SUFFERING AND SACRIFICE IN THE CLINICAL ENCOUNTER

Charles Ashbach, Karen Fraley, Paul Koehler, and James Poulton

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James Poulton

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Note to the reader

For purposes of confidentiality and privacy, the names and identifying details of all of the patients described in this book have been disguised.

For ease of reading, when non-specific situations are being referred to, "she" is used for the counsellor or therapist and "he" for the client or patient, but, at any point, the opposite gender can be substituted.

The infant tends to be "he" when discussed in relation to the mother to avoid confusion over to whom "she/her" is referring.

Foreword

Giuseppe Civitarese

I have always thought of theology, if seen as psychology in the form of narrative, as the most refined expression of what men know about themselves. In *Suffering and Sacrifice in the Clinical Encounter*, the authors use a figure from the Jewish and Catholic religions, Abraham, and a pivotal moment from his life: the episode of offering his son Isaac as a sacrifice to God. The central idea is to explain some of the more challenging kinds of psychological illness through the dynamics and meaning of ritual sacrifice. As Fairbairn (1943), quoted on p. 89, says, "It is better to be a sinner in a world ruled by God than to live in a world ruled by the devil."

The fact is these patients reveal themselves as devilishly difficult. Similar to the pseudo-neurotic patients described by Bion which recur massively to transformation into hallucinosis as a defence, they don't seem overtly severe; quite the opposite, they can be brilliant and well adapted. With the passing of time, however, therapy becomes a sacrificial ritual in itself. The analyst feels its lack of vitality with exasperation. The patient is always complaining about the same things. He lives but doesn't feel he lives, and torments and devalues both himself and the analyst. Resistances are tenacious and the so-called negative therapeutic reactions frequent. The analyst wonders if, perhaps, they are intractable patients.

The main difficulty to face is the deep sadomasochistic drive by which these patients seem to be dominated. It is as if they are intent, all the time, on sacrificing themselves to a cruel inner deity in the hope of reconciling with it and thus being left free to exist. Each of them has developed a kind of 'private religion'. Instead of an emotional position of openness and hospitality, this religion results in a fanatical moralism. As we know, moralism rather makes room for abstract and preconceived ideas, and therefore shows little concern for human interest. Rigid respect for the norm occurs at the expense of vitality and it leads to living as robotic beings incapable of 'feeling'.

From the point of view of psychoanalytic theory, it is important to have an idea of how this cruel superego and enemy of life could have been generated. It appears that it is formed in subjects for whom the experience of the non-breast or the absence of the breast that is at the origin of thought is not tolerable. To put it another way, the rhythm of positive and negative experiences given by the encounter of a preconception of the breast with concrete satisfaction and then by the encounter with a non-satisfaction is too much infiltrated with the negative of painful absence (Civitarese, 2016a, 2019). The object does not provide enough truth as food-for-the-mind. Things can be so irreparable that this absence (even in the shape of a 'too much' of imminence) leads to structuring a psychotic personality. Then the severity of the superego only reflects the hyperbolic degeneration of any disattunement with the object into a feeling of dread. The reason for this is that the slightest lack is resented as virtually catastrophic. As Tustin (1972) imagines for autistic children, absence is felt as the amputation of a part of the body.

When this is the imprint received from the primary relationship, the infant's instinctive reaction is to stick to the object to plug its holes. The total identification with the ruthless object, the non-distance from it, drastically reduces the degree of freedom of the subject with respect to the norm. Responses to stimuli tend to become fixed and 'automatic'. As it entails differentiation from the object, simple existence is already a fault. That's why basically a cruel superego and any form of moralism are against life. As in Kafka's *The Trial*, the dominant feeling is nameless anguish and a kind of passive resignation. Of course, attacks are not only directed at the self, in terms of the manifest symptom we define masochism, but also at the object and the analyst, and here we would use the word sadism. The paradox is that the unconscious meaning of any kind of sadomasochism is precisely, even if through hatred, to earn the love of the object. To be alive

in the sense of feeling vital—according to the definition of this term, being capable to live—is felt as guilt.

In fact, we have to presume that at the centre of the self, there is a void, which very likely is what remains from a trauma suffered at a very early stage of life. The main thematic area explored by the authors is clearly that of the primitive states of mind and of how these traumatic experiences can find in analysis an opportunity for representation or figurability and transformation. Achieving this goal is not simple. Such patients assume a posture of moral authority that implies superiority, perfection, and purity, which should lead them to the Freudian triad of "joy, exultation and triumph" (p. 121), and so challenge the therapist's capacity to stay there and remain alive and receptive. The reason is that renouncing their defensive organisation would be tantamount to suffering agony. The analyst should not get involved in the same magically salvific, and therefore masochistic, self-sacrificing, climate. There are limits to the possibilities of treatment. On the other hand, the therapist should be the object that can gradually help the patient to free himself from this addiction to arrogance. In this perspective, the significance of the concept of negative capacity and faith, and the resulting technical principle of listening without memory (voluntary), without desire (zeal) and without understanding (intellectual), is emphasised.

