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## A PERILOUS HIGH WIRE ACT: FRAMING PSYCHOANALYTIC RELATIONSHIPS WITH SEVERELY TRAUMATIZED PATIENTS

BY ALAN MICHAEL KARBELNIG

*Dual relationships, inappropriate self-disclosures, fee-setting irregularities, session-length extensions, and other boundary crossings punctuate this dramatic study of a psychoanalysis of an acutely traumatized patient. Describing the case from his point of view as supervisor, the author explores how overwhelming emotion, powerlessness, a wish to rescue, and a risk of ego boundary dissolution endangers psychoanalysts' clinical methodology with such patients. Self-monitoring, self-reflection, self-caring, and training helps, but working with this population, as the case example reveals, remains a difficult, even perilous endeavor.*

**Keywords:** Trauma, framing, boundaries, training, humility.

In contrast to the relatively straightforward professional boundary processes in medicine, law, or accounting, psychoanalysts' framing behaviors are delicate, sometimes difficult, and occasionally dangerous. Practitioners of these other professions remain in their social roles, delivering medical, legal, or financial knowledge. They may care about their patients or clients; they may react to them. But metacommunication about their professional relationships is not part of the work, let alone a *crucial* part. In contrast, psychoanalysts closely attend to their actual professional relationships. They either sense or enact countertransference and transference themes while observing, reflecting, and

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commenting upon them. For psychoanalysts, the relationship *is* the vehicle for the service, and metacommunication is central.

Further, because of the intensely intimate nature of their work, psychoanalysts cannot help but react personally to their patients. Often, they become attached to them, care for them, even love them. Sometimes they worry about them; sometimes they hate them. Even clinicians devoted to one-person theories of mind still rely upon the professional interpersonal relationship as a transformational vehicle, rendering personal involvement unavoidable. Psychoanalysts have no white coat, business suit, or spreadsheets to hide behind. Referring to Freud's (1915) caution to exercise special care when conducting psychoanalyses, Coen (2018) suggests this early warning led "to too much pressure on us to stifle our needs, temptations, and feelings in work with our patients, lest they get out of hand" (p. 313). Too much pressure, indeed. And yet out of hand psychoanalysts' emotions sometimes get.

By analogy, psychoanalysts walk along a tightrope clinging to a balancing pole. One side carries the weight of professionalism in the form of such standard psychoanalytic methods as interpretation, clarification of feelings, confrontations or focused empathy; the other side holds love, care, fear, irritation, anger, or other emotional reactions to patients. All psychoanalysts walk the same high wire, balancing technical methods and personal feelings. Sometimes the high wire shimmers and shakes. These tremulous forays along the high wire become aggravated by psychoanalysts' difficult personal situations, strong emotional reactions to patients, and/or countertransference problems.

## WHY EXPLORE THESE PERILOUS JOURNEYS?

Firstly, because they feature prominently in psychoanalysts' daily work. Sometimes, they include actual boundary violations, which, in turn, lead to complaints against licensed mental health professionals. Through my work as a forensic psychologist as well as a psychoanalyst, I have either psychologically evaluated, or reviewed the clinical work of, more than 100 psychotherapists who violated professional boundaries. I have observed several distinct trends. Only a few of the practitioners who slid down the proverbial slippery slope displayed signs of psychopathy. Most

of them were vulnerable human beings who found themselves emotionally overwhelmed by, generally, their personal problems. They lost their capacity to navigate through their countertransference reactions; they became incapable of properly framing their professional relationships. My anecdotal experience with these professionals who fell off the tight rope stoked my curiosity.

Secondly, my recent supervision of the last two years of a five-and-a-half-year psychoanalysis offered a particularly ripe, even frightening, example of a dangerous walk along the high wire. The colleague sought consultation from me after he had already lost his balance—a deterioration triggered by his patient's falling victim to a serious physical assault. In the months following the attack, he became overwhelmed with worry, concern, and helplessness. The ultimately failed case provides useful clinical material, specifically about the risks inherent in practicing psychoanalysis with acutely traumatized patients. The dynamics of the case also comports with the themes commonly encountered in my forensic work with mental health professionals who committed boundary violations.

In brief, I find the dynamics of walking along the high wire fascinating. Even though this investigation has significant delimitations, it will hopefully stimulate a longer, in-depth conversation. In the ensuing pages, I expand upon the extant literature, offering new insights and a few solutions. I explore how emotional reactions to acutely traumatized patients, the personal life situations of psychoanalysts, and countertransference reactions systemically interact with one another. The investigation exemplifies how, as Celenza's (1991, 1998, 2007, 2010a,b) scholarship regarding sexual countertransference reactions reveals, "the question of what accounts for the breakdown of controls can be answered only in the context of a particular case" (Celenza 1998, p. 393). In like manner, Ingram (1994) believes each psychoanalyst-patient dyad—intensely informed by the two persons as they encounter one another, multiple contextual factors, and the clinician's devotion to psychoanalytic theory—has its own unique "signature" (p. 175). The specific signature of the case I present illustrates a disastrous walk along the high wire.

The clinician approached, but did not actually become involved in, any overt sexual misconduct—differentiating it from cases focused

specifically on sexual enactments. To protect the privacy and confidentiality of the psychoanalyst, whom I call David, and his patient, Alice, I significantly altered identifying information, the sequencing of the psychoanalytic process, the nature of my supervisory relationships with him, and other details. The dynamics of the supervisory relationship warrant an entirely separate exploration but, except for a few comments, and for space considerations, I sideline that angle. Having outlined the primary themes for discussion and the nature of the case used to explore them, I turn to reviewing the concept of framing.

## THE CONCEPT OF FRAMING

Expanding upon my earlier articles proposing a unifying clinical nomenclature for psychoanalysis (Karbelnig 2014, 2016b, 2018), I utilize the word *framing* to describe the process of creating the environment for psychoanalytic processes to occur. Framing extends beyond simply maintaining professional boundaries. It refers to crafting a transformational space. It calls for a unique type of psychoanalytic attitude (Schafer 1983), necessitating a special receptiveness, a unique openness. Framing, along with *presence* and *engagement*, provides cross-theoretical ways to identify psychoanalysts' professional behaviors (Karbelnig 2018). Framing ranges from the most abstract, e.g. subtle interpersonal behaviors, to the most pragmatic, e.g. degree of self-disclosure.

Defining the boundaries around psychoanalytic relationships has always been difficult, particularly because psychoanalysts lack any technology, formal procedures, or algorithmic methods that naturally create them. Physicians typically don white coats with stethoscopes draped over their shoulders when encountering their patients, naked but for an examining gown. Lawyers dress in business attire, sitting behind desks with wall-to-wall legal journals, books, and stacks of case files arrayed behind them. Psychoanalysts, in contrast, meet with patients in more of a den-like setting, deliberately inviting them into a structured interpersonal relationship fomenting personal transformation. This feature, namely the intimacy of the encounter, regardless of the asymmetry of the relationship (Aron 1996), presents great challenges for psychoanalysts—particularly in terms of how they balance themselves as they walk along the high wire.

Framing consists of essentially two distinct professional behaviors. First, psychoanalysts establish various types of boundaries that establish the professional working relationship. This extends beyond simply appropriate interpersonal boundaries. To provide a literal space and time for the psychoanalytic process to unfold, psychoanalysts maintain a professional environment and hold regular appointment times with patients. They furnish their offices in a manner that provides patients enough warmth to facilitate an intimate conversation but not one that excessively invites informality. Psychoanalysts who prefer the use of the couch would, of course, have furniture that accommodates patients' reclining.

