood sexual abuse interact with the child's early, normative omnipotent fantasies as well as later oedipal fantasies and wishes (Shengold, 1989).

Trauma and early memory functioning

The "infantile condition" of the child's psychic functions precludes the use of more mature forms of ego defense in reaction to traumatic events; instead, experience itself must be obliterated (Loewald, 1955; see also A. Freud, 1967/1969). If events are too overwhelming during this period of ego immaturity, then neither psychic elaboration nor associative absorption of the events can occur. Traumatic experiences, instead,

*Ferenczi's (1933/1955) seminal paper on the "Confusion of Tongues" addressed this issue in terms of the adult's precocious superimposition of passionate love and hatred on the immature child, who seeks more "tender," passive forms of love.
are predominantly represented prementally, registered somatically, and expressed through the body.

These poorly structured replications are experience-based and non-declarative, representing what memory researchers term *implicit memory* (Clyman, 1991; Schacter, 1996; Scharff & Scharff, 1994). Cumulative traumatic events that are stored in the implicit memory system are unavailable for recall due to their initial lack of adequate language-based mental representation (Cohen, 1980; Lipin, 1963). This form of knowledge must therefore be elaborated and reworked into the more language-based, symbolic, and declarative system termed *explicit memory*. However, for these events, which Freud (1914/1955) called "reminiscences," to become consciously knowable (as recollections), they first must be relived (in the analytic process) in ways that correspond to their mode of registration in early childhood. This largely involves the sensory-motoric mode of expression by means of somatic sensations, acting, or being acted upon through massive projective identificatory processes and transference enactments. In other words, as Scharff and Scharff (1994) explain, the analyst must "infer memory and experience from silence, absence, and gesture—and from observed procedural behavior in the transference and ... countertransference" (p. 38).

**Dissociation**

In addition to transforming somatic memory traces into more "normal" memory functioning, which produces various dissociative splits in the personality as well as proneness to ego disorganization and fragmentation (e.g., Cohen, 1980; Davies & Frawley, 1994; Ferenczi, 1933/1955; Fliess, 1953; Krystal, 1978; Loewald, 1955; Shengold, 1989). This is important technically because these patients were not capable of symbolizing the violence and terror that they were subject to as small children. Both of the patients that I will discuss later could not repress the traumatic

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"Breuer and Freud (1893/1955) originally observed that most hysterical symptoms were precipitated by psychical trauma that was marked by the affect of fright. In this early seduction theory account, they argued consequently that “hysteric suffers mainly from reminiscences” (p. 7). Memory researchers recognize this phenomenon in terms of being dominated by implicit memories of events that the individual cannot remember explicitly. Contemporary analysts clearly recognize that reminiscences of such events remain trapped in the knotty realm of “the unrememberable and the unforgettable” (Frank, 1969, p. 48).
sexual events and their associated affects, impulses, and fantasies. Instead, each patient had to dissociate herself from them in order to avoid the overwhelming somatic, procedural memories and thus to survive psychically.

This "splitting off" of intense psychic material from associative communication with the rest of consciousness is the primary mechanism of defense. Functioning in a biologically based instinctual fashion to abolish experiences that are too unbearable to "inhabit" (Doctors, 1994), dissociation protects against the overwhelmingly painful experience of traumatic overstimulation and the "shock" of traumatic excitation (Breuer & Freud, 1893/1955; Spiegel, 1990). Dissociation, then, is "the escape when there is no escape" (Putnam, 1992, p. 104).

Dissociative defensive operations involve the segregation of interacting traumatic affects, impulses, bodily states, and memory representations, as well as associated self-states and self- and object-representations, from the mainstream of psychic life. Memories are not erased, but the links among memory systems are somehow severed (Schachter, 1996). Psyche and soma, as well as thinking and perception, are kept distant from one another and, consequently, the dialectic that is necessary for the symbolization of experience is absent (Goldberg, 1995; see also Namir, in press).

The dissociated units are isolated from the store of readily available mental contents and the remainder of conscious thought. The experience of personal selfhood is robbed of authenticity and the body often is not recognized as one's own. Ego-synthetic functions become further restricted by this mind-splitting operation wherein contradictory self- and parental images are not allowed to coalesce, and the self to whom the trauma occurs is obliterated (Bromberg, 1993; Modell, 1976; Shengold, 1989). In a phenomenological sense, the experiencing part of the ego is felt as being an object, a "not me," and the mind takes on an essential quality of "fleeing its own subjectivity to evacuate pain" (Schwartz, 1994, p. 191).