The revisitation of the oedipal (and pre-oedipal) drama, which is what goes wrong in these patients, is extremely evocative. We read amazing sentences—about symbolic (non-pathological) patricide/matricide—such as: "This murder starts out so minutely, so benignly, and so incidentally that it is hardly noticed as such: we learn to feed ourselves and to walk without assistance; we learn how to dress ourselves and to tie our own shoes; we learn how to read and to explore the world on our own; we learn how to compete in a sport or to play an instrument. With each of these little successes, these little victories, these little murders, we sever a part of our dependence on our real or symbolic parents and we claim an increasing responsibility and an increasing authority for ourselves" (p. 64). Now the expression used, "little murders", which could be the title of a novel by Agatha Christie, makes us think. These little 'assassinations' are normally paid ("atoned") with the formation of the superego. The verb 'atone' here is noteworthy because it is linked to 'atonement' as a religious concept and to Bion's *at-one-ment*, in which it represents the central mechanism for 'making a mind'.

Naturally, the more there have been failures in the mother–child dance at birth and the more severe this superego is, the more the at-one-ment

risks deteriorating and becoming an imperious need for total fusion at the expense of the possibility of growth and differentiation. Very pertinent and intriguing are also, on one side, references to the institution of the original temporality, or of the capacity "to suffer time", as the felicitous outcome of this process; and, on the other, to timelessness and other forms of disturbances of temporality as the failure of this same process. When there is a withdrawal into autistic shells, time is suspended through a dissolution (*unlink*) of the three modes of experience of past, present, and future that constitute it (or rather of the dialectical game that binds them to each other) and their collapse and agglutination in a whole as fused and still: then everything is organised around the cult of a god-object and the sense of superiority that gains from it.

But the Oedipus story is complex. Between patricide and incest lies the episode of the plague at Thebes and the confrontation with the Sphinx, followed by the latter's suicide. In his essay on arrogance, Bion (1957) proposes to see in *this* episode and not in the sexual crime the real theoretical treasure of the Oedipus myth. The sin of excess and arrogance lies—despite Tiresias' warnings—in wanting to know what *cannot* be known. The subsequent incest would be nothing more than an allegorical figure of this same sacrilegious curiosity that generates *monstra*. Like Oedipus, who sacrificed himself to save Thebes, the patient is the very prototype of the unknowing scapegoat; not only the sacrificial victim, but also the high priest of a private religion. The fact is that often this position is mirrored by the analyst who also behaves as the high priest of the positivist religion of an epistemic psychoanalysis; a psychoanalysis excessively based on intellectual understanding and not enough on becoming and being (Ogden, 2019).

So a possible subtitle I imagined for *Suffering and Sacrifice in the Clinical Encounter* could be 'Investigation of the origin of the cruel superego', an issue of the utmost interest—I dare to say—for *any* kind of psychic suffering we see in our consulting room and also as a key issue for the renovation of our theories. As in a good jazz session, the various contributions appear like happy variations on this core theme. Multiple vertices are used successfully. Concepts such as primitive agonies (Winnicott), the dead mother (Green), zones of non-existence (Bion), psychic retreats (Steiner), mutual captivity (Ogden), and the inaccessible unconscious find a new context in which their theoretical and heuristic value is demonstrated and expanded. The theory employed is rich and versatile, the clinical vignettes extremely

vivid and instructive. The style of the book is happily communicative and allows a pleasant and rewarding read. *Suffering and Sacrifice in the Clinical Encounter* is a generous book, with a remarkable unity of theme and style, fruit of vast experience and love for psychoanalytic knowledge. The central image of patients who are difficult to reach as followers of a fanatical religion that forces them to continuously sacrifice the scapegoat—depending on the case, alternatively or simultaneously—of either aspects of self or of the analyst to a tyrannical god, is memorable. As a powerful metaphor it can help theoretical understanding and guide clinical work. I can only recommend reading this fascinating and brilliant book to all analysts, psychotherapists, and scholars of human sciences interested in using psychoanalysis to understand humanity and alleviate psychic suffering.