Framing varies according to the style of each psychoanalyst and his or her devotion to one or more theories. Some of these constraints are obvious. For example, most psychoanalysts agree that engaging in dual relationships with patients violates the psychoanalytic frame. Even novice psychoanalysts understand that having coffee with patients, employing them as their personal assistants, or otherwise involving them in social roles that parallel their patient role causes confusion that hampers, if not destroys, psychoanalytic processes. Many psychoanalysts, with Gabbard (1995) among the most notable, have written extensively about boundary maintenance. Gabbard and Lester (1995) helpfully distinguish between *boundary crossings*—defined as departures from the typical professional frame that are harmless, non-exploitative, and possibly even helpful—and *boundary violations*, which, by definition, harm patients.

Second, psychoanalysts *may* utilize framing behaviors in the service of repairing previous interpersonal trauma. Depending on their theoretical preferences, they may consider caring for their patients healing. But even conservative psychoanalysts, devoted to the “Gemini twins of abstinence and neutrality” (Davies 1994, p. 156), interrupt transference enactments and interpret them. They avoid repeating the destructive interpersonal patterns patients unconsciously and habitually replicate. In other words, those psychoanalysts who disagree with the relational turn still behave in a certain way, within the confines of the psychoanalytic relationship, to effect change. They display curiosity about their patients; they attend closely to them. Since the relational turn, controversy lingers as to what extent psychoanalysts use their own subjectivities, or their own care, as part of the mutative process. Psychoanalysts may

attempt to help patients through various degrees of self-disclosure or by directly expressing caring, concern, or even love.

Framing behaviors also vary with the personal preferences of psychoanalysts. For example, and often a reflection of psychoanalysts' personal styles (Karbelnig 2016a) rather than theoretical approach, some practitioners prefer a more formal approach, valuing abstinence and neutrality. They typically structure their psychoanalytic relationships and engage their patients conservatively. One of my supervisors during my psychoanalytic training had such a style. He sat far from me. His office was sparsely decorated, "to invite negative transference," he said. Others work more informally. In my own case, I have, over time, relaxed an initial adherence to abstinence and neutrality in favor of attending more to my feelings about patients. I identified myself more with relational models, observing more closely how my own emotional reactions, as well as the vicissitudes of my personal life, impact my work. I felt liberated to receive the unique individuality of patients, and how they form unique relationships with me, with greater openness. The change affected my supervisory as well as clinical practices. While exploring the work between David and Alice, and my supervision of David, I cannot help but wonder if my more casual way of working with patients affected the psychoanalysis I supervised.

Furthermore, consideration of to what degree psychoanalysts' subjectivities figure in clinical work evolved significantly in the last half-century. Along with it, views of framing correspondingly changed. The debates surrounding degrees of, and benefits to, psychoanalysts sharing their personal or countertransference reactions to patients heated up. Previously distinct boundaries between the real relationship, the working alliance, the therapeutic alliance, and the analysis of transference and countertransference blurred. Jacobs (1990) considered psychoanalysts' using their subjectivities, as opposed to their simply offering insight, as not "mutually exclusive processes technically and theoretically worlds apart ... but, instead ... synergetic forces in treatment, in continual interaction, one paving the way for the other, each important, each contributing in essential ways to the therapeutic action of psychoanalysis" (p. 454). Boesky's (1990) proposal that countertransference enactments signal the *start* of true psychoanalytic processes rendered boundary crossings inevitable. Terms like role responsiveness (Sandler

1976), actualizations (Boesky 1982), countertransference enactments (Jacobs 1986), and modes of analytic listening (Schwaber 1986) increased awareness of how much of psychoanalysts' behaviors, verbal and nonverbal, influence their patients. Awareness of how patients influence their psychoanalysts also increased.

Reflecting on her decades studying the concept, Chused (1992) defined psychoanalytic neutrality as "a particular stance, learned over time, in which an analyst experiences the passion of the analytic situation and, at the same time, observes the passion (of both patient and analyst) dispassionately, nonjudgmentally, without condemnation" (p. 161). Her use of the word, *passion*, signifies the aforementioned sea change. Jacobs (1999) subsequent suggestion that clinical psychoanalysts' minds contain complex mixtures of countertransference, other subjective responses, and patients' projections validates the progression in the debate. He considered the professional relationship as a "creation forged out of the interplay of patient and analyst ... [becoming] an integral and inherent part of the analytic situation" (Jacobs 1999, p. 591). The case of David and Alice offers a particularly striking forged creation that emerged from such interplay.

In the 21<sup>st</sup> century, the previously heated debates over degrees of psychoanalysts' personal involvement with patients cooled. Mutually interactive features of psychoanalytic relationships gained broader acceptance. Just recently, the Boston Change Process Study Group (2018) acknowledged psychoanalysis evolved far past the idea of the clinician's neutrality, instead encompassing mutual influences between psychoanalysts and patients. They believe concepts such as transference must "encompass all levels of the embodied, intersubjective process between patient and analyst" (Boston Change Process Study Group 2018, p. 317). Mirroring the sentiment, Hirsch (2018) quips "we must become part of the problem in order to help solve it" (p. 292). As my case study reveals, David indeed became part of the problem, arguably too much of it. As a result, Alice had a chance to re-experience the rage she felt towards other abusers in her life—a potentially growth-enhancing enactment and an opportunity to vent pent-up rage. However, David's assuming the role he did in Alice's internal drama, combined with his own personal vulnerabilities, created a traumatic re-enactment that ultimately destroyed the psychoanalytic relationship.



In the final analysis, each psychoanalyst, facilitating his or her own unique version of psychoanalytic, transformational encounters due to variations in theory, personality, style, culture, and other factors, creates professional boundaries, externally (as in regular appointment times, punctuality in starting and ending sessions, or allowing contact by email or text) and internally (as in degree of expressed warmth or self-disclosure). Framing professional relationships occurs regardless of psychoanalytic models of mind or practice. Without reasonably proper framing, psychoanalytic processes cannot occur.

## UNIQUE FRAMING CONCERNS IN WORK WITH SEVERELY TRAUMATIZED PATIENTS

Integrating the recent psychoanalytic literature with my experience working with traumatized patients reveals four significant themes which, in turn, influence psychoanalysts' framing behaviors. First, psychoanalysts treating these patients tend to feel overwhelmed by their patients' emotional experiences. Celenza (1998) cautions psychotherapists to brace themselves for work with this population, recommending "the capacity to tolerate the full range of affect" (p. 393). Psychoanalysts' personal difficulties exacerbate their vulnerability to feeling overwhelmed. Many scholars' work validates this phenomenon. Dobrescu (2012), for example, acknowledges how stressful events in psychoanalysts' lives—i.e., divorce, disease, losses—worsen countertransference problems; Elisse (2015) discusses the specific impact of betrayals on the countertransference; Kogan (2015) describes how countertransference experienced by a Holocaust survivor treating another resulted in a defensive collusion. Earlier, Alder (1995), Bion (1967), Giovacchini (1979), Gunderson (1984), Kernberg (1984), Masterson (1976), Rinsley (1982), Searles (1986), and others also acknowledged how psychoanalysts ideally exert greater care managing their countertransference when treating acutely distraught patients. This line of scholarship suggests that emotional overwhelm commonly accompanies work with severely traumatized patients—a phenomenon worsened by personal problems, if present, in treating psychoanalysts.

Second, psychoanalysts often feel a sense of powerlessness—an irony given how the power of the psychoanalytic role may also contaminate

countertransference (Celenza 1998, 2007). Dodes (1990) believes “powerlessness or helplessness” constitutes “the essence of psychic trauma” (p. 401). These traumas, of course, enter the psyche-somas of clinicians. Harris (2009) suggests psychoanalysts ready themselves for a “mix of powerlessness, shame, and insistent demand” (p. 7). Celenza (1991) thinks the risk sexual enactments increases during times of psychoanalytic impasse that, in turn, elicits feelings of powerlessness. In sum, the literature substantiates this second theme, namely that working with this population often causes feelings of powerlessness.

