TOWARD
A PSYCHOLOGY OF
UNCERTAINTY

TRAUMA-CENTERED
PSYCHOANALYSIS

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CONTENTS

Preface ix
Acknowledgments xiii
1 The Laboratory and the Labyrinth: An Introduction 1
2 Making the Unbearable Bearable: Regulation, Expectation, and the Experience of Existential Uncertainty 19
3 Trauma as Exile: Terror, Shame, and the Destruction of Certainty 43
4 Sanctuary on the Ledge: Trauma-Centered Treatment 61
5 Muting the Sirens of Certainty: Beyond Dichotomous Gender and the Oedipus Complex 85
6 To Die With Our Dead: Ghosts, Ghouls, and the Denial of Life 107
7 Faith, False Gods, and the Surrender of Certitude 143
8 In the Ashes of Burnout: Lost (and Found) Faith 177
Epilogue: Rewinding the Thread 197
Bibliography 199
Index 217

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8. In the Ashes of Burnout

Lost (and Found) Faith

Here let us pause for a moment to assure the analyst that he has our sincere sympathy in the very exacting requirements of his practice. It almost looks as if analysis were the third of those “impossible” professions in which one can be sure only of unsatisfying results. The other two, as has long been agreed, are the bringing-up of children and the government of nations.

—Sigmund Freud (1937/1964)

Much that I have written in the preceding chapters reflects two interlocking premises: (1) A mutual desire to heal and to be healed from trauma draws patients and therapists into their analytic relationships, and (2) to the extent that healing occurs, it is a development-enhancing process by means of which trauma-generated relational patterns are relinquished and the experience of existential uncertainty becomes more tolerable for both partners. A reader could not be blamed for assuming that continual healing is the wonderful bonus we receive for working as clinicians. If only this were the whole story! While I am convinced that I have experienced considerable healing and growth

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through my work with patients, I have also endured spells of work-related misery so debilitating that, while in their grip, no promise of further development would have consoled me. The only relief I have found during these dark moments is in fantasies of finding another occupation. Conversations with analytic colleagues have convinced me that I am far from alone in having felt that to pursue what Freud (1937/1964) himself called “the impossible profession” was self-destructive, even dangerous.

Many of my colleagues who acknowledged having suffered periods of self-loathing and despair similar to mine used the term burnout to describe their experiences. Although professional burnout has been investigated extensively by occupational, organizational, and social psychologists, it comes as no surprise to me that it was a psychoanalyst, Herbert J. Freudenberger, who first coined the term. Freudenberger (1974, p. 13) suggested that overly dedicated and excessively committed individuals are most prone to burnout, which he defined as “a state of fatigue or frustration brought about by devotion to a cause, way of life, or relationship that failed to produce the expected reward.” As Grosch and Olsen (1994) point out, his definition, like a number of others that were subsequently proposed, recognizes that burnout is not just exhaustion from overwork; it involves a loss of faith in the very enterprise of helping, and it seems particularly prevalent in “the helping professions.” Insofar as psychoanalysis must be considered, first and foremost, a helping profession, analysts are far from immune to losses of faith of this magnitude. Indeed, I suspect we are especially vulnerable to them.

One of the few articles about burnout as it pertains specifically to psychoanalytic practice was written in 1986 by Arnold Cooper and entitled “Some Limitations of Therapeutic Effectiveness: The ‘Burnout Syndrome’ in Psychoanalysis.” Burnout syndromes, Cooper (1986, p. 576) contends, are likely to occur among “those working in a setting of great emotional intensity demanding high degrees of affective awareness and control, empathy, and tolerance of uncertainty,” which, as far as I can tell, is a fair description of the analytic situation. Sources of burnout, according to Cooper, are the loneliness and social isolation experienced by analysts who see patients all day, and the fact that analysts carry on their work without rewards, such as gifts and social contact.

Although Cooper seems to have addressed important aspects of the analyst’s experience, his adherence to traditional psychoanalytic theory
limits the applicability of his formulations. For example, he writes, “the analytic situation is so constructed that the analyst’s safety is assured — we need not answer embarrassing questions, we need not speak when spoken to, and our quirkiness is hidden behind our techniques” (Cooper, 1986, p. 580). I doubt that many analysts influenced by contemporary relational theories feel so sanguine about their safety. In contrast to Cooper, we do not consider such concepts as neutrality, abstinence, and a universally applicable technique as incontrovertible givens of the analytic situation.