Introduction

Charles Ashbach, Karen Fraley, Paul Koehler, and James Poulton

There is a type of patient encountered in the practice of dynamic psychoanalytic psychotherapy or psychoanalysis that presents as very motivated, with average or better intelligence, and with apparent life success, sometimes impressively so, but also with a deeply dissatisfied experience of his own character and accomplishments or, one might say, of his very essence. The treatment, which seems to start so well, after some time—months or even years—feels to have descended into a kind of agonising and repetitive stuck process that fails to achieve a deeper level of insight, understanding, and relief. Before too long we come to feel afflicted, even tormented by the patient's repetitive complaints and by the rote recitation of a narrow and shallow range of memories and associations along with the litany of continuing complaints concerning the failure to achieve greater satisfaction in his work, relationships, or love life.

The patient insists on maintaining the frame and continues to come to sessions even though no further progress seems possible. From the therapist's point of view the treatment seems to have devolved into an agonising, stuck process resembling an empty and tormenting ritual. A desperate frustration often emerges in the therapist, along with strong feelings of guilt, shame, and impotence. A cloud of inadequacy penetrates the field between patient and therapist, raining down doubt and confusion about the viability of the therapeutic process—is the therapeutic baby

alive and breathing, or is failure, or death represented in the therapeutic impasse?

Gregorio Kohon (1999), in his cogent and useful paper "Dreams, acting out, and symbolic impoverishment", describes how this category of patient often suffers from having "turned away from the primary object both prematurely and in hatred" (p. 80). It is both the prematurity and the hatefulness characteristic of this turning away—in reaction to early childhood trauma—that creates enormous turmoil and dissatisfaction for these patients in their lives and for us in our efforts to engage them therapeutically.

We have found that this traumatic turning away from the primary object was not necessarily prompted by obviously or dramatically traumatic events but often seems to have been prompted by a less obvious, but no less traumatic, lifeless indifference—by the absence of delight, joy, and vitality—in the mother's early nurturing characteristic of the "dead mother" (Green, 1986). Unable or unwilling to remember or represent those experiences, these patients can only convey them to us by way of their subtle or not-so-subtle expressions of "No", through inscriptions or behaviours in the transference relationship.

Thwarted in our attempts to make or sustain emotional contact, our increasing anger—our counter-"No"—sometimes moves us to make harsh or sadistic interpretations or judgements, all the while feeling helpless, sometimes desperately so, in the face of our patient's hateful refusal to allow ordinary therapeutic contact. Our potentially helpful and liberating recognition of the limits of our therapeutic capacities and of the potential hazards of our therapeutic ambitions may then deteriorate into a hostile or indifferent retreat that tragically replicates the scornful despair and hopelessness this patient has lived with since childhood.

This book seeks to offer the reader a particular paradigm through which this type of patient can be appreciated in a dynamic and alive way, utilising the multiple perspectives of a wide range of psychoanalytic theories and guidelines for practice. We seek to illuminate and elaborate what became known as an intense and chronic resistance that Freud (1923b) identified as the impenetrable circumstance of the patient's "negative therapeutic reaction" (p. 49) and offer a reframing of the concept to reveal the underlying traumatic crisis of radical alienation that the subject suffers from behind the boundary of his so-called "resistance".

Our work together as senior faculty at the International Psychotherapy Institute inspired us to study the particular violence we sensed behind the intense resistances found in these patients. As we listened to our students and our supervisees we noticed a pattern of increasing frustration, dismay, and shame accompanying their work with these patients and a palpable tendency to invest more—more energy, more supervision, more effort—into the challenge of dealing with the patient's "intractable" problem.

Concurrently, in the aftermath of the September 11 terrorist attacks, we turned to Franco Fornari's classic book, *The Psychoanalysis of War* (1975), for guidance and understanding as we tried to fathom those catastrophic social events. He saw in the collective the emergence of intense feelings of guilt and responsibility when the primary love object was experienced as damaged or lost. The war impulse arose to cover over the group's phantasy (this spelling used to specify the unconscious nature of the experience) that their imagined sadistic attack against the love object was at the core of the catastrophe. In such a context an external object is used as a scapegoat surrogate (Girard, 1977) to stand in place of the self, individual or collective, to absorb all guilt and blame for the evil power of the external Other. The experience of mourning is stopped and instead transformed from the sorrow, guilt, and remorse for the loss or damage of the love object into the "killing" of an enemy assumed to be the "destroyer" of the love object. Fornari (1975) stresses this attack against the object is a "security organisation" (p. xvi) that operates as a defence against the subject's "*psychotic anxieties*" (p. ix, our emphasis). In the clinical situation, then, the patient's impenetrable resistance reflects a similar condition of existential dread associated with his ultimate "crime" (killing the figure of love and dependence) and the attempt to extrude the crime into the person of the external bad object. This is the essence of the "paranoid elaboration of mourning …" (ibid., p. xviii).