Third, psychoanalysts often feel compelled to rescue these patients—another pressure which affects framing processes. Gabbard (1995, 1997) repeatedly alludes to such wishes in his articles about countertransference. In discussing patients who, like Alice, have histories of childhood sexual abuse, Gabbard (1997) identifies psychoanalysts’ propensities “to make up for the patient’s childhood trauma by becoming the perfect parent in the present” (p. 7), a parental figure who, naturally, wishes to rescue patients. Carsky and Yeomans (2012) describe how work with traumatized patients often leads to a dyad of “the *wounded patient* and the therapist as *rescuer and protector*” (p. 88, italics in the original). They directly reference the need to rescue. The third theme, then, surrounds the wish, desire, need, or even felt-pressure to rescue these severely traumatized patients.

Fourth, work with acutely traumatized patient may elicit such distress that, in both parties, ego boundaries dissolve and, with them, psychoanalysts’ framing behaviors. Atwood and Stolorow (1984) specifically identify working with traumatized patients as potentially resulting in ego boundaries becoming fluid. In these situations, Celenza (2007) writes, “the psychoanalytic situation inextricably entangles (and potentially erotizes) love, attention, and power” (p. 298). Briefly put, psychoanalysts may become distressed enough to confuse their own needs with their patients. Elsewhere, Celenza (1998, 2010a,b) references pressures placed on psychoanalysts to relinquish the asymmetric structure of the psychoanalytic relationship. Patients want “to have the multiple roles coalesce into one” (Celenza 2010b, p. 181). She has observed psychoanalysts over-identifying with their patients, resulting in a type of ego dissolution and “a perversion of the therapeutic process by using an empathic resonance to meet the therapist’s need” (Celenza 2010, p. 66).

Such over-identifications make managing the transference and countertransference more difficult. She described a case in which a seduction “involved an unconscious attempt to circumvent the negative transference and to sustain a positive, idealizing transference easier for both parties to bear” (Celenza 1991, p. 508).

Briefly put, psychoanalysts may experience such intense empathy and over-identification that they avoid either the traumatic pain, or the pain of negative transference, by unconsciously enabling idealization processes. In the case Celenza (1991) references, the psychotherapist acted out sexually to maintain just such an idealized transference. In doing so, a form of ego dissolution, or at least loss of social-role-identification, occurred. Similarly, Carsky and Yeomans (2012) suggest psychoanalysts prepare themselves to “resist dealing with the negative transference in such a way as to become the ‘good mother’” (p. 89). If so prepared, perhaps the sexual enactment described by Celenza (1991) would not have occurred. This final theme in the literature on treating acutely traumatized patients consistently warns of a risk of ego-boundary dissolutions.

Nodding to Foucault’s (2002) work on the arbitrary, always-incomplete nature of classification systems, these four trends represent but one way to organize countertransference phenomena with this specific patient population. Certainly, emotional reactions to acutely traumatized patients, and the ways they challenge framing behaviors, could be organized into other categories. But these four themes provide a descriptive classification system supported by the relevant literature as well as common clinical experience. They lead to the following question. How should these four risks—emotional overwhelm, feelings of powerlessness, a desire to rescue, and ego dissolution—influence psychoanalysts’ framing behaviors when working with such traumatized patients?

The literature offers a variety of recommendations. If mature and experiencing few personal problems, psychoanalysts may rely upon typical defenses like humor, suppression, anticipation, and similar higher-level defense mechanisms to prepare for expected challenges. Because these patients unconsciously beg their psychoanalysts to become a “real love object” who will “heal wounds from the past” (Gabbard 1997, p. 7), clinicians ideally strive to maintain their own emotional and personal stability when working with them. They enter work with this population

prepped, readied, armed to resist the expected, strong unconscious forces. They deflect the invitation to behave like the powerful, rescuing parent and, instead, maintain their usual, equally hovering psychoanalytic stance. As I describe in the case example, David encountered significant personal stressors while treating Alice. These stressors, which challenged his maturity as well as his emotional stability, contributed to him falling from the high wire. And, Alice's psychopathology also contributed to the fall.

In terms of using self-disclosure with these traumatized patients, the specific literature reveals the same level of controversy characteristic of the topic in general. Glucksman (2010) believes disclosure of loving feelings can be useful if carefully delivered to more mature, integrated patients. But can acutely traumatized patients feel mature and integrated? Certain scholars, like Gabbard (1994, 1996), argue against any such self-disclosures while others, like Davies (1994, 1998), find them helpful. Zachrisson (2013) proposes a third concept be added to the psychoanalytic lexicon, namely the phrase boundary "stretchings," to describe "transgression of the analytic but not the ethical boundary" (p. 246). In other words, he believes, some self-disclosures, demonstrations of actual caring, and the like may violate traditional analytic but not ethical frameworks. In the case of David and Alice, many examples exist of David expressing caring self-disclosures, and even providing Alice with financial help, which constitute such stretchings. However, some of his behaviors extended well beyond how framing is typically conceptualized.

Influenced by Ringstrom's (2001, 2007, 2012) scholarship on improvisation and by the relational turn more generally, I consider work with acutely traumatized patients more art than science. Each session is unique. It requires individualized methodology depending on the dynamic status of specific patients as well as of specific psychoanalysts. In terms of framing specifically, the needs of the individual patient, as they exist in any moment in time, call for different types of presence and engagement. Some moments call for absolute empathic attunement; others for confrontation or interpretation. However, the specifics of the frame—like session times, length, and fee—ideally remain as stable as possible. Such steadiness, in and of itself, at least partially defends against the intensity of the pressure to feel overwhelmed, powerless, pulled to rescue, or at risk of losing ego or social role boundaries.

By the time David began consulting me, he had already surpassed boundary stretchings and entered the realm of actual boundary violations. If I were in his shoes, I can imagine sharing my caring, and certainly my worry (particularly during the psychogenic fugue states), like David did. However, I fear that the relaxing in my initial, more formal psychoanalytic stance may have contributed to some of the perversions in framing processes that occurred. In the case description, I discuss the degree to which David's management of the frame represents his emotional availability as opposed to the boundary violations. I also touch on the isomorphic features of the supervision, namely how my own professional evolution altered how I evaluated David's work.

My review of these four framing themes completed, I present David's five-and-a-half-year psychoanalytic treatment of Alice work in three phases: the initial two-year pre-injury period when the framing process unfolded in a typical fashion; the 18-month post-injury period marked by David beginning to lose his way; the subsequent, two-year period when the frame deteriorated, collapsed, and the psychoanalysis terminated.

## I—THE PRE-INJURY PERIOD

I base my description of David's first, two-year period of his work with Alice on his retrospective narration of it. David's recollection of feeling "extremely attracted" to Alice, immediately after he met her, constitutes one of the more striking features of the first period. More than just an erotic attraction, David felt enchanted by her keen intellect. He became more intrigued as Alice described having enjoyed her married life, particularly its sexuality. David wondered how he might have been unconsciously drawn to her. He tracked how certain features of his personal life, particularly troubles in his own marriage, left him vulnerable to developing an erotic countertransference. An ambitious man, David had completed formal psychoanalytic training within four years. He was strongly devoted to work and productivity. He married young, and his wife and he had two sons. Both children were in their teenage years when David began working with Alice. He often felt fatigued and "flattened" during that first period, believing his work and family life "exhausted" him.