From a metapsychological perspective, conflicting intra- and intersystemic self- and object-representations, which are largely based upon identificatory processes with early caretakers, must be kept separated lest the "unbearable" be experienced. The individual relying on dissociative processes to manage traumatic states of terror cannot hold conflicting ways of seeing himself or herself vis-à-vis his or her objects within a single experiential state. Instead, as Bromberg (1993) reasoned, the developmentally adaptive "illusion of unity," as a result of being precipitously disrupted and shattered by early childhood trauma, becomes too dangerous to be maintained. This necessary and
culturally adaptive illusion consequently comes to evoke the dread of being overwhelmed by input that cannot be processed symbolically.

The dissociated, more or less sequestered units of experience residing in the implicit memory system can be elicited unexpectedly and reactivated under varying circumstances, typically in a state-dependent fashion (Spiegel, 1990). Davies and Frawley (1994) have demonstrated convincingly that regressive transference states occurring in psychoanalysis are particularly potent means for accessing and working through such dissociated experiences. Scharff and Scharff (1994) and Paul (1996) have advanced Davies and Frawley’s argument to clarify how dissociative processes occurring within the transference-countertransference matrix serve both as an important avenue for the work and as an interpretable form of resistance and defense that is motivated by fears of ego dissolution, shame, and self-hatred.

The effects of early trauma and the use of dissociation affect the psychoanalysis of survivors of early childhood sexual abuse in many ways. I shall next consider some of the important clinical manifestations of these structural effects.

**Effects of early trauma on psychic structuralization**

Psychoanalysis with adults who were sexually abused in early childhood must take into account specific structural effects of the traumatization, particularly as these effects resurface in the analytic space. The crucial failure of the protective shield and loss of the “auxiliary stimulus barrier” function provided by an attuned caretaker deprive the sexually abused child of protection from overwhelming stimulation as well as of a primary identificatory object for managing affective responsivity. Such a child is missing what Winnicott (1954-55/1958) termed “the environmental mother.” The fact that incest produces overwhelming sexual and aggressive stimulation in the context of a missing protective shield establishes a linkage in the child’s mind wherein intense stimulation results in overwhelming, traumatic affect, feelings of helplessness, and abandonment terror (Huizenga, 1990). Thus, massive mind-distorting, defensive operations are relied upon, enabling the mind to supply control by blocking, constricting, and shutting down feeling (Krystal, 1978; Shengold, 1989).

This fear of intense feelings reflects on a deeper level the fear of the fantasies that express such affect and of the memories linked to those fantasies. Lacking an internal protective shield, the person must ward off emotion, memory, and fantasy because they represent the beginning of feeling more than is bearable. Fantasy and other symbolic functions are defensively inhibited in order to close off the retraumatizing danger of the connection between the symbol and the real object that it might
come to represent (Bigras, 1990; Huizenga, 1990). What is foreclosed from the “Symbolic,” however, reappears in the “Real” (Lacan, 1973), and thus quasi-delusions, hallucinatory presences, and the compulsion to repeat the trauma in enactments tend to dominate in the affective realm while the patients themselves often seem like “quasi-dead,” “obedient automatons” (Bromberg, 1993; Ferenczi, 1933/1955). It is not surprising that such patients are often described as rigid, isolated, alexithymic, psychosomatic, and hypervigilant (Davies & Frawley, 1994; Krystal, 1978; Namir, in press).

Shengold (1989) suggests that the key technical consideration in treating such patients is understanding and empathizing with their basic struggle about feelings. These disturbances in affectivity, symbolic mental operations, and internal stimulus shielding and self-soothing necessitate that the analyst is familiar and comfortable with the dramatic mood changes, abrupt shifts in observing ego and symbolic functioning, and anatomization of experience. The resulting sudden disorganizing, regressive episodes become the “defining hallmarks of this complex work” (Davies & Frawley, 1994, p. 47).

At the core of the patient’s depression, self-hatred, low self-esteem, rejection of the body, and penchant for suicide is the tendency for self-blame and the inability to forgive oneself (Paul, 1996). I wish to clarify how this characteristic disposition impacts the treatment milieu by concentrating on identification and sadomasochism.