We also found the anthropological insights of Girard (1977) and the cultural insights of Bergmann (1992) to be important guideposts for understanding the mythic foundation of primitive mental states. Their studies of primitive cultures showed in a way similar to Fornari how human beings, in a context of loss and crisis, regress to a primeval psychic–emotional position that views the violent destruction of precious resources, especially human sacrifice to be the necessary means for propitiating and atoning to a deity, that is, a supernatural figure of ultimate power and moral authority, for their failures, sins, and crimes. We understood how this attitude of guilt

and primitive atonement came to constitute the unconscious, sadomasochistic attitude of the aggressively resistant patient and thus became central for understanding the unique and paradoxical transference and countertransference responses that characterise the treatment of this individual.

As we elaborated and knitted together these various vertices of understanding, we were able to conceive and imagine a process of psychic implosion and collapse following the experience of early traumatic events which diminished or precluded the child's (patient's) capacity to experience and internalise a solid and reliably loving attachment experience with the primary object, be it mother or father. This primal "lack" (Lacan, 1977, p. 259)—which is at once an absence and an injury—led to the collapse of a durable psychic structure and further to the construction of a substitute, compensatory system of internal objects. Denied the experience of real contact with sustaining objects the subject creates, manically, out of his omnipotent phantasies and desires an ideal object of an imagined perfect maternal figure as well as an all-bad object that acts as the container for the hatred and vengeance directed against the abandoning figure of the lost mother.

Following Freud's (1907b) observation, we began to see how these patients' regression to the depth of their personality sought to transform the therapeutic relationship into a "private religion" (p. 119) organised around the "rituals" and ceremonies of suffering and sacrifice, and came to appreciate the inadequacy of the term resistance to accurately describe the crisis of psychic deprivation and catastrophe that marked the core of this type of patient's inner world. This patient, following the judgement of his primitive superego, believes with a religious conviction that he is completely and utterly responsible for the damage done to the good object and a compensating sacrificial process must be continually engaged to deny and negate his feelings of complete guilt for the catastrophe. Thus, resistance could now be understood as a boundary condition that marks the point of the crisis of the self which is hidden behind the false-self (Winnicott, 1960) mask of the paradoxically innocent and guilty patient. The patient seeks to remain a stranger to himself in order to escape the threatening burden associated with his unconscious hatred and aggression.

Freud's (1907b) concept of the "private religion" (p. 119) and Fornari's (1975) idea of the "paranoid elaboration of mourning" (p. 103) are organised both around the breakdown in the subject's ability to differentiate between illusion and reality as well as around the perverse need for the power to

destroy the categories that define reality: differences in sex and generations. The patient's experience of object loss has caused his regression to the deepest psychic layers of the mind with the activation of radical splitting leading to fragmentation and the loss of the sense of personal responsibility. The subject in search of an absolute figure of power and protection creates an ideal god-object and sets about sacrificing to it to fend off the unbearable burden of guilt and shame. The devotion of the subject provides the illusion of the goodness of the self and his protestations concerning his adoration of his deity assert his innocence and purity. Having undergone such a radical transformation he can now say:

> As can be seen through my sacrifices I am a good, loyal and humble servant and the damage to the love object is not related to my weakness or lurking hostility but to the malicious activities of the evil-Other. To demonstrate my love I will attack and punish that figure for its crimes and will take revenge upon it.

Fornari (1975) underscores the problem of suffering guilt as the key to understanding such elaborations avoiding mourning and he writes: "The need to accuse someone else of the death of a loved person is the most obvious proof of *man's incapacity to bear guilt in the occasion of mourning*" (p. 55, original emphasis).

We have found that the problem of unconscious guilt cannot be underestimated. The challenge of suffering guilt constitutes the lynchpin of psychic growth, the turning point from which a narcissistic fusion with the ideal shifts to awareness of the self as separate, limited, small, and sometimes helpless to prevent the loss of a loved one. With the type of splitting described earlier, responsibility is fragmented (Segal, 1987), resulting in lack of clear accountability and compromising the capacity to inhabit one's particular and limited life. Riviere (1936) points out that the subject is tormented by the primary necessity to maintain the wellbeing and perfection of his love object, the unconscious primary object at the core of Klein's (1935) depressive position, and where the object is damaged or lost he feels that nothing may be done for himself until the object is completely and utterly restored. A type of unconscious sacrifice takes place through the transformation of the therapy into a sacrificial ritual.

