On Being a Psychotherapist: From Authority to Subjectivity

Susie Orbach

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It wasn't the first time I willed myself to sit still, keep my mouth zipped and remember that I was the therapist whose job it was to understand and hear behind the viciousness emanating from my patient. Every fifth one or so of Helena's sessions had that effect on me. We'd hit extreme turbulence and as if from someplace else, I'd hear a voice telling me to buckle up, hold steady, breathe normally and think hard. Momentarily, I became the passenger who needed to be calmed, rather than the analyst at least half in charge of the session.

Not that the turbulence was directed at me. On the face of it, Helena was simply giving an account of how life was for her. But as she told of the apparently trivial row she had had with her husband Tony earlier that day over domestic arrangements, she'd unleashed an attack on his failings so vicious, so venomous and so mean that I was stunned. I had to pause inside of myself to absorb it and not reject it and her.

Her cruel words and facial features flushed with hate repulsed me. Momentarily, I identified with the husband who seemed to be arousing this hatred. I felt an empathy for him. How could he live with this unreasonable harridan? How could he bear, no, why could he bear to be with such a rejecting woman?

My diversion into thinking about his psychology sent me back to Helena's hatred. What transgression, what deceit, what hurt had he perpetrated on her? What had he done, what had pulled her into this avalanche of hateful feelings?

Her hatred was ugly to be sure. It emanated from a personal history of disappointment, of being callously dropped in childhood and adolescence, which then made her susceptible to be with a man who was emotionally and physically volatile. The defence structure that had developed which held her together through the pain of a bruising and often brutal marriage was one which I could well understand. Hate can feel strengthening when one feels

powerless. For Helena it made a border between her and the awful behaviours of her husband, even though, in its apparent rejection of him, it simultaneously bound her to him, revealing and reinforcing an attachment which was damaging and self destructive.

Hatred such as this presents a substantial challenge in the consulting room. The sine qua non of the psychotherapist's work is to be able to register, absorb and think about whatever comes at us emotionally. While part of us feels repulsed and inclined to reject the hatred that a Helena pumps into the room, our training tells us precisely not do that, to refrain from acting out against the patient whose defence structure offends, alarms or repels us. The question is how do we do that? How do we, as individuals, working with people often in a great deal of difficulty, whose defence structures are often unappealing, manage this? What is required of us? How can we protect ourselves against what can feel like the most awful taint? How could I emotionally position myself so that I felt neither polluted by Helena's hatred nor complicit with her emotional world view?

As we enter our second century, our profession has begun to be surer of itself. As a result we are more open to what we don't know, what we have yet to learn, what we have to offer. We have begun to be less frightened of our patients. We have come to see those who consult us as partners in the therapeutic enterprise. We have moved away from the therapist being the one who knows and who treats, towards a view of the therapeutic relationship as one which is seen as an asymmetrical but nevertheless mutual endeavour. This has created change in the therapy relationship, for we now regard the subjectivity, the person of the therapist rather than the authority of the therapist, as central to the therapeutic enterprise.

This shift from authority to subjectivity has wide-reaching consequences for the conduct of therapy, for our understanding of what makes for psychic structural change in the patient, and for the demands on the therapist. In reassessing the presumed power of the analyst's mutative interpretations, in the move away from the idea of the therapist as a blank screen, we as therapists must rely on and scrutinise our own responses to our patients' utterances, feelings and physicality. We must examine the interpersonal ambience that is created between us and our patients not simply for its transferential meanings, nor for how it affects our understanding of countertransference and our contribution to transference-countertransference dynamics, but in terms of how we cope with what we experience in the consulting room, now unshielded,

no longer able to subsume everything as being part of the transference-countertransference. The job of a contemporary therapist, the experience of being a therapist, is an extremely emotionally demanding one. Previous generations of therapists could rely on interpretation as a way of distancing themselves from the often repugnant, awkward, seductive, irritating, boring or terrifying patient. When I am momentarily repulsed by a Helena, when I find her words and her stance arousing powerful reactions inside of myself, it is my job to understand my response, rather than simply interpret it as something about Helena or what she is doing to me or how she has cast me in the transference.