Identifications provide meaning in what would otherwise be an experience of chaos, nameless dread, and the “black hole” of the traumatic state (Grotstein, 1990). Automatic identifications function to resolve states of traumatic terror (Blum, 1987). Foremost among these identifications is an identification with the perpetrator. Blum (1987) described this as a process where “the helplessness of the ego is compensated for by identification with the aggressor, an expectable defense and a mode of adaptation” (p. 613, emphasis added). Such an identification combines the introjective elements pertaining to the perpetrator’s sadism and hatred (as stressed by Ferenczi, 1933/1955) with the projective elements mobilized by the victim’s aggression and sadomasochistic fantasies (as discussed by Shengold, 1989, and emphasized by Kleinian theorists such as O’Shaughnessy, 1983). Other crucial identifications that are made for adaptive and defensive purposes include an identification with the victim, with the frequently silent or denying protector, with the rescuer, with the comforter and other love objects in their caretaking and sustaining roles, and, finally, with the unconsciously guilty perpetrator.

These identifications, particularly with the abusive and neglecting objects, serve to bolster the victim’s use of what Fairbairn (1943/1952) termed the “moral defense,” in which the unprotected, traumatized
child assumes the mantle of badness in order to construct a sense of outer security at the price of inner security. In Fairbairn’s pithy terms, “it is better to be a sinner in a world ruled by God than to live in a world ruled by the devil” (pp. 66–67). The abused child, consequently, creates the delusion of a bad self along with a delusion of good and loving parents (Shengold, 1989) through this “malevolent transformation” (Sullivan, 1953).

These fantasy operations serve to ward off the overwhelming annihilation of identity that results from traumatic overstimulation in the context of an unprotected, bad parental image. The illusion of goodness wards off the perception of parental badness, as the survivor maintains the self-experience as a “bad,” “evil” person deserving of abuse and torture. Adult survivors feel possessed, in a demoniclike fashion, by their repressed bad objects, which were identified with precisely because they were once so desperately needed (Fairbairn, 1943/1952; Grothstein, 1979; Paul, 1996).*

Bigras (1990) has clinically demonstrated how this sadomasochistic fixation serves to deny the profound maternal deprivation inevitably accompanying childhood sexual abuse. As a result of the lack of a containing, metabolic capacity on the mother’s part, the “bad” internal parents are solidified in the unconscious psychic structure. The sadomasochistic repetition of being the victim of an assaultive adult caretaker effectively supplies the missing protective shield to the melancholic, unbearable emptiness of the child who is deprived of the mother’s protective availability. This profound maternal void is re-created in the analysis and represents what Bigras (1990) found to be the major transference process to be worked through.

The stubborn persistence of such sadomasochistic ties, as indicated by the patient’s unrelenting self-hatred and blame, as well as by the terrified reliving of the abuse at the hand of the analyst’s interpretations, can be better understood, then, as a means to hold onto the “illusion” of the good, protective, and rescuing object. This illusion originates in childhood omnipotence wherein the patient unconsciously believes that the undoing of the abuse and the wished-for magical reparation will ensue only by continuing to be masochistically victimized by the agonizing assaults that are caused by the patient’s badness. These toxic, dangerous internal representations of “bad,” evil, and demonic thus become linked in the patient’s mind with the hoped-for curative effects of the omnipotently “good,” powerful, and rescuing imagoes. One result

*This process can be exacerbated by the introjection of (and identification with) the abuser’s unconscious guilt feelings, further rendering the victim as blameworthy, responsible, and self-hating (cf. Ferenczi, 1933/1955).
of this intrapsychic dynamism is that the analytic treatment is characterized by both the patient's enactive and projective identificatory operations and the analyst's concordant and complementary identifications with these internal objects.

Particular effects on the transference-countertransference matrix

How does all of this affect the transference-countertransference matrix? In short, the transference reliving of early experience that cannot be remembered renders the analytic situation as *The Trauma* in the patient's psychic reality. These traumatic transferences are consequently experienced and enacted by the patient primarily around the analyst's "seduction" and "failure to protect."

Every transference situation provokes countertransference identifications and reactions, including intense tendencies to remedy evil and to retaliate in talionic ("eye for an eye") fashion (Racker, 1968). My point, however, is that, particularly intense induced countertransference responses are more likely in reaction to the archaic anxieties and primary defensive operations inherent in the momentary transference situation of the abused patient. This is exacerbated by the patient's tendency to express dissociated "data of experience" through enactment in the analytic relationship, which keeps the patient from experiencing the phenomena intrapsychically (Bromberg, 1993; Davies & Frawley, 1994).