In light of the many changes in the field since Cooper’s article appeared, and the fact that my informal discussions with colleagues about burnout raised more questions for me than they answered, it occurred to me that I might better understand this phenomenon by canvassing a larger number of analysts than those in my acquaintance. Consequently, I developed a questionnaire about burnout in the hope of obtaining a large sampling of responses around which face-to-face conversations with concerned colleagues could revolve. The questionnaire was made available to attendees of the 24th Annual Self Psychology conference in San Francisco in November 2001 and also mailed to clinicians who were listed in the membership directory of the National Association for the Advancement of Psychoanalysis. Only 17 of the 136 clinicians (12.4 percent) who submitted completed questionnaires indicated that they had never experienced burnout, which seems to confirm my hunch that my suffering is widely shared. That the topic touched a sensitive nerve was suggested by the highly detailed and impassioned comments many respondents wrote in the spaces provided. Some even attached extra pages. Asked to comment on “your experience of burnout,” for example, one respondent wrote: “Feel like I hate the work — hate my patients, no energy, no enthusiasm, sleepy, disconnected, feel overwhelmed — thankfully it doesn’t happen often or for very long.” Another wrote: “Losing the belief that therapy is as helpful as I once thought. Overwhelmed at times with others’ grief.” Asked “what else do you associate with the experience of burnout?” (besides the items listed), one respondent wrote: “Impatience, irritability, decreased tolerance, anger (more frequent, more intense), yearning for something unknown, for excitement, gratification, ease, leisure, fun, recognition, attention, creativity.”

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In October 2002, Annette Richard and I used the results of the questionnaire as the basis for a workshop on burnout we led at the 25th Annual Self Psychology conference in Washington, D.C., entitled “Healing the Wounds of Healing” (Brothers & Richard, 2002). Of the relatively large number of conference attendees who chose to participate in our workshop, many took the opportunity to describe their own painful experiences of burnout and their efforts to combat it. Although there were a number of commonalities in what they described, their widely disparate accounts reinforced my suspicion that it makes little sense to attempt a comprehensive theory of burnout. Rather, it seems that there are as many forms of burnout as there are clinicians who suffer from it (see also Grosch & Olsen, 1994). Nevertheless, it has recently occurred to me that one way to understand some experiences of burnout is to regard them as crises of the kind of faith I described in the last chapter, which, you may recall, sometimes arises in the aftermath of trauma. Experiences of such posttraumatic faith, I suggested, involve deep acceptance of the ineluctable uncertainty of life and, at the same time, a strong belief that one’s ties to an other (or others, human or divine) cannot be broken. This sort of faith, however, is not immune to disruption or loss. Just as it is born of trauma, it may also be destroyed by trauma, and even by the threat of retraumatization.

Trauma and Burnout

In recent years traumatologists (the name that has been given to clinicians and researchers in the field of traumatic stress) have applied such labels as “compassion fatigue” (Figley, 1995), “vicarious traumatization” (Pearlman & Saakvitne, 1995), “secondary trauma” (Figley, 1997), and “trauma contagion” (Herman, 1992) to experiences that bear a great deal of resemblance to what others call burnout. A number of traumatologists have commented on this resemblance. Courtois (1993), for example, mentions that an overlap exists among vicarious traumatization, burnout (which she views as a response to a demanding, stressful, or unrewarding work situation), and counter-transference. Figley (1997) considers compassion fatigue to be a form of burnout.
Vicarious traumatization is defined by Saakvitne and Pearlman (1996, p. 25) as “the transformation of the therapist’s or helper’s inner experience as a result of empathic engagement with survivor clients and their trauma material.” They add, “Simply put, when we open our hearts to hear someone’s story of devastation or betrayal, our cherished beliefs are challenged and we are changed” (Saakvitne & Pearlman, 1996, p. 25). I believe their remarks contain two assumptions held in common by the leading traumatologists: (1) Trauma or PTSD found among clinicians who treat trauma survivors is likely to be secondary; it results from exposure to the suffering of those in their care; and (2) prolonged experiences of empathy and compassion for trauma patients contribute to the clinician’s suffering.