At one level of course it feels as if she is doing it to me. It feels as if she is dumping her hatred out into the room and turning me off, or away from her as the transference object. But the task for me as the therapist is to absorb that hatred, not to interpret it back, which feels like some kind of unconscious retaliatory stance, not to reject it or her, but to work towards a way of assimilating it inside of myself. I need to find a way to let enter, to find a home for those feelings in me as they are, rather than my transforming them in the first instance into something that is easier, more comprehensible, less repulsive for me.

The therapist can do these things, we are beginning to understand, not solely through analysing her countertransference at a cognitive level but by allowing inside of herself a surrender to the feelings that are coming at her, that her patient arouses in her. With Helena, in order to be of any use, I had to find a way to register and then tolerate my own feelings of rejection and revulsion towards her. I hated what she was saying or the ways in which she was saying what she was saying. Sure a partner can be awful, irritating, can let you down in ways you expect as well as ways you hadn't anticipated. But the level of murderous hate Helena expressed entered me viscerally. I felt besmirched, corroded, as though an acid had been spilt on my insides. Much as I wanted to bat these horrid feelings away from myself I knew that it would only be in the process of embodying what was coming at me that I could be of any use to her. I knew that if I could embrace rather than be frightened by what was being aroused in me I might reach a psychological approximation of what she was feeling. I might be able to get both a sense of the compelling nature of her hatred as well as the impulse she has to expel it and then — for this is where the therapy comes in — to do what Helena is unable to do, which is to be able to go behind the hate to see what more problematic feelings may reside there for her.

While Helena's hate posed one set of problems in the therapy, it was actually another of her behaviours that caused much greater challenges at both a technical and an emotional level. For side by side with her hate went an intimidation of me. Periodically in her sessions, Helena would threaten to sue me when it looked as though I didn't take seriously enough her view that her husband was a psychopath. For her, that diagnosis was the only thing at issue. But I wasn't in a position to share such a diagnosis for I did not have direct knowledge of him and her reports of his behaviour did not incline me towards her assessment, so much so that I kept thinking I was missing the subtlety with which he persecuted her. But even if I did share her diagnosis it would not exempt me from trying to help her to develop the capacity to find other ways of breaking her attachment to him outside her habitual haranguing and hating.

To try and redescribe a situation she had drawn for me as I saw it would invite a barrage of rejection couched in legal language which left me in no doubt as to both the folly and the danger of my trying to act in a way consonant with my views. I felt stopped and while it was possible for me to explain this to myself as a possible communication from her about the ways in which she felt paralysed and powerless, and I could even tender my sense of her dilemma back to her, this nevertheless did not relieve my feelings of both being intimidated and worried by her. Even if I could see the difficulty which she was having in experiencing me as a separate mind just as her husband most irritatingly was to her, it didn't really relieve things either. I think it is all too easy in our work to believe that if we only analyse our feelings sufficiently, if we understand the ways in which certain feelings have a particular salience for us, if we see our feelings as a refraction of our patient's feelings, then they will be less of a trouble to us, as though in the doing of that we can bleach out our fear and our worry. And this is undoubtedly true and helpful, the capacity to conceptualise, to think, to make personal historical sense of issues to which we are especially vulnerable. The truth of the matter, however, is that there are feelings that we have to contend with in the course of our work as psychotherapists which if we cannot allow ourselves to recognise are almost impossible to bear from time to time. Then we will slowly and perhaps without realising it, be seduced into theoretical stances, ways of thinking, ways of theorising about what occurs between therapist and therapee which render the patient once again as an object that we treat rather than seeing ourselves as part of a dynamic therapeutic enterprise. We will then run the risk of being jaded, of being cynical, of having heard it all before because we have not risked feeling what

has been aroused in us in the particular idiosyncratic way it has, with the notes and register that are personal to the individual and the therapist. Without an authentic surrender to the emotional demand of the session, of the patient, we become technicians rather than providers of a potential relationship in which conflictual and shameful pain can be accepted and transformation can occur.

In saying this, I am not in any sense suggesting that the emotional territory we are required to bear is something that makes technical sense to share with the people we are working with. The feelings I am naming are feelings which are difficult in part precisely because we have to abide them on our own in the silence and aloneness of our bodies, hearts and minds while trying to concentrate on the manifest and unconscious utterances of our patients. What I am suggesting is that the thrust of our training and supervision needs to pay special attention in this area, for just as we believe it is not possible for our patients to think without our getting to the feelings that they are so frightened of, nor is it possible for us to think without our doing so either.