During such phases of the analysis, these patients can neither "inhabit their experience" (Doctors, 1994) nor talk about their experience as an object. Instead, the dissociated units of experience become observable only through the analyst's capacity to live with the patient in a psychoanalytic reality that is often characterized by a "somatic chaos" (Namir, in press). The analyst is made to feel helpless to intervene and, consequently, is "vicariously traumatized" (Pearlman & Saakvitne, 1995; see also Bromberg, 1993).

I will next present a clinical vignette, in part to illustrate how the analyst's ability to struggle with taking his or her own experience as an object of analytic examination becomes crucial in working with patients traumatized by early childhood sexual abuse.*

*There was a cluster of converging material in this analysis (as well as in the case of Ann, discussed later in this article) that corroborated the "historical reality" of the traumatic sexual abuse experienced by the patient (see the beginning of this article for an extensive discussion of the criteria that I employ in the reconstruction of early trauma). It is beyond the scope of this article, however, to discuss the specific analytic material that was used to establish the existence of traumatic abuse in the two cases.
Clinical vignette 1: Teresa

Teresa, a 38-year-old survivor of her father’s incestuous sexual abuse from about age 3 until age 8, was beginning her third year of treatment in psychoanalysis. Early in the session, she suddenly became visibly agitated and spoke of having a “terrible headache all day.” She said she was feeling “very afraid all of a sudden,” and when I encouraged her to elaborate, she replied, “I don’t know what’s happening—it just feels like I’m going to be attacked by a man.” She recalled an old boyfriend who had violently shaken her when she was unresponsive to him, and now, with me, she described herself as becoming very “spaced out.”

“I feel like I am coming apart,” she said, while curling herself into a ball on the couch, as she often would in order to cope with the sense of becoming disorganized. From my understanding of her history and the nature of the transference, I had the sense that Teresa was feeling so unsafe because sense memories of her early trauma were emerging in her relationship to me. I tried therefore to provide words to help understand and contain her state of mind, and I said to her something along the lines of “and it feels now like you are being dissolved by your memories and what they bring up for you.” “I am dissolving,” she replied hastily, while tightly gripping her body as if to keep herself from dispersing.

I felt her torment and my own accompanying urgency to do something, anything—the very least, a desperate need to find understanding words that might attenuate the anguish that seemed to besiege both of us. Soon my compelling need to “do something” became all-absorbing, while I felt increasingly helpless, stuck, and ineffective as my own capacity to think was dissolving. I recognized my desire to “violently” address and shake her as she wordlessly sank further into herself. Teresa was becoming more and more lost, and I was feeling increasingly helpless.

By this time in the treatment, I was better able to recover my “analytic thinking capacity,” and fortunately, in time, I could recognize that my own feelings of helplessness and urgency concordantly reflected Teresa’s sense of the absence of a containing object (and thus her ensuing ego dissolution). In this process of my “recuperation,” I sought to use my countertransference experience to ferret out the negative transference underlying Teresa’s relived traumatic state of terrifying disorganization. I interpreted that something was making her feel that I would leave her “alone, unprotected, and in danger of being attacked and feeling overwhelmed.” She then began to recall being a “little, naked girl dressed only in a lace undershirt without panties.” She remembered being in a bathroom and then “going numb.” Once again, Teresa
seemed to start fragmenting as she finished recounting this incident. She sat up on the couch, looked at me in an ominous manner, and stated, “I have to leave now!”

I tried to hold steadfast despite being startled by the abruptness of Teresa’s shifting consciousness and changing demeanor. Disturbing thoughts began dominating my mind: Why was I feeling like I wanted to withdraw, give up, and just escape? How much time was left in the hour? How could I be so worried about myself? What happened to my compassion—is this what analytic training has created of me?

As I gathered my analytic wits and made note of these internal reactions, I recognized once more an all too familiar and important experience that could point the way to Teresa’s nonexperienced transference. I awkwardly focused my comments on the concerns she had about me after her recent revelation of being the little girl in the bathroom. Teresa’s agony continued, although she was aware to respond to my intervention. “You’ll hate me,” she replied tearfully. She then disclosed how she had enjoyed sitting on her father’s lap while being made to “feel very special.” She berated herself mercilessly, condemning herself for wanting to be special and feel cared for, to which I added, “as if that meant that you had wanted to be sexually abused and were responsible for your father’s sexual transgressions.”

Teresa remained upright, too frightened to lie back down on the couch. I drew her back to her fear of my “hating” her by requesting that she explore what it was about me that made her think that I would “hate” her for having sat on her father’s lap. She, too, seemed to gather her “wits” and replied thoughtfully, “I don’t know what it is about you. You do seem to accept me as a person in spite of what I tell you.”

