

# Under Attack

## *Devaluation and the Challenge of Tolerating the Transference*

Bill Robbins, Ph.D.

*Devaluation presents one of the therapist's most difficult challenges: conducting therapy and managing resistance with patients who force the therapist into very aggressive and uncomfortable experiences. When these situations arise, the therapist has a twofold task. He or she must tolerate the transference so as not to engage in a countertransferential enactment. Additionally, from this vulnerable vantage point, he or she must help the patient understand both the meaning of and the consequences of devaluations of the therapist. Two cases are presented that recognize devaluation as an example of projective identification and illustrate the challenge in working with this dynamic.*

(The Journal of Psychotherapy Practice and Research 2000; 9:136-141)

Simply put, to devalue is to diminish the worth of something or someone, to attack, to criticize. Criticism can be an objective investigation of merits and faults. Whereas criticism can be constructive, devaluation has multiple functions. It is meant to weaken, hurt, or even annihilate the object while establishing a sense of control, all in the service of reducing the experience of vulnerability or fragmentation. It is clearly aggressive, it can be sadistic, and it heightens feelings of grandiosity and invulnerability. Devaluation can also function as a form of retaliation to punish the therapist—who is experienced as the one who is inflicting emotional pain—thereby helping the patient distance from vulnerability and disappointment.

### ENTERING INTO AN ENACTMENT<sup>1,2</sup>

Some time ago, working with Ms. D., I was startled by the effect devaluation had on me. It brought to my attention how painful devaluation can be and how significant its consequences.

Received December 15, 1998; revised March 15, 2000; accepted March 20, 2000. Address correspondence to Dr. Robbins, 1939 Divisadero Street #2, San Francisco, CA 94115.

This article is a revised and enlarged version of the chapter "Neutrality Under Attack: Devaluation in the Therapeutic Relationship," by Bill Robbins, published in *Disorders of the Self: New Therapeutic Horizons—The Masterson Approach*, ed. James F. Masterson and Ralph Klein. (New York: Brunner/Mazel, 1995). Material originally published in that chapter is reprinted by permission of the publisher.

Copyright © 2000 American Psychiatric Association

I announced to Ms. D. that I would need to change her appointment time. She said that it was okay with her because in another month she would be changing jobs and would need the time change herself. My schedule contained three open hours.

I offered her one of the free hours and she declined, for what was a legitimate reason. I offered her the second option. She said that choice would impose a great hardship. I then offered her the third of the free hours. She was pleased, and accepted the time.

But then she added, "What's happening, are all your patients leaving you?" I felt wounded, but it was at the end of the session, and I quickly discounted my feeling of vulnerability, mistakenly thinking I had let it pass. But I had not let it pass. I wrote down the earlier appointment time that she had told me was unsuitable. The next day, when a new patient called, I filled the time Ms. D. had chosen with the new patient.

By chance, Ms. D. was a few moments late to her next appointment and I, unaware that two patients had the same hour, ushered in the new patient. When Ms. D. arrived, she waited about 15 minutes and left. At the end of the hour I found a legitimately angry message on my answering machine. I had made an upsetting blunder that had to be repaired.

Technically, I had responded to the patient's devaluation by inadvertently entering a countertransference enactment involving a sadistic projective identification back into the patient. I momentarily had rid myself of an exquisite vulnerability, but the price was my countertransferential withdrawal and retaliation by denying her her own hour, essentially leaving her. It made me realize my own vulnerability and its potential consequences, and led me to take another look at the issue of devaluation.

If I had had the awareness not to enter into this mutually sadomasochistic enactment I would have been able to tolerate and metabolize her projection, use it as important transferential information, and explore with her some of the dimensions of her experience. From my knowledge of her history and dynamics, I could have surmised that she was identifying with a fantasy of my being abandoned by my patients and, in fear that that could happen to her, was only asking for clarification. Or perhaps she was feeling guilty and frightened at getting her own needs met, and needed to attack me to handle her own anxiety. In either case, her devaluation seemed likely to have been used to manage fear and conflict. Now, as a result of my entering into a countertransferential enactment, it would be difficult for me to help her focus on the exploration of these dynamics.