Bergmann (1992) describes two forms of sacrifice. In the first, older form, hostility and persecution are projected into the deity so that "He" is established in an especially violent and ferocious form reflecting the

common experience of the superego of the group. Fear and terror of the deity's persecuting recriminations and condemnations take hold and the deity is felt to demand an exclusive and costly sacrifice to appease his anger. The sacrificing people atone their guilt through the propitiating action of the sacrifice of a valuable resource, most importantly the killing of an alive and valuable object. In response, the deity is felt to look favourably on the special ones who offered the sacrifice, softening his hostility and persecution into love and acceptance. The sacrificers are now the chosen people, secured in their connection with the deity, who is now obligated to extend a loving and protective hand in return. Examples of this type of sacrifice abound in classical myths, as we see in the sacrifice of Iphigenia by Agamemnon to appease the wrath of the goddess Artemis, who responds by turning the winds in favour of the Greek army, speeding their way to make war in Troy.

A second, more humane and communal form of sacrifice follows the group's development of a more mature superego where the deity (superego-ideal) is felt to be more benevolent and shares the sacrifice with the community. In this scenario a sacrificial beast is killed and the best parts of the meat are given to the deity, while the group consumes the rest. This is seen today in the Christian ritual of communion. Here the deity and the sacrificers share the strength and nourishment of the beast, the offering that "gives" its life for the worshippers, and bonds of love and gratitude unite both aspects of the community. This form of belief and sacrifice affirms the importance of love alongside the violence of the destruction of the offering.

The form of sacrifice used in this book is derived from the earlier, more primitive and ruthless form of the relationship between the subject and his deity. In the clinical context, the traumatically abandoned patient feels the violence of his radical separation from primary objects as a punishment and constructs his god-object in line with the violence that is at the core of his alienated circumstances. In primitive cultures a vulnerable, dependent, and vivacious object (a child or kid goat), considered to be innocent, carries the projected sins and guilt for the sacrificers (family, group) and must be destroyed, typically through burning, that is, in the Holocaustic mode. As the group believed their sacrifice atoned for the guilt of their sin and united them with their god-object, so the patient at an unconscious level expects a similar release from the agony of disconnection from his deity. The sacrifice substantiates and enriches the power of the god-object,

a manic restitution of the ego-ideal and the followers, here the patient, secure the promise of deliverance from pain and suffering.

An important aspect of this primitive form of sacrifice is that emotional pain (guilt, loss, perdition) is magically dissipated rather than worked through and integrated. Emotional agony and shame are likewise dissipated rather than experienced, represented, suffered, and accepted. We use the term "*regressive* suffering" to refer to the defensive function of the enacted sacrifice that takes place through the repetitious and empty ritual of the clinical sessions that seeks to avoid the pain of accepting loss, helplessness, and the tasks of working through in the depressive position. In this version of treatment the patient feels pain in a masochistic mode, with the goal of evacuating it out of the self, that is, without seeking to transform it into understanding and growth. In such a setting the therapy partnership cannot produce the baby, the new life of the self as all forms of pleasure, sexuality, hope, and generativity are also sacrificed on the altar of guilt.

Where the patient accepts the working-through process of the treatment and identifies and carries the burden of the guilt and shame forward towards understanding and integration we consider that to be "*progressive* suffering". This process is predicated upon the establishment of a bond of safety and acceptance within the relationship by means of the mitigation of the subject's harsh superego and the recognition that the ideal replacement object must be relinquished. In such a setting the patient might be able to work towards the mourning of the loss of the primary object and the ability to derive more pleasure from the growing success of the treatment. Bion (1962) observes how such an experience enables the subject to "learn from experience" and as he can suffer pain so he is able to "suffer" pleasure (Bion, 1965). An example of the reluctance to accept emotional pain was expressed by a patient who said, "If I turn back towards all the pain inside, then I will know it really happened and I will have to accept there is nothing I could do about it."

We can see how the patient's use of regressed suffering leaves him completely in the role of the victim, where he experiences life as having descended upon him, as fate or bad luck but not related to his choices or desires. He remains chronically innocent and bears no responsibility for his experience, and accordingly is unable to understand and accept the tragic pattern of his life. In such a state the patient seeks to disable the forward movement of the treatment by reversing the roles. Now the therapist must suffer the guilt, shame, and impotence the patient

feels; must apologise for the errors of her ways and must make the joylessness of the treatment her total responsibility. The patient, identified with the internal bad object of the aggressor feels relieved of the moral burden of his conscience and is able to look down on the therapist and use her as his scapegoat surrogate.

The patient, trapped within the unconscious experience of his radical ambivalence and psychic fragmentation, moves between seeking to activate his hatred and vengeance, by tormenting and frustrating the therapist or activating his desire to give and receive some measure of love and care that might lead towards separation and understanding. This double-bind condition of love and hate freezes the patient in the agony of a constantly repetitive relationship. He sacrifices the therapist as stand-in for the original lost loved object and sacrifices himself in his confusion about who is to blame for the crisis of his life and psyche. But because of psychic fragmentation, the subject can take almost any external figure or part of the self and use this object to act as the container for the patient's guilt, shame, and self-condemnation.

