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MESSAGE FROM THE PRESIDENT

Welcome to another of the *Open Chapter's* Newsletters which continues to evolve in scope and function!

The *Open Chapter* held its first board meeting in quite some time this June where we discussed and brainstormed ways to further our goals of creating an egalitarian organization for the psychoanalytically inclined! To this end, we will soon be sending out a survey to solicit your input on ways we could reach out to the psychoanalytic community and provide linkage and services in the greater Chicagoland area. As always, we encourage your participation and feedback.

In this issue, we continue to publish two more papers from the *symposium* "Psychoanalysis: A Hidden Activity", presented at the 104th Annual APA Convention in August and at the International Federation of Psychoanalytic Education (IFPE) annual conference in San Francisco this past November. Cathy Wilson's paper on countertransference issues in the rehabilitation setting focuses on her struggle to conceptualize and apply analytic concepts in a setting that not only isolates her from others who share her ideas on theory or practice, but also demands a unique sensitivity to countertransference issues. Garth Amundson's paper outlines some of the personal challenges and personal costs psychoanalytic clinicians face during a time when its values are derided. Garth shares some of the conflicts he has faced with co-workers at a state hospital.

Elsewhere in this issue you will find a call for a Self-Psychology Study Group lead by Colby Martin, PhD, which will start this fall. We would like to continue to offer ways for clinicians/educators/students to further their psychoanalytic studies in supportive and engaging ways.

I would also like to remind you that IFPE will hold its annual convention in Chicago at the Palmer House Hilton from November 3-5, 2000. The theme will be "Psychoanalysis and Psychosis." We are planning to host a get-together right before the formal convention with details to follow!

Finally, it is again time to renew your membership. Note we have continued to keep your dues at a modest level! Please consider re-joining us and telling a friend or colleague about us. The Membership Form is included in the back of this issue. Your support is appreciated!

Russell Omens, PsyD

Countertransference Dangers in a Rehabilitation Setting

Catherine S. Wilson, Psy. D.

Paper Presentation, as part of the Panel *Psychoanalysis as a Hidden Activity*
(David L. Downing, Chair), Division of Psychoanalysis Meeting of the APA
Annual Convention, Boston, Massachusetts, 20-24 August 1999

Working in a Rehabilitation hospital setting as a psychologist or a caregiver brings many burdens. There is an array of factors cited to explain these burdens. Patients with life threatening illnesses and anatomy-altering occurrences, where restoration to pre-morbid functioning will never occur, confront the therapist or worker with limitations of hope, cure, time, and helplessness when faced with a reality beyond his/her control. Physical disabilities tend to destroy fantasies of omnipotence and mortality. Many factors lead to difficulty in working with patients. Burn-out and intense financial pressures to produce faster results in less time, using easily measurable improvement outcomes, all weigh on the clinician. In addition, paradoxical expectations are imposed by administration to justify psychologists' time by having a specific percentage of billable hours, with the goal of having 90% of patients rate services as excellent. Inadequacy of staff training and talent, motivation of caregivers, demands from inadequately informed and frightened patients and families for cures rather than rehabilitation, and finally, counterproductive forms of protest if a cure is not achieved, can also effect the treatement. How does one use a psychoanalytical perspective in such an environment? It can be especially difficult with current concerns about the high costs of medical care, and the growth of HMO's that stipulate goals and outcomes. While Cognitive-Behavior therapy often is the treatment of choice in a medical setting, since it is more amenable to managed care treatment plans, psychoanalytical activity is often viewed as inefficient because it is difficult to measure outcomes. The approach most often taken in this setting is one that examines grief and depression associated to Spinal Cord Injury (SCI). Textbooks on rehabilitation suggest that patients require a supportive stance that fully maximizes recognition of their *remaining capacities*.

Winnicott (1969) emphasized that there are times when we succeed by "failing," and the value of our interpretation often lies in what it can convey about the limits of the analyst's understanding. He stresses how important it can be for the patient to have the opportunity to discover that it is possible for the therapist to withstand and survive patients' aggression and destructive fantasies. It is from the perspective of acknowledging and embracing my failures that I can now acknowledge the successes.

It is the purpose of this paper to explore some of the ethical dilemmas which arise from working in a rehabilitation setting with special regard to counter-transference issues involving the metabolization of intense emotions engendered by patients who are at their most vulnerable and dependent state. The paper will focus on issues which are highlighted by my own personal process of coming to better understand through my work with Spinal Cord Injury patients. I will first define what counter-transference is in this setting and describe the background of the institution, its patients, and myself. The following sections will discuss behavioral and emotional difficulties encountered by caregivers in the course of working to rehabilitate people who have sustained severe

physical disabilities. These difficulties include managing and tolerating the patient's hate (Winnicott, 1947), power struggles, withdrawal and regression, and personal feelings about the therapist's own illness(es). I will explore the process of how my own distancing occurred and how I managed it.

Transference and Counter-transference

Transference and counter-transference are extremely powerful and difficult to manage when one works with people who have life threatening conditions with severe consequences, and in which restoration to pre-illness normality is impossible. Counter-transference is recognized by most therapists not only as integral to the therapeutic relationship, but also powerful and critical as a therapeutic tool. Gunther (1979) and Winnicott (1947) felt that reluctance to face loss and painful reality is the hidden situational factor in the background of many counter-transference experiences. Ehrenberg (1992) believes that counter-transference resistance constitutes one of the gravest threats to analytical work. Ehrenberg identifies resistance as "identification and reaction formation, or defenses such as detachment, resistance to awareness of one's own affective reaction, or resistance to awareness of particular nuances of the transference/counter-transference interaction … but also to allowing any kind of emotional engagement with the patient" (1992, Ehrenberg, p. 80).

Myron Gunther (1979), who works frequently with staff of hospital settings around these issues, feels that counter-transference reactions are most powerful when working with the rehabilitation population. Transference and counter-transference can be "that component of either personal experience from the unacknowledged past that virtually influences one's current view of others and variously determines the nature of any interpersonal interaction;" or "the displacement of patterns of feelings, thoughts and behavior originally experienced in relation to significant figures during childhood onto a person involved in a current interpersonal relationship." Gunther proposes that counter-transference is not a singular thing but a combination of feelings, attitudes, ideas and behavior usually arising unexpectedly around a specific problem of issues within a working relationship. It leads to some form of verbal response, which in this setting, is believed to be appropriately useful, but ultimately is not. Gunther separates individual sources of counter-transference from four universally shared sources. Individual counter-transference arises through some threatening stimulation to a particularly vulnerable area in the therapists' own personality. The four universal sources of counter-transference are: 1) vulnerabilities of professional self-esteem/expectation, found in situations in where the patient's distressed state or negativistic attitudes threaten to thwart the caregiver's intentions; 2) the degree of regression - both physical and psychological - in the patient; 3) behaviors that evoke caregiver aggression and its derivatives - envy, hatred, or sadism – as such feelings are aroused by patient behavior that may seem provocative, selfish, negativistic or otherwise outrageous to the caregiver; 4) and the ultimate narcissistic vulnerability in the caregiver, exemplified by the phrase, "There but for the grace of God go I." The caveat that "We are all only temporarily able-bodied" becomes incredibly threatening

Gunther (1979) points out there are several characteristic qualities that can help the caregiver identify these experiences: 1) some degree of anxiety, special intensity of feeling, or nonspecific distress is present within the caregiver, easily recognizable by an outside observer but usually unrecognized by the caregiver; 2) doubt or curiosity regarding one's own reactions or understanding seldom troubles the caregiver and stepping aside for a "Second Look" at both participants is seldom thought about; 3) The caregiver's part of the transaction typically may be experienced as disappointing or provocative by the patient, and an angry reaction may be evoked in him or her - this, in turn, drives the caregiver into an evermore rigid, narrow, insistent stance.

Description of the Patients on the Unit

Physically ill patients in a rehabilitation unit have to deal with both the internal and external aspects of their situation, which demands all their attention, as their most basic resource — the body — is in danger. Dignity and productivity are stripped by the disability. They experience increased rage, despair, and desire in this crisis. Pain, loss of function, an uncertain future, fear of death, loss of the usual daily satisfactions, routines, and social roles result in tremendous feelings of fear, grief, and anger. Being undressed in front of strangers, and feeling subject to humiliating and uncomfortable inspections, in turn undermines confidence, self-pride, and sense of adequacy. The patient is usually overwhelmed and extremely vulnerable, the ego poorly supported. Thus the patient has less capacity in his responses to social stress and situations. Regression to dependency occurs and it is not uncommon for the patient to be anxious, demanding, over-dependent, panicky, hostile, hysterical, withdrawn, or accusatory to those around him. The patient is often in a temporary regressed state, partially retreated from reality because it is too upsetting, too emotionally evocative, too un-giving, too discouraging for them to relate in a reflective way. The loss of body function is the most basic kind of loss of control that a person can sustain. The inability to control bowel and bladder function can further facilitate regression. Without the ability to walk or use other limbs, a person feels deprived of most of the basic sources of achievement, satisfaction, and independence.

Background Information

I began at the rehabilitation institution after finishing by internship at a long-term medical hospital that included a rehabilitation setting. While I was on internship, my supervisor encouraged me and I felt I had developed a style of treatment where I was able to incorporate psychoanalytic concepts that place the emphasis on the healing power of relationship and finding meaning. Patients admitted to the rehabilitation unit stay in the hospital anywhere from six to 12 weeks depending on their injury. I was able to schedule patients twice weekly for 30-minute sessions. My goal was to allow them time to process their experience, express their frustrations, grief, anger, and sometimes their relief. I did some psycho-education, but most of my time was spent trying to be in tune with the patient in the moment. I had a small room with a table that was surrounded on all four sides with windows that looked out to a park. There was a sense of solitude and comfort from the surrounding nature that could be seen from the windows.

As I wrote this, I realized that the environment was probably more calming for me than the patient. I remember seeing an older man in his late 70's, a Native American who had fallen and broken his back. He had a long history of ETOH abuse and his goal for rehabilitation was to be able to return to his reservation in Wisconsin. He had been living in the Chicago area for over 50 years. As we sat in that room, he would look out the window and talk about what nature meant to him and how living with the stresses of the "white man's world" were overwhelming. He told me he was ready to die but wanted first to return to the reservation. He spoke with wisdom; describing his struggle as the natural ebb and flow of life itself. He was not interested in getting stronger in order to transfer independently or to dress himself. The team felt that he was not participating in his therapy and needed to be sent on to a nursing home. In effect, like the patient, the staff gave up. Conflicted, I felt I was the only one interested in the patient's wishes. I wondered if I should take a stance to try to fix the situation by motivating him to go to therapies long enough for him to be able to be transferred back to his reservation in Wisconsin, or try to create an environment for him to express his wishes and dreams, and confront staff on their own internal fears of death and isolation that this patient represented to them. But I was too afraid to be labeled as just a "psychologist" and of being disliked by the staff, so I did not. The staff's reaction was to withdraw and to send their failure away. I felt I failed to help the staff understand their internal universal counter-transference of self-esteem of not being able to fix this person or help him get better. This is somewhat typical of the issues faced in this environment, neither patient nor therapist felt

supported, and yet staff was hoping to have support and compliance.