It had become evident that Teresa’s wishes to “feel very special” to me were triggering somatically based memory forms of unrecollected experiences and their associated self- and object-representations. As this linkage was analyzed, Teresa’s escalating requests that I hold her hand became more interpretable in terms of her wishes to be reassured that I would not turn away from her in “disgust” in the face of her desires to be “special,” both to me and originally to the father who had transgressed the incest boundary with her.

The sadomasochistic nature of the transference-countertransference

The sadomasochistic tone of treatment with adult survivors of childhood sexual abuse has been noted by most analysts who have written about their work (e.g., Biglas, 1990; Davies & Frawley, 1994; Levine, 1990a; Shengold, 1989). The intensity of the traumatic transferences fertilizes the soil for the particularly sadomasochistic nature of the
reenactments. The patient's defenses against need, defects in the capacity to symbolize, and the adaptive and defensive use of self-mutilation as a self-regulatory mechanism further set the stage for the agonizing work in the transference-countertransference field.

Fairbairn's (1943/1952) explanation for what he considered the deepest source of resistance to analytic treatment is useful in comprehending the basis for this sadomasochistic undercurrent. This deep resistance was understood as stemming from the analysand's fear of the release of the unconscious bad objects. The analyst necessarily opposes this resistance by setting out to release them, "even at the expense of a severe transference neurosis" (p. 69). It is the patient's sadism in the realm of the identified-with, seemingly indispensable repressed bad objects that creates a sense of being possessed by evil forces too terrifying to face.

Other analysts have taken up this issue in terms of the child's adaptation to the hating love object and to the concomitant need for the parental tie, both of which constitute the core of the resistance to change. Shengold (1989) views this as the patient's commitment to "soul murder" through delusional ties designed to preserve contents of the mind that are felt to be precious and essential. The analyst's most difficult task, then, is to interpret the patient's "murderously intense hatred and aggression," which is retreated from and denied "in the service of preserving the inner pictures of benevolent parents ... once imperatively needed" (p. 316).

Considerable analytic skill is required for such work in view of the ease of getting mired in an inevitable sadomasochistic reenactment, with the patient experiencing the analyst's interpretations as verbal beatings. Stalemates, retraumatizing treatments, which eventuate only in destructive action or increasing masochistic self-punishment rather than in meaningful insight and structural change, are always a danger (cf. Shengold, 1989). Successful analytic work therefore requires that the patient should become capable of tolerating simultaneously his or her intense need and care for the analyst as well as the destructive hatred toward the very same analyst.

The analyst must simultaneously be capable of living in the psychic and somatic chaos with the patient without defensively resorting to interpretation prematurely. In this respect, the analyst's skill in taking his or her own countertransference experience as an object of analytic examination is crucial (Bromberg, 1993; Diamond, 1989). Enormous patience and "staying power" (Schafer, 1983) are perhaps nowhere more a necessity than in the long and stormy treatments of these patients (Levine, 1990a).

A final clinical example graphically illustrates the sadomasochistic
nature of the analytic process. This vignette depicts both the resistance to knowing served by the patient’s dissociative processes and my interpretive usage of here-and-now transference cues in providing the necessary linkage for interpreting the patient’s defensive efforts to cope with an overwhelming, traumatized state of mind.*

Clinical vignette 2: Ann

Ann was a 44-year-old survivor of massive childhood sexual abuse by her maternal grandfather (along with several more distant relatives). It appeared that the trauma occurred largely when Ann was between 5 and 8 years old, in a context wherein both her parents responded to any signs of abuse with disbelief and denial (although her mother, too, was sexually abused by her own father). Ann became actively suicidal within the first several months of the treatment, after feeling “invaded” by intrusive and terrifying bodily sensations and partial images of the early violent abuse. She was more stabilized in the second year of treatment, and we had been analyzing her self-cutting and its relationship to her wishes to have her inner pain and torment “seen” as well as “believed” by a mother (analyst) who would intervene and protect her from the abuse. She commented during a session on how she had become more able to think about her impulse to cut herself, surmising that it had something to do with her being able to “picture” me as someone calm inside her who did not want her to be hurt. She suddenly became visibly disturbed, grimacing as she said, “I’m afraid. I see you turning into him [grandfather]. I don’t want you to get in. He was nice too, then.... I can’t talk about it. I’m falling apart ... the darkness. I must get out of here right away.”