Because self and object are interchangeable in the unconscious, the designated sacrificial aspects of the patient's personality—that is, their vulnerability, dependency, or vivacity—may be projected on to, inscribed into, the therapist, or into any other person separate from the patient. When this occurs, the therapist or other figure becomes the sacrificial victim, in the sense that their skills are devalued, their achievements erased or negated, their liveliness deadened, or their significance as a figure of dependency denied. This recognition helps to explain why therapists working with this type of patient experience a wide range of painful and overwhelming countertransferential responses. The sacrifice of the therapist or the therapy, then, can be seen as a displaced but potentially representable form of the sacrifice of the self.

Clinical implications/considerations

The clinical situation with the chronically resistant patient presents the therapist with a series of daunting challenges. First, we have to adjust our expectations and therapeutic stance to accommodate the fact that the subject's internal world has become part "crypt" and part "fortress", reflecting the trauma of the loss of his primary figure of attachment and the collapse of his psychic structure. It is this bifurcated world that exists behind the

boundary condition of the patient's resistance. Unable to function without connection to an alive and available primary, internal figure, the subject establishes an internal ideal figure (replacement object) that he possesses and controls that allows him to deny the loss of the actual object and keep alive the hope of reversing his psychic tragedy. The ideal object functions as a "fetish" figure (an object used to cover over a missing reality; Freud, 1927e) to protect against the emergence of feelings of panic, madness, and completely alienated aloneness.

Second, a damaged, reproachful internal object is internalised as the bad object (superego component) that continues to attack and judge the subject for his responsibility in causing the loss of the primary object. Here a distorted sense of "omnipotent responsibility" (Wurmser, 2013, p. 27) causes him to feel chronically guilty, morally shamed, and relentlessly haunted. To bear up under the ruthless clash of his love and hate the subject radically splits himself into a condition of a dissociated, double-psychic reality.

Third, the patient seeks to transform his intrapsychic conflicts into interpersonal, *moral* ones (Britton, 2003) so that he may externalise them and feel justified in continually attacking the therapist (as stand-in for the actual lost object) and dominate her through manic triumph, humiliation, and obsessive control. The shame that the patient was forced to endure as a child becomes a weapon in his hands to both force the therapist to suffer in his place, what we have termed the scapegoat role, and as a communication to the therapist to demonstrate the savagery of his childhood experiences. In this way the treatment becomes saturated with an accusatory and relentless tone, inscribed into the soul of the therapist that allows for no resolution or relief and leads to states of intense and miserable countertransference.

Fourth, the patient is clinically depressed and suffers anxiety, persecution, mania, and excessive grievance due to the grave distortions of his primitive psyche, where he feels absolutely guilty and must project outward the bad parts of himself. This projection leads to what Fornari (1975) describes as the "paranoid elaboration of mourning" (p. 103) and the subject will not allow the recognition of his situation in order to deny the reality of his loss and aggression. This stance enables the patient to be free of any sense of gratitude for the therapist's help and support or any feeling of responsibility for the guilt he experiences for his incessant, sadistic attacks against the therapist.

The affect states become intense and tormenting, reflecting the double bind of wishing for relief and chronically preparing for battle. Rosenfeld (1975)

speaks of the subject's "omnipotent inner structure" (p. 221) as being loaded with envy that attacks both the dependent part of the self and the needy part of therapist. In this way we can understand that the subject's exclusion from the emotional and narcissistic centre of the mother's world has left him destitute and deprived of the investiture of the mother's acceptance and joy of life. As Bion (1962) observes, such individuals have not been able to satisfy their need for love, understanding, and mental development and therefore deflect such needs into a search for "material comforts" and the need for love turns into "overweening and misdirected greed". The patient is often the individual that "appears to be incapable of gratitude or concern either for himself or others" (Bion, 1962, p. 11).

The sacrificial act we describe in this book is an unconscious enactment of a primal phantasy (Wurmser, 2007, p. 268) where the subject's destruction of a therapeutic good, on the altar of his "private religion" (Freud, 1907b, p. 119), constitutes a sacred offering to his deity, the subject's self-created ideal god-object. The primary benefit of the sacrifice in the patient's desperate belief is the magical inversion of his catastrophic loss transformed into the deity's gratifying answer of fulfilment and union: the original object reappears and the unbearable gap between self and the maternal object is closed. There is no observable event in the session, only the patient's behaviour or communication indicating his refusal to accept the offering of the therapist. The sacrificial act both affirms the subject's complete loyalty to his god-figure, repudiating the therapist, and at the same time is a vengeful act against the therapist, now felt to be the original tormenting, parental object. Vengeance and sacred loyalty are combined in this one paradoxical moment.