While I was working at this setting, I had two important sources of assistance. First, a person who supported the psychoanalytic perspective supervised me. Second, I belonged to a psychoanalytical study group where I was able to discuss my dilemma and question the counter-transference issues that this case brought to the surface in that supportive environment. I was able to look at my own counter-transference without judgment and take responsibility for my actions and feelings.

I began my post-doctorate year at The Rehabilitation Institute of Chicago energized. I came with the belief that I could continue to work form this same perspective. I strove to create a safe environment within a supportive structure in order to be able to understand and validate the patient's psychological world without being judgmental. I structured my appointments to see all my patients at least once a week for 50 minutes, and saw some patients twice a week for 30 minutes. My caseload consisted of 10 to18 people between the ages of 18 - 86 years old, with diverse backgrounds. Most were diagnosed with spinal cord injuries or amputations. I began my job by ignoring and denying the poor conditions that existed. I did not want to acknowledge the negative environment, a fact my supervisor aptly pointed out. Just as the person with a disability lives in a non-accessible environment, so did I. It was difficult to meet with peers, as there was no permanent office for me. And, I had no supportive staff to assist me.

This hospital setting, however, was very different from my internship. My first temporary office was an old storage room, and my next office was so small wheelchairs could not fit in it. I was then moved to a lovely, but small, room that looked out over the lake, only to be moved again to another room where the window looked out to a gray cement wall; symbolically, the wall of indifference I was facing with administration. I was unable to meet in a safe and consistent environment and so I was unable to create a safe atmosphere for the patient or myself to work. Patients were interviewed either in a room with no window, cramped quarters, or in bed with a roommate 10 feet away. Often staff would interrupt as they went about their tasks. How can anyone ethically do therapy under these conditions? I had a supervisor that agreed that meeting the patient twice a week was best for establishing a therapeutic relationship, but that our role was not to act as a therapist, but rather as a consultant who was to come in, meet the patient, identify problem areas which would either block the patient from performing and having a successful rehabilitation stay, or determine whether it would be safe for him/her to go home to live alone. The focus was on diagnoses of high-risk patients who would have difficulty in the rehabilitation setting, assessment for behavioral management, psycho-education which was outcome oriented, and referral for linkage. I changed my scheduling from weekly appointments to an as-needed basis, determined after rounds. I found myself spending more time writing reports and less time with the patients, maybe seeing them once a week for 20 minutes and/or in a "group setting."

Hate in the Rehabilitation Setting

Therapeutic goals in a rehabilitation setting sometimes seem more geared towards management of the patient then psychological adjustment. There are many times when the staff has asked me if I could "please" stop this person's negative behavior? Can I change the way this person reacts? The patient may be a person who has just been transferred from the acute setting and is terribly frightened and completely dependent. For example, he/she still has a tracheotomy tube in place and needs to be suctioned because he/she no longer has the ability to use the stomach muscle to cough on his/her own. It is not uncommon for the patients to fear being alone. This feeling is reality-based, because the patient can choke to death if no one can hear a request for help. The staff complains of having to answer the call light every 10 minutes. The patient's intense fear is met with frustration. The sound of the cough, and the machine, are disgusting to me at times and I wonder if that may be a part of the reason why staff complain about constantly being called to the room. Staff will talk of how the patient acts like "such a baby" because the call bell is going every few minutes. This remark serves to help them distance themselves from their own fears of dependence. Stepping back and asking myself why I feel so uncomfortable with

the patient, I realize that the sound reminds me of when I was a child and the many times my father struggled with his pneumonia. In order not to be overwhelmed by feelings of helplessness, I get busy, making suggestions to increase or begin medication in order to decrease the anxiety, because I do not want to take the time and feel the anxiety. I rationalize that I do not have the time to be available, to just be with the patient. I distance myself. The patient's feeling of abandonment, rejection, or sadism can be overwhelming. The reality is that at times they are rejected by those around them for their dependency. At other times patients can mistake the staff's unavailability, which can mobilize fears as abandonment, and so patients become filled with rage and hate. Staff, in turn, can respond by being unavailable, activating the patient's worst fears. At times it appears that no one can hold the hate, because we all feel helpless and powerless. Ideally, staff want the patient to be motivated, think positive, demonstrate willpower, and only express sadness and grief. In effect, we ask the patient at the most dependent time to take care of his or her own anxiety, because it is triggering our own. If the patient's physical function progresses, the staff experiences satisfaction in the accomplishments, and feel powerful. If the patient's anxiety increases, interfering with the functional progress, then the staff feels powerless and impotent.

Provoked by interactions in which the patient feels disappointed or angry, the therapist may feel threatened and shift to a more authoritarian stance, focusing on "doing" rather than concentrating on what is taking place in the therapeutic relationship. When unchecked, a full-blown power struggle can ensue with the therapist withdrawing from the patient or provoking the patient to withdraw. The therapist can also be seduced by other staff interpretations and, thus, impact the alliance with the patient.

After working on the unit for about six months, I realized how helpless I felt to decrease the anxiety of patients who were on ventilators or who had tracheotomies. This helplessness was demonstrated symbolically by my own physical reaction one day on the unit. Renovation of the hospital was being completed. I was exposed to a chemical coating that resulted in the loss of my voice and ultimately breath, resulting in a trip to the Emergency Room. Like the patients, I felt voiceless, impotent, and helpless. After this experience, I was able to recognize the counter-transference issues of my own narcissistic vulnerability, of being only temporarily able-bodied. This realization helped me to lose the fear of being with these patients and I found myself spending more time in sessions with them. Prior to this realization, I would only stay a short time, rationalizing that they are unable to converse with me.

When my office was moved for the third time in 18 months, my immediate reaction was to tell the administrator that I was going to quit. I knew on one level that I wanted an office with a view of the lake in order to help patients and myself to be comfortable. On a latent level, I needed the office for my own self-soothing, and when I did not get it, I was outraged and lost my temper. When the actual move took place, I threw all my papers flying into the office. In a parallel process, I felt like the patient, completely out of control, unable to make contact with the institution, or get my emotional needs met. I regressed to a child with no voice, unable to perform. I slowly began to pull away from the patients. I blamed my reactions on the environmental constraints, but now I know there was much more going on. I ended my group supervision and slowly distanced myself from the patients by seeing them less. I was unable to hold the patient's anger, hate, rage, grief, or loss because I had no one to hold mine. How did I end up in such a state? I immediately asked to cut my hours. Fewer hours and less patient load would fix the problem. Not wanting to look inside myself, I focused on outside forces. But my load stayed the same, allowing me to stay in a situation where it became impossible to be as therapeutic as I felt I needed to be. As I now relate this event, I realize there was another layer of vulnerability that was inside of me. First, I had no one to listen to my internal struggles. Second, I had the fear of not being liked or appreciated for all that I gave and did. Patients and administration did not recognize me. I focused my efforts on creating a better environment for the patients, because that was what I needed. I shied away from dealing with the intense feelings of rejection and dependency of the patient, since that was what I too was feeling, and so got busy in the details of whatever they might have

needed in order to fulfill *my rescue fantasy*. I felt as though if I rescued them, someone would notice me. To write this paper means I must face these issues and take responsibility for them. I can continue to place blame on the environment of the institution, administration, the patient, or the unwillingness of the staff to understand their own vulnerabilities and hate issues, or I can acknowledge them and give powers to my voice. Therefore the questions I must address are, what situations make me uncomfortable, and what situations are comfortable for me?

I feel relaxed and in control when working with grief issues and loss. Sessions last longer and my energy level is higher. But when I have to confront a patient about aggressive behavior, I tend to talk more and not allow the opportunity for the patient to share his/her inner-most concerns of permanent losses and hate towards my able-body. I shy away from the possibility of the patient's hate because of my own fears of not being liked and being seen as helpful. In some ways, I collude with administration's desire for the 90% excellent rating. I learned not to ask the uncomfortable questions, and used the excuse I just did not have enough time to deal with those issues. I easily step into a rehabilitation stance of giving all the facts on the possibility of improvement. I intellectually said, "I really don't know how to respond," but I did know to acknowledge and hold the fear, anger, rage or hate. But to do this, I needed first be comfortable acknowledging my own vulnerabilities.

Three Case Examples

Three case examples illustrate the different approaches. The first involves a 40-year-old white male, diagnosed with spinal cancer. Angry and dissatisfied with all the care he was receiving, he refused to go to therapies. He did not want to hear any information about his diagnosis or prognosis, and he stated he was depressed and wanted to go home. Staff complained about his angry outburst. I went into his room and began to talk to him about his behavior with staff. He immediately yelled for me to leave. I left and stayed away until the next week, and then returned once again to talk about my agenda — not his. He responded, "I don't want to talk about this illness. I'm depressed and irritated." I asked him what he would like to talk about, and after a few minutes, he stated that he wanted to be able to go home to die, and that he was worried about how his mother was going to manage her house without his help. He cried. I realized that just like other staff, I wanted to get busy and "do", in order to manage the anxiety that the vulnerability of my professional self-esteem elicited. I learned from the patient that he needed to have someone listen to his fears, and not simply convince him to work in therapies. His negative attitude threatened my intention to help him. It was too painful to just sit with his anger. I learned that only by carefully monitoring my own internal state was I able to stay connected to the patients' and my work.

I worked with a 21-year-old who sustained a C4-5 lesion as a result of an MVA, resulting in quadriplegia. She was transferred to the rehabilitation hospital and was extremely distressed that her mother could not stay overnight by her side. She rang the call button continually through the night and had difficulty breathing. Staff were upset that her mother was staying at the hospital but not helping with her care. The patient did not want her mother preoccupied with her care. The patient and I talked about her fears of being alone and her lost dreams. For her, loneliness represented fear of rejection and abandonment. By talking about her fears she was able to problem solve, and identified a night staff person who did talk and spend time with her. The patients' fears decreased and her mother stopped spending the night.

A 46-year-old male doctor, sustained a C4-5 spinal cord injury while body surfing at a medical conference. He was bitter, anxious, dissatisfied with his therapies. He felt everybody had given up on him. The patient's voice was whiny. Every time I tried to talk to him about his anxiety, he changed the subject. During a group session, he left when the topic concerned anxiety reactions to traumatic events. After three months of just dropping in to talk superficially, he finally shared his feeling of being abandoned and discarded. He was unable to make any decisions about his future, because he still had the fantasy that he would walk, if only … the "if only" was his hate. The hate was a projection of his self-hate. "If only" he did not go in for the last wave; "if only" the staff worked more on his legs, he would be walking. I did not confront him during

this session about his anxiety, I merely listened and realized his continued rejection of my help was his way of testing my willingness and ability to be there with him, to hold his negative feelings about the staff and myself.

Gans' article, "Hate in the Rehab Setting," points out that the middle phase of rehabilitation is when denial has receded and the limitations imposed by the disability seem insurmountable. It is at this time that the patient's hatred of staff is most evident. Patients hate staff because they have not been able to make more progress, because the staff are able-bodied (which constantly reminds them of their losses), and because staff witness their constant humiliation. In the previous example, the patient hated the staff for terminating his rehabilitation and for depriving him of one more chance or even of hope itself. At this phase, he was able to verbalize his feelings of rejection. After identifying his anger he was able to work through issues of dependence that blocked his ability to make decisions for himself.