I find myself at odds with both of these assumptions. My reasons for rejecting them may help to explain how I see the relationships among trauma, faith, and burnout. First of all, from my perspective, the traumas that are involved in the burnout experiences of analysts are neither secondary nor vicarious. Since I assume that analysts are as likely to have undergone traumas as their patients (see Chapter 4), the traumas that may ignite burnout are those we have already experienced and dread reexperiencing in our work with patients. I do not mean to suggest that we are unaffected by our patients’ traumas, but listening to their accounts of them, harrowing as they may be, is not likely to be traumatizing. That is, they are not likely to destroy the certainties that organize our experience. It is the dread of a retraumatizing loss of certainty that I see as setting the stage for burnout. Insofar as this dread is often the impetus for the emergence of extreme and inflexible relational patterns like those I described in earlier chapters, they are antithetical to experiences of the sort of faith I outlined above.

Second, I disagree that it is the provision of empathy or compassion, the opening of their hearts per se, that renders clinicians vulnerable to burnout. I see burnout as more likely to occur among clinicians whose empathy and compassion have been thrown into question or who find themselves unable to feel empathic and compassionate. I can think of no worse fate for someone who has committed his or her life to healing the wounds of trauma than to discover that no healing has occurred.
Faith Healer


Although these questions might well have been asked by an analyst in the throes of burnout, one whose ability to heal has been thrown into question, they are not. They are lines spoken on stage by Frank Hardy, the central character in Brian Friel’s (1980) masterful play entitled Faith Healer, which was first produced at the Longacre Theatre in New York on April 5, 1979, and then revived in New York in 2006. I found in Friel’s play, which is as much an inquiry into faith as it is into healing, profound understanding of the challenges confronting those of us who have chosen to work in what Goldner (1991, p. 251) has called “the discipline most practiced in the art of uncertainty.”

As a man tormented with uncertainty over his life’s work, Frank attempts to explain what drove him to offer miracle cures during performances in seedy town halls across Wales and Scotland by alluding to “nights of exultation, of consummation,” (Friel, 1980, p. 12). These occurred after he had laid his hands on someone and “watched him become whole in my presence” (Friel, 1980, p. 12). As it is for many of us who are convinced that our psychological survival depends on healing others, when Frank was able to believe in the authenticity of his gift for healing, he was filled with hope.

I doubt that there are many analytic writers who have captured the dilemma of those whose urgent desire for healing conflicts with an even more urgent desire for certainty as acutely as Friel has done in this play. Consider Frank’s description of his audiences:

They were a despairing people.... Longing to open themselves and at the same time fearfully herding the anguish they contained against disturbance.... And even though they told themselves they
were here because of the remote possibility of a cure, they knew in their hearts they had come not to be cured but for confirmation that they were incurable; not in hope but for the elimination of hope; for the removal of that final, impossible chance — that’s why they came — to seal their anguish, for the content of a finality. (Friel, 1980, p. 15)

His lines reminded me of a number of patients for whom the only certainty in a horribly unpredictable world is their own suffering. For them, any sign that healing has occurred, or is even possible, must be denied lest it catapult them into a vortex of uncertainty. That Friel thoroughly comprehended experiences of this sort is evident in Frank’s account of what followed when “the miracle would happen”:

And then — panic — panic — panic! Their ripping apart! The explosion of their careful calculations! The sudden flooding of dreadful, hopeless hope! I often thought it would have been a kindness not to go near them. (Friel, 1980, p. 15)

Not only are patients who have undergone repeated retraumatization vulnerable to “dreadful, hopeless hope,” but analysts as well. I have been filled with this tormenting mix of feelings with some patients who, over and over, seem to come within range of their dreams, only to have those dreams splintered by some cruel circumstance beyond their control. I think of being with Sue, whose treatment I described in Chapter 6, when a stressful experience puts her at the mercy of wildly swinging moods that grind her creative efforts to a halt. As she once again seeks comfort in her certitude that she is doomed to misery and failure like her mother, my faith in the power of our connection dissolves. At such moments, hope becomes my enemy, and I see nothing ahead for us but darkness.

This darkness, I find, does not only congeal around my relationship with Sue, but, to some extent, spreads itself throughout the network of systems that comprise my relational universe. Is it possible that all of my patients are bound together in ways they know little about? Could it be that the ups and downs that any one of them experiences affect all the others? And what of the countless friends and relatives whose lives are touched by my patients’ experiences and my own? Are they also affected?

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Brothers

Friel’s belief in the interconnectedness of all who heal and seek healers is conveyed in the following observation Frank offers about his audience:

I would look at them and sometimes I got a strange sense that they weren’t there on their own behalf at all but as delegates, *legati*, chosen because of their audacity; and that outside, poised, mute, waiting in the half-light, were hundreds of people who held their breath while we were in the locality. (Friel, 1980, p. 15)

If we realize that to heal one person is to bring a glimmer of hope to everyone in that person’s relational universe, how much more appalling is the discovery that our efforts to heal have failed!