In a way this act is a "human sacrifice" (Grotstein, 2000, p. 221) because the depth of the therapist's being is offered to the patient by means of her understanding and interpretations and the rejection of her care and understanding triggers a great loss and narcissistic insult as well as an outbreak of anxieties, seeming to confirm for the therapist that she is the reason for the patient's suffering and misery. The subject at the deepest level of his personality can feel annihilated by the perverse circumstances of his childhood and therefore it is perhaps not too dramatic to consider the patient's renunciation of the therapist's contributions a brutal act of cruelty and indifference (psychic murder?) that the patient has felt so many times throughout his development. It is the continual frustration of the therapist's offerings, ideas, and associations

that lead to the buildup of a very pernicious and toxic form of the countertransference that undermines the therapist's capacity to remain symbolic and not to react from the damaged parts of her personality.

The treatment process with a traumatised patient involves a long-term experience of the interpenetration of the therapist's self by the patient. The patient suffered the collapse of psychic structure and with that the weakening of his ego as well as the intensification of his superego in a primitive and attacking mode. Having suffered the loss of the primary figure, the subject has a chasmic void in his psyche that he seeks to fill with the ideal figure of the god-object. He continues to experience the paradox of his schizoid retreat against the therapy or, in a full-fledged assault, to merge or fuse with the therapist. Both conditions can threaten to overwhelm the therapist's position of manageable balance and containment felt in the countertransference. The therapist must work to first survive the chaotic and at times psychotic elements in the transference and, having mastered that, must seek to recover her mind and feelings so that she can begin to function once again as a symbolic, thoughtful, and sensitive container for the storms continuing to emerge from the patient.

Racker (1968) warns therapists against the dangers of *masochism* hiding in our empathy and of *sadism* hiding in our ambition. We seek the patient's affirmation in order to feel that our therapeutic care is actually real and effective and, what's more, that it is appreciated. The patient has an awareness of our motivations and can tell whether or not we understand and can appreciate the existential dimension of the crisis of his circumstance. The movement out of the register of the narcissistic, the perfect, and ideal requires an enormous amount of courage, faith, and hope, and the patient must gain some recognition that we appreciate the scope of his efforts. Such movement means that he is trying to descend down out of the mythical–magical narcissistic register of his injured unconscious into the register of reality-testing in the context of object relations, where progress is achieved through the hard work of reflection and integration and not through the power of moral purity and wish. We might even consider that the patient must forgo the pleasures of his imagined perfect feast in order to be able to participate at the table of the therapy meal prepared by the clinical partnership.

The class of patient we are addressing includes those that suffer from primitive mental states. Victims of trauma erect barriers against the re-experience of the original catastrophic circumstances and can manifest

the most intransigent resistant positions against the re-emergence of perverse and primitive experience and psychotic states. Likewise, the subject's identification with the aggressor objects leads to a perverse attitude towards the differences between the sexes and the generations. The sexual impulse loses its value in the generating of a new "life" in the treatment, the new child emerging from within the patient, and becomes degraded as a seduction or hysterical means of control, distraction, and complicity. Lurking behind the sterile sexuality of the traumatised patient is the wish not for new life but the attempt to "open the door to the past" in order to find an infantile retreat from the dangers of growth and maturity.

Lombardi's work (2016, 2017) seeks to support the patient in establishing a deeper and more compelling integration of the split, fragmented, and dissociated emotional network of feelings and experiences that protect the subject from reactivating the original trauma within his body. Our careful, slow, and sensitive containment efforts assist the subject in organising a "vertical connection" within his body so that the essential "body–mind link" (2017, p. 94) can be made (an internal vertical experience) and blocked feelings and memories can be accessed and liberated or, where they were unrepresented, they might be assembled from the material of the present. As the subject begins to come alive, the "horizontal relationship" (Lombardi, 2017, p. 94) between us can be strengthened with the subject neutralising some of the primitive horror and dread of his earliest experience. We move forward supporting the therapy and developing an intuitive appreciation for the creative efforts shown in his life and in his dreams. The path forward must be travelled carefully, slowly, without the greed for "accomplishment", and accepting the limits that continue to announce themselves.