For therapy to be helpful, negative feelings towards the patient must be managed, identified, and forgiven. Therapists must first process how they react to someone who assails him/her with rage, before compassion or empathy can exist. How can compassion or empathy be expressed to someone who is feeling rage? Winnicott (1949) believed that hate, as a counter-transference reaction, is unavoidable with many patients. He believed that hate is natural and even healthy. Although the analyst "loves his patients, he cannot avoid hating them and fearing them, and the better he knows this the less will hate and fear be the motive determining what he does to his patient (p. 167)." It is important that people working with the rehabilitation population learn to hate objectively because it leads to the patients learning to trust and accept their own feelings of hate and love. Gans (1982) specifically identified the factors that make hate an intrinsic part of the rehabilitation process.

Patient's self-hatred, patient hatred of the staff, and staff hatred of the patients and their families, create a steady ambience of hate. In order to accept and deal with this hate, one must first understand that it results from actual clinical conditions, rather than idiosyncratic human perversity. These powerful negative feelings are products of regression. Gunther (1994) pointed out that staff has difficulty dealing with regression because it does not respond to rational explanation or punishment and cannot be overcome by motivation, will power, or positive thinking. It is natural, and the dichotomy of love. To be human is to be able to both love and hate.

Elements needed in a Rehabilitation Setting

Winnicott emphasized the holding function and its role in creating a facilitating environment. He described the importance of the physical holding that parents do with infants, which is a form of loving. It is equivalent to the stage of merger or of absolute dependence. Ego-support continues to be a need of the growing child, the adolescent, and at times the adult with a debilitation illness or physical disability, when unmanageable stress can lead to confusion or disintegration. Thus the holding environment is natural and appropriate in the rehabilitation setting. For example: A patient experienced a high fever, and had difficulty breathing. A cool compress to his head and stroking to his face done with the assurance that this was not unusual transmitted energy of calmness and love. The patient felt my strength. The strength and energy from one's touch is able to calm. The patient's breathing calmed down, and this indicated to me that I tolerated his anguish. The same occurred with another patient who began to cry that her life as she planned was over. By gently wiping away the tears and stroking her cheek, a smile returned as she said to me, "Please tell me about other people who have lived productively after this type of injury." It is as if she felt my assurance, and could trust that I was stronger than her fear. This contrasts with when I was in my own fear state, unconsciously feeling the infantile rage of not being able to create my own safe environment at the hospital. I would distance myself by reciting the interview questions and shortening my session time. I noticed that I would think "What could I possibly do to help this person in such a short stay?" In those situations, I found myself distancing and discounting the curative function of being with the patient in relationship.

Ehrenberg (1992) emphasized that what facilitates a psychoanalytic process has to be

determined in each new context as we learn from the work itself what kind of engagement and participation is most helpful with each patient. In order to do this we must recognize that our understanding of this mutual impact can only evolve out of the work, our experiences, and requires collaborative responsiveness of both parties. She emphasized, "If we recognize that we always are limited by our own subjectivity and by our vulnerability to counter-transference, it becomes clear that there is no other way to work than from within this subjectivity (p. 65)." This belief forces us from any illusion we may have about the potential for objectivity. If I use the awareness of how patients affect, or even at times threaten me, to inform the work and convey an openness to explore how I affect or threaten them, something meaningful can happen. By consciously following the intention to be reflective, I can then allow the transitional space for the healing growth of the relationship to emerge.

This paper identifies my failures and the process of this identification has allowed me, as a therapist, to begin to withstand and survive the patient's aggression and fears. I hid behind a "holier than thou" attitude. I distanced myself from patients and staff. I kept my office in disarray and made the outward statement that I was feeling out of control and regressed to a child state. By writing this paper, reflecting on my own personal perspective, I highlighted key elements which I must watch for in order to be in synch with my internal purpose of wanting to create a healing environment where change may take place. This has only been possible by acknowledging the counter-transference issues, which include my own need for a supportive environment, my acceptance and identification of my vulnerabilities, and the realization that I cannot work in isolation. If support is not available, I can create it by requesting consultation with other peers. If I am willing to continue my growth, I then can facilitate and allow the growth of others as well. The commitment must first be to my own growth through reflection, and then I can be a model for others. As a therapist I realize that at times I am the teacher, and at other times, the student. The patients I work with every day teach me, and learn from me, how to manage and deal with loss, helplessness, dependency, anger, rage, and hate. Most important of all, we teach each other how to accept our vulnerabilities, and how to love unconditionally.

There are certainly other issues and factors that can generate transference and counter-transference issues, but these are ones that stimulated my process, and most likely may affect other persons working in a rehabilitation setting. It is not possible or desirable to eliminate the phenomenon of transference and counter-transference. These phenomena, rather, are key elements to success.

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The Challenge of Psychoanalysis to Common Ways of Knowing

Garth W. Amundson, PsyD
Forest Park, Illinois

After the long years of work upon himself which free him from the image of his power, the analyst will recognize that his real power resides simply in this: making possible the emergence of the subject's truth. - Antoine Vergote

Throughout its history psychoanalysis has been derided by many within the mental health field. The complaints against psychoanalysis are by now well known: it is scientifically unverifiable, fosters unhealthy dependence in patients, and so on. The fact that these charges have never withstood careful scrutiny has done little to quell the suspicion harbored by many clinicians toward psychoanalysis. Currently, these attacks continue with unabated vigor, albeit in new forms. The recent rise of so-called "managed" care, with its profit-driven emphasis upon brief, supportive therapies, and the increasing dominance of the medical model as a way to conceptualize human behavior, are two of the latest social trends fueling the longstanding contempt many mental health practitioners feel toward psychoanalytic ways of knowing.

This malevolence is a real phenomenon, with serious practical consequences for the professional prospects, and even emotional well-being, of psychoanalytically-oriented therapists. As a group, psychoanalytic clinicians have learned that practicing their discipline in the current social milieu often comes at a cost, namely, the disdain of other professionals. Contempt for the psychoanalytic understanding of human nature is often expressed openly in work environments, and can result in ostracism for those who approach clinical matters from this perspective. In this article I will discuss how my interest in applying an analytic approach to the treatment of patients in a state hospital led me into often severe conflict with co-workers. I share my story both as an exercise in self-healing and as an expression of solidarity with other psychoanalytically-oriented clinicians working in environments which subtly, or even openly, disparage psychoanalytic treatment approaches.

The often visceral nature of the attacks on our discipline implies that they are not simply or primarily the result of disagreements about theoretical matters (such as the effectiveness of longer-term therapies or the relative importance of biology and genetics in human behavior). How, then, can we explain the extraordinary fear of, and hostility toward, psychoanalysis? In this article I wish to offer a partial explanation for this attitude toward our discipline by exploring the contrast between psychoanalytic and socially-dominant ways of relating to and knowing the world.

Specifically, I will argue that psychoanalysis implicitly represents a way of knowing the world which in key respects diverges from the dominant *weltanschanuung* of rationalism and materialism, and, related to this, the valorization of consciousness as a tool for mastering the environment, common to contemporary Western social groups. I believe that one element setting psychoanalysis apart from pervasive, "common sense" Western notions of reality is its emphasis upon an open, receptive, and nonintrusive stance toward the world, a worldview contrasting

sharply with contemporary Western attempts to aggressively control and shape the natural and social environments. That is, I will propose that in psychoanalysis knowledge is derived from a position of psychological *receptivity* toward, rather than forceful attack upon, reality. I will outline the paradox that the psychoanalytic understanding of the unconscious as shaping and directing consciousness implicitly challenges aspects of the very Western value system from which it arose. A focus of this article is the manner in which psychoanalysis's stance of openness toward reality informs clinical work often in ways contrasting sharply with treatment philosophies derived from, and reflecting, facets of the aforementioned Western values promoting control of psychic processes. Descriptions of my work in a state psychiatric facility will illustrate some therapeutic and professional implications of adopting a psychologically open and receptive stance toward patient material.

Toward the end of this article I will more fully discuss ways in which psychoanalysis' embrace of a thoughtful, nonintrusive stance toward human nature (and, specifically, of this attitude as a preliminary step toward an encounter with the unconscious aspects of the psyche) causes it to appear as a subversive activity to modern, industrial and postindustrial societies which value certainty about, and control of, both the external environment and the self. I will outline my belief that part of the psychoanalyst's responsibility to society is to balance the one-sided idealization of knowing with a respect for and receptivity toward the non-rational regions of the psyche (or, stated more accurately, the variety of logic peculiar to the unconscious).

Defensive Aspects of the Therapist's Need to Know

In recent years various schools of psychoanalysis have developed very divergent understandings of the unconscious and its contents and, therefore, of the way in which unconscious processes emerge, and are to be addressed within, the therapist-patient dyad. However, despite this diversity of opinions most current psychoanalytic perspectives continue see cure as occurring in the context of a therapist-patient relationship facilitating the spontaneous unfolding of patients' unconscious meaning-making schemata, in the form of transference phenomena. Another seeming point of agreement between various psychoanalytic theories involves an aspect of therapeutic technique central to facilitating the unfolding of the unconscious. Specifically, most analytically-oriented clinicians continue to feel, as did Freud, that the therapist who attempts to hurry the emergence of unconscious processes along through heightened levels of activity, such as suggestion, education, or encouragement, interferes with the spontaneous and natural rhythms of this process and, further, drives these back into the unconscious where they continue to direct the patient's behavior in self-defeating directions.

An implication of this perspective is that the therapist who strives to prematurely "make sense" out of patients' behaviors will necessarily ignore the complex and paradoxical nature of the unconscious, leading to a cure based upon the fueling of the client's denial of important aspects of his or her subjectivity. A further implication of this view is that psychoanalysis understands change as resulting, in important respects, from the willingness of therapist and patient to adopt an open, receptive, and, by implication, non-intrusive stance toward the emergence of unconscious wishes and/or needs within the context of their interactions. These qualities of the analytic encounter mean that the therapist's intelligence, knowledge-base, and ability to intervene interpretively are not the only elements in a successful psychoanalytic treatment. Rather, in this form of therapy psychological healing is equally dependent upon the therapist's capacity to forego the false security of easy or self-evident formulations and to tolerate (and, in a certain sense, value) the anxiety of not knowing what other, more complex and textured forms of meaning may emerge from his or her encounter with this person.

Put differently, we can say that psychoanalysis is a form of clinical interaction asking both therapist and patient to temporarily suspend certain aspects of their accustomed ways of knowing the world, that is, to surrender aspects

of their allegiance to what psychoanalysis calls the ego or, to be terminologically precise, that aspect of the ego called the self, in which the subjective sensation of "I" that we commonly mistake for the entirety of our nature, exists.[1] The fundamental rule of psychoanalysis to which every analysand consents, namely, that he or she will speak without censoring spontaneous associations, may be seen as a formal commitment to loosening one's grip on familiar ways of organizing and making meaning of experience that support and perpetuate old, impoverished editions of selfhood.