Ann looked terrified and held herself tightly. I interpreted that she had just recalled how she had been able to picture me as someone calm “inside her,” only then to experience me as like her grandfather, who used kindness for seducing and then betraying her. “It’s better to just be abused, get it over with once and for all,” she replied, and then

*Both this and the preceding clinical example are presented to indicate how an interpretive stance is employed within an established psychoanalytic process with such patients. It cannot always be taken for granted, however, that patients with a history of extensive early trauma will possess the necessary ego strength, capacity for reflection, and ability to reestablish the necessary level of therapeutic alliance in order to work analytically. I believe that an important consideration for working psychoanalytically involves the analyst’s assessment of, as well as skill in accessing, the patient’s ability to regain the sense of connection with his or her analyst when in the midst of dissociative states.
mentioned a recent session when I had offered her a glass of water during her coughing bout.

Ann spoke of how afraid she was, as she huddled on the corner of the couch mumbling, "I can't be sure you're not like him." Searching for the "cues" in the here-and-now transference experience, I asked her what it was about me that was making her feel that I would lead her on and then betray her. She replied, "You're a man, that's all," as she again became visibly afraid, curling herself up in silence. The air became heavy as I struggled with my own discomfort in feeling first like a rapist because I was male, and then utterly helpless to do anything for this fragile yet unreachable woman-child. I eventually offered the most obvious perspective on what seemed to be the unconscious source of Ann's reaction. I said, "You are afraid of me because you believe that somehow because I am a man, I must be like your grandfather who will seduce and then exploit you." "You will," she declared without hesitation or thought.

She remained motionless and then, a few minutes later, she touched her face and said in a detached manner, "I'm concerned. I've never felt this way; something very bad is happening now. I'm being taken over. It's like a mask is on my face, covering the 'real me' that's so little." I felt scared as I watched her, while having thoughts of the multiple, switching "faces" of Eve. The ambiance became eerie in a demonic way, and I began to feel as though I could not use words to effectively clarify anything.

I managed finally to recover my own analytic thinking capacity and spoke haltingly of her fear of what might be "under the mask," namely, what's inside her and part of the "real" her. She responded, "It's bad, it's awful—make it go away. I must hurt myself." I commented on how afraid she might be that I would be as rejecting of her "needy" self as she was. She seemed to be "upping the ante" in her sadomasochistic enactment as she boldly declared, "I really must hurt myself," to which I replied, "Yes, that's your way of trying to make your need for me disappear."

She looked at me strangely and started to laugh, saying, "I want you to hurt me ... now, hurt me ... hurt me, please!" I said, "You are so terrified that I will exploit your need for me, that I will indeed hurt you, so you want me to hurry up and get it over with so you won't have to sit helplessly and passively wait for the pain." She appeared somewhat relieved as she began elaborating on how afraid she was of needing me, experiencing it as "wrong."

Ann could begin to understand how needing me evoked in her a terrified sense of impending abandonment (associated with her parents) and further abuse (linked to her grandfather, who often "baby-sat" when
her parents went on business trips). Thus, in this analytic context of Ann’s achieving greater integrative capacity, we can see how she employed dissociative operations in an effort to cope with the yet insufficiently symbolized, unbearable effects of a traumatized state of mind.

**Beyond sadomasochism: Two additional features of the traumatic transference and countertransference**

I will next briefly consider two crucial vicissitudes of the traumatic transference-countertransference configuration beyond sadomasochism. One particular manifestation which frequently contributes to the torment of the analytic treatment is a common transference that reflects the need for magical rescue. Analysts, in their complementary role-responsiveness (Sandler, 1976), often experience intense countertransference longings to rescue their patient and obliterate the evil that was experienced.

For example, in the later stages of her analysis, Ann was painfully conveying her disappointment about the limitations of our analytic work together. Her underlying fantasy, which by this point we had explored together, was evident in her tearful declaration, “Why couldn’t you have been that ‘White God’ that wiped out the ‘darkness?’” “I always believed,” she added, “that if only I went along with you, that you’d be like [Bob] Dylan’s ‘Tambourine Man’ and use your psychoanalytic powers to rid me of all memory and fate.” Needless to say, I had longed for such “powers” myself, most particularly when I listened or watched with exasperation, revulsion, rage, sympathy, or terror throughout her treatment.