## OBJECT RELATIONS AND PROJECTIVE IDENTIFICATION

The patient who uses the defense of devaluation often responds to anyone who threatens his or her sense of emotional safety. The function of devaluation is to maintain a grandiose self-image.<sup>3</sup> Furthermore, the patient is ready to fight, if necessary, to sustain this self-image, as will be seen in the next clinical example. Devaluation in the therapeutic relationship is an exceedingly active form of projective identification, in which painful and disavowed self-representations are verbally forced into the therapist. There have been numerous explanations and elaborations of projective identification.<sup>4-8</sup> Langs<sup>7</sup> provides a useful definition:

Projective identification is an actual interactional effort to place or dump into, and to interactionally arouse in the object some aspect of the subject's inner mental world and functioning. The term *identification* in projective identification . . . implies that the subject is still identified with the contents or mechanisms that he or she is attempting to place into the object . . . and because of the realization that the subject is attempting to evoke an identification with some aspect of himself or herself by the object. (p. 113)

A useful way of understanding the dynamics of projective identification is to see it as a reversal, under stress, of self and object representations, as described by Klein:<sup>9</sup>

The process of projective identification is often far more insidious [than projection] and can be "upon" the therapist before he is prepared for it. Further, the distorted perception of reality which leads to active participation in these projective mechanisms is not easily corrected, as it invokes basic and virtually universal questions about our professional identity as well as our personal self-identity (such as whether the therapist has the ability to help a patient, or if someone else might be far more qualified or able to do so).

In the process of projective identification, the patient projects aspects of the self-representation of the rewarding or withdrawing object relations part-unit while simultaneously identifying with aspects of the object representation of the respective rewarding or withdrawing units. When the projective identification involves the rewarding unit, the therapist is made to feel helpless, manipulated, and dependent on the patient for a feeling of well-being and to set

the feeling tone of the session. For example, when the therapist finds himself awaiting the arrival of the patient with a sense of diffuse anxiety, which escalates if the patient walks in obviously angry or moody or is dissipated if the patient walks in smiling or bright, he is caught in projective identification. A related phenomenon also associated with an aspect of the self-representation of the rewarding unit is the therapist's felt need to be perfect, which derives from the projection of the patient's felt need to be perfectly compliant or "good." The therapist here feels vulnerable to, and upset by, the patient's criticism or his own self-criticism, usually experienced as guilt.

When the projective identification involves the withdrawn unit, the therapist feels inadequate, inferior, worthless, or bad in response to the patient's explicit or implicit characterization of the therapist as unhelpful, inexperienced, incapable, confused, or simply stupid. (pp. 283–284)

In a more commonsense explanation, the patient exchanges his identity, the vulnerable experience of the moment, and protects himself by taking on the role of a more powerful and harsh parental identity. We are seeing a reenactment of a distressing emotional historical event, but now the patient is identifying with the attacking parental representation and the therapist is forced into the role of a vulnerable self-representation: the patient as a child.<sup>10</sup>

The patient is now repeating his history in vivo, but this time in the role of a parent, and the therapist is forced into the experience of a victimized child, to feel the now-disavowed worthlessness and fear. The patient has emptied these feelings out of himself and into the therapist, and thus can regain a momentary feeling of psychic equilibrium. The devaluation has protected the patient from painful self-representations. Fortunately, it has also allowed a communication between the patient and the therapist of a disavowed experience that could not be expressed in verbal language.<sup>11</sup>

#### THE TEST OF TOLERATING THE TRANSFERENCE

The therapist's tolerance is severely strained by devaluation, and this can lead to the enacting of countertransference feelings, as in the example with Ms. D. The patient's use of devaluation, generally joined with aggressive, manipulative, and competitive drives,<sup>12</sup> presents a complex therapeutic dilemma. Because of the patient's sensitivity to criticism, the interpretation and management of devaluation may be experienced as

critical or as merely an effort to evade the patient's aggression, rather than as exploratory.