As is well known, suggestions for the most helpful attitude of the therapist toward the patient's free associations are first outlined by Freud (1912), in his article on therapeutic technique entitled *Recommendations to Physicians Practicing Psycho-Analysis*. In this treatise he stresses the fundamental importance of simply listening attentively and non-selectively to the patient's remarks. He calls this "observing," a state of mind characterized by relaxed attentiveness to the patient's presentation, minus the attempt to place this in a rational scheme. He says that an observational stance toward the patient is possible through the use of "evenly-hovering attention," which he describes as a form of "calm, quiet attentiveness" (p. 111) that does not attempt to discriminate or make judgments about what the patient says or does. Freud outlines his belief that the proper use of observing lays the groundwork for later intellectual formulations and interpretations. These formulations are the products of a way of processing clinical material he calls "reflecting," which is the attempt to distill abstract meanings from patient statements and behaviors through the active use of intellectual discrimination.

C.G. Jung (1944/1953), while not speaking from a perspective typically defined as psychoanalytic, eloquently describes why the patient's willingness to speak freely, and the therapist's capacity to listen without intruding, are central to the therapeutic endeavor:

> The unconscious is an autonomous psychic entity; any efforts to drill it are only apparently successful, and moreover harmful to consciousness. It is and remains beyond the reach of subjective arbitrary control, a realm where nature and her secrets can be neither improved upon nor perverted, where we can listen but may not meddle. (p. 51)

Tolerance for, and interest in, the unknown and non-rational aspects of human nature sets psychoanalysis apart from the many other schools of psychotherapy which, in their own ways, prescribe an active, "problem-solving" approach to patients' problems based in a heightening of the patient's dependence upon the ego and, specifically, its function as a tool of environmental mastery. As will be discussed later in this article, this quest for mastery of the environment (and the concomitant valorizing of both the ego and consciousness itself) is part of a more general stance toward the world that is peculiar to Western social groups. I believe that underlying the emphasis of many schools of therapy upon bolstering the patient's capacities to master both intrapsychic and interpersonal environments is a dread of the unconscious and, therefore, of a stance of receptivity and openness of this dimension of the psyche. I believe that this potent fear of the unconscious is related, in part, to the tendency of the dynamic forces therein to challenge, destabilize, and occasionally dethrone the familiar sensation of "I" to which we all cling with varying degrees of desperation.

Given the unstable existential ground upon which consciousness rests, it is understandable that the instinctive reaction of most people toward an encounter with the hidden dimensions of the psyche is to attempt a hasty retreat. This is an expectable response because relaxing one's normal ego functions stirs up profound anxiety about the loss of the familiar sense of "I". This anxiety is often of an annihilatory nature, and can be related to the dread of being engulfed by either our own or another's unconscious wishes and needs. Psychoanalysis may be usefully defined as providing a guide into the sometimes

[1] As Anna Freud pointed out, the ego cannot be simply or uniformly identified with our conscious experience, since it too has sectors that are unconscious (such as the defenses and the superego). The self, as the center of consciousness, is derived from, but not identical to, the ego.

dark and frightening realm of the unconscious, where the light of an ego-based perspective fades and we find ourselves in the presence of painful disavowed memories and associated emotions, bottomless pits of need, and/or omnipotent wishes for control and conquest, among other things.

The mutual journey of therapist and patient into the realm of the unconscious is typically accompanied in both by a steadily rising sense of disorientation and uncertainty. As Matte-Blanco (1975) and others have observed, this is because all the ontological and epistemological rules are different in the unconscious: love can appear as hate; masculine as feminine; no as yes; past as present; many experiences may be distilled and represented in one image; and wishes may seem real. I propose that effective therapy is, in key respects, a fruit of the ability of both therapist and patient to reign in their anxiety about this seeming loss of clarity and direction, and simply attend to the different sensations and feelings stirred by the encounter with these forces, without resorting to the overuse of denial or rationalization. The therapist facilitates a potentially useful encounter with the unconscious by first knowing how to *leave things alone*, metaphorically speaking.

Specifically, psychoanalysis advocates the idea that the patient finds lasting relief only in the context of a relationship with a therapist that challenges the belief that all that is important to know about oneself is or should be easily accessible to consciousness, discoverable by a simple application of reason. Like the masters of Zen Buddhism, psychoanalysis says to both patient and therapist, "Stop *trying* so hard. Stop *thinking* so much. Look! Feel!" Another quote from C.G. Jung (1931/1953) further defines the spirit of this open and receptive stance toward the unconscious. He states...

> We must be able to let things happen in the psyche. For us, this is an art of which most people know nothing. Consciousness is forever interfering, helping, correcting, and negating, never leaving the psychic processes to grow in peace. It would be simple enough, if only simplicity were not the most difficult of all things. (p. 20)

However, in stark contrast to the attitude described above, most clinicians are trained, not to await the emergence of unknown facets of the patient's inner world, but, rather, to efficiently bring the forces of reason to bear upon the patient's symptoms. This style of intervening is based on a disregard or denial of the importance of unconscious factors in symptom formation, and a concomitant emphasis upon strengthening the patient's ego functions, such as reality testing, so as to help him or her function more effectively.

Clinicians influenced by the attitude that one must masterfully dispel uncertainty about the patient's dilemmas so as to inculcate increased mastery of the environment are often heard to ask "What does the *research* say?" when faced with a novel clinical problem. Of course, this phrase contains the superficial veneer of a disinterested scientific attitude. Its use implies the desire to know. However, it is a phrase used so often (and so often *instead* of taking time to actually listen to the patient) that one wonders if those uttering it secretly believe that it provides a magical, protective talisman against the dark and (they imagine) malevolent forces lurking within the patient's psyche. Viewed from this perspective, the compulsive flight to research implies, not the desire to know what underlies the patient's symptoms, but, on the contrary, the wish to remain self-protectively *ignorant* of this.

How Psychoanalysis Transcends its Embeddednes in Popular Conceptions of Human Nature

This article's premise that psychoanalysis implicitly contrasts with and challenges popular conceptions of reality is not without its difficulties. Here I wish to address one possible objection to the understanding of this discipline's relationship to the social milieu proposed in this article. This is an objection based in the observation that psychoanalysis is allied with and valorizes certain dominant contemporary Western views of human nature,

and, therefore, that it cannot offer a real alternative to these dominant views.

For example, many academics see Freud's theory of mind as implicitly promoting the subject/object dualism of the Enlightenment era, a philosophical stance toward reality that is arguably at the core of contemporary Western social groups' attempt to exert control over reality. Put simply, the dualist vision of reality assumes that there is a fundamental separation between self and non-self. An implication of this view is that human consciousness is not meaningfully related to the rest of the human organism (including many of its own needs or wishes) or to the external environment. Rather, elements of the intrapsychic terrain and of the external world are viewed as utterly divorced from the perceiving human subject, and as perpetually threatening to encroach upon and overwhelm the perceiving self. This, in turn, prescribes the development of a sense of self built around ongoing efforts to defend against, control, and master internal and external forces. This mastery is obtained primarily through the hyperdevelopment of objectifying reason, or what existential thinker Martin Heidegger (1966) calls "calculative thought". Enlightenment-era contributions to Western culture, such as the scientific method, are pragmatic applications of calculative thinking. The final result of this view of reality is that life is understood as a contest between the isolated human subject, and impersonal forces within the psyche and in the external environment.

Historian Peter Gay (1987) describes Freud as a hard-nosed scientist working in the best tradition of Enlightenment-era rationalism and materialism, and as one bringing calculative thought to bear upon the unruly forces of irrational emotion dwelling within the psyche. This characterization seems undeniable in many respects. For example, in his writings Freud repeatedly lauds the use of objectifying forms of thought as taming potentially unmanageable psychic processes. Arguably, Freud's insistence that the analyst attend non-intrusively to the unconscious reflects his sense of resignation over the fact that the ego is not able to fully master the forces therein, rather than delight in the exercise of a mindful receptivity to the various ways in which the patient forms meanings. That is, Freud's view regarding the need to attend to the unconscious is perhaps best understood as the brave conclusion of someone who has looked unflinchingly at the "hard facts" of the psyche, has drawn the inference that humans are not masters of their own thoughts and feelings, and has surmised that they must therefore listen to the stirrings of the unconscious or face destructive outbreaks of instinctual forces. An implication of Freud's dualism is that evenly-hovering attention is simply the best way to get oneself into a position of mastery (albeit one that is limited and temporary) over these superior psychic forces, like a boxer who leans in apparent helplessness on the ropes so as to draw his opponent closer for a debilitating blow.

However, while speaking from within the context of Enlightenment-era rationalism and materialism, Freud's reflections upon the nature of the unconscious tend to have the practical effect of checking our tendency to one-sidedly valorize this worldview. Specifically, while I see the view of Freud as traditional Western scientist as essentially accurate, I also believe that his promotion of a curious and receptive attitude to the irrational (or "differently rational") forces within human nature unwittingly acts to soften the more aggressively dualistic and domineering aspects of the scientific worldview. While allied with the longstanding Western fear of, and desire for control over so-called "natural" forces, including those of the unconscious, Freud also demonstrates a certain implicit and, in modern Western societies, unprecedented respect for these hidden dimensions of human nature.

For example, in his concept of sublimation we find the premise that, once tamed, unconscious elements of personality evolve into the ability to work and love, as well as into the building blocks of creativity and high culture. While this is a dualistic understanding of the relationship between the ego and the rest of the personality (with the ego reigning in and channeling potentially dangerous unconscious wishes and aims) it nevertheless places the unconscious in a position of preeminence in relation to rest of the personality, as a dimension

of human experience to be explored, understood, and nurtured, rather than controlled and repressed. This view is a serious threat to social orders based upon the assumption that reason (and, implicitly, consciousness itself) may be counted upon to wisely direct human destiny. Freud's advocacy of this view was a central reason that he and psychoanalysis quickly became objects of contempt to many within the Viennese medical community.

Therefore, while speaking from the position of a rationalist and materialist, Freud also opened the door for other ways of knowing to enter into our way of thinking about human nature. Psychoanalyst Erich Fromm (in Fromm, Suzuki, & DeMartino, 1960) shares a similar view of Freud's relationship to Western culture and its ways of knowing. He says, "While Freud represents the culmination of Western rationalism, it was his genius to overcome at the same time the false rationalistic and superficially optimistic aspects of rationalism (by his) interest in and reverence for the irrational, affective side of man "(pp. 81-82). Fromm continues, "Whatever criticism may be made of the *contents* of Freud's unconscious, the fact remains that by emphasizing free association as against logical thought, he transcended in an essential point the conventional rationalistic mode of thinking of the Western world" (p. 83, italics his).