We could say that bearing intense feelings of helplessness or hatred or paranoia, reminds us of the extreme difficulty our patients are in. It insists that we experience some modified version of the way in which they are troubled and it therefore has clinical usefulness. This is undoubtedly the case. As we grapple to cope with feeling x or y, we feel its force and the ways in which it can become a source of self condemnation, a block on action, a brake on thinking. And as we live within that feeling, however temporary or short lived it is, we usually discover that the feeling is problematic not because it is an inherently more difficult feeling to countenance than any other, but for reasons of our patient's or our own personal history, the feelings in question are somewhat muddy. We can get a hold of them, but they don't fit quite properly. As with Helena, the hate produced no relief for her, no emotional settling, no psychic 'aha' for there was something off about it. It wasn't quite the right feeling.

When feelings get accurately named they can sit within us even if they are extremely painful and disagreeable. Feelings which are muddy by contrast are especially hard to bear, because they contain within them defences. They are in fact the expression of a defence structure — an emotional construction that the individual has found to use because they have little experience with holding, naming, knowing the feelings that are behind them. In other words these are feelings being used as a shield and a weapon, that offer neither the individual expressing them nor the therapist receiving them any relief or clarity. They can't be digested, they have to be repeatedly expressed because

part of their function is to bind up the individual who, without them, would be beset by other kinds of feelings — of vulnerability, of weakness, of terror, of dependency, of desire, of disintegrative rage, feelings which may have been insufficiently acknowledged and recognised in childhood and thus never been able to be assimilated because they do not form part of the individual's emotional repertoire.

Helena can feel hate but she has a very hard time stretching the psychological space enough to feel her vulnerability and her fear. She can threaten, menace and intimidate me because the idea of acting seriously on her desire to be out of her marriage is beyond her emotional capacity. Her desire has failed her. Either it has become eroded or it was undeveloped initially or, as we find with many women, it is so embedded in conflict that even when she has a sense of a want, she simultaneously has a stronger sense of punishment. She can't feel the desire but only experience the prohibition against it. Her hate then is part of her defence structure helping her to off-load her conflict by seeing the other as the one who stops her.

We can make many mistakes in therapy by taking the surface of our patients' feelings for the depth. We can take a strong forceful feeling such as anger or hate as the feeling that needs to be addressed when what is really required of us is to be sufficiently unfrightened of the anger and hatred to be able to allow it to enter us. If we find when it saturates us that it feels hard to assimilate or to take on, that it is in some way not quite right, that muddiness can be one kind of guide to its inauthenticity or defensive functions, a way of letting us know we might not have got it quite right. Often anger that doesn't sit quite right is a shield against disappointment, anxiety about failing is a defence against the multiple fears of success, pathological jealousy is a defence against taking in available love.

This is not to say that all misplaced or ugly feelings we encounter in the course of our work are defensive. Far from it. One of the challenges of being a therapist is to find a way to tolerate the appalling accounts of torture, cruelty and neglect that visit our consulting rooms. We have to develop the capacity to be robust in relation to such accounts, to hear the stories and the responses without wanting to reject what we know about people's cruelty to one another. To call such acts inhumane, which they are, is to cordon them off, to say that they are outside of what we consider reasonable human behaviour, and while that is evidently true it avoids what we have to be able to take on board as therapists, which is the perversity that exists in our relations to one another both

interpersonally and between groups, classes, genders and ethnic groups. Therapy is not about sanitising feelings but being sufficiently released from living in the past to have a fresh response to experience rather than a preformulated response. As we allow ourselves such feelings how do we manage inside of ourselves an account of a three-year-old child being tied to a radiator with a dog bowl of water at her feet, left alone for hours, with no stimulation and intermittent food and company? How do we take on stories of sexual torture? How do we take on what it is like to be on the receiving end of this confusing and hateful experience? How do we take on the psychic sequelae of the individual who, introduced to this form of relationship, then confuses brutality with love and feels adrift in a relationship that is designed to meet their intimate needs if it doesn't involve coercion? How do we manage this?

