THE ANALYST'S TORMENT

Unbearable Mental States in Countertransference

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To Mia and Maanav

For helping me remember what is important

Contents

Acknowledgments

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Introduction

> *The capacity for countertransference is a measure of the analyst's ability to analyze.*
>
> —Hans Loewald (1986, pp. 285–286)

There was a time when I thought that my patients lived in a different world than I did. I imagined their world centered upon "character pathology" and "maladaptive defensive coping strategies"; my world involved knowledge and insight, the tools I could use to help my patients get better. I fantasized about taking in everything in the introductory psychoanalytic textbooks on personality psychopathology I treasured—my favorites were Nancy McWilliams's *Psychoanalytic Diagnosis*, Glen Gabbard's *Psychodynamic Psychiatry in Clinical Practice*, and David Shapiro's *Neurotic Styles*—and using the immense accumulated wisdom and insight these authors demonstrated psychoanalysis had to offer. These books had secret knowledge of what was going on inside the minds of my patients, knowledge I could master as a technique to help them.

Of course, this hunger for knowledge had motivations unknown to me at the time. There was an unconscious omnipotent fantasy driving this quest to know—inhabiting the role of "a hero in training," a future

champion who could conquer any psychopathology that came my way. The divide between me and my patients gave me a safe distance from their psychic pain to enact this fantasy—clearly, they were the ill ones needing my expert help.

This was also a move away from my own troubled past, my family history, and the ghosts that led me to this strange profession where I am paid to be with mental suffering in all of its forms. Rendering them "the sick patients" and me "the healthy doctor" blocked my ability to authentically know and feel my own personal suffering and to honestly face my patients' inner torment and psychic pain that I could not bear to feel along with them.

I should have known better, if my unconscious did not get in my way. My first psychology professor, who was also the first psychoanalyst I ever came across, was George Atwood. Warm, wise, and self-effacing, George Atwood always emphasized that our psychological theories and formulations about our patients are not objective rational constructs—far from it. They are deeply embedded in our way of being and created by our own subjective experiences, our histories, and the intersubjective space between us and our patients.

In fact, the first psychoanalytic book I was assigned to read as an undergraduate was Atwood and Stolorow's coauthored book *Faces in a Cloud*. Reviewing the lives of several early psychoanalytic pioneers, including Freud, Jung, Reich, and Rank, Atwood and Stolorow demonstrate how their brilliant psychoanalytic theorizing was deeply intertwined with their biographies and life histories. I especially appreciated how Atwood and Stolorow put themselves and their theories on the chopping block as well, describing how their own personal histories brought them to intersubjectivity and self psychology.

This book is an attempt at a similar kind of emotional honesty, although this went unrecognized by me during the process of writing these chapters. In a sense, it is about a shift in emphasis in our psychoanalytic theorizing towards *our* subjectivity, using what we know as psychoanalytic clinicians to understand our own therapeutic motivations, mishaps, and stumbles with our patients. The purpose of this shift in emphasis towards our subjectivity is to highlight what gets in the way of our capacity to face up to what we are feeling and how it is impacting our patients.

George Atwood's emotional honesty and ability to reflect on what was happening within himself in his encounters with patients resonated with me after years of facing my own clinical limitations and failures as a psychotherapist. As Mike Tyson famously quipped, we all have a plan until we are punched in the mouth. Being a therapist requires one to take many punches in often unexpected and painful ways that reach us in our most private and guarded places. To make matters worse, our knowledge of our patients and what they need often ends up being based on our own illusions of healing that can be more narcissistic than helpful. Acknowledging that we never fully know what we or others feel encourages caution, humility, and genuine curiosity about ourselves and others (Jurist, 2018).

One central theme in this book is how our uncomfortable and disowned emotional states of mind are inevitably entangled with our understanding of patients, potentially derailing the therapeutic process as well as at times facilitating it. Our knowledge and formulations of our patients are always inherently flawed and biased, often unknowingly based on our own psychological conflicts.