Alice had been referred by her prior psychoanalyst, with whom she had consulted twice a week for ten years. With his assistance, Alice completed a four-year state college, majoring in American history. She progressed into a doctoral program in the same field. Unable to find a tenure-track position in a university, Alice accepted a position as an acquisition editor for a small publishing company. She had just begun working there when she began consulting David. Her psychoanalyst referred her because he became terminally ill. Following Alice's lead, David focused initially on helping her work through her feelings regarding her previous psychoanalyst. David provided the same twice weekly, psychoanalytic psychotherapy sessions at \$150 each, like the prior psychoanalyst. Alice mourned the ending of the previous psychoanalytic work; she also pondered the status of her prior psychoanalyst. She worried she had overwhelmed him. Also, she felt angry. These complex emotional states lingered. The prior psychoanalyst died approximately one year into Alice's work with David. As the other psychoanalyst neared death, David recommended formal psychoanalysis, provided four weekly session times, and lowered his fee to \$100 per session. He felt no conscious resentment of the arrangement. Alice denied feeling guilty about it.

Several months after the prior analyst's death, Alice returned to discussing themes dominating the prior ten years of psychotherapy. She had been subjected to emotional and sexual abuse as a child. Her father, a physician, ignored his two daughters. Her mother overtly rejected Alice, favoring her younger sister. Alice's father's medical partner molested her when she was age six, and sexually assaulted her when she was 16. She coped with both traumata in silence, alone. Alice married when she was in her young 20s. Her husband abandoned the family after the birth of their only child, a daughter. An extremely intelligent man who, unlike Alice, attained a professorship, he felt Alice could not sufficiently attend to him after the birth of their daughter. They remained cordial after their relationship dissolved. He paid her fair levels of spousal and child support. Shortly after their divorce, he accepted a tenured faculty position in a European country. Alice subsequently reared her daughter on her own.

As the psychoanalysis progressed, David's initial attraction to Alice waned. He remembers becoming so deeply involved in her unconscious themes, and in their mutual work, that his erotic countertransference "moved into the background." He felt relieved. Again, he reflected on

his personal vulnerability to feeling attracted to Alice, and realized contributors other than mid-life and marital problems. David had endured significant childhood trauma himself. He felt rejected by an anxious and narcissistic mother. His devotion to his marriage, his involvement with his sons, and his ambition compensated for these narcissistic injuries. However, having endured two decades of marriage, David felt constrained by the relationship. He considered their routines “mundane”; he feared his career had “plateaued.” His sons preparing to leave for college created an emotional vacuum, increasing his personal vulnerability. While these personal life themes contributed to later difficulties in his managing the frame with Alice, he remained in good control of his countertransference during that initial period.

Through their work together, Alice learned how her childhood trauma created a propensity toward self-negation manifested by, for example, her excessively sacrificial behavior in relationships. She missed some obvious cues about her ex-husband’s limited interpersonal capabilities; she gave excessively to her daughter; she seemed attracted, in her post-marital dating life, to men who neglected her. In addition to exploring these current life themes, David brought Alice’s attention to how her self-negation manifested in the transference. For example, when Alice reported feeling sexually attracted to David, she expressed her belief that he could not possibly feel the same way towards her. She assumed he viewed her as inferior in some ways, i.e., unintelligent and “homely.” Subsequent interpretations included the possibility that Alice’s erotic transference might have developed, or intensified, to avoid dealing with the loss of the prior psychoanalytic relationship, the psychoanalyst himself, or other painful material.

Mirroring David’s psychoanalytic behavior, Alice showed sound behavioral control in that she verbalized, rather than enacted, her erotic transference. Her behavior suggested that, to use Balint’s (1979) terminology, she regressed to seeking recognition rather than “instinctual gratification” (pp. 186-187). She participated actively in the sessions, openly exploring themes from her past, present, and in the transference. As the many self-negating, masochistic motifs emerged, Alice associated to childhood memories. Sometimes she wept, mourning many painful experiences of loss, neglect, and abuse. At other times, she felt enraged. Also, and on occasion, Alice experienced episodic but intense anxiety states, re-experiencing the disintegration she felt during her early childhood.

David became equally engaged in the intense psychoanalytic process with Alice. Although he identified himself as working relationally, he often referred to middle school theorists, particularly Fairbairn (1952), whose work he admired. David particularly liked how Fairbairn (1952) compared the unconscious to dramatic themes unfolding in “a Black mass ... celebrated in the crypt” (p. 70) while another, parallel theme, manifested in consciousness. Fairbairn (1952) continues, “it becomes evident, then, that the psychotherapist is the true successor to the exorcist, and that he is concerned, not only with the ‘forgiveness of sins,’ but also with the ‘casting out of devils.’” (p. 70). In his work with Alice, David narrated how he and Alice had entered the crypt, uncovering hidden unconscious schemata. He described how certain phenomena, such as Alice’s assumption that he found her unintelligent and unattractive, represented her projection of the rejecting object component of a “dynamic structure” (Fairbairn 1952, p. 377). As he received and processed these projections, David served as “exorcist,” to use Fairbairn’s terms (1943), or as a “container” (p. 90), to use Bion’s (1962). David also explored how, consistent with psychoanalytic field theory (Baranger and Baranger 2009; Katz 2013), these projections affected both parties.

Toward the end of this initial period, David’s initial sexual/romantic fantasies about Alice transitioned into more parental ones. He imagined rearing Alice as his daughter. David felt an invitation to rescue, partially communicated unconsciously by Alice, and partially emerging from his own wish to help. He kept these images to himself, however, using them to inform his work. Meanwhile, Alice had made several positive changes: she re-entered the dating world, showing an improved capacity to evaluate romantic partners. She became firmer with her teenage daughter, ending a trend toward excessive, arguably enabling generosity towards her. She also owned her competency as an acquisition editor. Signs of a propensity toward “malignant regression” (Balint 1979, p. 186) remained absent.

## COMMENTS ON THE FIRST PERIOD

In retrospect, David passed by several danger signs—the reduction in fee, the meaning of his initially intense attraction to her, its transition into a more maternal countertransference, and the effects of his own personal difficulties—with insufficient exploration within the analysis or



introspection on his part. He reported monitoring these trends. However, later developments call his self-evaluation into question. He probably could have better managed the conjoint devaluation of self in Alice, and over-valuation of self in him, e.g., the wish to rescue, as it emerged in their relationship. His description of the emergent sadomasochistic theme had a passive, matter-of-fact, feel to it. The power differential of which Celenza (2007, 2010) warns appears to have influenced this unconscious, interpersonal theme. Perhaps David could have interpreted these more intensely, at least lessening its intensity during this first period.

Existential features of David's life also served as an accelerant. Alice's intelligence, academic interests, and attitudes toward marriage and sexuality matched what he felt was missing from his personal life. Partially during this initial two-year period, and significantly during the time following Alice's injury, David's personal problems had an almost additive effect, diminishing his psychoanalytic capabilities and unsettling the psychoanalytic boundaries. Perhaps David's struggles with his marriage and his other mid-life difficulties betray a significant self-destructive streak.

However, both parties influence the psychoanalytic dance. Alice endured severe childhood trauma in the form of neglect, emotional abuse, and sexual abuse. She was unable to find work in academia, as she preferred, and her husband left her shortly after the birth of their child. The way she felt abandoned by the prior analyst, not to mention his illness and subsequent death, immensely affected her. Probably David's initial attraction to Alice blinded him to some of her vulnerability, specifically the borderline personality features which, as will soon become evident, feature significantly. Overall, and despite some serious vulnerabilities lurking in the background, the initial psychoanalytic psychotherapy, and subsequent psychoanalysis, appears to have, overtly at least, unfolded in a proper, well-bounded way. The fault lines in their work became much more apparent when Alice's condition abruptly worsened after she was attacked.

## II—THE IMMEDIATE POST-INJURY PERIOD

After an annual office holiday party at a local hotel, Alice was attacked in an underground parking lot by men who robbed her and beat her,

causing injuries to her cervical spine severe enough to require surgery. The assault and its aftermath dominated the psychoanalysis for months. In addition to her physical and emotional wounds, Alice felt abandoned by her employer. Only a few of her colleagues visited or telephoned her. She obtained financial assistance from the State's Victims of Crime (VOC) program, which later helped to pay for the psychoanalysis.

