

PART III

AT THE CROSSROADS OF THE THERAPIST'S PERSONAL AND PROFESSIONAL WORLDS

When we recover,
what have we mastered—
our love or our grief?

—Jody Bolz

IN THIS section, we examine the clinicians' experience of coping with personal changes and loss, which can profoundly affect one's sense of self as a therapist. When the frame of our work is shaken—whether by illness, old age, institutional changes, or the everyday losses we encounter in our practice—our identity as therapists is challenged. Such changes can land us in the realm of the middle-distance, where we may lose our perspective. Here, each of our authors examines the consequences of such shifts and highlights the inevitability of the denial and disavowal that we encounter in the middle-distance. These authors describe their efforts to be mindful of these pitfalls, even as their vision is partially obscured.

In her chapter, Jenifer Niels considers the question: how does illness in the therapist affect the frame of the treatment? She describes the onset of a debilitating and mysterious illness that interfered with her work as a psychiatrist, both as a therapist and as a supervisor. It took many long months to receive a diagnosis, during which time she experienced fear, isolation, and confusion. With neither a diagnosis nor a road map to plan the future, she too was trapped in the middle-distance. She relates a disruption in her sense of personal and professional identity, one that profoundly derailed

her long-anticipated professional trajectory. Suddenly, she felt she no longer knew what her future would hold.

As with many of our authors, Nields describes the magical omnipotent wish that she could preserve and protect both her patients and her supervisee from the pain of uncertainty and loss. While her illness is invisible to others, its presence leaves an indelible trace. In the countertransference, she becomes aware of holding on to the idea that her recovery is just around the corner, which keeps despair at bay but at the same time keeps her patients on hold too long, with diminished therapeutic benefit. Importantly, she points out that “crisis also breeds intensity of attachment: those who are nearby and empathic at a time of tragedy in one’s life become especially important to us.” This observation also sheds light on the many ways in which therapists may find themselves holding on to patients too long.

Richard Waugaman’s chapter, “The Loss of an Institution: Mourning Chestnut Lodge,” expands the scope of our lens. For Waugaman, the closing of Chestnut Lodge required that he take his leave not only from each and every patient but also from his cherished hospital and the professional identity he had developed there over the course of many years. Through his correspondence with Harold Searles, which evolved toward the end of their decades-long relationship as student, mentee, and colleague, we get a glimpse of how both men—one still in the prime of his career, the other already retired—coped with the closing of the hospital. Waugaman writes, “Bereft’ ultimately comes from a word that means ‘rob,’ and we certainly felt robbed of our beloved hospital.”

As therapists, we are all shaped in by our connections with colleagues, supervisors, and the institutions where we trained and with which we are affiliated. Our professional identity is also rooted, in part, in our identification with the professional world of which we are members. Many of us feel that the institutions where we trained, worked, honed our skills, and developed our voices as clinicians become, in a sense, our professional homes. Our colleagues can be like family—at times we support one another, at other times we squabble, but still, we speak a shared language. Waugaman provides a moving eulogy for Chestnut Lodge and for a long-ago era of intensive inpatient care, where patients’ dignity and selfhood were in the foreground.

Robert Galatzer-Levy addresses the issue of the analyst’s difficulty in assessing when illness or old age interferes with the capacity to work. He wonders: how are we to judge when we can and when we cannot continue to work effectively? Like Nields, he highlights the various ways that

analysts may “need” their patients and their work even more when they are ill or dying.

Galatzer-Levy points out that there is an additional layer of communal and institutional disavowal that heightens the risk of ethical violations under such circumstances. He discusses the tendency, even within our “impaired analyst committees,” to replace what might be effective and useful oversight with perceived kindness and leniency, in the hope of “protecting” the reputation and the well-being of the impaired analyst. He argues that the analytic community fails to address productively this issue in part because it brings our own mortality to the forefront and gives rise to primitive fantasies and defenses. He writes, “The fantasy that ‘we could all be in his shoes’ hides the reality that we all are already in his shoes. . . . Every confrontation with a colleague’s death is a confrontation with our own mortality and thus is experienced as a hostile attack.”

Barbara Stimmel also addresses the question: how is the patient most effectively helped at the moment when the analyst is ill or dying? In contrast to Galatzer-Levy, she suggests that valuable and important therapeutic work can be achieved in the face of the analyst’s illness or impending death. In her discussion, she suggests that ultimately there is no one right way. Each dyad must struggle with complex decisions. For example, how much does one reveal to the patient about the details of one’s illness? For each therapist, the choice is partly informed by theoretical underpinnings and also by the idiosyncrasies of the therapist. Stimmel suggests that the outcomes of any such decisions are also specific to that particular patient-therapist pair.

Multiple fantasies and fears exist alongside the reality of an illness or impairment. Therefore, how can we know for sure when the decisions we make—for example, when to tell a patient the details of our illness—are based on the best interest of the patient or, instead, on our own needs? Stimmel makes the point that, with the dying analyst, as with any other aspect of the therapeutic encounter, both sides inevitably exert their influence. “The hope is,” she writes, “that each of the two can play his or her part, helping one another with dignity, respect, and intelligence, until the time to stop is clear. And then mourning can fully begin.”

As therapists we strive to hold simultaneously in mind multiple perspectives and to be aware of how internal and external forces affect the therapy and the therapeutic dyad. However, as we come to understand in this section, we are all in the sway of unconscious factors that we can never fully know and longings that can never be fully quelled.

CHAPTER 8

WHEN THE FRAME SHIFTS

A Multilayered Perspective on Illness in the Therapist

JENIFER NIELDS

Those who know ghosts tell us that they long to be released from their ghost life and led to rest as ancestors. . . . In analysis, ghosts of the unconscious, imprisoned by defenses but haunting the patient in the dark of his defenses and symptoms, are allowed to taste blood, are let loose.

—Hans Loewald, “On the Therapeutic Action of Psychoanalysis” (1960)

INTRODUCTION: CRACKS IN THE FRAME

ONE’S PHYSICAL experience makes up a “frame” within which psychic action takes place. We don’t notice the power of our bodily experience until it changes. For me, this occurred most dramatically through illness.

What do we notice then? What happens to us psychologically when our bodily “frame” shifts because of an illness, and we find ourselves functioning under altered conditions, adjusting to new physical sensations, or unable to function at all?

As therapists, how are we to judge when we can and when we cannot continue to work effectively despite the effects of illness? How are we to discern when the frame is shifted and when it is broken or too bent and deformed to contain the treatment effectively? What are the countertransference and transference ramifications of our being ill?