More recent permutations of psychoanalytic theory, particularly those from the relational and intersubjective schools, continue to ameliorate the radical dualism of Freudian drive theory. I believe that, in doing so, these theories allow for the more "subversive", socially-critical elements of psychoanalysis to emerge overtly. For example, relational and intersubjective theories challenge widespread social fictions of the human as an isolated island of consciousness, by looking to the interpersonal and social contexts of emotional dilemmas rather than only to forces assumed to be "within" a dualistically-separate self. These psychoanalytic theories discount Freud's concept of the unconscious as a self-contained intrapsychic entity, preferring instead to analyze interpersonal phenomena as a way to understand the patient's heretofore unrecognized agendas and needs.

While it is interesting to consider the implications of the increasing contextualization of analytic thought for the role of psychoanalysis as a challenge to dominant Western social values, to do so would take us far afield of our topic. Rather, I simply wish to conclude this section of the article by proposing that, while psychoanalysis is indeed allied with key Western value systems, built into its various metapsychologies are also important (albeit implicit) challenges to the pervasive belief that we can control and guide our personal and collective destinies by one-sidedly cultivating the powers of the ego.

At this point I will turn to a case example describing the results of operating from a psychoanalytic understanding of human nature in a state hospital setting, an environment which, because it is owned by and serves the public, has as part of its mission a duty to embody popular, “common sense” ways of knowing. As will become clear, the "case" to be cited is not that of an individual patient. Rather, it is a study of a collection of individuals, who together form a system with a collective "personality" of its own, one that each member shaped and, in turn, was shaped by.

Case Example

An example from my clinical work illustrates what I have said about the function of letting things happen in the therapy relationship, and the threat which this poses to the need of human groups to maintain a circumscribed vision of human nature around which its members may rally. This example is from my employment as a staff psychologist in a state mental hospital. I believe that what follows is a good illustration of the manner in which common ways of knowing collide with the worldview and ideals of many who practice psychoanalysis.[2]

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[2] In our American democracy, publicly-owned, state-sponsored institutions reflect and transmit common social values in rather pure form (such as the current valorization of biological models of the mind). This is a byproduct of the fact that these institutions aim to transmit the majority’s views of reality, in accord with the aim of democratic social groups to make government an extension of the people’s will. The undiluted manner in which these common values are conveyed within these institutions causes them to contrast all the more starkly with analytic views, something arguably fueling conflicts between these two value systems.

The particular unit where I was stationed was set aside as an intensive treatment milieu for the most uncooperative clients in the hospital, the majority of whom were profoundly disturbed schizophrenics. Most of these patients had been with the hospital for several years or more, having failed to make the slightest progress toward discharge. Collectively, they were deemed completely incurable by previous therapists. At first glance, it was difficult to disagree with this prognosis. Some of these patients were unable to converse rationally with another person. When approached by nursing staff they exhibited various symptoms such as angrily protesting that talking to others might result in their thoughts being stolen, staring quizzically, defecating into their clothing, or simply walking away. However, in examining their records I rarely, if ever, found documentation that these therapists had spent time listening seriously to their patients' thoughts, feelings, or perceptions. The label "incurable" was apparently applied because these patients had not responded to large doses of medication, or had failed to internalize the techniques of the numerous psychoeducational groups offered by the hospital.

Theoretically, our unit was supposed to aid this group of patients by offering unique, individualized treatment plans addressing their specific deficits. That is, we were supposed to try something new with our charges. There were occasional, half-hearted efforts to do so. For example, nursing staff sometimes tried to coax isolative patients from their bedrooms by offering rewards of extra cigarettes or food. However, these and other attempts to engage the patients were quickly abandoned, undermined, in my opinion, by the presence among employees of a pervasive attitude of contempt for -- and, I believe, at a deeper level, profound fear of -- the patients.

Evidence of this amalgam of contempt and fear was found in the often voiced assumption among staff members on the unit, including other therapists, that patients' chronic interpersonal problems resulted from manipulativeness and laziness. Based on this premise, confrontation, encouragement, and education about socially appropriate behavior was deemed the best way to effect change in patients' lives.

Hospital policy officially emphasized a milieu approach, in which different treatment modalities are used in integrated fashion. However, typical of most modern institutions charged with the care of emotionally disturbed persons, the use of medications was unofficially considered the best -- and, for many staff members, the *only* -- hope for managing patients' behavior. This was evident in the large amount of time devoted to discussing patients' medication regimens at treatment planning meetings, and the obsequious deference shown to the unit psychiatrist by other staff members.

Although most of my coworkers pinned whatever hopes they had for patients on drug treatments, nominal credence was also given to psycho-educational groups as effective mediums for altering patients' behavior. Patients listened to daily lectures from various staff members on such topics as safe sex, grooming, and the uses and effects of psychotropic medications. There were also less structured groups, in which patients were required to set daily goals for themselves, such as attending meals promptly, cleaning their bedrooms, and so on.

To me, such groups seemed potentially helpful for our patients, at least in principle. However, in practice, groups were simply another arena in which staff members expressed their disdain for the patients under the guise of therapy. Employees' expressions of contempt were typically triggered by patients' unwillingness or inability to follow common rules of social etiquette. For example, group leaders regularly became exasperated by patients falling asleep during discussions, talking to themselves, or obliviously walking out in the middle of group meetings. At these times the offending group member was usually publicly scolded, and was made an example of

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Due to the above-mentioned factors, what follows may seem to contain rather extreme examples of conflict between widespread social values and the analytic perspective. However, while perhaps comparatively extreme, I feel that these examples reflect essential and common aspects of the analytically-oriented therapist's struggles with socially-dominant views of human nature.

someone exhibiting "sick" or "inappropriate" behavior. Following this, other group members were typically warned in moralistic tones of how they could never hope to leave the hospital and become socially responsible persons unless they altered such offensive behavior.

Staff members' frustration with patients can only be fully understood within the context of administrative attempts to enforce the idea that patients must make measurable progress toward discharge. Specifically, hospital policy dictated that those in our care were not to be allowed to wallow in their symptoms, only to end up as permanent residents of the facility. Rather, patients were to advance toward specific behavioral goals established jointly with the treatment team. This treatment philosophy served the twin goals of ensuring that patients actually received services, and of protecting the already depleted state mental health department budget from being drained further.

While perhaps reasonable in theory, when applied to the treatment of the most disturbed patients this administratively-sanctioned treatment philosophy resulted in the counter-therapeutic power struggles described above. Under pressure from administration to discharge patients as quickly as possible, and their own internally-generated sense of helplessness in the face of patients' severely disturbed behavior, staff members were intolerant of any behavior from their charges implying regressive rather than progressive wishes. Patients, in turn, responded with an equal lack of tolerance for staff members' entreaties that their behavior be more adult-like or "appropriate".

On units serving less disturbed populations, patients' participation in formulating treatment goals with staff was more likely to be a collaborative process. This is because the patients on these units were often functioning well enough upon admission to actually want a speedy discharge. While these patients may have secretly resented staff members' attempts to "help" them, they were willing to work compliantly toward specific behavioral goals so as to be released from the confines of the hospital. However, the patients housed on our unit were the most disturbed in the facility. Consumed with the task of maintaining their precarious hold on reality, and resistant to anything threatening their tenuous inner equilibrium, they had no wish to cooperate with the official agenda that they advance psychologically. This fueled the standoff between staff members and patients characteristic of our unit.

Rather than persisting in what appeared to me as a failed treatment orientation, I tried something new, beginning daily, psychoanalytically-informed individual sessions with the group of seven patients assigned to my care. Such an approach to severely-disturbed patients may surprise some readers. This is because the popular view among members of the mental health community is that severe psychopathology, and particularly the psychoses, are biochemically and/or genetically-based, and, therefore, that "talk therapy" is useless for these conditions.

I do not wish to stray too far from my story to address the question of the usefulness of psychotherapy for severely-disturbed persons. However, I should note that there is a body of research raising serious doubts about the correctness of the view that severe psychopathology is largely the result of biochemical or genetic abnormalities. Further, there is additional research evidence that modified, interpersonal therapies with even very disturbed persons (including schizophrenics) are not only effective, but may even be the treatment of choice. Unfortunately, these studies are not widely known due to the current dominance of medical models of these disorders. Interested readers should refer to Karon and VandenBos (1992) for a trenchant critique of currently popular, "medicalized" views of emotional disturbance, and a description of research-based evidence for the remarkable effectiveness of psychodynamic approaches to understanding and treating profoundly disturbed persons.

My wish to conduct analytically-oriented treatments was approved by the treatment team during one of our daily meetings. Most of my co-workers appeared puzzled that I was curious about patient behavior that they themselves found burdensome or frightening. However, while they seemed to consider my views on the

possibility of intervening therapeutically with the patients to be unusual, even odd, there were no arguments voiced against my wish to do so. There even seemed to be some displays of mild interest among this work group when I outlined the above-mentioned research indicating the potential of interactive therapies to help severely disturbed persons. Several nurses voiced a desire to assist me in this new approach, by having patients dressed and ready for their appointments.

However, there were also not-so-subtle attempts to see that I would not do anything to upset the homeostasis of the work group. For example, toward the end of the meeting the unit psychiatrist inquired in sarcastic tones why I wished to see patients individually on such an intensive basis for the purpose of exploring their emotional dilemmas, noting that what they needed most was not exploration of feelings but lessons in manners. I was keenly aware that the unspoken *ethos* of the hospital was that patients alter their behavior to fit in with society better. I also knew that, as an analytically-oriented clinician, I believed that I could be most helpful to patients, not by pushing an agenda, but simply by understanding and, if possible, clarifying or interpreting their thoughts and feelings. Trying to find some point of integration between these competing philosophies, I diplomatically replied that sometimes behavior change occurs simply as a result of being listened to. This seemed to satisfy the doctor, although I should have seen the writing on the wall when he added, "Just make sure they learn how to behave. After all, there are social realities they must face." Of course, the clear implication of this comment was that my treatment orientation was merely to be tolerated as an adjunct (and a non-essential one, at that) to the overriding goal of inculcating prosocial behavior in the patients.

Drawing on Winnicottian and certain relational views that development occurs in an atmosphere conducive to the natural unfolding of the capacity to play creatively and spontaneously with different ways of relating to self and other, I inquired of my patients how they wished to use their daily session time with me. Nearly all voiced the wish to get off the unit at these times, due to what they described as the torturous sense of confinement generated by life behind locked doors. I complied with these requests, taking patients on my caseload off the unit for cigarettes, soda, or simply to walk about the grounds. I rarely initiated discussions of their thoughts or feelings, nor did I attempt to use these moments as an opportunity to covertly inculcate social skills. This is not to say that such therapeutic moments did not arise. In fact, some of my patients began to speak to me at great length, describing both fantasized and realistic accounts of their families, relationships with staff members, and dreams.

While I eagerly welcomed these stories, I generally did not feel any inner pressure to set an agenda, establish "goals," or even to "cure" these patients. As a result, discussions about memories, current events, and inner states came and went in an unhurried manner, like cloud formations slowly billowing into different shapes and configurations, then dissipating. My only goal for these encounters was that we simply spend time with each other doing whatever came naturally. To this end, I usually let the patients decide how they wished to use their time, unless their judgment was so grossly impaired by their emotional disturbance that I literally had to act as an auxiliary ego for them.