*Faith Healer* consists of four monologues; between the two delivered by Frank Hardy is one by Grace, a woman whose love for him seems to be unconditional, and another by Teddy, his loyal manager. Insofar as each character tells a different, often contradictory, version of his or her tragic story, the play brings to mind a familiar source of uncertainty in our work as analysts: Much as we may accept, without questioning its veracity, a patient’s evolving story of his or her life, we cannot help but realize that what we are being told might very well contradict versions told by others in that patient’s life. We also know that our own involvement with a patient affects the unfolding of his or her story, but just how it does so cannot be determined with any precision.

Insofar as the conflicting accounts of Frank’s relationship with Grace offered by the play’s three characters are never fully reconciled, many questions about their enduring bond remain unanswered. For example, we might ask what made being with Frank so compelling that Grace abandoned her career as a solicitor in order to be with him. What kept her bound to him despite his cruel “erasion” of her during the times when he agonized over the unpredictability of his ability to heal? Perhaps, despite his mistreatment of her, Grace devoted herself to Frank in the same way that adherents cling to a brutal, although charismatic cult leader, that is, as a guardian of certainty (see Chapter 7). Grace’s recollection of Frank as he prepared to confront an audience supports this understanding:

And when you speak to him he turns his head and looks beyond you with those damn benign eyes of his, looking past you out of

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his completion, out of that private power, out of that *certainty*
that was accessible only to him. (Friel, 1980, p. 20, italics added)

Friel strongly hints that Frank’s quest for certainty was born of trauma. In Chapter 3, I suggested that trauma might, metaphorically, be considered exile from a world of hope. Since a great deal of Irish drama in the last century concerned itself with the experience of actual exile, it is not surprising to find that this theme is prominent in Friel’s work as well (Deane, 1986). Quite a few of his characters are social outsiders or outcasts who have been forced to abandon the Ireland they love, not on account of economic or political pressure, but out of psychological necessity. Frank is no exception. His 20-year exile from his family home in Ballybeg seems to have followed traumatic disruptions in his relationship with his father. He recounts an incident from his childhood in which his father is asked by a friend, Eamon Boyle, about the occupation Frank might choose in adulthood. After recalling that his father answered, “Be Jaysus, Boyle, it’ll be hard for him to beat his aul fella!” Frank adds:

And for the first time I saw that his mouth was filled with rotten teeth. And I remember being ashamed in case Boyle (his father’s friend) had seen them, too. (Friel, 1980, p. 42)

Frank’s painful memory hints at the traumatizing destruction of a childhood certainty that his father was worthy of his idealization. Kohut (1971, 1977, 1984) has suggested that failures in the realm of our idealized connections to caretaking figures may result in future problems in our work lives, as well as deficits in the ability to self-soothe, leaving us vulnerable to addictions (we learn that Frank’s alcoholism worsened as he aged). Frank’s memory also suggests traumatizing disappointments related to his experience of himself as a unique, differentiated person. His father clearly was unable to see Frank as anything but an extension of himself, and therefore unable to appreciate, much less celebrate, Frank’s alterity. Kohut has argued that such failures result in “narcissistic disorders” similar to those manifested in Frank’s alternations between shame-ridden self-deprecation and grandiose claims to a god-like endowment.

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Seamus Deane (1986) notes that Friel’s characters often invent “consoling fictions” about themselves and others. Frank’s inventions about his father’s occupation is a perfect example. Although, according to Grace, Frank’s father worked as a storeman in a factory in Limerick, Frank variously described him as “a stonemason and a gardener and a bus-driver and a guard and a musician” (Friel, 1980, p. 22). Such fictions, to the extent that they camouflage assaults on one’s psychological integrity, function much like the uncertainty-transforming dreams and fantasies that often come to dominate a traumatized person’s experience.

We have also seen that iron certitude frequently dominates posttraumatic experience. Frank’s unwavering conviction that he was worthless unless he could exert absolute command over his gift for healing is a good example. Tragically, the only times Frank was able to feel such command was when he knew that his gift would fail him. This dreadful article of faith was closely linked to another: that an early death would end his suffering. Friel leaves little doubt that Frank went willingly to a death he seems to have anticipated.

