False Happiness – A Misplaced Fantasy of Rescue

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Among my diverse research activities I recently have become involved in studying errors of therapists. As an approach to study such phenomena I offer seminars for experienced therapists where the participants are invited to share their worst technical failures. I deliberately exclude young, inexperienced colleagues as their technical errors should be a matter of good supervision but little can be learned from them.

Although there is wide agreement that the transgression of certain borders in conducting psychoanalytic therapy is not likely to be helpful for a patient one encounters situations where a therapist feels entitled or even forced to act in such way that he or she may feel it difficult to share with colleagues what has happened in a given treatment.

Today I would like to share with you the report of a female senior psychoanalyst who – after some hesitations – chose to report the following incidence in one of those group meetings:

Some years ago she started the psychoanalytic treatment of a fifty year old officer of the army who had been dismissed from the army due to repetitive struggles with his commander leading to depressions and psycho-somatic disturbances. Although these complaints were

clearly related to those troublesome events in his professional environment, - f.e. the feeling not being respected enough among his peers, the feeling not being respected by his senior commanders, the presenting collegue reported that she gained the strong impression that his basic issue was related to his not being perceived adequately by his mother. This feeling was strongly corroborated by her counter-transference, which conveyed to her time and again that what he was lacking was the gaze of a mother exactly as Kohut had described it.

Recounting this initial opening, the colleague turned to her files which she had brought to the seminar and said:

Let me read to you from my reports for the insurance company. In the first report I noted that the patient behaved like an insecure enmeshed baby not at all feeling safe in an environment of quiet attention and evenly listening from my side. His suicidal ideation which he initially came with has been reduced but I was afraid for quite a while that latently he still was in danger of suicide. He expected to be exposed to critical remarks just as it was usual from him in his army environment. I realized that I should encourage him to spell out wishes that he had never uttered before, simple as asking for a glass of water on hot days.

While the reporting colleague detailed these initial warming up technical moves, other members of the group started to make little side-remarks which I – as leader of the seminar -, pointed out as being intrusive to the reporting

colleague. Let us listen more to get the unfolding of the story " I said … be patient".

The presenting analyst then detailed many dreams and memories from the patient's early childhood that all pointed to deep narcissistic violations. The development of the transference situation was increasingly characterized by a first quite demanding attitude which was replaced by strong attachments needs. Even short interruptions of the treatment triggered strong negative emotions which the therapist tried to counterbalance by an intensification of her maternal feelings for him.

For example she reported that the patient dreamed more and more about images which she easily related to his early traumatic experiences; howver she discovered besides recurring bouts of depressions „islands of optimism and even happiness". Interruption of sessions for external reasons led to feelings of catastrophe: after reunions the patient spoke about being „disconnected from his infusion". She characterized the transference as a state of total dependency as a regression to the early phase of symbiotic mother-child unity.

Then the analyst went on to depict how the climate of the sessions was turning. The patient who initially had come in his army uniform, changed into informal appearance, and became more and more demanding. First in small things, like „could we open the window", but then went and opened the window without asking her consent. Later he would suggest to go for a walk in the neighhood park because it would be easier for him to talk about something

more painful while walking. In the third year the patient had gained so much confidence in the therapeutic relationship that the therapist had the feeling that she really had achieved something noteworthy. The patient offered to accompany the two daughters of her to a horse riding farm. As the analyst had divorced her husband some years ago, she was glad that her guilt feelings of not providing a decent father to her daughters were somewhat ameliorated.

Towards the end of this year of the treatment the patient became more outspoken about having fallen in love with her.

“At first” – she said – “I was quite firm in stating ‘what you love in me is your mother, the kind of mother, you never had.’ I was convinced that we could handle his newborn faith in a new life. His depressions were fairly in control and we were able to even scrutinize his former relations to women in respect to his relationship to his mother.

His mother was a fairly cool detached and controlling person; hence his experiences with women had been shaped by his expectation. He did realize that in his relationship onto me he now experienced a different sort of embracing, warm relationship. My counter-transference feelings remained fairly steady and indeed embracing. After 240 sessions I wrote to the peer reviewer (that works on behalf of the paying insurance company) that the patient was in the firm grip of a transference love. The patient criticized our work saying “this is only an experiment, you do not really love me”.