Severe post-traumatic stress disorder (PTSD) symptoms emerged. Alice felt terrified. She suffered insomnia, nightmares, and intrusive recollections of the attack. She was hospitalized for treatment of a ruptured cervical disc. She remained acutely symptomatic after her discharge. Alice also developed psychogenic fugue states. While her daughter slept, she wandered around her neighborhood in an amnesic state. Worried that Alice could be raped, murdered, or otherwise harmed, David contemplated psychiatric hospitalization. Instead, he increased session frequency from four to five times a week. He also contacted the treating psycho-pharmacologist who added a major tranquilizer to Alice's medication regimen.

Alice nonetheless remained acutely distressed and unable to work. As her psychological symptoms persisted, and physical symptoms such as chronic neck pain lingered, her physicians considered her disabled on a long-term basis. This development elicited suicidal thoughts. Alice had means (medication) and plan (overdose). She lacked immediate intent. Were it not for her daughter, Alice's suicidal risk would have been severe. David successfully contained her distress, fragmentation, and suicidality. However, his countertransference intensified immediately after her injury. He felt "immersed in her pain." Between sessions, he worried about her. He, too, had trouble sleeping. He had more elaborate fantasies of helping her, specifically imagining Alice moving into a vacant room in his house. He thought of other ways he could intervene, e.g., lending her money or arranging for better medical care.

Mirroring his increased personal involvement, David's framing behaviors changed. He disclosed his concern for her. He described his feelings of powerlessness. He often extended session lengths, ending sessions 10 or 15 minutes beyond their usual stopping time. Sometimes he did so because of Alice's distress; other times he ran over because he felt unable to provide enough comfort by the time sessions ended. He called the orthopedic surgeon to ensure he understood Alice's mental fragility.

Supporting her intention to sue her employer for negligence, David referred her to attorneys. He also met with her daughter. In a phrase, David became personally overinvolved. What had been a challenging psychotherapeutic situation due to Alice's childhood trauma and his strong, initial erotic countertransference rapidly transcended into one dominated by his own experience of her pain, his intense feelings of powerlessness, and his wish to rescue her. Ego boundaries began to dissolve.

Toward the end of this second period, further stressors affected their work. Alice's financial status deteriorated. Her income plummeted from \$84,000 per year in salary to \$24,000 per year in disability benefits. She moved into a small one-bedroom apartment with her teenage daughter. The payment for the psychoanalysis was assumed by the VOC program, contributing to the context for the next and most dangerous part of David's professional behavior. VOC paid \$80 per session, and, surprisingly, authorized him to continue to provide her with five sessions per week. David accepted the fee reduction without any overt psychological reaction. However, the VOC featured a Kafkaesque bureaucracy requiring extensive documentation of sessions. The agency fell months behind in paying David. He kept this information from Alice. When she later learned of the situation, she reacted with strong emotion: she felt guilty regarding his not being compensated fairly; she felt ashamed at being a "low-fee patient." She specifically mentioned, for example, that David was earning essentially half-per-session compared to when she first consulted him.

Meanwhile, David believed he remained capable of meaningful psychoanalytic work. Concerned about his self-disclosures and how his emotional reaction echoed hers, he initiated consultations with me—a senior colleague of his—at the end of this second period. As Alice's acute reaction subsided, David helped her understand how the assault opened vulnerabilities discussed prior to the injury. For example, she wondered if she had provoked her assailants; she worried that walking to her car so late had invited the attack. Paradoxically, Alice also began to feel anger at the perpetrators and also at her employer. David helped Alice weave these emotional reactions into the tapestry of her self-understanding. They made connections between the objectification inherent

in the assault and the ways she had been objectified by her abusive father's partner and other men.

## COMMENTS ON THE SECOND PERIOD

Numerous factors contributed to David feeling more overwhelmed during this phase: Alice had previously neither displayed psychogenic fugue states nor suicidality. She endured a serious assault followed by surgery, chronic pain, and disability. Also, Alice's propensities towards self-negation worsened. Particularly noteworthy are her fantasies that she bore some responsibility for the assault. David's resultant overwhelmed state—a common feature of working with trauma (Celenza 1998; Dobrescu 2012; Dodes 1990; Elisse 2015; Harris 2009; Kogan 2015; Poland 2000) contributed to his professional judgment slipping. Towards the end of this period, he reached out for weekly consultations with me—*itself* signifying his awareness of losing his way.

If some slippage in David's framing processes was evident in his first period of work with her, it became overtly problematic in this second phase. He felt more desperately called to rescue; he experienced even greater feelings of powerlessness. David showed signs of his losing his ability to maintain the asymmetry of the psychoanalytic relationship (Aron 1996). He committed boundary "stretchings" (Zachrisson 2013, p. 246) as well as crossings, e.g., discussing her condition with Alice's orthopedist and daughter. His self-disclosures became excessive, as did his identification with her, demonstrating how common countertransference themes were enacted rather than analyzed. His fragile self-image likely contributed to his improper professional behaviors. His relationship with Alice became dominated by romantic, rescuer themes. A complete destruction of the treatment process had not yet occurred, but David began to slide down the proverbial "slippery slope" (Gabbard 1995, p. 1126). His awareness of how his professional behaviors could be affecting Alice, or his own life, diminished.

Paralleling David's difficulties, Alice demonstrated significantly more severe psychopathology. Her behavior suggests the presence of borderline personality features, if not an overt personality disorder, underlying the PTSD. The psychogenic fugue states—a particularly acute form of dissociation—are particularly remarkable. David had little

reason to suspect such primitive mental functioning earlier in the treatment. She had enjoyed a ten-year, stable relationship with her prior psychotherapist; she had functioned well in prior academic and occupational settings. However, and characteristic of patients who encounter severe adult trauma layered upon early childhood injury, the attack elicited intense emotional pain and a correspondingly decline in adaptive coping behaviors.

While David seemed to entirely join Alice in her sense of victimization, the severity of her reaction offered additional information. Had she alienated coworkers in some way to prevent them from reaching out to her after the attack, suggesting broader deficits in social relating? In retrospect, David may have better served Alice by introducing more supportive, and less psychoanalytic, features to their work. Reducing the frequency of the sessions, rather than increasing them, may have better prepared Alice for subsequent events. Her financial situation had already become compromised. Perhaps David could have referred her to some form of social service, perhaps through the VOC? In many ways, she required as much the help of a more social-work-oriented treatment than a psychoanalyst. On the one hand, the increased session frequency, and the provision of the psychotropic medication, lessened the intensity and frequency of the fugue states and other PTSD symptoms. On the other hand, the guilt Alice felt at the fee reduction, and David's likely unconscious reaction to the fee reduction, created an underlying breach in the psychoanalysis. Such difficult psychoanalytic situations always seem clearer in retrospect. I too may have missed the fragility in the psychoanalytic relationship, wondering if an isomorphism—namely my caring for and wishing to rescue David—entered our supervisory relationship. David and I had just begun discussing these themes, particularly Alice's unconscious contributions to the problematic situation and his increasingly challenged sense of judgment, when matters got much worse.

### PHASE III—THE FRAME COLLAPSES

The psychoanalytic frame deteriorated further when subsequent stressors affected Alice's life. Her daughter moved out, leaving her feeling abandoned by her. David felt "forced" to abruptly reduce the frequency

of the sessions. Administrators of the VOC program had monitored the psychoanalysis closely—a treatment-complicating invasion of privacy. David wrote monthly “psychotherapy reports” to VOC officials. They, in turn, noticed the improvement in Alice’s symptoms, and discontinued paying for the psychoanalysis. David formally protested, but the agency insisted on paying only for twice-weekly sessions. Alice could not afford any additional meetings.