Having ended his long exile and returned to Ireland, Frank cures the injured finger of a member of a wedding party at a pub in Ballybeg. This act provokes the drunken and, as it turns out, murderous partygoers to fetch a wheelchair-bound invalid named McGarvey for Frank to cure. When the pub’s landlord tells Frank that McGarvey’s condition is incurable, Frank responds that he knows this to be true. And when the landlord warns that these “savage bloody men” will kill him for failing to heal McGarvey, Frank says, “I know that, too” (Friel, 1980, p. 43).

The play ends as Frank describes approaching McGarvey and his killers. His last monologue ends with the following words:

And as I moved across the yard towards them and offered myself to them, then for the first time I had a simple and genuine sense of home-coming. Then for the first time there was no atrophying terror; and the maddening questions were silent. At long last I was renouncing chance. (Friel, 1980, p. 44)

Let us consider the possible meaning of Frank’s final words. Does he utter them as an expression of suicidal despair? Or are they, as Margaret Strain (2004) suggests, evidence that the healer has humbled himself to accept that which defies reason and control — faith and salvific
illumination? She suggests that in proclaiming that he was “renouncing chance,” Frank accepts that his gift is the result of neither randomness nor accident, but the “presence of the transcendent within him” (Strain, 2004, p. 68). Strain is not alone in finding elements of mysticism, Celtic legend, and Christian faith in the play. Block (2000) and Robinson (1987) see Frank as a Christ figure.

I have wondered if, in its conclusion, Faith Healer illuminates the sort of faith that may arise in the wake of trauma. Does Frank’s mention of a “genuine sense of home-coming” signal his emergence from the lonely exile that followed his traumatizing disappointments in his father? In renouncing “chance,” has Frank cast off his tormenting uncertainty about the endurance of selfhood? Does he surrender himself and his impossible quest for control over his gift in the faith that he will be held, at last, by a divine “father,” with whom his spirit would endure? Frank’s penultimate lines suggest this may be true:

... as I walked [toward McGarvey] I became possessed of a strange and trembling intimation; that the whole corporeal world — the cobbles, the trees, the sky ... somehow they had shed their physical reality and had become mere imaginings.... And that intimation in turn gave way to a stronger sense: that even we had ceased to be physical and existed only in spirit, only in the need we had for each other. (Friel, 1980, p. 44)

Sarah

I have located the roots of Frank’s tormenting uncertainty about himself and his capacity to heal in early childhood traumas. Early traumas seem also to have played a role in the burnout experience of Sarah, a dear and esteemed colleague who has discussed her life and her work with me over long dinners in Italian restaurants.

In what we agreed must be a “model scene” (Lichtenberg, 1989), Sarah vividly recalls herself at age six, peering up at a hospital window. Behind the glass, she can barely discern the form of her beloved grandmother who is waving to her for the last time. Experiences of being barred from contact with a sickly, elusive woman, from whom she desperately seeks emotional sustenance, pervade Sarah’s life. Her
relationship with her mother seems to have been filled with them. One 
that grievously affected Sarah occurred immediately following her 
grandmother’s death. Not only did her grief-stricken mother fall into a 
prolonged depression, but she seems to have used what limited energy 
she could summon to care for Sarah’s little brother, barely a year old at 
the time, as well as her father, a stroke victim.

A repetition of this traumatizing abandonment occurred a few years 
later when Sarah’s mother developed tuberculosis. Out of fear that she 
might infect her children with the highly contagious disease, she was 
quarantined in her room. Once again, Sarah found herself barred from 
the sickroom of a woman whose relational engagement she urgently 
required. To make matters worse, she was deprived of witnesses to her 
lonely exile. Because tuberculosis was considered a shameful “disease 
of poverty,” she was sworn to secrecy about the nature of her mother’s 
illness. From that time on, Sarah remembers her mother as either ill (the 
tuberculosis medication she was given predisposed her to other debili-
tating conditions) or preoccupied with illness. Sarah finally found the 
healing closeness she craved as she nursed her mother through her last 
ilness, amyotrophic lateral sclerosis (ALS).

Sarah recalls her mother as warm, generous, and loving. In fact, 
despite the illnesses that deprived her of continuous maternal contact, 
Sarah believes hers was a reasonably happy childhood. Fortunate in 
possessing the social skills needed to form vital relationships with other 
children, she looks back fondly on the many contented hours she spent 
at play with peers. Her gifts as an athlete also enabled her to take pride 
in her physical as well as emotional strength. In this respect, as well as 
in temperament, Sarah feels she more closely resembled her working-
class father than her refined, well-educated mother.