Obviously, my approach to the patients on my caseload was radically different from the manner in which other hospital staff engaged them. As a result, although the treatment team had initially approved my request to see patients individually, I soon became an object of intense suspicion when it became clear that I was not genuinely interested in making the patients behave and, further, that I actually seemed more interested in what my patients thought, felt, and how they construed reality.

Consequently, I began to be harshly criticized at staff meetings by colleagues for coddling a group of persons they viewed as simply unmotivated for change. During these meetings I was also lambasted for what was variously described as my naiveté, impracticality (sometimes referred to more diplomatically as my "idealism"), or lack of knowledge as to how to interact with the so-called chronically mentally ill. My coworkers

appeared most uncomfortable when I spoke of patients in terms implying that their behavior was an expression of common human needs and conflicts. I noticed that at these times someone invariably introduced an observation about the patients implicitly framing their behavior in opposite terms, that is, as abnormal, and as something to be altered rather than understood. For example, immediately following my discussion of a patient's hallucinations as providing some rudimentary form of self-soothing, the unit psychiatrist assertively pronounced that he would switch the patient's medications in an attempt to eliminate this symptom altogether. The message was clear -- we were not on the "same page" philosophically, or even in the same metaphorical book. My attempt to introduce the idea of some underlying psychological similarity between we employees and our patients was a threat to the work group's unspoken premise that the patients were *ill* and, hence, fundamentally different creatures from the rest of us, who conceived of ourselves as *healthy*. Such interactions were disheartening to me, for they alerted me to the perhaps irreconcilable differences in our respective visions of patient's symptoms and, indeed, of human nature itself.

Distaste for the psychoanalytic viewpoint (and for me as its representative) was often not so subtle or well concealed as the above interactions would imply. Specifically, in addition to the aforementioned covert attempts to disparage my approach, there also began to appear startling displays of barely-contained rage directed at me during treatment planning meetings and elsewhere. For example, I recall one nurse literally shrieking at me during a staff meeting that my treatment approach was, in her words, "making things too comfortable for the patients" so that they would never want to be discharged. This nurse stormed dramatically from the room before I could respond.

Other staff members approached my supervisors with laundry lists of complaints about what they described as my unprofessional behavior. These complaints were often serious in nature, with potentially ruinous consequences for my career. One co-worker, an African-American charge nurse who, among all those who disparaged my treatment approach, was the most vitriolic and abusive toward me, went so far as to allege that I refused to treat an African-American man because of his ethnicity, and that I had made sexual advances to her. Prior to making these charges against me, this nurse had unsuccessfully rallied co-workers to sign a petition demanding that I discontinue my treatment of patients. In addition, she regularly displayed a marked and overt envy toward me and my position. For example, during treatment planning meetings she often took credit for originating certain analytically-informed treatments which were my own suggestions. Further, this nurse was often heard loudly complaining to peers and supervisors that she, not therapists (and, in particular, not *me*), truly understood and helped patients, an assertion contrasting with her hard and distancing attitude towards them. However, despite her dismissal of my therapeutic contributions, during staff meetings I often caught her listening with rapt attention to my thoughts about certain patients. At these times I felt as if she desperately wanted something from me, despite her hostile protestations to the contrary.

This nurse's relentless pursuit of me became a standing joke among many employees, one of whom told me, "The way you occupy her every waking moment, if she didn't say she hated you so much I'd swear she was in love with you!" This was an eerie foreshadowing of the sexualized manner in which this nurse came to interpret out relationship.

Privately, I viewed this nurse's uncontained hostility and lack of objectivity about this behavior as flowing from a fragile and unintegrated self-structure. I believe this opinion was shared by the administrators (themselves clinicians) who explored her charges against me and found them to be fabrications or distortions. Despite this vindication, it was nevertheless emotionally exhausting for me to have to formally rebut these accusations. A pervasive lack of support from co-workers fueled by sense of helplessness and emotional depletion. Not surprisingly, many staff members seemed happy to stand by silently while I was publicly savaged by this nurse's attacks.

Despite the toxicity of the work environment, and my lack of enthusiasm for confrontation, social skills training, goal setting, and even for the notion of cure itself, my patients often showed surprising progress as a result of our interactions. Specifically, as a group they exhibited small but important increases in the ability to delay gratification, attend, concentrate, and communicate using words. One patient of mine, who had spent the majority of her day laying on the floor begging nurses for water and snacks, was eventually able to sit quietly at the morning community meeting for brief periods. Another patient, suffering from a psychotic depression, suddenly took an interest in reading tabloid newspapers, which he occasionally discussed with his roommate.

How did I survive in this conflict-ridden work setting? Over time, the unrelenting nature of my colleagues' hatred caused me to feel increasingly alienated from and angry at them, and doubtful about the worth of my own work. I often went for long walks alone during my lunch break or read in my office, to reestablish a sense of calm and purpose.

During my two-year tenure at the hospital I also approached hospital administrators on numerous occasions to help. More than once I asked supervisors to facilitate personal discussions between myself and other employees, with an eye to identifying and resolving sources of conflict. Unfortunately, administrators were unwilling to do this, noting that they were aware of the abuse I suffered but preferred to stay out of the fray so as not to be accused of taking sides once disciplinary action was initiated. (I am still unable to fathom how facilitating a face-to-face discussion between myself and other employees could be taken to imply partiality. I infer that paranoid and schizoid anxieties, rather than savvy political judgement, made administrators opt to remain aloof.) Rather, administrators asked that I document the more egregious incidents of abuse which I endured, and wait for the wheels of bureaucratic justice to turn. Against my better judgment, I complied. As I might have foreseen, had I felt less desperate for a respite from constant attack and hence muddled in my thinking about the most effective way to achieve this, documenting and reporting the abusers' acts only made me more of an outcast, as it provided validation for their growing belief that I was a danger to the work groups' collective self-image. Feeling haggard by two years of unrelenting abuse, and unable to obtain what I deemed meaningful administrative support, I finally resigned.

Discussion

In the above description of the hospital work environment we may infer the subtle interweaving of personal and social dynamics and defensive strategies. What light can psychoanalysis shed on this topic?

Contrary to the popular view that psychoanalysis only concerns itself with the intrapsychic, Freud's thought was imbued with a deep concern for the social and cultural. In *Group Psychology and the Analysis of the Ego*, Freud (1921) states that individual psychology reflects, not only personal conflicts and defensive strategies derived from one's own developmental history, but also group conflicts and defensive strategies. In this work Freud outlines his belief that in the course of development the individual introjects socioculturally-specific collective norms, expectations, resistances, and defensive or adaptational styles, which are expressed in his or her daily behavior. This process of identification with the group is the central way in which the individual creates him or herself in the image of his or her sociocultural tradition, with all its strengths and foibles recapitulated in microcosmic form upon the stage of his or her daily existence. In his analysis of group psychology, Freud emphasized how these collective forces come to form key aspects of the superego. Reciprocally, social groups themselves come to reflect key aspects of individual character. Neo-Freudians, such as Hartmann (1958) and Fromm (1941), have elaborated extensively on the sociocultural aspects and implications of Freud's thought.

The staff-patient relationships I have described in the preceding section reflect the interpenetration of personal, group, and societal

defenses and normative ways of interpreting reality. Let us look at the characteristics of each level, and the synergistic interaction occurring between them. We will start with the personal and move to the social.

Harold Searles, an object-relational theorist who has worked extensively with hospitalized schizophrenics, notes that a common pathological feature of staff-patient relationships on inpatient psychiatric units is the manner in which each uses the other to simultaneously defend against, and maintain vicarious contact with, threatening and therefore disowned aspects of the self (Searles, 1968/1979). To staff members, patients represent frighteningly "sick", or "disabled" aspects of themselves. Searles states that persons employed in the mental health field are typically driven by intense ambivalence about the prospect of integrating these elements of the self into consciousness, and seek to have contact with these disowned aspects of the self while simultaneously remaining defended against them. Working with overtly disturbed persons meets both needs, at least to a degree. Specifically, it offers the professional vicarious contact with these repressed or dissociated facets of the personality, while also providing a rationale for avoiding the frightening recognition that these seemingly alien aspects of the psyche are also parts of one's own character structure. Such avoidance is made easy, since all that is "ill" or "disordered" is embodied outside of the self, in the patients (Searles, 1967/1979).

Patients, in turn, project onto staff the disavowed "healthy" and/or "competent" elements of themselves, such as the capacity to test reality, think logically, and, more generally, function effectively in the world. Searles states that patients unconsciously seek to maintain vicarious contact with their ability to function effectively, but need to experience the mental capacities which make this level of functioning possible as belonging to a more powerful “other”, in the same way that young children need parents to manage the environment for them. “Owning” these mental capacities is threatening to patients for various reasons. One is that, if made an integral part of the personality, these capacities could clarify their grasp of their situation enough to make possible the awareness of the glaring failures of families of origin. This means coming to terms with unbearable feelings of loss, rage, and disillusionment, something all patients, including the high functioning, typically wish to avoid unless offered a containing therapeutic relationship.

Searles also points out the intense hostility expressed in patients’ attempts to goad caretakers into attempting to cure them, curative efforts that inevitably fail and even trigger additional symptoms. For patients, this repetitive interactional cycle can represent a pyrrhic victory over internalized images of family members who, like therapists and other professionals, claim to wish to help them while actually using them as containers for their own repudiated unconscious conflicts.

Implied in Searles's view of inpatient staff-patient relationships is the idea that staff persons are often unconsciously motivated to prevent patients from resolving emotional conflicts, since patients are needed, in fantasy, to act as containers of staff members' disowned needs and dilemmas. At the same time, patients may need staff to remain entrenched in their fear and defensiveness, and, hence, one-sidedly allied with unconsciously omnipotent agendas to cure what is taken to be the "sick" behavior of their charges.

On the hospital unit where I worked, the personal need of staff and patients to remain defended against disowned aspects of their needs and wishes dictated the way in which their respective subgroups were structured and related to one another. Specifically, fearful of the afore-mentioned unconscious processes, staff members one-sidedly aligned themselves with the qualities of reality-testing, logic, order, and the quest for mastery characteristic of consciousness. Patients responded to staff members' attempts to forcefully inculcate mastery and control of behavior by one-sidedly aligning themselves with the darker, more disorganized aspects of the unconscious, something causing them to become progressively more entrenched in chaotic,

bizarre, and, from staff members' perspective, "ill" behavior.

Of course, it is supremely ironic that, despite attempts to align themselves with the qualities of logic and order characteristic of consciousness, a chief quality of staff members' behavior was its remarkable *irrationality*. For the most part, it seemed to me that the individuals with whom I worked felt besieged by patients and unfulfilled in their jobs, and were blind to alternative, more enhancing behaviors or attitudes toward their work which would be self-evident to an objective observer. This is because a rigid and exaggerated emphasis upon the ego and its powers cuts off this sector of the personality from the true source of its creativity in the unconscious, something which is ultimately self-defeating. Therefore, a stance toward the unconscious that denies or attempts to control its natural processes has the paradoxical effect of leaving the individual or group more, not less, vulnerable to falling under its spell! In a sense, to adequately test reality, we must be receptive to fantasies, grandiose wishes, and primitive strivings, rather than compulsively braced against them.