Thus the therapist attempts to tolerate the patient's transference with awareness of the potential for, in this case, masochistic countertransference responses. These communications (through projective identification) can perhaps become the basis for appropriate affect-laden interpretation of the transference. However, because of the power and personal specificity of these projections, they present a risk as well as an opportunity. Few defenses require so much from the therapist as devaluation.

When the patient's vulnerable thoughts and feelings are projected onto the therapist, they can easily provoke the therapist's own vulnerabilities. When the patient is attempting in this way to force the therapist to experience the feelings associated with the patient's own vulnerability, it often becomes very difficult for the therapist to be present, empathic, and nonretaliatory. Yet it is essential that the therapist remain neutral, not respond with criticism, and stay available to the patient throughout this struggle.

Additionally, the therapist may also be responding to his or her own intolerance of the display of the patient's primary narcissism. The patient's demands for perfect mirroring, exact attunement, and admiration can stir envy and resentment in the therapist. Underneath the therapist's discomfort with some of the patient's more blatant narcissistic self-entitlements can lie a sadness and rage at the necessity to manage, rather than give free rein to, his or her own unresolved infantile grandiosity. If one of the goals of treatment with a patient who uses devaluation is to help the patient manage aggression, the therapist, in the interest of maintaining therapeutic neutrality, is required to do the same.

#### CASE REPORT

**Presenting Problem and History.** Mr. C., a 35-year-old attorney, was one of my more challenging cases, specifically because he used devaluation as a primary defense. He had been referred to me for help with his stressful work situation. Mr. C.'s early history revealed that he had had to protect himself from any expression of grief or anger because this would endanger his relationship with his mother. She could be physically abusive, but more often she was extraordinarily unpredictable. She could be charming and seductive or ruthlessly rejecting. When his mother pushed him away, Mr. C. had to manage the terrible pain of being rejected by the one he loved and whose love sustained him.

In a household with three other siblings, Mr. C. soothed himself with the knowledge that he was the brightest and most favored in the family and the one who could most consistently calm his mother's anger and frustration. This experience of fusion with his mother, the omnipotent object, was the source of a grandiose self-image. This allowed him to develop a sense of superiority as well as a unique closeness to her. There was, however, another side to this experience of fusion. It involved a mother who, while very punitive, was often weak and unconfident, and a family environment pervaded by chaos and lack of direction. This aspect was experienced in the pain and anxiety of a dangerous and hidden vulnerable self. To cope with this vulnerability, he identified with his mother's aggressive defenses (identification with the aggressor), and this became the origin of his use of devaluation.

Although sadness was extraordinarily difficult for Mr. C. to access, fear and anger were not. When these emotions overtook him in childhood, sometimes as a result of a disagreement and especially when his mother lost interest in him or became interested in a new lover, he would retreat to the attic of his home. Here he had set up a room full of model airplanes hanging from the ceiling in combat formations. He would proceed to discharge his rage by battling the enemy in "dogfights" and triumphing as the victor. In this way he could avoid facing his rage and helplessness directly. It was a metaphorical but also a very real struggle between victory and annihilation, which survived into adulthood. Mr. C. learned to protect his vulnerability to rejection and criticism in important relationships by making sure he felt victorious whenever possible. In adulthood he transformed the battle into the intellectual domain, where he often excelled.

**The Challenge of Treatment: The Testing Phase.** Coming into therapy presented a unique problem to Mr. C. It required him to focus on himself without my admiration of his display of grandiosity. Feeling and revealing his weaknesses to me led him to feel vulnerable to attack. When I didn't start the session and direct him, he handled his difficulties by voicing a series of intense, persistent, almost reflexive devaluations.

