Refinding the Object and Reclaiming the Self

The Object Relations of the Therapist

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In the process of supervision of psychotherapy, we are interested in many aspects of the work from the details of technique to transference and countertransference. One of the richest areas of growth for a trainee at every stage is in the interplay between the professional's personal issues and the issues of the client. In the object relations approach to therapy, we focus our work in this area because this is where we can understand clients from inside their resonance with our own object relations. Similarly, in doing supervision, we

focus on the correspondence between the trainee's issues and those of his or her client because here we find the greatest potential for making strengths and vulnerabilities of a therapist fully available for the work of therapy.

The following vignette from supervision offers an opportunity to look at an instance of this interplay that resonated between patients and therapist as it did between therapist and supervisor.

MRS. MILLS AND THE SMITH FAMILY

Mrs. Mills was a moderately experienced therapist of children and adults, who, however, had not been working professionally for the preceding five years while having children. She was reentering the field by taking a training program in object relations family therapy.

I supervised Mrs. Mills in the treatment of Mary Smith, a woman in her early twenties, and her family. Mrs. Mills met with the family regularly and saw individual members occasionally. Some years before, Mrs. Mills, then recently licensed, had seen Mary when she was a homeless adolescent, ejected by her parents for oppositional behavior. Mary kept in touch with Mrs. Mills on and off over the next few years. At the time of the supervision, Mary had been in a tumultuous marriage for the previous four years. Her husband, Mr. Smith, had an 11-year-old daughter from an earlier marriage. The Smiths now had a 3-year-old boy. But the tragedy in the Smith family centered around the death of their infant daughter less than a year before these sessions. The baby developed a rapidly malignant and horribly deforming tumor at 2 months of age and died at home at 5 months of age. The already borderline Smith family had been coming apart at the seams ever since. Mr. and Mrs. Smith railed at each other, the 11-

year-old girl was angry, and the 3-year-old boy talked incessantly and dominated the family. He was, however, the only one to talk directly about the baby's illness and death.

Mrs. Mills was often anxious about this family, who could not discuss the death. They became more chaotic with each reminder. She often wished they would go away, although she felt responsible to help. At the time of the following vignette, the anger between husband and wife had reached a boiling point, and Mr. Smith's anger seemed particularly threatening to Mrs. Mills. When Mrs. Mills thought the husband might be violent, she presented the case to classmates in the family training program's group supervision in such a manner that they were all convinced that he was likely to go out of control and hurt not his wife but Mrs. Mills. With their encouragement, Mrs. Mills arranged to move an individual session she had scheduled with Mr. Smith from her regular office to an office in the

suite of a male classmate while he was also seeing patients, so that she would feel protected. In our supervisory session, I could not find anything in the material or history to justify a realistic fear, so I tried to understand her fear as countertransference — although I supported her need to protect herself meanwhile. It was clear that the therapist's fears for her own survival were impairing her capacity to provide containment for this chaotic family, and that these fears were especially prominent in this phase.

The chaos continued. Mary Smith began feeling suicidal as she had before, and on one occasion she stormed out of the house with the 3-year-old boy. A couple of days later, after both a family and a couple session, Mary came back. The couple session had allowed Mr. Smith to explore and express his rage that his wife "dumped everything on him." It began to look as though the therapist's fear for her own life when meeting with

the husband represented an overidentification with the wife. Mrs. Smith's contention that the husband would do something violent to her was, I thought, a projection of her own rage, which Mrs. Mills, in her own identification with Mrs. Smith, could not see. I asked Mrs. Mills if anything occurred to her about her own vulnerability in trying to contain this chaos, the projected rage, and the family's difficulty in mourning the baby's death.

Mrs. Mills told me that at age 17, on one day's notice, she had emergency surgery for a mass in her chest. She was convinced she was going to die. Her normally reserved father sat outside the operating room crying. Both parents stayed with her at the hospital. The mass was not malignant, but, as the surgeons could not remove all of it, they contemplated another operation. She vividly recalled being wheeled into a room "full of a hundred doctors" for a case conference.

We agreed that she was identified with the threat to life that this family could not metabolize. When Mrs. Mills first met her, Mary Smith had been 16 and abandoned by her parents. The girl's age and her sense of aloneness when her parents were crippled with fear resonated with Mrs. Mills' own anxieties during her adolescent surgical threat.