Shortly after the reduction in session frequency, Alice regressed. The acute symptoms of the PTSD, including the fugue states, recurred. To compensate for the reduced contact, David extended the length of those bi-weekly sessions from 45 to 60 minutes—without extra compensation. He still had difficulties containing Alice’s exacerbated symptoms. She called in crisis between sessions; she again contemplated suicide although without any immediate intent. The psychotropic medication provided her with worrisome means, though. Worsening his already-problematic practice, he began extending these sessions beyond 60 minutes. Once again, David became over-identified with Alice and her pain, obsessively ruminating about her. He expressed more of his feelings of powerlessness, almost as if he sought *her* to comfort *him*.

Meanwhile, and on a pragmatic level, David experienced the VOC paperwork as burdensome. After several additional months, and in a fit of acute irritation at the VOC bureaucracy and its invasiveness, David suggested he provide Alice privately with two sessions per week at \$30 each. They discussed the potential change at length. Finally, Alice accepted the new arrangement with reluctance, knowing he was fiscally sacrificing. Her self-perception as an economically disadvantaged patient grew in intensity. Her sense of inadequacy increased. I specifically expressed concern at David abruptly reducing the fee, particularly since Alice had some resources in terms of her ex-husband’s support payments in addition to disability benefits. He listened, but told me I did not understand Alice’s situation as well as he did.

After the fee-reduction, David noticed himself feeling an even greater sense of powerlessness. For some months, he found himself feeling sleepy or drifting off into daydreams during sessions. These symptoms—likely manifestations of unconscious resentment—passed as David became more aware of his negative countertransference. However, he remained flooded with feelings of powerlessness and

emotional overwhelm. Soon, his unprofessional behaviors progressed into overt boundary violations. David told Alice he loved her. He shared details of his fantasies of taking her into his home. Striving to help with her worsening financial situation, he employed Alice to conduct literature research for a book he planned to write. He paid her \$30 an hour. The dual relationship bolstered Alice financially. However, because of her psychiatric disability, she had difficulty competently conducting, and reporting on, these literature reviews. David felt irritated at her requests for extensions of deadlines as well as at the disorganized nature of her work.

Meanwhile, two significant events occurred in David's life. He began experiencing headaches for which he consulted several physicians. He felt little reassured by a negative MRI of the brain. He consulted a neurologist who diagnosed migraine and prescribed medication. David also separated from his wife for the first time, renting an apartment. The small unit reminded him of Alice's. He too felt lonely, frightened, and abandoned. Coincidentally, Alice developed a seizure disorder, requiring an in-patient neurological evaluation, during this same period. The discharge orders included a prescription for an expensive anti-seizure medication. She went without it, regressing even further. At times, Alice became disoriented. Her already socially isolated, restricted lifestyle became more so. She became bedridden. The suicidal ideation became more prominent. She cancelled one or two of her twice-weekly appointments with David each week. They held some sessions by telephone.

Increasingly desperate to help her, and resisting my urgent recommendations to restore a proper frame, David decided to discontinue charging Alice for the treatment. He had achieved a level of financial stability, despite his newly separated status. He advised me he had the ability to provide pro-bono work; he felt an "ethical duty" to do so. He used the rationalization to counter my grave concerns about his psychoanalytic behaviors. David at least heeded my near-insistence that he obtain psychoanalytic psychotherapy for himself—specifically focusing on his countertransference.

Just as I began feeling nearly as powerless with David as he did with Alice, his acting-out with Alice reached a peak. A point came at which David feared Alice's suicide was imminent. During a phone session, he offered to give her \$400 in cash—specifically to pay for anti-seizure

medication—if she attended a session. Feeling dizzy and ill, Alice came in. Clearly conflicted, she reluctantly accepted the cash. She felt torn by loving and hateful feelings for him. David reported to me that he literally trembled as he handed her the money. He felt nauseated, disoriented. Handing over the money to Alice—a transaction reminiscent of an illicit drug deal—struck David like lightening. David realized he had exited his usual professional role, assuming instead the role of a frightened, omnipotent parent desperately attempting to rescue Alice; Alice had, in turn, unconsciously relinquished agency by becoming increasingly helpless. Unable to attend sessions, threatening suicide, and becoming functionally paralyzed, she too departed from a workable patient-of-psychoanalysis role. The perversion of the relationship became suddenly obvious to David. Of course, I felt greatly relieved by his realization.

In the weeks following the cash encounter, David's denial vanished. His near delusional, dissociated self-state gradually became integrated with his observing ego: he realized how far he had fallen off the tight-rope. He steadfastly worked to repair the framing process, and he held to this role despite Alice's intense reaction to it. He refrained from overtly reacting to her intense emotional states. Instead, he responded with focused empathy. He helped clarify her feelings. He interpreted the rescue-victim dynamic, and further explained the deeper, sadomasochistic contract. Further, David assumed full responsibility for his frame violations. He admitted his error in employing her and giving her the \$400. He apologized.

After providing several weeks of sessions at no cost to allow a transition, he resumed charging her \$30 per session on a twice-weekly basis. Next, David prepared her for monthly fee increases until she reached a rate manageable by her and equitable for him. He terminated their employer-employee relationship. Also, he refrained from any further self-disclosures of significance. He realized how his migraine headaches, and his separation from his wife, contributed to his loss of judgment. In brief, the abruptness of the assault on Alice had mixed, in an explosive way, with David's personal vulnerabilities. After his epiphany, he kept these realizations to himself, simply telling Alice, "I understand I let my own vulnerabilities interfere with our work." David worked through his own feelings of anger with his own psychoanalyst. He looked back on



the months of fee reductions, and on his employing Alice, with embarrassment. He believed he allowed himself to be exploited. Rather than act out against Alice, he channeled this negative affect into restoring the psychoanalytic frame.

Despite David's sensitivity to her, Alice's intense ambivalence at his generosity, evident when he handed her the \$400, turned to pure rage. She became furious when he stopped paying her to do literature searches for him. Whereas Alice previously had difficulty accessing the anger she felt at how she was abused as a child, at the other men who exploited her, at the men who attacked her, and at the publisher who abandoned her, her hostility emerged with fiery intensity. Many sessions consisted of Alice shouting at David, recounting the many ways he failed her. She raged at him for becoming the rescuer, for employing her, and for "firing" her. She accused David of lacking empathy for her situation: impoverished, alone, disabled.

At some points, Alice's ire gave way to sadness. She wept at the loss of experiencing David as more of a friend to her. Although she knew her work capacities had become impaired, she hated losing the collegial-like level of their relationship. By carefully listening to such concerns and displaying a more modulated warmth toward her, David helped Alice integrate these dissociated self-states. Alice's fury nonetheless overshadowed his efforts. Even though Alice admitted positive changes had occurred, she remained steadfast in her belief that her work with David had to end. Her attendance became sporadic; more sessions were held by telephone. Ultimately, Alice terminated the psychoanalytic psychotherapy.

## COMMENTS ON THE THIRD PERIOD

Many traumatic changes in Alice's life, in David's, and in the psychoanalytic frame occurred during the final, tumultuous period of the analysis. In Alice's life, a combination of her daughter moving out, the stress of living alone, and her working for David increased her level of distress and instability. The employer-employee level of their relationship, despite her conscious appreciation of it, deprived her of the psychoanalytic one. Also, the VOC's abruptly reduced session frequency, requiring rapid adaptation by both parties. David also faced distinct extra-analytic

stressors, e.g. the headaches and the separation from his wife. These events adversely affected his professional judgment, causing further harm to Alice. Further, the complex bureaucracy of the VOC burdened David and also violated the sanctity of the consulting room. David's behaviors during this final period show a worsening in the unconscious, sadomasochistic themes. For example, David's spending time appealing the VOC's decision, providing services for reduced cost, and then for free, demonstrate his assuming a more prominent masochistic role. These changes suggest much more than a propensity to be more emotionally available to Alice. David certainly strived to be present, but his professional behaviors unequivocally violated the concept of the psychoanalytic frame. Also, his deep immersion in the unconscious enactment with Alice made him resistant to my frenetic efforts to intervene.