On entering the room he would often criticize the temperature of the office or its ventilation. He used a devaluative tone of voice to reduce his fear and uncertainty on beginning the session. At other times, he would devalue me to deal with his disappointment when I didn't have anything useful enough to say that might enable him to feel better about himself. "You're a shitty therapist," he would shout. "God damn it, say something."

He would devalue me when I couldn't help or soothe him, especially with his stressful interpersonal difficulties at work. He would also criticize me for dust in the office, some ants on the floor, a mistake on his bill, my looking at the clock, my raising my fee, my colorful sport jacket, or my seven-year-old car, which he had seen. Some of the devaluations were more subtle and were reflected in his body lan-

guage. His facial expressions could clearly show disdain, or he might display a smile of superiority when he was shown into the office.

Additionally, he got involved with a number of other authority figures, which helped to dilute his involvement with me and reflected a more subtle but additional devaluation of his treatment. He was in group therapy and would consistently compare me with the other therapist. I was portrayed as inept, while the other therapist seemed extraordinarily gifted and helpful. He was also in a very close relationship with a therapist uncle. Mr. C. often talked over his therapy with the uncle and got his opinion on many issues related to treatment. Although it gave Mr. C. a greater intellectual understanding of what was happening to him, it also diluted his emotional connection to the treatment. It allowed him to protect himself from fears of full involvement with me, banishing me to relative insignificance. These were ways of dealing with his fears of exploitation and abuse, which he projected onto me.

Mr. C. was also using devaluation outside the office. He would continually criticize his colleagues as dull and stupid. It was preferable to focus on the fools at work so as not to focus on himself. Mr. C. was using the same well-crafted skills he had developed in childhood. His major weapons were devaluation and distancing. These "dogfights" were primarily a protection against vulnerability but were also a way to punish me, his colleagues, or anyone who didn't meet his insistent demands for mirroring.

**The Interpretation of Devaluation.** When I recognized these maneuvers, I would intervene with a variety of interpretations of narcissistic vulnerability. I would remind him that he had come into therapy to understand why his self-esteem fluctuated so markedly. It seemed to me, I told him, that when he was required to turn his attention on himself to explore and attempt to understand his situation, it was either too dangerous or too painful for him to contemplate these feelings with me.

I added that I had to wonder if by focusing on the annoyance of events outside himself, the temperature of the office, my car, my clothes, he was perhaps managing his fears by focusing his attention on what he judged were my limitations. I also wondered if he was experiencing me as a dangerous rival, for he seemed to be attacking me, trying to render me helpless and harmless. Mr. C.'s responses varied. He might mirror me by agreeing with me, but my interventions did not take into account his still limited capacity to respond to the meaning of my interpretations emotionally as well as intellectually. His defense was still too entrenched to make any lasting change.<sup>13</sup>

At this stage of treatment, the limitation on my ability to help him control his devaluations was partly a consequence of my participation in these "dogfight" enactments. My inability to control my own feelings of narcissistic vulnerability in the face of his devaluations made it more difficult for him to establish an idealizing transference, safety through a relationship with me as an idealized object. This

important process often develops slowly but naturally, but in the beginning of treatment I had often been wounded and somewhat immobilized, identifying with his projections. Thus I had not been able to follow through fully to examine and interpret his resistance to my interpretations.

Although outwardly I was making accurate interpretations, more personally I was accepting some of his projections onto me and often experiencing myself as inept and useless. This was the result of my entering the enactment with him, taking responsibility for a sense of failure at his inability to access feelings and his strong resistance against an emotional recognition of the therapeutic relationship. In the face of his attacks, *I* was experiencing the helplessness and *he* was feeling superior. Mr. C. was quite perceptive in recognizing my limitations, the shortcomings in the delivery of some of my interpretations as well as the occasional shifts in my own self-confidence. His devaluations were wounding my own narcissistic sensitivity, confirming feelings of deficiency and imperfection.