By the next week's supervision, Mrs. Mills had reflected more on her surgery and her identification with the wife. She realized that her own parents had been under enormous stress at the time of the surgery, leading to fears for their survival as a couple. During the week, Mrs. Mills had a dream.

> In the dream, I am going to face my own surgery, but it is happening now. I said to the doctors, "I won't let you operate until I write letters to my children." I wrote letters to each of them, including my baby, telling them how special they are and

recalling special moments I've had with them.

Mrs. Mills had commented before how hard it was for her to work with this family, because she so often thought of her own healthy young children and because this family made her think about things she would like to forget. Now she remembered being at the funeral of the Smiths' infant. The family was not then in treatment with Mrs. Mills, but Mary had been in touch with her during the baby's illness. Looking at the coffin, Mrs. Mills had had the fantasy that she could see the baby inside and could see the horrible distortion of the baby's face from the tumor. She had been overwhelmed with sorrow, whose depth had seemed to extend personally even beyond that of the Smiths' tragic situation.

I said that we had both seen that she was identified with Mrs. Smith as a frightened adolescent and as the parent of young children. She was also identified with her own mother seen in Mrs. Smith

as the mother of a dead baby. I said, "You came close to death from a mass yourself as an adolescent."

Mrs. Mills wiped a few tears from the corners of her eyes.

After a few moments, I said, "I think this dream means you identify yourself with the dead baby. Maybe you couldn't face that earlier."

She said, "I don't think I ever understood how frightened I was of dying. I was just so mad at my parents for being depressed themselves that I felt like they abandoned me in the hospital. I couldn't understand their fear I would die." Then she sobbed for some minutes.

Recovering, Mrs. Mills then pursued the theme of abandonment, the feeling that had consciously dominated her own adolescent experience of surgery. She said that Mary Smith's mother had left when Mary was 4, leaving seven children. Mrs. Smith had felt terribly abandoned

throughout her life, reenacting it in her adolescence by getting herself ejected by her father and stepmother. We could see that the baby girl who died had represented the patient's fantasied chance to give her daughter the love and care she herself had missed. Because it was Mary's first daughter, the baby had been more of a focus for these hopes than her son. Through the relationship with the baby girl, the patient had hoped to make up for what she never got from or gave to her mother.

I said that things seemed a bit more complex than we had understood. Mrs. Mills was identified with Mary, who was herself identified with the dead baby and who was also guiltily reacting to its death as though Mary herself were the abandoning mother she had when she was 16.

Mrs. Mills agreed and thought this might explain Mary's becoming suicidal after the death of the infant and again at

its first anniversary. We could now trace the effects of this ambivalent identification of the patient with her abandoning mother. The baby's death must have reactivated this desperate bind for her.

We could also see how the whole constellation resonated with Mrs. Mills' history. Just as the two living Smith children were not getting what they needed from their depressed parents, and just as the fragile bond of the parental couple was riven by the infant's death, so Mrs. Mills had been unable to provide effective holding to the Smith family because of being unable to bear the idea of herself as a dead object and because of her identification with the mother through which she had joined them in their predicament. The Smith family had also become a dying baby to her, and here she became the parent who could not stand the loss and failure.

The identification that we fashioned together in supervision could now provide

the means to understand the Smith family, and particularly Mary's dilemma. It enabled Mrs. Mills to move toward providing the holding that the family had been unable to provide for itself.

THE ROLE OF THE THERAPIST'S UNIQUE HISTORY

Mrs. Mills then asked a question of great interest to us. "But what if I hadn't had my own surgery? How would I know what had happened?"

The answer is that we each have our own unique history, our own internal objects that will resonate with our patients' situations in unique ways to provide us with the clues we need. The issue is not whether a therapist has had surgery or her own acute threat of death. It is that the

specific facts of Mrs. Mills's personal situation provided her own way of joining with this family and of working with me. Her dream provided us with clues to the countertransference, clues that were consistent with other clues we could now understand.

For instance, Mrs. Mills had not wanted to think about her own vulnerability or past situation. At the same time, she had been feeling more and more dread about treating this family. In the supervision sessions, I had been trying to contain her hopelessness about the family's chaos. When I urged Mrs. Mills to stick with this family, I felt as though I was brutalizing her. I suffered increasing doubt about my faith in the therapy and in my ability to help Mrs. Mills through supervision. I agonized about whether I was exposing her to harm in questioning her

judgment about the potential for violence by the husband.