I call this the *mythical, curative other transference*, which essentially represents an externalization of an archaic, grandiose imago designed to omnipotently remove all psychic pain, particularly the horror associated with the childhood trauma, and in its stead, restore a blissful, conflict-free universe. This transferential longing involves the patient’s deeply unconscious fantasy that cooperating with the “extraordinarily powerful” analyst in the analytic work will eliminate the pain of childhood trauma and its consequences on development. This idealizing form of transference with patients who suffered profound early trauma is best considered an essential narcissistic function that was precipitately arrested due to premature, traumatic interference with (maternal) symbiotic containment and (paternal) dyadic protectiveness. It once functioned to protect the enfeebled, fragmenting self of the traumatized, helpless child. By giving the patient a hope for cure, this reparative transference fantasy often proves indispensable in providing impetus to the work. At the same time, this fantasy often conceals the extent of the
patient’s distrust about meaningful attachments (Shengold, 1989). The interpretation of this transference configuration, typically during the latter half of the analysis, becomes essential in attenuating the patient’s “unbearable agony of being.”

A final transferential dimension with these patients that I will allude to stems from their powerful yearnings for what Wrye and Welles (1994) termed the maternal erotic transference. This includes all manner of sensual, preverbal bodily fantasy in relation to the analyst’s body which, as a “slippery, sticky sensual adhesion [serves as] ... the medium for bonding” (p. 35). These wishes reflect the patient’s search for safe yet permeable boundaries with the maternal object, whereby the psyche and soma can be adaptively re-integrated.

These longings for the deeper, sensual realms of maternal comfort, holding, and soothing may, however, create complications for survivors of childhood sexual abuse, who tend to confuse and merge such wishes for nurturance and bonding with shameful sexuality and the retraumatizing dangers of arousal, violation, and betrayal. As illustrated in the vignette with Ann, a patient’s experience of being deeply cared for and comforted by her analyst, regardless of the analyst’s gender, may evoke the terrors of abuse and the accompanying dissociative defenses. In the countertransference, the analyst frequently feels guilty, often in response to his or her own unexpected sensual, bodily arousal, evoked by the patient’s experience of bonding and protective care.

Technical considerations

It becomes the analyst’s responsibility to bear disturbing, and at times excruciating, countertransference reactions in the analytic milieu with the survivor of childhood sexual abuse. As I have indicated, it is necessary for the analyst to feel the patient’s unbearable states of traumatic anxiety and panic as well as with dissociated terrors of fragmenting and falling apart. In these countertransference identifications (Racker, 1968), the analyst concordantly identifies with the patient’s unsymbolized terrors as well as with the experiences of being painfully assaulted. Similarly, in the analyst’s complementary identifications, he or she guiltily hurts the patient as a sadistic abuser while becoming the long awaited protector and rescuer.

In the traumatic countertransference, the analyst inevitably experiences feeling confused, overwhelmed, helpless, enraged, betrayed, guilty, powerfully protective, and driven to act. Moreover, in this upsetting and charged atmosphere, the analyst must discern the patient’s negative transferences, which often remain disguised by compliant and/or defiant character modes, and are likewise avoided by the
analyst's own countertransference resistances toward facing the patient's hidden hatred and contempt (Ferenczi, 1933/1955). The potential is high for the analyst to enact rather than contain—particularly to assume a masochistic or sadistic stance as he or she identifies with the patient's inner objects. Analysts must walk a narrow line between the Scylla of indifference and the Charybdis of immersion, reflected in becoming too distanced and aloof themselves lest they drown in an overidentification with a patient constantly living on the precipice of chaos and terror.

Two technical points warrant special emphasis in view of the particular types of demands placed upon the analyst and the analytic relationship by a patient severely affected by a traumatic early history. The first pertains to the necessity of working in the here-and-now transference, and the second involves the particulars of the analyst's "analytic attitude" in interpreting the patient's traumatized states of mind.

**Working in the here-and-now transference**

Gill's (1979) argument that the bulk of the analytic work should take place in the here-and-now transference is especially pertinent with these patients once the unbearable psychic states have been accessed.* Patients and their analysts tend to strongly resist the affect-laden, potentially disorganizing interaction within the transference, where repetition-compulsion functioning and reenactment dominate. It is in this context that aggressive, violent, and sadistic psychic elements as well as intense affect states are both prominent and dangerously retraumatizing.