Therapy, at this stage, almost came to a standstill. My immobility was actively reinforcing a major resistance, and I came to understand that Mr. C. was experiencing my interpretations merely as maneuvers to evade his aggression. However, as I pondered the difficulties of therapy with Mr. C., both by myself and with consultation, I began to gain control of my own participation in the enactments. While at this stage of treatment Mr. C. could only discharge his rage rather than hear my interpretations, I was becoming less sensitive to his devaluations, less fearful, more able to think clearly in the face of his resistance. Therapy can't work with two scared people in the room.

My first strategy of interpretation was an attempt to use the communication inherent in the projective identification to help Mr. C. more fully understand the genesis of these enactments. When a devaluation was being forced into me, I used the moment to share with him that I was experiencing myself as vulnerable and weak and subject to attack, and I wondered, since this was an experience not generally familiar to me, if he wasn't communicating this feeling to me in an attempt to help me understand his experience. He seemed interested in what I had to say. I sensed a momentary affective response, but it did not lead to any obvious change.

**Confrontation.** Finally, I recognized that to help Mr. C. control his acting in, I would have to get my message across with a broad and affect-laden limit-setting confrontation of his devaluative defenses. I knew there was a chance of losing him as a patient, but I saw no other choice. Importantly, I had to first evaluate, through introspection, that a secure enough attachment was in place and that I was not using my role in a countertransference enactment. When I felt as sure as I could be that I was expressing myself from a neutral platform, I offered him my understanding of how his difficulty in dealing with his vulnerability, grief, and rage led to these "dogfights" and how these also reflected his identification with his experiences with his mother's abusive dis-

charges. However, I also told Mr. C. that whatever our understanding of this sequence of discharging his painful feelings, the brief satisfaction he was getting out of these maneuvers was not therapy. I added that I was no longer going to be the dumping ground for these ultimately self-destructive efforts to feel better about himself. I then suggested that I thought he was no longer an innocent bystander, that he was now quite aware of the destructiveness of his own behavior in treatment, as well as outside. Finally, I told him that if the devaluations were to continue he would have to find another therapist. It was a strong confrontation, forcefully delivered, and had a very significant impact. Without this new challenge, he and I would never have been able to reach a therapeutic alliance.

From a neutral platform my confrontation, combined with the management of my countertransference, now set the foundation for his control as well as his understanding of his devaluative defense, which was also contributing to the difficulties in which he found himself outside of therapy. Although Mr. C.'s first response was fear, of me and of abandonment, I made clear that abandoning him was not on my agenda, but that I did mean business.

The devaluations gradually decreased in intensity, although it was still often necessary for me to interpret or confront his devaluations on the spot when they occurred. Next, Mr. C. began to take on that responsibility. He would announce his devaluative thoughts, but they were one step removed from action. At this stage I might often confront or interpret unnecessarily, and he would ask me calmly and movingly to not push him, that he knew what was happening. He had begun to deal with his vulnerable feelings in a self-reflective way. Finally, the devaluations were brought under control and he could express his disappointment that at times I did not fully understand his inner workings, rather than attack me for my imperfect formulations.

As he exerted his willpower and concentration in controlling his acting out, the therapeutic relationship slowly but measurably deepened. Mr. C. was learning that if he controlled his aggression there were still safe avenues available to express his pain and disappointment, both in others and himself. I, in turn, was learning that my most essential task, addressing his devaluations and their meaning from a neutral position, required the management of my own vulnerable feelings when attacked and bruised.

In the next few months, especially as Mr. C.'s treatment began to make a difference to his life and feelings about himself, he expressed a heartfelt remorse at his previous behavior. He seemed honestly shocked in hindsight at the consequences of his devaluation. It had imperiled his relationship with me and had delayed significantly the focus on himself. He began to understand how his need to protect himself, by devaluing others and upholding an image of superiority, was creating additional challenges to his very survival at work as well as the possibility of any romantic relationship. He now began, for the first time since the beginning of treatment, a serious relationship with a woman. Within this context, and to my surprise, he began to seri-

ously reevaluate his career goals and to contemplate life in a family as well as work that was not so driven by a need to display and be admired.