How can we take on the experience of a perpetrator of violence? We can't reject them. It is our clinical responsibility to understand what makes their offending behaviour compulsive. We have no short cuts like the rest of the population who can construct an 'us and them' to protect themselves from the terror that is invoked in them.

We can't invoke a vigilante either in our heads or in our communities to keep out what offends or scares us, because we work with these people and see the humanity that lives side by side with their acts of cruelty. More than that, we come to understand, through working with them, the roots of the distress which in effect they are in the process of trying to expel as they enlist others into their hurtful acts. We understand, all too often, how their viciousness is an enactment, an attempt to be active in relation to an abuse that was consistently perpetrated on them and so we see them in a context which makes it impossible for us to only censure them or see them as banishable from the human family. We hear on a daily basis about the gross and subtle acts of discrimination, of racism or sexism, that individuals we are seeing are either victims of or partake in. Such witnessing also exacts a cost and a challenge.

And what of the other side? I remember when I was starting out, I saw a young poor Jewish woman, Ellie, whose mother had tried to suffocate her at birth and told her so frequently. Her life had been very difficult, birth being a prelude for the shape of relationship from then on. Ellie had a damaging psychiatric history from early adolescence and when I saw her in her early 20s she very much supported those people taking on the psychiatric establishment through organisations such as Mental Patients' Liberation. Ellie, sadly, was unable to

participate in their activities because she found joining in with others very hard. Her isolation was part of her response to what had happened to her. About a year into seeing me, Ellie expressed racist sentiments towards the people living in the flats where she was housed. Her words and delivery were foul. In them was an invitation to spar with her. Sensing my surprise she became indignant that I should expect her to be less racist than the next person just because she herself had suffered. She resented any assumption that her victim status as a very poor Jew who had faced discrimination as a child, and been on the receiving end of poor psychiatry as an adult, disqualified her from her 'right' to be racist.

I remembered this incident for 25 years because it was the first of many kinds of tests that the therapist encounters in the course of their work. These are tests which challenge our belief systems and moral values and help us to understand how frequently the moral positions we hold are a way of managing the complexity of issues thrown up in life which the therapeutic discourse dismantles and deconstructs. I did have unworked out moral issues which Ellie challenged. I don't like racism and I was surprised by hers. I had made assumptions whereas something more was required of me.

Our work demands a kind of neutrality which means not a non-feeling about the things we find difficult or things we find pleasurable in our patients, but rather having the capacity to be curious towards those things we find challenging. We may have a transient judgement but our training and professional stance bids us to take a look at our judgement privately inside of ourselves — precisely what I failed to do with Ellie — and then to wonder about the patient's words or actions and what it means to them rather than to reject it.

As therapists, we often work with people whose symptoms or whose ideas about how to live are at first glance repugnant and morally startling to us. The vampirising Casanova who scoops out and marauds woman after woman in his quest to quell his dependency need; the banker who keeps his sense of self going by asset stripping companies and laying waste to productive enough enterprises which provided a context for many people's lives; the faithless woman who stays with the rich husband she despises in a reckless abandon of either of their needs. Of course there is humanity in these people's stories. It is not hard to understand the responses they have found for themselves. Indeed, it is our clinical responsibility to do so, for if we can't do that we are of little use in helping them. We understand how the fornicator has felt ripped off himself

and so on, but, confronted with a fornicator, a thief and a cheat, we are forced to interrogate our own ethics and the bases from which they spring. We enter the profession with certainties but if we stay open and alert to what comes at us in the clinical situation, these so-called certainties inevitably come up for reconsideration. This is both one of the more pleasing by-products of our work as we learn as individuals to tolerate greater levels of complexity and ambiguity in our views, as well as one of the curses. From where we sit things no longer look so cut and dried. In a way it is easier to deal with the feelings of the clear-cut victim. Feelings of pain, of anger, of horror, of disgust, of rage, of helplessness are the expectable, dare I say sane, counterpoint to acts of emotional barbarity. We have no moral dilemma with such feelings. We face no tests about our own moral stance. But there are other issues. As we endeavour to help our patients reverse their experience of victimisation in their own lives, we are left seeing the detritus that our social arrangements create. We have our own sensitivities. And precisely because we are trained to see and feel, not to cut off, not to repress, we may be swelled up with feelings that can have no expression in a clinical context. We are over exposed to the emotional damage that our society creates. How might we handle such feelings?