Since her mother and many of her mother’s relatives were educators, 
Sarah never felt that she actually “chose” her first career as a kinder-
garten teacher. It was only after she left teaching to attend social work 
school that she found her calling as a psychotherapist. After completing 
a course of training at a reputable psychoanalytic institute, she devel-
oped a successful private practice. Her professional life was enriched by 
her participation in a study group led by eminent figures in the field, as 
well as a peer supervision group that would “hire” supervisors among 
the field’s elite.

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When Sarah first discussed her experiences of burnout with me, she suggested that they might be associated with loss. In fact, a recent bout of burnout had coincided with the deaths of five important people in her life, including two long-term patients. Around the same time, several patients had ended their successful therapeutic relationships with her and her patient load had dwindled. Her inability to resolve her grief as quickly as she had expected left her feeling disillusioned, demoralized, and morbidly preoccupied with signs of her own aging.

Just at the time Sarah was reeling from her losses, she learned from colleagues that her analyst, whom she had first consulted at the time of her mother’s battle with ALS, was also grieving the death of someone close. Longing to bridge the distance that had begun to separate her from this highly competent woman, and hoping to find a consoling echo in her grief, Sarah summoned the courage to ask her about the death. To her dismay, her analyst steadfastly refused to answer her, perhaps in the belief that doing so would violate the “frame” of their analytic relationship. Crushed by the sense of hopelessness and apathy that spread like a shadow across her life, Sarah felt she had little choice but to leave the treatment.

Although Sarah did not connect her analyst’s withdrawal behind a wall of analytic anonymity with her mother’s withdrawal into depression and illness, it soon became apparent that she experienced the woman’s refusal to confide in her as a retraumatizing blow. She was again relegated to a bleak and lonely place beyond arm’s reach of a beloved woman.

To understand what it was about her analyst’s refusal that proved so devastating, it is useful to return to what Stern (2004) describes as “present moments,” “now moments,” and “moments of meeting.” Of present moments, his term for directly lived, temporal experiences, Stern (2004, p. 219) notes that while they last only several seconds, they “accumulate and probably account for the majority of incremental therapeutic change that is slow, progressive and silent.” “A now moment,” he notes, “is a present moment that suddenly pops up and is highly charged with immediately impending consequences” (Stern, 2004, p. 151). Describing their significance for therapeutic change, Stern explains:

These special present moments, when they suddenly arise, threaten the status quo of the relationship and challenge the intersubjective field as it has been mutually accepted until then.... They test the therapist and the therapy. They set the stage for a crisis that
needs some kind of resolution. This resolution occurs in a different kind of special moment called a moment of meeting. (Stern, 2004, p. 220)

I suspect that Sarah’s question about her analyst’s loss constituted a now moment in her treatment. By refusing to answer, Sarah’s analyst failed the test it posed. That is, her analyst’s refusal to answer Sarah’s question prevented a moment of meeting from occurring. You may remember that in Chapter 7 I develop the notion that it is within moments of meeting that experiences of faith may emerge within the therapeutic relationship. I suggest that such faith may well be the “something more” than interpretation that promotes therapeutic change. Since analysts and patients are more likely to develop faith when they are freed from what Stern et al. (1998, p. 908) call “the imperative of regulation,” it strikes me that the analyst’s rigid clinging to what she may have believed was proper technique resulted in a devastating loss of faith.

A similar failure occurred in my work with one of my own patients, although the circumstances were quite different. Permit me a brief detour that I hope will serve to introduce my own burnout experience. In my discussion of Faith Healer I have called attention to the ways in which Frank’s struggles as a healer resembled those of many analysts. A striking dissimilarity between them lies in his apparent lack of remorse for, and obliviousness to, the cruelty he inflicted on those close to him. As analysts, many of us seem to drape ourselves in mantles of “goodness.” That is, we experience ourselves, and feel that we are experienced by others, as caring, trustworthy, and altruistic. However, as anyone who has worked as a therapist for even a short time comes to know, our mantles are often in danger of falling in tatters from our shoulders. It is not only that we are often faced with patients who reproach us for being uncaring, untrustworthy, and self-serving, but also that we are continually forced to question how far short of our own ideal of “the good healer” we have fallen.