I felt it was high time to consult a colleague as the patient became increasingly angry and finally broke off the treatment. The consultation helped

me to regain my emotional balance and I invited the patient to resume the sessions. His resistance against working through the love feelings could be analyzed, I thought. In the fire of the now full – blown transference love his depressive mood completely melted away and the patient was able to show to me his positive aspects of his personality".

Looking back it is easy to perceive that the invitation to resume the treatment was on the unconscious level read by the patient that finally his love might be responded to. So in the following months the patient insisted more and more: his love was directed to her, and not toward his mother. After many isolated years as a divorced person, with some mismatching in two marriages, he finally thought, to have found the real, only person that would matter to him.

The final confession of the presenting colleague certainly was not easy for her and for us: "I finally had to give in," she said with tears in her eyes when she told this to the group. They both agreed to terminate the treatment and the ex-patient moved into her house only four weeks after the formal ending of the analytic work.

You may imagine what the seminar group was able to discuss in the remaining session. Questions like these one were dominant: "How come you did not question the patient's professional situation more pervasively? How come you allowed the patient to draw you into the maternal pre-oedipal orbit only? What was the patient's attractiveness like? What was the role of your own private situation? Etc. Any well informed group of analysts is able to formulate these questions.

Looking back on the seminar we found a number of issues that coloured the analyst's initial countertransference. There was a preformed theoretical issue in the development of this state of relationship. It would be fair to say that being a follower of Kohut, this analyst was more prone to see the likely early developmental deficits in the patient's personality organization but less so what he used his deficit organization for. Given the facts she might have been right to diagnose early deprivation correctly; still, one would have to trace to further development in the patient's pubertal and adolescent development. Especially the role of male figures was notoriously absent from the material that had been presented to the seminar.

'It takes two to dance tango' has become a well-known expression to characterize the therapeutic work as a joint endeavour of patient and therapist. While in such clinical seminars it is not helpful to be too explicit about personal aspects of countertransference enmeshments, it certainly is important to try to shed some light on personal motivations for such decisions. Many authors have written about the issue of countertransference love (i.e., Gabbard 1994). To put a discussion in a proper perspective it is helpful first to refer to the notion of the real relationship in therapeutic encounters (Gelso 2011; Schachter & Kächele, 2012).

The real relationship is considered to consist of two key elements: a) genuineness and b) realism. Genuineness may involve some self-disclosure by the analyst, but this should be constrained by considerations of the impact on the patient. "Strong and effective real relationships require that the patient

and therapist have basically positive feelings toward the realistically perceived and experienced other. … These positive feelings may be termed liking, caring … or even a kind of loving" (Gelso, 2011, p. 155).

The relational psychoanalyst Levenson points out that in analytic treatment "The therapist is required to be real, to have reactions and to be able to use them without shame or guilt" (2005a, p.201). "The most loving act of the therapist is to be real, to be there and to permit himself the discomfort of engaging the patient's system" (p.214). Presumably, this includes the analyst's expressing either angry feelings or affectionate feelings to the patient, as well as acknowledging being scared of the patient, all constrained by consideration of these expressions' impact on the patient. With regard to "transference" Levenson writes, "The interpersonal therapist must grapple with the *real* matrix of events and personalities in which every therapy is embedded. It is not a question of what the patient has projected "onto" or "into" the therapist, but of really *who* the therapist is and *what* he brings to the therapy encounter" (2005b, p.21).

So one may ask what this therapist brought to this treatment; which kind of rescue fantasy was operating in her mind to be ready to be invaded by this man's intensive needs for real confirmation. Usually, following Freud's "Observations on transference-love" (1915a), we hear about hysterical women (with pre-oedipal pathology) that are invading male analysts´ mind with their concretized wishes. In this case a man evoked the readiness to believe him

that he really needed this confirmation of being acknowledged by concrete action.

Based on the by now widely accepted notion that Balint's (1952) “primary love” might be anchored in attachment systems that have a strong biological underpinning, we have learned that maternal and romantic love have a shared neurobiological basis (Bartel & Zeki, 2004). It might be that sometimes a confusion arises and the sexual connotations maternal feelings become so powerful that our respected colleague “finally had to give in.”

As I followed up the case, I learned that a few months later the anti-therapeutic honeymoon ended. The patient continued to seek treatment for his depressions and psychosomatic problems with a number of other therapists, mostly in vain. Five years later he learned from a television event about malpractice and he sued his former analyst. The court ruled that the treatment was terminated by his own initiative and although the termination process was not really as it should have been, the analyst got away with only a ‘black eye’.

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