## DISCUSSION

Stepping back from the case material, I would like to suggest some general guidelines for dealing with devaluation in the therapeutic relationship. First, therapy with patients who use a defense of devaluation requires an ability on the therapist's part to tolerate the transference, especially when it touches on his or her own narcissistic vulnerabilities. It is fundamental, in spite of our own limitations, that we appreciate that we are good enough therapists, and that our motives are essentially in the patient's best interest. Therapy is stalled when both people in the room need to be perfect. Additionally, it is important to try to avoid taking the transference personally. The transference acting in represents an in vivo survival strategy, one that may have been our patient's most essential protection against fragmentation. The therapist becomes a stand-in, usually for parents who were experienced as unavailable or intrusive.

In addition, although it is not unusual to experience anger at being devalued and used in this way, therapeutic neutrality implies the need to tolerate the transference. It is the therapist's task to interpret the devaluation, but it is also important to set limits on the degree of contempt and devaluation that the therapist

is willing to tolerate. On occasion, it may be helpful to include an explicit communication to the patient of how the therapist is experiencing the aggression directed against him or her.

A genuine therapeutic alliance can be established only on the basis of a respectful engagement between the two parties in treatment; it is only within a therapeutic alliance that working-through can be contemplated. It may be possible to accomplish this by interpretation, but at times it may be necessary to use confrontation. If we let the patient emotionally destroy us, he or she will be repeating the destruction of yet another object who might have provided some relief. It will reinforce the patient's perception of a dangerous, destructive, even murderous self-image. Underneath the facade of devaluation may be fear as well as remorse for the methods that had seemed to be the only recourse at this person's disposal to remain sane.

We should also try to distinguish criticism and disappointment from the act of devaluation. The therapist should try to be available for the patient to express any perception of the therapeutic relationship, whether it be accurate or more fully a projection. We must consider the expression of criticism or disappointment seriously, as well as observe how it is presented, especially if it is used to evaluate and explore. As with so many of the obstacles to growth in our clinical work, we learn more about ourselves through the process, which ultimately brings meaning to both participants in the therapeutic relationship.

## REFERENCES

1. Johan M: Enactments in psychoanalysis: panel report. *J Am Psychoanal Assoc* 1992; 40:40-41
2. McLaughlin JT: Clinical and theoretical aspects of enactment. *J Am Psychoanal Assoc* 1991; 39:595-614
3. Masterson J: *The Narcissistic and Borderline Disorders: An Integrated Developmental Approach*. New York, Brunner/Mazel, 1981
4. Sandler J: *Projection, Identification, Projective Identification*. Madison, CT, International Universities Press, 1987
5. Klein M: Notes on some schizoid mechanisms. *Int J Psychoanal* 1946; 27:99-110
6. Ogden T: On projective identification. *Int J Psychoanal* 1979; 60:357-373
7. Langs R: *Psychotherapy: A Basic Text*. New York, Jason Aronson, 1982
8. Ogden T: *Projective Identification and Psychotherapeutic Technique*. New York, Jason Aronson, 1982
9. Klein R: Confrontation with the borderline patient, in *Psychotherapy of the Disorders of the Self*, edited by Masterson J, Klein R. New York, Brunner/Mazel, 1989, pp 283-284
10. Seligman S: Integrating Kleinian theory and intersubjective infant research observing projective identification. *Psychoanalytic Dialogues* 1999; 9:129-159
11. Ogden T: *Projective Identification and Psychotherapeutic Technique*. New York, Jason Aronson, 1982
12. Masterson J: *The Narcissistic and Borderline Disorders: An Integrated Developmental Approach*. New York, Brunner/Mazel, 1981
13. Cartwright D: The reversal of pathological projective identifications: the problem of patient receptivity. *British Journal of Psychotherapy* 1998; 15:3-18