A number of the postings to an online colloquium sponsored by IARPP (2005) that was entitled “The Analyst’s ‘Badness’ in the Analytic Process: A Roundtable Discussion” seemed to capture the horror many analysts feel when they become aware of themselves as falling short of their own standard of goodness. As I reflect on what was probably the worst bout of burnout in my professional life, I realize that it involved
this horror. It all seemed to turn on one particular moment in a therapeutic relationship, a moment in which I raised my shoulders and then dropped them again. Yet this brief gesture — a shrug — proved devastating for me as well as for the patient toward whom it was directed.

The Shrug

Zoe, a highly articulate, intelligent, and sophisticated 34-year-old woman, entered treatment with me in the throes of profound disappointment in Arnold, her previous therapist. Zoe explained that during the first several years of therapy with Arnold she had felt more clearly seen and better cared for than ever before in her life. However, at some point, according to Zoe, Arnold began to change. He took phone calls during sessions, forgot appointments, and otherwise showed gross insensitivity to Zoe’s needs. When her efforts to confront Arnold with the changes she perceived in his behavior were met with denials and pathologizing interpretations about her hypersensitivity, Zoe left treatment.

In the early months of our work together Zoe and I seemed to feel equally appreciative of one another. I found Zoe to be charming, engaging, and insightful, and I felt very lucky to have her for a patient. Comparing me to Arnold, Zoe said, with her characteristic eloquence, “I thought Venice was the most magnificent city in the world until I saw Paris.” Our Parisian honeymoon was very short indeed. To my chagrin, I realized that I was increasingly falling short of Zoe’s expectations — and my own. The effortless attunement of our first sessions broke down as I chose the wrong words, or uttered them with a discordant tone of voice, or failed to speak when she had hoped I would. Although we both suffered from the injurious aftereffects of my behavior, which, we came to understand, reopened wounds inflicted during her abusive childhood, I remained convinced that our work together would eventually prove healing.

On one fateful day, however, Zoe’s pained expression informed me that I had committed an especially egregious error in relating. How could I have failed to return a phone message in which she had informed me of her father’s death? she demanded. I explained that since she had been estranged from her father for many years and had not sounded particularly upset, I had not understood that she needed to hear from
me right away. She replied that any responsible therapist would have known better than to have accepted her blasé manner at face value. After all, her father’s abusiveness had affected every part of her life. Was not word of his death worthy of some notice on my part? What could I have been thinking? After listening to her complaints for several minutes, I shrugged. On reflection, I believe I meant to convey something like, “Yes, I know I let you down, but, come now, my not calling you wasn’t that big a deal.”

“You shrugged!” Zoe said, her voice dripping with contempt, “How could you!” But then, as if possessed by some particularly malicious demon, and hardly aware of doing so, I shrugged a second time. “You did it again?” Zoe said in disbelief. Finally, after a long silence in which she seemed overcome with excruciating pain, she murmured, “Haven’t you anything to say to me?” “I’m terribly sorry,” I blurted, overcome with shame and remorse. Zoe’s eyes, which had been fixed on me searchingly, now filled with tears. She ran out of my office without looking back.

What could possibly have led me to shrug that second time? I wondered. I knew very well that Zoe reacted intensely to the implicit, non-verbal dimension of our interactions, and that she often interpreted my behavior in ways that seemed to have little to do with my conscious intentions. I decided that my first shrug was a spontaneous, self-protective action, devoid of malicious intention. But to have shrugged again seemed to me inexplicable — and inexcusable!

When Zoe appeared for her next appointment, she appeared to be more angry than hurt. She insisted that I explain my reason for shrugging. “I think I was feeling vulnerable and I shrugged to protect myself from your anger,” I said feebly. “Is that all you can say?” Zoe asked icily. With that she rose and left my office again. When I phoned to entreat her to return so that we could explore what had happened, she indicated that if I did not know, it would not be safe for her to continue working with me.

Unable to make sense of my behavior, or Zoe’s for that matter, I consulted a number of colleagues. All offered words of comfort and support, but none helped me to understand what had happened. Several suggested that I would feel relieved by her absence. And for a time I did feel liberated by the thought that perhaps with Zoe gone, the tormenting mixture of guilt and shame I felt would eventually subside. But it was not long after Zoe left treatment that I began to feel that the burdens I
carried as an analyst were weighing down upon me more heavily than I had imagined possible. I found it increasingly difficult to rouse myself from bed to begin my day. I could barely remember the pleasure I once had taken in the sights and sounds of my early morning stroll to my office. My gaze seemed to have become permanently locked to the pavement, and as I walked, I heard nothing but my own sighs. Once at work, the hours seemed to drag. I worried that my therapeutic relationships were stagnating. Was I really helping anyone? Had I ever helped anyone? Perhaps I was not cut out to be an analyst after all. Perhaps I would feel better if I devoted myself entirely to teaching and writing and gave up clinical practice.