The chapter on arrogance addresses this potentially problematic use of knowledge directly. Creatively inspired by Bion's celebrated and enigmatic paper "On Arrogance" (1958), this chapter discusses some common ways in which we stop listening and become to varying degrees "self-important, stupid and flat" in the face of uncertainty and intensity. Overcoming our narcissism and being able to be with our patients without resorting to arrogant or masochistic defensive strategies to cope with the unbearable experiences inherent in analytic and psychotherapeutic work is a lifelong struggle for me, and I suspect it is for many of us.

This theme of facing unbearable experiences with our patients is continued in the chapter on racism. Here the focus is on dealing with historical and culturally loaded traumatic experiences outside of the consulting room that collide with associative material in the session, potentially derailing the therapeutic process. I am grateful to Jill McElligott for creating a panel at Division 39 of the American Psychological Association in 2019 on "Clinical Considerations of Psychic Emancipation in a Racialized Society," where I was able to present some of this material with Dionne Powell, a psychoanalyst whose writings and talks on racism inspired much of this chapter.

This focus on what unknowingly gets in our way in helping our patients has echoes of Freud's original ideas on countertransference, which have to do with the unconscious inhibitions and conflicts within us that impede our ability to be an effective analyst. Despite his limitations, there is much to value about Freud's original conceptualizations of countertransference—they aimed to safeguard the patient from the analyst's own unconscious reactions and narcissism that could harm the patient. Returning to Freud's original contributions on analytic listening and countertransference from a contemporary perspective, Pinsky (2017) notes that in stark contrast to recommending treating the patient like a "trite caricature of the silent doctor," with coldness or indifference, ideally the analyst should be "self-restrained and open-minded, non-intrusive and affectively involved," always remembering they are human with limitations (Pinsky, 2017).

Freud originally used the term countertransference to highlight the dangers of analysts' succumbing to erotic transferences. The chapter on erotic dread describes this in more detail and discusses the dreaded erotic intermingling of genders, bodies, and minds that occurs in every in-depth analytic treatment. In contrast to Freud's at times defensively insisting on a need to "conquer" what we are feeling in the erotic countertransference, I highlight contemporary psychoanalytic approaches which emphasize the necessity to be open, curious, and receptive to what is happening within our bodies and our intersubjective self-experiences.

This disruption of our ability to be with our patients in an affective and embodied way is also highlighted in the chapter on dissociation. Our dissociative defenses against psychic trauma and how we create distances between ourselves and our patients by unwittingly removing ourselves from our lived experiences of our body, our affects, and our ability to be present and alive as we encounter and reexperience trauma with our patients is known to all of us but infrequently addressed in detail.

Dissociation allows us to survive our patients' unbearable affects and trauma, but at a cost. I did not understand what this cost was when I first encountered the first psychoanalytic paper that was truly meaningful to me as a psychiatric resident, "Countertransference Hate in the Treatment of Suicidal Patients" by Maltsberger and Buie, written in 1974, published in the *Archives of General Psychiatry*. One of my psychiatric supervisors at the time, an irritable no-nonsense former naval lieutenant who

detested psychoanalysis, tossed this wonderful "old school" article at me early in the morning in our psychiatric emergency room after I told him how detached and emotionally exhausted I was by all the trauma and violence I was bearing witness to. "Well, read this and learn about why that is," he growled at me. "If you want to be in this for real you better get used to feeling other people's intensity thrown at you."

This deeply psychoanalytically rich article about our most intense reactions to our patients in crisis, enigmatically given to me by a psychiatrist who had no patience for psychoanalysts, was a revelation to me and, in many ways, another catalyst for this book. Following in the tradition of Winnicott's courageous work, "Hate in the Countertransference" (1949), Maltsberger and Buie concisely describe why we harbor often unrecognized hatred towards our patients in crisis and how we end up expressing this hatred through various means of aversive tactics, affectively communicating to the patient, "I do not want to be with you." Our patients feel more abandoned in this distanced stance, which worsens the crisis. Allowing space for language that described the emotional onslaught I was facing and how to deal with it clinically helped me immeasurably, and inspiration and direct references to "Hatred in the Countertransference in Suicidal Patients" are featured in several chapters in this book, including the chapters on dread and hopelessness, both of which are unbearable states of mind familiar to all clinicians who work with patients who are suicidal or suffering acute psychic trauma.