On the unit where I worked, staff persons' paradoxical vulnerability to the upsurge of their unconscious wishes, in the midst of their superficially "reasonable" attempts to "cure" the patients, was seen in destructive outbreaks of their rage, expressed both directly and indirectly. This rage was perhaps most clearly evident in their attempts to both undermine my patients' individual treatments and to symbolically destroy me with allegations of misconduct (that is, they sought to kill me off in the professional arena, rather than literally).

I feel that a primary reason for the contempt unleashed against me by coworkers is that, by standing firm in my conviction about the helpfulness of an analytic treatment approach, I implicitly challenged their underlying, unvoiced assumptions about their work. Of course, psychologically speaking, work is a reflection of the self. Because this is so, many of my co-workers likely experienced my quiet but clear assertion of independence from the work groups' consensual view of reality to be a threat, not only to their daily manner of thinking about their jobs, but also (and more fundamentally) to their taken-for-granted sense of selfhood. Their response to this was to draw upon the self-protective properties of rage to mobilize a defense against this perceived assault, and to reassert the *status quo*.

Of course, as psychoanalytic theory and practice has aptly demonstrated, no expression of feeling is ever purely positive or negative, but always contains an ambivalent admixture of both. Therefore, in staff members' attacks upon me we may also infer the presence of frustrated longings that they *themselves* be psychologically healed. For example, in the complaints of the aforementioned charge nurse that I refused to treat a patient because he was an African-American, and that I had been sexually provocative with her, may be seen a poorly disguised wish that I attend to *her* emotional wounds. That is, I believe that her complaint that I ignored an African-American in need reflected (in displaced form) her fear that she, another African-American in need, was being deprived of essential care and concern. Her charge that I had approached her sexually was a more elaborate, eroticized version of this same wish to be attended to, albeit one which she remained self-protectively unaware of by projecting onto me. As a result of this defensive distortion, to this nurse *I* (and not *she*) seemed to be the one full of need and longing, much of which she interpreted in sexual terms.

Her use of projection can also be understood as supporting her fragile narcissistic equilibrium. In this regard, we may recall that pathological narcissism infused this individual's perceptions of me. This narcissism existed primarily as primitive envy, evident in her devaluing me by taking credit for my ideas, and publicly diminishing my role as therapist by insisting that I was unable to match her own, self-ascribed therapeutic skills. I believe that her projection of her needs onto me created for her the narcissistically gratifying, if fleeting experience of *me* as wishing to possess *her* valued qualities, including those of a sexual nature (a reversal of what I believe to have been the actual situation).

Finally, the narcissistic inflation of self resulting from this defensive strategy appears to have served to ward off awareness of the envy and greed this nurse harbored toward me as the supposed "keeper" of desired emotional healing and integration. As a result of these various motivations and conflicts, I came to represent to this nurse aspects of her own, disavowed needs and wishes, in the manner described by Searles. Consequently, I was both desired and dreaded by her, much like she both desired and dreaded the patients.

Of course, the above-mentioned use of projection is a flimsy buffer against the unconscious, ultimately failing to bind profound need and envious rage. I believe that, as these intense affects continued to badger this charge nurse, it became important for her to take action against me directly. In all likelihood, being exposed to my physical presence on a daily basis was emotionally overwhelming for her, as this continuously provoked her poorly-contained, primitive need, and envy of both my role as "healer" and my imagined curative powers. Therefore, her unabated rage at me, and her attempts to obliterate me professionally, may be understood as expressions of a wish to destroy the intensely desired emotional "goods" she imagined I harbored, goods which she could not, in reality, possess.

I believe that this charge nurse's view of me was a highly exaggerated version of the manner in which I was perceived by many other employees. In fact, I suspect that part of her role in maintaining the work groups' homeostasis was to act as spokesperson for the unconscious agendas of her colleagues, one of which was to keep themselves and the patients in their accustomed roles, and to resist anyone or anything which might alter or subvert this interpersonal structure. Most telling in this regard is the fact that no other staff member took the initiative to defend me against this nurse's damaging accusations, although none supported her charges when approached privately by administrators. Of course, such collective silence allowed this nurse to proceed against me unchallenged, at least up to a point. This, in turn, implies that this nurse's destructive behavior fulfilled an unspoken group agenda to maintain the work groups' longstanding structure in the face of my attempts to provoke different ways of thinking about staff-patient relationship. This nurse's "spokesperson" role is an example of how private pathology may serve pathological collective agendas, and specifically, demonstrates how human groups silently (and unconsciously) collude to utilize their most psychologically fragile members to achieve certain collective agendas.

The view that staff and patients were heavily invested in maintaining the chronic divisions between them can be understood as an interpersonal expression of the intrapsychic defensive process commonly called splitting, in which contradictory wishes and needs are not integrated to form a nuanced perception of reality, but, rather, are separated from one another to construct an artificially simple, unidimensional view of the world. Adopting this theoretical focus further clarifies aspects of staff members' behavior that initially appear puzzling or unreasonable. For example, the hypothesis that staff needed to maintain splits in their personal and collective visions of reality explains why they persisted in treatment approaches prescribing interactions inevitably leading patients to resist and, ironically, become further entrenched in their ineffective behavior.

Specifically, staff members unconsciously required patients to remain resistant and, therefore, unable to make progress in an emotional sense, so that they would continue to be available to act as symbolic containers of the work groups' disowned needs.

A need to maintain splitting was also evident in the treatment team's phobic avoidance of discussions directly or indirectly implying similarities between the needs of staff and patients. Such avoidance may be seen as serving a need to maintain an illusory separateness between staff and patients, because seriously entertaining the idea that the individuals in these groups share common dilemmas, needs, and experiences would have made it difficult to justify the division of roles between them. In retrospect, I realize that by directly expressing an interest in the patients on my caseload, I was implicitly differentiating

myself from what might be called the paranoid-schizoid qualities of this work group, in which all that "not-me", "bad", or undesirable was viewed as residing "out there", in the patients. In the eyes of my co-workers, such an act of self-definition seemed to ally me with the patients' "sickness". Therefore, like the patients, I too came to be viewed as a frightening alien presence to be controlled, or, failing this, eliminated. For these and other reasons, my orientation threatened to undermine the basis of the working group's collective identity (or "group ego").

In keeping with the thesis of this article, I propose that the split between conscious and unconscious ways of making meaning characteristic of this hospital unit reflects broader, divisive sociocultural attitudes toward the unknown. Specifically, I believe that staff and patients used common social attitudes valorizing the aggressive mastery of those aspects of human nature deemed irrational to both maintain and legitimize the interpersonal stalemate described above. An example of this is found in staff members' reliance upon medical explanations for patients' behavior. In modern Western societies, the medical model's dualistic understanding of the human as striving to overcome and tame the supposedly chaotic forces of nature (including those supposed to exist within the psyche), is the central social fiction upon which many groups of mental health providers establish their personal and collective identities.[3]

On this hospital unit, collective resistance to unconscious processes and dynamics was supported by unreflective adherence to popularized and simplistic editions of scientific ways of viewing patient behavior. This was most clearly evident in the unquestioning esteem in which staff members held drug therapies. Arguably, this uncritical stance toward drug treatments is an expression of a societally-endorsed delusional system, characterized by the primitive belief that an individual can be infused with a subjective sense of wholeness merely by ingesting certain potions, a kind of postindustrial-era holy communion, if you will. I suspect that for many staff members, the hope that drug treatments might control patient behavior meant that they would never have to become personally involved in grappling with the meaning of such things as hallucinations, transference psychoses, and other manifestations of the unconscious.

The use (or misuse) of commonly accepted scientific way of knowing to support defenses against unconscious processes is also seen in the notion that patients suffered from a form of sickness or mental disease. Whatever truth there may be to the view that biologic and genetic factors predispose individuals to specific behaviors, the point here is that, in my estimation, staff members defensively appropriated this viewpoint to rationalize their avoidance of more personal, humanizing contact with their charges. That is, staff used aspects of the socially-dominant medical model to create and maintain a *dehumanized* vision of the patients. I believe that this dehumanizing agenda reflected a more fundamental wish among many of my coworkers to deny the similarities between themselves and the patients, specifically the universal nature of the developmental struggles and experience residing in that common well-spring of humanity called the unconscious. This illustrates how, in key respects, modern, socially-dominant ways of interpreting reality are both derived from, and, in turn, act to legitimize, individuals' dread of all that is unknown and uncontrollable. For their part, patients internalized popular views of themselves as ill or disordered, in part, to maintain their despair about their capacity to live more independently. The patients exacted revenge upon their families by remaining "stuck" in irresponsible behaviors under the socially-sanctioned guise of suffering from an illness.

Kirschner (1996) describes how contemporary social groups require individuals to foster states of self-alienation, and how this process of inner division fuels the quest of modern mental health establishments to identify

[3] Evidence of the pervasiveness of the medical model is seen in the ironic fact that, even in this article, which is critical of medicalized visions of humanity, I feel compelled to use medical terminology to describe the people who come to me for help (i.e., I refer to them as *patients*).

and remediate "abnormal" mental states and persons. She says...

> It is a hallmark of modernity that citizens are incited and taught to police themselves through the creation and strengthening of their "subjectivity" (a capacity for self-monitoring and self-management). The intrusion of the modern social discipline into the self's very core is seen by genealogists to be effected in great measure by a process called "normalization." In order to ensure that subjects not only will act in accord with, but also will experience themselves as endorsing, the social order, "others" (repudiated forms of behavior and experience) must be identified both within and outside of the self ... They are then marginalized and excluded, or contained, rehabilitated, or "cured," so that the self comes to experience itself and to be perceived as more closely harmonized with the "normal" order. (p. 207)

This is arguably a description of splitting occurring at the levels of society and culture.

As a member of the treatment team, my intent was to contribute to the healing of the kind of splitting described by Kirschner, by working from an intermediary position between the need to set limits on patient behavior and the need to allow it free expression, so as to allow for an integration of conscious and unconscious meaning-making modes. However, unable or unwilling to step away from the self-imposed misery of their roles with the patients, my coworkers could not interpret my actions as representing other than a dangerous wish to allow free reign to frightening and heretofore repressed unconscious desires. Consequently, I became *persona non grata* in this work group, and was identified, not as a healer, but as a representative of the dreaded facets of the psyche from which they individually and collectively sought to dissociate themselves.

Of course, one might ask what could have possessed me to attempt to practice psychoanalytically in a system so clearly fraught with dread of the unknown reaches of the psyche, and so openly and adamantly opposed to attempts to explore these. Not surprisingly, part of the answer is found in my personal history. Specifically, my attempts to introduce an interest in the unconscious among my coworkers were driven, among other things, by my wish to vicariously heal my parents' defensively concrete and superficial manner of interpreting reality, particularly their compulsive avoidance of any discussion which might provoke genuine, spontaneous expressions of feeling. In my family, this superficiality was needed so as to maintain control over the emergence of certain unpleasant truths, such as the fact of my parent's rocky marriage. I have come to believe that, in my attempts to interest hospital coworkers in aspects of human nature beyond the immediately apparent, I was attempting to master unresolved feelings of disappointment and loss related to my parents' failure to see and respond to my own "true self", that is, those aspects of my personality existing beyond the merely self-evident.