It was only when memories of my work with Zoe began to intrude into my waking thoughts and permeate my dreams that I connected my misery with what had happened between us. In one dream during this period, I welcome her into my office only to find it littered with shards of broken glass. Reflecting on the dream, it finally dawned on me that I had meant to hurt Zoe. Shrugging a second time after I knew full well she had been injured by my first shrug had been a hostile act. For the first time, I connected my failure to return her call informing me of her father’s death with what had been happening in my own life at the time. I had been terribly worried that the illness of a beloved relative would prove life threatening. Now it occurred to me that I could not have returned her call without confronting her with the powerful meanings of her father’s death. Nor could I have made the call without confronting myself with the fearful possibility that my relative might die. When, in that fateful session, she inadvertently called my avoidance into question, my shrug expressed the rage I could not feel, or accept.

As soon as I acknowledged my intention to inflict pain, Zoe’s reactions began to make sense to me. I realized that by failing to admit my wish to hurt her, I had subjected her to what she had claimed was the worst part of her father’s abusiveness. A handsome politician who was well respected in their community, Zoe’s father had blamed his vicious physical and verbal attacks on her provocations. How could she remain in treatment with someone who also disavowed her hurtfulness? At the same time, I glimpsed what it was about my shrugging that had been even more devastating. Zoe’s abusive father had claimed so much of our attention that her mother had remained a shadowy figure in the background of our therapeutic scrutiny. Yet, I had long suspected that

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Brothers

her mother’s neglect and indifference, her tendency to respond to Zoe’s reproaches with silence or self-justifications, had been equally, if not more, harmful to Zoe’s development. It was as if she had responded to Zoe with one long shrug. That her mother might never have actually raised her shoulders did not matter. It was her mother’s virtual shrug that had thrown Zoe’s relational world into meaningless chaos. It informed Zoe that she could not count on anyone to acknowledge that her suffering mattered, that she mattered, that she even existed.

Within days of these realizations, a strange, I would almost say uncanny, thing occurred: Zoe and I found ourselves on the same cross-town bus, something that had never happened before. My greeting must have conveyed to her that I had changed. The next day she phoned me, “I’m doing much better,” she said, “thanks to our work together. But I had to leave, didn’t I?” I said that I thought I understood why she did. Almost as soon as we resumed our twice-weekly sessions, my burnout vanished. I felt transformed, eager to tackle the challenges that working with Zoe presented.

Just as Sarah’s analyst failed her test of faith, so had I failed Zoe’s. I believe that my inability to acknowledge my wish to hurt her with my shrug prevented a moment of meeting from occurring. How could I have been so blind to my own experience? I have already mentioned that I feel most certain of maintaining self-sustaining connections when I experience myself as serving others. So, it is one thing for me to be accused of being hurtful when I mean no harm, and quite another to actually wish to hurt another person, especially one entrusted to my care. Given Zoe’s severe distress and my dread of facing the specter of a loved one’s death, I could not surrender myself to uncertainty. I was held in the grip of my own “regulatory imperative” (Stern et al., 1998, p. 908), which, in this situation, involved disavowing and dissociating my hurtful intention. Having prevented a moment of meeting from occurring, not only was an opportunity for faith precluded, but the delicate shoots of faith that had begun to sprout between Zoe and me were trampled.

I believe that it was just this destruction of faith that made my life as an analyst seem intolerably burdensome. Maintaining my disavowal took every ounce of strength at my disposal. Once I was able to face my wish to hurt Zoe, I could consider my hurtfulness in a context that allowed me to feel compassion for the painful dilemma into which Zoe’s phone call had plunged me. I am grateful for the many moments of

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meeting that have occurred between us since her return, and I deeply regret those in which our faith in one another is sorely tested.

Most of the psychoanalysts I know would be quite distressed to be called faith healers. The appellation rings with charlatanism and fakery. Yet, if a faith healer can be thought of as someone who heals faith, I am not sure I would mind. In a profession that confronts us with the fragility and precariousness of life, sometimes on a moment-to-moment basis, healing the faith that allows us to live uncertainly seems a worthy enough purpose.