From our study of antiquity (Bergmann, 1992; Davoine & Gaudillière, 2004; Girard, 1977) and of the literature of *Don Quixote* and the *Iliad*, we have identified two primary modes of therapeutic engagement that emerge when working with traumatised and compromised resistant patients. In the *regressive mode* the therapeutic process is organised around the idea of the therapist serving as the "scapegoat surrogate" (Girard, 1977) who accepts the patient's projected guilt and shame and mistakenly believes that her "sacrificial" efforts can lead the subject towards some resolution of the trauma of his childhood. Here guilt distorts her empathy and the paranoid–schizoid patient seeks to transform the cooperative nature of the alliance with the master–slave dichotomy where she is overwhelmed and subordinated to his will (Nietzsche, 1994). The patient, still in the grasp of the trauma and

madness of his childhood seeks to control the therapist as he was controlled by the figures of care that abandoned him. The patient's transitory evacuation of the bad into the therapist allows him to experience momentary innocence and relief and to use his narcissism and scorn to hold the therapist at bay as helpless, worthless, and a fraud. The treatment is sacrificed to the delusion of purification that is the imagined outcome of the scapegoat ritual offering.

The second form of the clinical relationship is a *progressive mode* where the boundaries and rules of the frame are maintained and where a therapeutic partnership is allowed to evolve that offers the patient the participation of the therapist as "*therapon*" (Davoine & Gaudillière, 2004, p. 150). This term, taken from the Greek, finds its most famous application in the *Iliad* where Patroclus is *therapon* to Achilles. *Therapon* means agent, representative, attendant, caretaker, and second-in-command, and this figure is the "keeper of the mind" (Shay, 1994, p. 44) of the master or warrior colleague. His job is to assist but not to replace. In the *Iliad*, Patroclus, in seeking to protect Achilles from the shame of his retreat from Agamemnon's greed and scorn, takes over his identity (wears his armour) and takes up the challenge of battle with the mighty Hector. Here he exceeds the role of the *therapon* and brings about the tragedy of his death and the scorn of the Trojans. Thus, in his confusion and manic response, Patroclus becomes the scapegoat for Achilles and brings about the crisis of Achaean leadership. He is killed and Achilles goes berserk with guilt and shame and engages in an orgy of murder and destruction.

In *Don Quixote* (Cervantes, 2005), the figure of Sancho Panza is a better *therapon* than Protroclus is to Achilles. He assists the Don in his mercurial adventures but does not take his place and does not impose his standards and goals upon the Don. His role as loyal second-in-command remains constant and he does not violate the implicit contract that holds the Don's values and goals as primary. Likewise Sancho Panza feels the agony when Don Quixote suffers the repetition of the failure of his many impossible dreams but he is not moved to exceed his role. The therapist in the role of the *therapon* is challenged to find the balance point between caring for the traumatised subject but remaining steadfast in her position and unwilling to offer the patient a form of help that defeats his essential dignity. She is a type of alter ego but always with the understanding that the subject must be supported so that he can cast off the illusions of his omnipotence and thus descend into the realm of the actual and the real. Progressive suffering emerges as meaning results from solving the problems of the past-in-the-present.

The humility of the *therapon* provides a sharp contrast with the grandiosity of the regressive hunger to use mythical–magical elements to make the impossible occur.

This book attempts to change the focus on treating an individual that Freud (1923b) described as suffering from a condition he termed the "*negative therapeutic reaction*" (p. 49, our emphasis). His hypothesis focused on his drive theory and the ways in which his speculative idea of the death instinct overwhelmed the patient's self and corrupted his superego, producing a measure of unconscious guilt that overwhelms the subject's ego and makes it impossible for him to participate in the treatment. The subject, unable to participate in the treatment, lapses into a masochistic process of self-abuse as the price to be paid for his sins and crimes and creates an intractable and inaccessible barrier of resistance that Freud (1937c, p. 252) felt was beyond the power of the psychoanalytic method to transform.

Our view presents a matrix of ideas that focuses upon the subject's loss of connection to the primal object of attachment, the internal figure of the mother and the resulting psychic collapse that presents him with a melancholic condition that compels him to create an internal ideal god-object to be used as a fetish replacement figure. The subject's retrospective construction of an internal realm of a "private religion" (Freud, 1907b, p. 119), validated and renewed through the use of the ritual of "sacrificial scapegoats" (Girard, 1977), provides the delusion that he is not alone, abandoned, and helpless. He operates in an order of traumatic compensation where the suffering of others in his stead can maintain his sense of omnipotence and acts as a barrier against his isolated and frustrating existence that threatens to drive him ever closer to madness or suicide. Rather than judging him as stubborn or obnoxious or pathologically masochistic, we present this subject as suffering from the tragedy of his disconnected emotional experience. The frustration and hopelessness he evokes in the therapist's experience of attempting to treat him, the painfully high price he pays through his suffering and sacrifice, may be reframed as the frantic activity of a lost subject of an imagined desperate "religion" that may be the path forward in treating such a tragic and traumatised human being.