The chapter on hopelessness focuses on the collapse of an analytic vision and the often unconscious thwarted *hopeful* fantasies underlying our experience of hopelessness in our therapeutic work. Our often unrecognized dread of our patient's most intense affective experiences and the rupture of empathy that follows from this is the basis of the chapter on dread, which highlights suicidality as an especially potent experience in the countertransference that can stir unbearable feelings that lead us to unconsciously distance ourselves from our patients.

Maltsberger and Buie's article also helped me honestly face up to what they call "the three narcissistic snares" all psychotherapists harbor to some degree: to love all, know all, and heal all. When we inevitably fall short of these ideals, we are prone to experiencing shame, which is an important countertransference experience we all need to face as clinicians. Learning how to face our shame in a dignified way that allows

for us to continue to make contact with our patients and grow from the experience is the focus of the chapter on shame, which also describes other difficult and unbearable experiences we shamefully face as therapists, including failure, greed, and envy.

One unbearable emotion I struggled writing about was jealousy. After Salman Akhtar graciously invited me to write a chapter on countertransference jealousy for his edited volume on the topic, I felt at a loss at how to describe this painful and tormenting experience in a clinically meaningful way. Salman Akhtar thankfully introduced me to the writings of Harold Searles and his innocuously titled book *My Work with Borderline Patients* (1986). Searles's chapter entitled "Jealousy Involving an Internal Object" was challenging, shockingly honest, and clinically useful, giving me the inspiration for the chapter on jealousy, included in this book in a slightly revised form.

Harold Searles, Heinrick Racker, Paula Heimann, and other psychoanalytic theorists influenced by Melanie Klein informed my understanding of how my emotional reactions like jealousy can guide me in understanding my patients' inner experience. I have reservations about this way of knowing, as I have outlined in several of the chapters of this book. Overall, however, it is indisputable to me that what we feel, in our affects, bodies, and reveries with our patients, is vital in helping us understand and metabolize their emotional experience. This is fraught and dangerous territory, however, leaving us vulnerable to assumptions, biases, and concrete ways of thinking that can close down the therapeutic process and colonize our patients' minds with our fantasies of what they are going through based on our biased feelings and intuitions.

Being able to first recognize and then make sense of our disturbed state of mind is crucial in these situations. As Busch (2019) notes, it is not just the recognition of a countertransference reaction that is helpful therapeutically for our patients, but this recognition combined with an honest self-analysis of our own contribution. What is essential is the difficult work of discernment, uncomfortable emotional honesty, and sorting out what is happening in every unique encounter within the shared space of both the analyst and patient. We can never assume our feelings are useful or related to our patients' emotional experience without authentically being in the struggle with them. We strive to be responsive, yet disciplined—alert to our internal experience, with

the aim of distinguishing between constructive and harmful uses of the countertransference, always with the goal of finding a way to be with our patients (Pinsky, 2017). This type of emotionally honest, uncomfortable, and close attention to the bidirectional and intersubjective processes of what happens between analyst and analysand has its origins in the work of Sàndor Ferenczi. Over ninety years ago, in 1928, Ferenczi wrote that the analyst

> has to let the patient's free associations play upon him, simultaneously he lets his own fantasy get to work with the association material; from time to time he compares the new connections that arise with earlier results of the analysis; *and not for one moment must he relax the vigilance and criticism made necessary by his own subjective trends*. (p. 86, quoted in Meszaros, 2015, italics mine)

The variety of ways we fall short of this type of engagement described above is at the heart of what this book is attempting to describe. The focus should always be on the patient and what gets in our way of being able to authentically engage with what is most difficult for them to bear.

This requires the work of mentalization on our part, our capacity to affectively make sense of and interpret behavior in terms of mental states, whether our own or others' (Jurist, 2018). We actively mentalize about our patients' mental states and invite our patients to mentalize about their own mental states and about others', including our own. As Jurist (2018) notes, "All psychotherapy boils down to being a project of two minds engaging each other and trying to make sense together" (p. 2). The process of mentalization is not just about providing intellectual interpretations to patients to further their self knowledge, or to encourage behavioral change. Instead, it is a focus on emotional communication, valuing being able to receive input from others and being vulnerable to revealing oneself to another. Mentalization encourages open-mindedness and "being able to sustain an active, fallible investment in reevaluation of self and others, past and present" (Jurist, 2018, p. 2). This involves the work of improving our skill in identifying, modulating, and expressing emotions. It also requires us to increase our range of emotions we are aware of and being more at ease with the

emotional intensity and uncertainty that occurs in our communications with patients.