Overwhelmed by his own emotional reaction (aggravated by personal life concerns), David reacted paradoxically. Briefly, he became more distracted during sessions; he then resumed his over-involvement. He reported his fantasies about her; he reiterated his feelings of powerlessness; he even professed his love. Such self-disclosures, if properly timed and modulated (Glucksman 2010), might have proved helpful. They were not. They increased Alice's discomfort. They likely unconsciously triggered her affective (or actual) memories of her childhood sexual abuse. Her emotions vacillated between extremes. At times, she felt touched, even moved by David's level of involvement and care; at other times, she felt guilty; ultimately, she became enraged. Over time, Alice almost entirely assumed the sadistic role. Also, she had descended into such a disabled state that she became incapable of meaningfully participating in the psychoanalytic process.

David's professional behaviors also vacillated between extremes during this final period. On one level, he behaved masochistically by spending hours writing reports for the VOC, supervising Alice's work, and providing services for her at reduced cost and then no cost; on another level, David deprived her of more of his psychoanalytic presence by employing her, pulling away from her, and otherwise failing her. What had been a distinctly beneficial psychoanalytic process during the first phase devolved into a clearly counter-therapeutic one in the third and last one.

Ultimately, David fell so far from the proper boundaries of psychoanalytic relating that the frame of the psychoanalysis barely existed by the time he handed her \$400. He remained formally the psychoanalyst, and Alice, the patient, in terms of their social roles. But the number of conflicting contractual arrangements exceeds precise enumeration. They consisted, at least, of psychoanalyst-patient, employer-employee, friend-friend, and (reversing) abuser-abused. After the cash episode, with my assistance, and with the help provided by his own psychoanalyst, David realized how his feeling powerless, particularly when combined with his own personal problems, had triggered an overwhelming wish to rescue Alice. He learned a great deal about this unconscious theme and how, when combined with Alice's unconscious dynamics, his personal life stressors, and the intensive romantic attraction he initially felt to her, a perfect storm developed. He addressed his maladaptive coping mechanisms, i.e., fantasizing about taking Alice into his home, and confronted the self- and other-destructiveness of his behavior. His psychoanalyst and I helped David navigate back to a proper psychoanalytic frame.

In accordance with Sandler's (1976, 1993) observations, David observed most of his troubling professional behaviors only in retrospect. Sandler (1976) added to the transference-countertransference literature by suggesting that, rather than considering countertransference emerging entirely from within, psychoanalysts could more usefully view it "as a *compromise* between [their] own tendencies or propensities and the role-relationship which the patient is unconsciously seeking to establish" (p. 47, italics in the original). In other words, countertransference enactments such as David's towards Alice represented partially David's personality vulnerabilities and partially a perverse unconscious interpersonal contract. Sandler (1993) believes psychoanalysts respond to demands placed upon them to assume certain roles, a phenomenon he calls "role-responsiveness" (p. 1105). When remaining within reasonable limits, such play in the countertransference offers useful insights; when excessive, it creates problems like occurred in David's work with Alice. Interestingly, Sandler (1976) argues against psychoanalysts excessively accepting responsibility for inappropriate countertransference reactions, writing:

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I should add that I do not find the terms “projection”, “externalization”, “projective identification” and “putting parts of oneself into the analyst” sufficient to explain and to understand the processes of dynamic interaction which occur in the transference and countertransference. It seems that a complicated system of unconscious cues, both given and received, is involved. [p. 47]

Indeed, the devolution in David and Alice’s psychoanalytic relationship represents precisely the complexities Sandler (1976, 1993) suggests. David knew, on some level, he had lost his balance even before the severity of it became self-evident in retrospect. And, a combination of their personal styles, his personal life stressors, and the pull of Alice’s unconscious created a disastrous combination. Further supporting Sandler’s (1976, 1993) ideas, David could not have anticipated that his handing over the \$400 cash payment would elicit a nearly instantaneous, abrupt change in his view of the psychoanalytic process. He awakened, as if from a trance.

The rigid, resistant configuration of Alice as sadist and David as masochist lasted for most of the last six months of the treatment. David steadily brought his presence to Alice. He listened to her detailed delineation of the ways he failed her. He absorbed her many comparisons between him and the other narcissistic figures in her life. He responded rather than reacted (Symington 1990; Wilkinson and Gabbard 1995). Despite David’s consistent, stable resumption of his professional role, and his demonstrating patience, humility, and care, Alice remained enraged until the bitter end. The last period arguably allowed some growth in terms of access to her anger. She revisited sadness at the many losses she sustained. But her anger— and the damage to the sanctuary of their psychoanalytic relationship—ultimately overshadowed David’s efforts.

## CONCLUSION

In evaluating the clinical work or the mental status of psychoanalysts who lost their capacity to properly frame transformational relationships, I occasionally encounter psychoanalysts like David. Some years ago, I evaluated a female psychotherapist who—never previously identified as

a lesbian—engaged in sexual activities with a female patient. The clinician felt her patient “could not feel loved.” The therapist too had become estranged from her husband. Additionally, she suffered the loss of both of her parents in the two years prior to acting out with her patient. In another situation, a male psychoanalyst developed a neurological condition and separated from his wife, contributing to his acting out sexually with a female patient. In both cases, the clinicians were treating acutely traumatized patients. Most often, psychoanalysts like these become swept away by personal life factors adversely affecting their capacity to facilitate the unique professional relationship characteristic of psychoanalysis—in addition to managing the usual, magnetic-like pull of the countertransference and the unique stressors involved in treating victims of acute trauma.

As occurred with David, these clinicians’ reactions to trauma in their personal lives, their responses to patients, and their countertransference interacted in complex, dynamic ways, disrupting their capacity to maintain proper psychoanalytic framing behaviors. The resulting, tumultuous interpersonal themes exemplify the complicated intermixtures of psychoanalysts’ countertransference and other subjective responses to which Jacobs (1999) alludes. As they fell from the high wire, committing boundary crossings, stretchings, or violations, these psychoanalysts’ management of their psychoanalytic contracts deteriorated. Certain well-established themes encountered in work with severely traumatized patients—empathizing with patients’ pain, feeling powerless, needing to rescue, and witnessing ego boundaries dissolve—are well-established. However, these clinical phenomena, particularly when extreme or excessive, and particularly when involving troubled psychoanalysts, literally taint, infect, pollute psychoanalytic processes. The story of David’s work with Alice provides a painful illustration.

Sometimes, as occurred in their case, the psychoanalytic process is completely eclipsed by non-professional levels. Early on, and despite some warning signs evident in retrospect, David seemed in good control of the analysis. After Alice sustained the acute trauma (layered atop severe childhood trauma), he made a series of choices that contributed to the destruction of the psychoanalysis. Interestingly, many of his personal vulnerabilities, i.e., his boredom in his marriage and his feeling “exhausted,” were present during the first, two-year phase. Some other

warning signs also existed then. For example, the degree of his immediate physical attraction to Alice was significant. Perhaps, in retrospect, David missed several worrisome signs. He failed to sufficiently attend to his own personal difficulties. But nothing during that first phase pushed him to lose his judgment to the degree occurring at the end of the second phase.