Her experience of feeling threat to her personal survival while trying to help this family was triggered both by her own prior life experience and by factors particular to Mary and the Smith family. The confluence of these produced a crisis in the therapy and in the therapist's training. Mrs. Mills began to doubt that she could remain an effective mother to her own children while reentering the field of psychotherapy. Here was a resonance with the Smith family's fears for survival. Mrs. Mills doubted that she could care for her own needs and those of her children, and she thought that she might therefore have to let her professional self remain dead.

The therapist's dream was primarily an expression of her personal struggle, which she experienced as she was torn both by the family and by me in the supervision. My urging her on with this family felt to her as though I were the doctor of her own adolescence, pressing dangerous surgery upon her, surgery that threatened her existence now. When she wanted to write to her children before proceeding with the operation, she was telling me, in the supervisory transference, how endangered she felt with my prescription for her work, how our work and her work had threatened to take her away from her children. I was giving her a prescription she felt to resonate with the life-threatening surgery many years before.

For a long time I had felt, in the supervisory countertransference, how threatened Mrs. Mills

was. I was threatened, too. I acknowledged my own fears for risk and my doubts concerning my supervision. The work on this dream let us both understand from various levels of countertransference how her own fears as a student resonated with the family's internal risk. It allowed us to understand the resonance of the internal experience of risk in the patients, in the therapist, and in me as the supervisor. This work gave Mrs. Mills new comfort in staying with this family and in her reentry into the field of analytic psychotherapy. And, as her supervisor, I also felt better for having worked this through.

There are threats to personal survival when any of us undertakes a new venture. Some kinds of work, however, accentuate the sense of risk dramatically. Just as a doctor reacts to the threat of the inherent risk in the gravely ill patient by

an unconscious accentuation in concern for his or her personal survival, so the psychotherapist learning to deal with high risk patients must react in resonance with his or her personal vulnerability and inevitably will act self-protectively. In a similar way, parents view themselves in new ways and experience threats to their self-esteem as they see the progress and travails of their children. Personal histories of vulnerability are triggered. Those psychotherapy trainees who are the most at risk personally will be most apt to suffer crises of larger proportions. The amount of vulnerability is determined by a blend of personal vulnerability of the therapist and the extent of external stress imposed by the patient or client population.

Therapists all seek to have their identity confirmed by healing their patients. So the

interaction of the therapist's object relations with the unconscious of the patient reflects this fundamental hope to repair the object and to help our dependent objects grow as an expression of our own hopes for growth and survival. It is only when the object is made "good-enough" that we can dispel our own fears of damage caused by our envy, greed, anger, and narcissism. The failure of repair of psychotherapy patients, like the death of the medical patient or the faltering of a child, threatens therapists with the evidence of their own destructiveness. This defeat of our efforts at repair also deprives us of an image of a person who can confirm our goodness in return. There is no object to help keep at bay the ever-present possibility of the return of our infantile

destructiveness or helplessness against the forces of disintegration.

VULNERABILITY AND LEARNING

A psychotherapy trainee, like a medical trainee, feels his or her own survival is linked to the life-or-death issues of the patient. This situation of vulnerability is also a time of great learning potential. As supervisors and teachers of psychotherapists, we have many chances to work directly to strengthen the vulnerabilities of our students. At times we do so by teaching technical skills or examining transference. At other times, we can facilitate the examination of the relevance of the therapist's personal history to the patient or family's therapeutic situation, as I was able to do in this instance with Mrs. Mills.

And at all times, we are a model for our trainee-therapists as they take in our ways of working with the unknown, with anxiety, and with the supervisory relationship.

There are complex issues of countertransference for the supervisor. I worried that I might be jeopardizing the safety of my trainee. Was I propelling her into a dangerous or hopeless situation? Yet, I also worried that unless she could develop an understanding that would let her continue with the family, I might not be able to teach her anything worth knowing. My countertransference conflict concerned the question of her safety balanced against her growth. As I struggled, I suffered my own pangs of hopelessness about her and about myself.

We all live with this situation when we supervise psychotherapists who encounter patients at risk. When we support them to confront their internal risk, and especially when we do so by confronting our own sense of being at risk, we offer an opportunity in which it is often possible to transform old vulnerabilities into new strengths—both for our trainees and for ourselves.

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