Our ability to "go there" with our patients and give ourselves over to their unbearable experiences of suffering and annihilating states of mind is in the end what offers the best chance at helping them. As opposed to an overemphasis on focusing on the content of our countertransference reveries to understand our patients, I favor paying close attention to our ability to allow our patients' emotional and subjective reality to impose itself on us, our receptive capacity to be genuinely affected and stay with what is unbearable for them to experience alone (Bollas, 1983; Eshel, 2019).

Here our countertransference reactions can be described as an inability to creatively dream with our patients' emotional life, our ways of avoiding an encounter with the overwhelming pain accompanying their excessive suffering, and the alive, unpredictable, and uncontrollable aspects of the emotional encounter with an other (Bergstein, 2018). By honestly discussing what gets in our way with our patients, we can hopefully find creative and authentic ways of being with their suffering and inner torment that help them have a place to articulate and feel what before was unbearable for them.

A note about writing about patients

Over the years, I have become increasingly uneasy about writing about patients[1] and clinical material. The intimacy and privacy of a therapeutic setting should be safeguarded at all costs, especially in our current

[1] I use the term patient as opposed to "analysand" and "client." My reasons for doing so are largely based in my medical training and feeling comfortable with the term in its associations to a healing profession, despite its potential problematic connotations. The term "client" always felt too business oriented and corporate, and the term analysand, while preferable, is not technically accurate, because some of the patients I describe are in psychoanalytically informed psychotherapy as opposed to psychoanalysis. I interchange the terms "psychoanalyst," "analyst," and psychotherapist as well, in part to highlight how most of what I describe applies to all psychodynamically informed clinicians working with patients intensively. Also, for ease of reading, when nonspecific situations are being referred to, "she" is used for the psychoanalyst and "he" for the patient, but the points raised are applicable to all.

political and cultural climate, where issues of privacy and confidentiality have been shockingly disregarded. The most important virtue a psychoanalytic clinician strives for is confidentiality, because confidentiality is constitutive of the process itself (Lear, 2003).

This book contains numerous anecdotes and clinical vignettes, which constitute a potential breach of confidentiality. I struggled with how to present this material and not compromise my patients' confidentiality and trust. A book intended for clinicians without clinical material seems highly suspect and abstract, especially when it involves our emotional and subjective reactions to our patients and how they affect our clinical treatment of them.

It seems psychoanalytic clinicians who write or talk about patients do so either by getting informed consent from their patients and making minor changes to the clinical material written, or by changing substantial details about patients in order to cover up any relationship to their actual patients in the consulting room. An argument can reasonably be made that the details in a psychoanalytic treatment matter, and without significant details about the patient and the process of what unfolds in the treatment, including various unconscious motivations and meanings, transferences and enactments that occur cannot reliably be made sense of.

Despite this, I lean heavily on the side of preserving patients' confidentiality by fabricating the details in my case descriptions. None of the clinical vignettes in this book are actual patients, they are all imaginary constructions based on my clinical experiences over time and are for illustrative purposes only. In instances when there were details in particular case descriptions I could not avoid, specifically in the chapters on racism, jealousy, and dread, I asked my patients to read what I wrote and was given informed consent to publish the vignettes with any corrections they asked for.

All of them agreed and made some minor changes to what I wrote without protest. Subsequently, a majority of them had associations and dreams of being exploited and misused—as we talked more about it, they all had complex emotional reactions to what I wrote, to my asking them for permission, and to their knowing that it would be published. Of course, I should have expected this, and apparently this is common when permission is asked by the analyst to disclose personal details of a

deeply private encounter (McWilliams, personal communication). I also had to face unsettling truths about my own desire to breach the private space of the analytic setting. Alongside a genuine desire to transmit knowledge and expand our understanding of the psychoanalytic process, there was also my desire for recognition as well (Lear, 2003). In the end, I hope I was able to preserve my patients' confidentiality by using case vignettes that are generic and fictional, with the purpose of demonstrating the clinical process and what potentially gets in the way of helping our patients.