Our discipline has spent a century learning about the private costs of our social arrangements. Psychotherapy and psychoanalysis in all its manifestations is an attempt to understand the subjective experience of being human. In the work, we have come to understand a good deal about what happens when things go dreadfully wrong, about the difficulties of change, and the positive consequence of things going well enough. Our observations and research place us in a position to have a great deal to say to the outside world about the damaging consequences of our social arrangements. One way in which the pain we are required to hold and process on a daily basis could be managed is if we could come together more successfully as a profession to say what we know where it matters about the roots of that pain. While there has always been a part of psychoanalysis that has seen its insights as necessarily challenging to the status quo, we are not always confident or capable about returning the implications of those insights back to society, where they could be thought about and acted upon in ways that might make it possible for future generations to grow up in ways that decrease rather than increase the pool of psychological pain.

Our psychic pain is stimulated by the amount of distress we witness and engage in and we are often made to feel helpless by it. But just as we need to be able to identify for our patients the feelings that are allied to, protected by, or

beneath their defences, so we need to do that for ourselves. We need to ask ourselves whether there are feelings that we are defending against, actions we are defending against, behaviours we are defending against. If we ask ourselves those kinds of questions, I think we'll find that some of the answers to the difficulties we bear in caring for our patients may lie in our reticence to take the implications of our work outside of its normal boundaries into the public sphere, where what we've come to understand can begin to contribute to a different kind of public conversation about what makes change possible in society. At present, we are for ever involved in a mop-up operation for the social relations that capitalism creates. We know from our daily work the enormous pain it exacts. We know that it shapes our relation to self and to one another in particular ways. We know the psychology of market-based societies creates a problematic notion of the individual, which in elevating the idea of individual accomplishment and individual freedom in order to fit the ideology of the market, paradoxically makes it difficult for the individual to thrive.

I'm not so naive as to believe that therapists' views would overturn capitalism. Indeed psychotherapy as a discipline is one that arises in the late 19th century at the apex of the development of the idea of the individual bourgeois man and woman. We wouldn't understand what we understand about the psyche outside of capitalism's social relations. So I'm not suggesting that therapy sees itself as an anti-capitalism crusade. But I do think that in the fight that is going on to do with what global capitalism is going to look like, and what values we want to emphasise and the means by which to do so, we as therapists have a not inconsiderable contribution to make.

We have things to say in various arenas. There are those that are obviously our sort of agendas such as parenting, health, schooling, social exclusion, delinquency, drug dependency, marital relations, sexuality, and there are those that are less obvious. Some of the less immediately obvious ones have to do with how our discipline's understanding can help transform internalised psychologies of despair and oppression which arise out of damaging social economic conditions, into positive social capital. Others have to do with reconceiving the idea of citizenship and reflecting on what we know about what makes it possible for people to participate in the decisions that shape their own lives and what makes it hard for them to do so. We have knowledge about how to enable people to work well together, how and what constitutes good kinds of leadership, mechanisms for decision-making when conflict is rife, and so on. We have the conceptual tools to contribute imaginative ideas to debates in the

public realm about the dire social and economic problems that beset us. This is not to suggest that our ideas should supplant other forms of analyses, economic, sociological or anthropological. But it is to insist that we have a role to play with those other disciplines which can reframe and revitalise some of the rather stale public discourse about what is wrong and what approaches might yield some use in trying to right them. Here, then, is a place where the feelings which are provoked in the clinical situation, but which have no place for expressing within it, can find a thoughtful and useful arena. We see the damage society creates and we can then act responsibly by offering our understanding back to society.

To do so usefully, however, we need to find a way that our contribution can be heard. We need to be wary of psychologising social problems, because that is not what is required. What is required is understanding and conveying the bit of the problem, or the solution to the problem that we have understood, so that we can join with the other disciplines that make social policy their area. Psychological understandings can enhance the conceptual tools that are presently used in both the formulation and solution to social problems. I think we have a responsibility to do this, to do the hard work of working out what it is we do have to offer and how we might do that. In doing so we will have a sane vehicle for the creative use of the distress we encounter as a result of our work. We will also be working towards solutions which are preventative rather than inevitable.