That second period validates the themes the recent psychoanalytic literature reveals regarding typical problems encountered in work with acutely traumatized patients. David's personal difficulties, considered by many scholars (Celenza 1998, 2000a,b; Dobrescu 2012; Elisse 2015; Kogan 2015) as predictors of countertransference problems, had worsened. He felt powerlessness—commonly experienced in working with acutely traumatized patients (Celenza 1998, 2007; Dodes 1990; Harris 2009). At one point, David's need to distance himself from his painful emotional reactions left him fatigued and caused him to retreat into daydreaming. The common propensity to rescue noted by, Carsky and Yeomans (2012), Gabbard (1997), and others, took strong hold of him. David's efforts at helping Alice rose to such perverse levels as his employing her, treating her for free, and giving her cash. David found himself on the psychoanalytic tightrope with the balancing pole dipping perilously onto the side of his personal feeling towards Alice. Ultimately, he fell completely from the high wire.

I have seen such sudden, disastrous falls in many psychotherapists and psychoanalysts whose work I have become familiar—such as in the case of the psychotherapist and the psychoanalyst who both engaged in sexual misconduct with patients. Rather dramatic in this case, David essentially woke up from his hypnoid state when he gave Alice the cash. She seems to have felt as horrified by his bribery-like behavior, and by his depleting more of his emotional and financial resources, as he did. By the time he climbed back onto the tightrope wire, it was too late. If David deserved punishment for his boundary violations, he received it. His guilt likely facilitated his tolerance for the seething, intense fury erupting from Alice for the rest of the analysis. In any event, and as the ending of the story illustrates, David's efforts to regain control came too late. Positive transference, hope, and many other factors provide a certain plasticity in psychoanalytic relationships, allowing them to endure

vacillations in idealization and devaluation. But they all have a breaking point.

McLaughlin (1993) describes how even seasoned psychoanalysts, comfortable with their personal and professional styles, remain

liable to new twists and bendings under the impact of our work. No two of us respond alike to this forging. Years of showing and being shown, of working and searching with my fellows to see what it is that we do, have allowed me to watch them and me changing and settling, evolving and congealing, coming upon mixes of our own unique blending as our years have gone on. [p. 366]

The story of David's psychoanalytic work with Alice validates that, despite his status as well-trained and experienced clinician, the twists, bending, and meanderings of his own life, particularly when engaged with Alice's, created a situation in which he essentially lost control of his work. In a hopeful fashion, Chused and Raphling (1992) consider psychoanalytic errors as inevitable in clinical work as they are in real life. They suggest psychoanalysts explore rather than deny them. Along the same lines, Jacobs (2002) believes much of psychoanalysis consists of the working through of "impasses and stalemates that result from the development of those hard spots and dumb spots in the analyst linked to the stirrings of familiar ghosts" (p. 615). Spirits awakening make trouble, he notes, an almost prescient validation of what occurred in David's psychoanalytic relationship with Alice. The errors David made seem clear. As he strived to repair them, he explored such familiar ghosts of Alice's as him displaying the same objectification her earlier abusers had, his enabling her disability, and his paradoxically attempting to rescue her from it.

As I presented and discussed this clinical tale, I left many motifs either briefly examined or entirely ignored. Beginning with the psychoanalytic relationship itself, I lacked the space for more detailed explorations of the many changes that occurred over the five and a half years of the analysis. These include greater discussion of the impact of changes in fee, in session frequency, in changes of status from payment made by a public agency back to Alice as well as the VOC's invasiveness, the impact of the surgery on her cervical spine, the ensuing chronic pain

and disability, the development of the seizure condition (causing reduced attendance, telephone sessions, and erratic session frequency), and the involvement of the psycho-pharmacologist and other medical providers. The fact that a terminally ill psychoanalyst referred Alice to David deserves in-depth study by itself, as would the significant impact of the psychoanalysts' death. Also, I could not provide greater details of how David's struggles with his marriage, his stage of life, and his own medical condition affected the process. Nor, as I mentioned initially, did I have time to explore the specifics of my supervision of David.

Certainly, concepts such as unconscious sadomasochistic contracts, power differentials, striving to maintain the asymmetry of the psychoanalytic contract, and responding rather than reacting are helpful, even crucial, in understanding work with acutely traumatized patients. However, and ironically because psychoanalysis involves the "analyst's irreducible subjectivity" (Renik 1993, p. 562), as well as the patient's, it will always defy reduction to these and other psychoanalytic concepts. Psychoanalysis resembles performance art (Karbelnig 2014). If psychoanalysts lean too much on the technical side of the balancing pole, they objectify their patients; if they bend too far towards their personal feelings, they risk compromising the psychoanalytic processes they facilitate.

Regardless of their theoretical orientation, psychoanalysts have nothing but their fragile relationships with other human persons with which to work. Nahum (2005) refers to a "sloppiness" that "arises from the intrinsic indeterminacy of the co-creative process between two minds" (p. 693). But can human interactions be anything but sloppy? Do psychoanalysts believe they will find ways to scientifically manipulate every feature of human interaction? Of course not. Human subjectivity fits poorly into empiricist boxes. Clinicians are simply human beings working in a specific social role. Poland (2011) describes how clinical work "demands appreciation of the singularity, the particularity, the distinctiveness of each person" (p. 355-356). Psychoanalysts are anything but free from encountering the erratic, even volatile course of a human life, of a distinct personhood, not to mention the specific stressors to which they themselves are exposed when working with their arguably more vulnerable patients.

What can readers take away from this terribly painful example? Agreeing with Celenza (2007), psychoanalysts ideally begin their work



“with an awareness of the full extent of the seductive power inherent in the psychoanalytic role and its multiple constituents” (p. 299). Further, her ideas on the vicissitudes of empowerment and disempowerment, the paradox of depletion and stimulation, and the universal wish to be loved felt by both parties to psychoanalysis represent sound clinical wisdom. These common clinical phenomena become more pronounced in working with acutely traumatized patients, and still more so if practitioners face serious difficulties in their personal lives. Gabbard (1994, 1995, 1996, 1997), Celenza (1991, 1998, 2007, 2010a,b) and others recommend introspection with vigilance for vulnerabilities. It behooves psychoanalysts to ensure they attend as sufficiently to their own needs for exercise, recreation, love, play, etc., as they do to their patients’ needs.

These scholars have also suggested improved training of psychoanalysts, particularly in working with difficult populations. Training should emphasize examination of the psychoanalysts’ unresolved conflicts and unmet deficits, of their capacity for coping with challenges to their professional relationships’ asymmetry, and of their tolerance for transference reactions like rage and hate. In a similar vein, McLaughlin (1991) recommends self-reflection to assess psychoanalysts’ contributions and to “foster a more comfortable stance towards ... lapses and their transference roots” (p. 613). At least in the final phase of his work with Alice, David was highly motivated to reflect on his own contributions, felt less ashamed of his errors, and strived intensely to correct them.

In addition to these self-monitoring, self-caring, self-reflection, and training suggestions, I add another: humility. Psychoanalysts are anything but immune from feeling influenced if not outright pressured to respond to primitive needs, inviting temptations, and other highly emotionally charged conscious or unconscious demands from patients. Added to the dynamic flaws in their own personalities or the vicissitudes in their life situations, these factors sometimes dangerously combine. Some readers may judge David harshly for losing sight of the power of the combination just noted or ignoring the seriously self-destructive component of his behavior; others may consider Alice as unsuitable for psychoanalysis, as too dominated by borderline personality features to tolerate such a regression-inducing treatment. David needed help—much earlier than he received it. Inevitably, parents will mistreat children, husbands their wives, governments their constituents, and

psychoanalysts their patients. As this clinical story validated, even well meaning, well trained, and experienced psychoanalysts—even when consulting supervisors and psychoanalysts—can fall from the high wire. A humbling thought indeed, but as long as they breathe and have a pulse, psychoanalysts risk losing their footing. We would be well served by acknowledging our vulnerabilities with modesty while we monitor ourselves and continue to train in a method forever eluding mastery.

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