The handling of the transference is the "hardest part of analysis," as Bird (1972) incisively argued, precisely because of the analyst's resistance to the negative, destructive elements of the patient's psychopathology, which must be *reenacted* in the transference. This is most applicable in the analysis of victims of early traumatic abuse where repetition-compulsion functioning dominates. Thus, the analyst's most reliable guide to the patient's resistance to the awareness

*It frequently takes several years for these unbearable psychic states to make their appearance. The analytic setting often functions, until the middle phase of the analysis, as a holding environment that is necessary to establish a sufficient therapeutic alliance (Model, 1976). Under these circumstances, abused patients rely on protective "cocoon fantasies" to shield their traumatized, core self. The cocoon is necessarily shattered when the mental pain of early trauma is allowed in. This is retraumatizing for the patient (and analyst), in that the dissociated psychic states and memories of abusive experience break through the transference in the form of overwhelming terror and hatred.
of the transference—and ultimately to the dissociated representations, affects, bodily experiences, memories, and fantasies—resides in the cues offered by what actually goes on in the analytic situation.

The interpretation of “traumatized” states of mind
The abused patient’s proclivity for reliving traumatized states of mind requires that the analyst be skillful in creating the conditions for the interpretation of transference and resistance. In short, the analyst must adequately protect the patient from overwhelming stimulation in order to allow the therapeutic alliance and positive transference to develop sufficiently. Without the necessary safety afforded by the alliance and positive transference elements, the conflicts produced by the sexual abuse and abandonment cannot be worked through.

The analytic space consequently remains the necessary and sufficient holding environment only when the analyst can interpret in words the terrifyingly helpless, flooded, and dissociating states of mind that are reaccessed by the treatment. This analytic holding function, as described by Modell (1976), provides the necessary “illusion” of protection by “conveying in words at the appropriate moment something that shows that the analyst knows and understands the deepest anxiety that is being experienced or that is waiting to be experienced” (p. 240).

This requires that the analyst be familiar with, attuned to, and capable of articulating the patient’s traumatized states of mind while living in and with the unbearable psychic and somatic pain. The analyst must become a containing, metabolizing background object who helps to structure into language and affect the somatic, gestural, and enacted expressions by which traumatic experiences are registered and conveyed (Cohen, 1980; Loewald, 1955; Namir, in press; O’Shaughnessy, 1983).

The analyst’s interpretive function with the unsymbolized yet available experience of the traumatized patient thereby requires giving fitting names, images, and interpretive linkages where the patient cannot associate. This analytic provision in the realm of the patient’s most agonizing distress consequently introduces the absent containing function into the deepest strata of the patient’s psychic structure (cf. Biglas, 1990; Bion, 1963; Lacan, 1973). I am consequently suggesting that only by dint of the analyst’s capacity to associate to and expand upon what the patient has dissociated from can the patient develop the necessary ability to associatively absorb and psychically elaborate unsymbolized realms of inner experience essential for reintegrating the internal world. The analyst’s associative activity provides the narrative
form to enable the patient’s implicit, nondeclarative memories to be reworked into structure-building, explicit, declarative memories (Clyman, 1991; Schachter, 1996). This specifically calls for the analyst’s skill in taking his or her own countertransferential experience as an object of analytic examination.

The traumatic states themselves are not modifiable by interpretation until a link has been rebuilt between the patient’s self and the containing, metabolizing “background” analyst (cf. Bigras, 1990; Bromberg, 1993; Huizenga, 1990). This linkage is essential in order to establish sufficient conditions of safety in the realm of the disavowed. When the analyst is successful in finding words to describe and make sense of the moments of traumatic reliving, he or she not only symbolically subsumes the missing parental containing function, but also is on the way to becoming internalized as an analytic introject capable of associating to, elaborating, and observing internal experience (Giovacchini, 1980).

Such a linkage can be established only when the analyst interprets both the patient’s use of dissociative defensive operations and the underlying terror of reliving traumatic states in the feared absence of an analyst providing such containment (which is provided through understanding word symbols). This is illustrated in my example of Ann, who was able to “picture me inside her” in spite of the dangers reevoked.

Conclusion

It would be difficult for me to conclude this article without mentioning how this work must deeply affect and change the analyst. I think we have to be ready to be changed by our patients in all cases, but especially with a soul so tortured by early experience that the analyst must be willing to accept, live within, and contain rather than foreclose the most horrific of nonencoded human experience. I think we are well served in closing with Freud’s (1905/1953) sage insight about the repercussions of such work on the analyst: “No one who, like me, conjures up the most evil of those half-tamed demons that inhabit the human breast, and seeks to wrestle with them, can expect to come through the struggle unscarred” (p. 109).

*Interpretations in the more classical sense, particularly pertaining to the patient’s use of projective identificatory mechanisms in the transference, become more applicable once the analyst has first helped the patient to translate and render comprehensible the traumatic, unsymbolized psychic experience of each living-through phase.

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