This is not to say that my attitude toward my work was merely a later edition of childhood conflicts. Creative work in any field is invariably fueled by multiple motives, including the wish to symbolically repair emotional damage to the self. I merely wish to point out what I believe to be a central reason for the vigor with which I pursued my therapeutic agenda in the face of growing evidence that such an agenda was completely unwelcome. Such a determination to go against the popular grain was partially based in my own, incompletely resolved omnipotent strivings to act as a healer. Arguably, the unrelenting manner in which I stuck to my theoretical “guns”, despite massive opposition from colleagues, is quite similar to the manner in which these colleagues persisted in failed treatment approaches with the patients, and implies that we shared similar fantasies of omnipotently curing or changing what was clearly *not* curable or changeable, at least fundamentally. To some degree, one shares a secret identity with the thing he or she fights against most ardently. In retrospect, I see that this was certainly true of my relations with co-workers on this unit.

In outlining my own contribution to the interpersonal conflicts between myself and coworkers, I also wish to make a more general point about how the encounter with one's personal history and character leads naturally to

certain ways of encountering the history and character of the social order in which one lives. Specifically, I suspect that people like myself, who have emerged from the superficialities and collective illusions of their families of origin with an attitude of skepticism about human relationships generally, are predisposed to becoming social critics in adulthood. Obviously, much self-created unhappiness and maladjustment may flow from chronically heightened vigilance about other's motivations. However, the skeptic may also be willing to look at subtle interactional processes most others wish to deny. Assuming that he or she does not fall into self-righteous narcissism, resentfulness, and/or despair, the skeptic may nurture an accurate and socially-useful take on interpersonal reality.

Understood psychoanalytically, the skeptic's first assault is aimed at that aspect of the ego in which the sense of self resides, in the form of questions about the sanity or truthfulness of key guiding premises around which life may be structured. Many of these premises are derived from the sociocultural milieu in the form of taken-for-granted assumptions about the good life, meaning, and so on. Assuming that he or she is fundamentally honest, the skeptic wants to see through the illusions which populate his or her consciousness so as to grasp some hidden, essential feature of life existing beyond what the collective has defined as "normal." Therefore, it is completely natural that the individual who has begun to question the supremacy of the ego will eventually come to view society and culture with a similarly critical attitude. In a real sense, to see through the distortions and "vital lies" of the ego is to begin to see through the distortions and lies of one's social group. Put differently, we may say that the encounter with the unconscious only occurs after one has loosened one's grip on the comforting illusions of the ego, and those of the social milieu which it, in key respects, reflects.

In the next section, I explore some ethical implications of the therapist's encounter with the unconscious.

The Encounter with the Unconscious: Implications for the Therapist's Encounter with Society

When a therapist suspends his or her knowledge of the patient's personality and listens to the stirrings of the unconscious, he or she implicitly facilitates a spontaneous and "playful" relationship with this person (Winnicott, 1989). Playfulness is essential to the process of fostering such receptivity to the as-yet-unknown aspects of the self and the interaction between self and other. Yet, it is unfortunately common to meet therapists of all theoretical orientations, including psychoanalytic, who lack this capacity to "play" creatively in the intrapsychic and interpersonal realms with patients. Freud's view of the way in which group norms and resistances are incorporated into the personality may illuminate one common way in which the therapist's capacity to "play" with patients is stunted or even destroyed.

Specifically, the therapist who places a premium upon fitting in with peers and/or with an institutional culture often becomes one-sidedly preoccupied with fostering social adaptation in patients. This is usually not done in a blatant or overt manner. Rather, the therapist may subtly guide the course of his or her interaction with the patient away from the exploration of subjective experiences, needs, and longings, and toward a discussion of how he or she is getting along with others. In addition, popular catch phrases may be present in the language which the therapist uses during sessions to describe the patient's dilemmas. For example, rather than inquiring about the patient's feelings of sadness, the therapist may inquire in a more objectified way about the patient's "depression." It is not uncommon for therapists of various theoretical orientations, including psychoanalytic, to unilaterally introduce to patients the idea that they suffer from a mental disease or illness, through the use of diagnostic labels such as "ADHD" or "bipolar disorder." I believe that such language creates distance between therapist and patient by implicitly placing the therapist in the socially prestigious role of scientist. In our current

social milieu, this identification of oneself as scientist means, more specifically, one who is aligned with current trends in the social sciences that thoughtlessly reduce emotional suffering to biochemical imbalances or genetic defects. Therapists who interact with clients in the ways described above may do so, in part, out of an unconscious submission to internalized superego prohibitions. These prohibitions exist as psychic representations of group ideals and norms shielding the therapist from a more authentic encounter with the meaningfulness of human suffering, one aspect of which derives from the encounter with the complexity, ambiguity, and uncertainty of the self, relationships, and life itself.

I strongly believe that psychoanalytic ways of knowing carry with them an implicit ethical mandate toward society. Specifically, in the act of exploring and elucidating unconscious processes, the analyst or analytically-oriented therapist is also engaging in an implicit act of social criticism. This is because unconscious wishes and needs are not easily controllable, but enter consciousness on their own timetable. There is little the analyst or patient can do to hurry this process along. Rather, the most that either party can do is to wait attentively for their appearance in dreams, associations, or behavioral enactments and attempt to understand them as best possible. This is an attitude most social organizations find profoundly threatening, since human groups are organized, in part, to offer protection from all that is unknown and mysterious about existence. As Becker (1972) points out in his classic treatise *The Denial of Death*, society and even culture itself stands as a check against the awareness of the instability and finitude of human life. This may explain why social groups generally attempt to silence those who choose to introduce the idea of mystery into daily life. To the vast majority of people, patients and analytically-oriented therapists focused upon exploration of the mysteries of the unconscious fall within the parameters of those interested in such "subversive" topics, and are therefore viewed with suspicion and even contempt.

An implication of the above view is that, in important respects, society is based on lies and other defensive strategies aimed at suppressing the emergence of what is unknown about life. In modern, postindustrial societies, these lies tend to cluster around the illusion that all things are ultimately knowable (and therefore that mystery is simply that which we have yet to figure out or discover), that reason can supply answers to life's central questions, and that the march of reason in the form of progress will carry us forward to an ever more perfect existence. Understood psychoanalytically, we might say that society functions to maintain the illusion that we are precisely what we think ourselves to be, that is, that human nature is identical with consciousness.

I suggest that to be uncritically allied with one's society is to collude with these lies. In the lives of most people, their involvement in the mass conspiracy to resist the unfolding of unconscious processes is not easily evident. It may only manifest itself in isolated incidents of discomfort about an individual stepping outside of a social role, as when a police officer is found weeping or a clergyman is discovered in bed with a prostitute. However, as my experience in the state psychiatric hospital illustrates, the majority of people exhibit swift and transparently defensive behavior when faced with individuals, such as mental hospital residents, who are profoundly destabilized by primitive needs and wishes intruding into consciousness, and enact this state of destabilization openly. People become defensive toward such individuals, in part, because they perceive in such disorganized behavior a threat to their socially-generated illusions of mastery over the unknown elements of existence.

It is part of the task of the psychoanalyst or psychoanalytically-oriented therapist to act as a bridge between the known and the unknown elements of the psyche, that is, between consciousness and unconsciousness. A concrete way in which he or she performs this task is in helping those involved in the daily care of disturbed individuals to experience less dread toward the unknown aspects of the personality by, among other things, helping them to tolerate the experience of not knowing what certain regressive mental states mean, and/or by not

intervening precipitously to control the expression of these states. The clinician who performs this function must be largely free of narcissistic wishes to gain attention by crafting an identity as a rebel or nay-sayer. (I say *largely* free because it is hard for me to imagine anyone being able to withstand the inevitable hatred of others for expressing an interest in these mental states, without some underlying need to stand apart from the collective.) In addition, he or she must be interpersonally skillful and empathic to avoid becoming the hapless victim of others' anxiety.

Even so, in my personal experience it is not possible to practice as an analytically-oriented therapist and emerge unscathed from social systems opposed to the experience of unconscious processes. In fact, I would go so far as to say that any therapist employed in an institutional setting, particularly one treating severely disturbed persons, who has not had the experience of being feared or hated by a group of colleagues, is probably colluding with collective resistances to understanding and valuing unconscious processes. Such a clinician's therapy cannot go beyond the unthinking valorization of commonly accepted ideas about the so-called "well adjusted" person. In losing touch with the unknown aspects of the patient's psyche, the clinician him or herself becomes less of an individual, and more of a socially-sanctioned caricature of a human being, one in whom the ability to effectively influence the patient's feelings masquerades as authentic interpersonal contact.

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Study Group
Led by J. Colby Martin, PhD

Introduction to Self Psychology

Self Psychology will be explored in the historical context of evolving psychoanalytic thought. The focus of the study group will be the basic tenets, the variety of views, including the intersubjective, and the practical application of self psychology. The study is intended to have a strong clinical focus. A background in psychoanalytic thought and access to clinical material will enhance the value of this study group, but are not necessary to find this a useful learning experience. *Psychotherapy After Kohut: A Textbook of Self Psychology*, co-authored by Dr. Martin, will be used as a basic text and is available either through him or Analytic Press for about $45. In addition to the text, a substantial amount of supplemental readings will be provided. The study group will meet monthly for nine sessions, from September to May, time and place to be announced. The cost for the nine sessions is $200.

Dr. Martin is in private practice in Naperville. He taught the seminar in Self Psychology at Forest Hospital in Des Plaines, IL, and provided clinical supervision for interns and post-doctoral residents there as well. He also has presented at the American Institute of Medical Education, Santa Fe, NM, and at the Institute for Pastoral Studies, Loyola University of Chicago. Please contact Dr. Martin at 630.355.9933 for further information.

Chicago Open Chapter for the Study of Psychoanalysis

Section 4 (Local Chapters) Division 39 - Psychoanalysis, American Psychological Association
344 West Chestnut Street
Chicago, Illinois 60610

Membership Application

The *Chicago Open Chapter for the Study of Psychoanalysis* is affiliated with Division 39 (Psychoanalysis) of the American Psychological Association. Founded in 1985, its mission is to provide a forum for the discussion of various trends in psychoanalysis, and to promote the application of psychoanalytic theory to a wide variety of areas (including, but not limited to, anthropology, history, literature, and religion). The *Open Chapter* strives to provide a democratic and egalitarian atmosphere for the exchange of ideas. Hence, although the organization sponsors presentations by nationally and locally recognized analysts, it does not view psychoanalysis as the sole domain of mental health professionals. As its name implies, the *Open Chapter* is truly "open", in that it encourages the application of psychoanalytic inquiry to the work being done by other disciplines.

If you are interested in becoming a member, please complete the registration form below and return it with your $40.00 check made payable to "Chicago Open Chapter" to: David L. Downing, PsyD, 344 West Chestnut Street, Second Floor, Chicago, Illinois 60610. If you have questions, please contact David L. Downing, PsyD at 312.266.1665.

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