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# Problems, Pitfalls and Potentials of the Unexpected in Psychotherapy

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## Abstract

When the life-threatening illness of the therapist necessitates an unexpected and prolonged break in therapy, intense transference and countertransference responses are evoked. This discussion paper considers the complex repercussions for the therapeutic exchange following re-engagement with clients, when awareness of conflicts over separation, loss and the inevitability of death are likely to be heightened.

## Introduction

Gaily I lived at ease and nature taught  
And dispensed my little life without a thought  
And am amazed that Death, that tyrant grim  
Should think of me who never thought of him.

This epigram by Rene Regnier (1935:376) suggests the avoidant defence we are prone to bring to the uncomfortable subject of our mortality.

Irvin Yalom, from within his existential commitment to the quality of life, challenges us to confront that which most of us would rather deny or ignore. He speaks to both our personal and professional selves as he addresses the "truths of existence":

. . . the inevitability of death for each of us and for those we love; the freedom to make our lives as we will; our ultimate aloneness . . . . However grim these givens may seem, they contain the seeds of wisdom and redemption. . . . it is possible to confront the truths of existence and harness their power in the service of change and growth. (1991:4-5)

As psychotherapists we are well aware of the impact of changes or situations occurring in our lives that may affect our clients' perception of us, and may thus affect the course of therapy. These situations can range from a change of hairstyle or therapy room, to a move to new premises, to a therapist's pregnancy. The sudden unplanned disappearance of the therapist as a result of

illness inevitably creates a more complicated dilemma. This was the situation that my clients experienced when I underwent a totally unexpected cardiac bypass operation. I had a busy psychotherapy practice and no opportunity to prepare my clients for what turned out to be a four-month break from therapy.

The invitation to write this paper has provided an opportunity for me to stand back and reflect again on this experience, four months after having returned to my practice. The issues I have encountered remind me of an experience I had at the Grand Canyon, Arizona. It is as if, until now, I have been involved in the steep climb up from the depths of that canyon, seeing only parts of the view as I wound my way up, preoccupied with how to reach the next corner as the path twisted and turned upwards. But now I am on the rim, looking out over the whole of that vast scene. This seems an apt metaphor to reflect the myriad transference and countertransference issues I encountered on returning to my practice, and which needed the objectivity afforded by time to come into clearer focus.

### **The challenge of the unexpected**

It is true that all situations or changes that occur in psychotherapy provide the opportunity for challenge to both therapist and client, which can encourage progress. It is also true that, depending on the nature and degree of the unexpected circumstance and the inherent difficulties of the client, problems can emerge, particularly if the event is in uncharted territory. Such was my experience when I returned to my clients.

The problems that arise usually signal transference or countertransference issues which may well become “pitfalls”. What do I mean by pitfalls? In the arena of transference, this implies for me the sudden downward plunge which describes the sense I had with some (but not all) of my clients. It was as if something had suddenly shifted. The solid ground was no longer there: the easy rapport, the trust, the warmth of the relationship. Words like “betrayed”, “lost”, “can no longer rely on you”, “abandoned”, even “despair” became the language of the pitfall.

My countertransference pitfalls involved guilty feelings (how I had let my client down), hurt in that I was still vulnerable myself, anxiety (was I going to be able to be fully present?), even resentment at what seemed the incredible neediness surrounding me. I sensed within me an urgency to restore the status quo, to have my clients regain their security and trust, to return to the safe place we were in before, yet that was *my* need. What my clients needed was rather to have me match their pace and simply allow the process to unfold.

The phrase “grist to the mill” came to my mind as I realised that every pitfall can provide a potential in the task of psychotherapy. In the struggle to regain what seems lost, much is freed up to emerge. Unconscious motivations and defences become conscious, losing their grasp on the client’s life, allowing a new kind of self-experience and relationship to begin to emerge. Guntrip’s comment on the working alliance in psychotherapy and the therapist’s contribution is appropriate here: “Only when the therapist finds the person behind the patient’s defences, and perhaps the patient finds the person behind the therapist’s defences, does true psychotherapy happen” (1969:352).

### **Three clinical vignettes**

Three clinical vignettes may illustrate the conscious and unconscious responses in both client and therapist that were evoked by the unexpected break in therapy: the fear of loss, separation, the inevitability of death and a new awareness of the value of life.

#### *Client A*

Prior to our scheduled first appointment after the break A telephoned me stating that she wanted to cancel her session. I asked her what that seemed to be mostly about.

A: “Well, how do I know you’re not going to do that to me again?”

I reflected how she might be feeling and said I thought it was important that we talk about it together, rather than on the telephone. The session began with A repeating her question, adding that she only came to please me. I again responded by reflecting her feelings and wondered whether she felt she could rely on me now to be there for her.

A: “Well, I can’t, can I?”

Response: “There’s a lot of intense feeling in that, A. What’s there mainly?”

A: “I feel cheated. That’s why I want to end. Not right today, but soon. I want to be sure I can say ‘goodbye’ to you, rather than not have a chance to do that.”

Response: “Saying goodbyes are important - perhaps also you want to leave me before I leave you?”

A: “Yes. My security is believing you’ll always be there, even years after I’ve left.”

These themes occupied the following sessions, increasingly revealing the empty self clinging to the external object. More recently the theme has shifted somewhat and the following transcript demonstrates the continuing theme:

A: "I want to feel about you deeply and I don't know whether I do. I have needed you for security somehow, but when you die I'd like to think I'd be really upset. I'd like to feel the loss of you very very deeply."

There was quite a silence then, and I noted that I was probably adjusting to the therapeutic usefulness of my dying (with a mix of feelings!). I suggested she might be able to say some more.

A: "Well, it's as if, if I felt more intensely, then I'd know I really did care a lot for you. To sort of know it, to feel the pain of it."

Response: "Perhaps, if you did have loving, warm feelings for me and I died, and that caused you to feel real pain and grief, then you would also find something kind of alive in you? . . . a reaction, a response, a kind of realness?"

A: "Yes, but is it awful to say that?"

Response: "You mean, is it awful to speak about my dying, and to feel there could be something helpful for you in that? It's OK for me. I felt relieved you were able to say that. It's helpful for you, I think, to begin to wonder what that kind of deadness inside is about and to picture some kind of experience to prove to yourself you are alive and can feel and grieve and hurt and love."

A: "Yes" (said softly and tearfully). "I would feel relieved if I could do that".

I sensed the internalised, depressed (dead) mother and A's self-experience as being insignificant, empty, numb, dead, having no impact. I thought of Guntrip's words:

Whereas all other parts of the psyche tend to the rigidities characteristic of defensive structures, the regressed libidinal ego retains the primary capacity for spontaneous and vigorous growth once it has been freed from its fears.(1961:433).

I believe A is at last moving slowly towards finding the real core of an aliveness, but for now it seems to her that it would take a "real" external experience to discover that was there. "It is the relationship with the therapist that creates a situation in which problems can be solved" (Stadter:1996:29).

Moments like these make our wise voices from the past, such as Guntrip's, come again to life!

### *Client B*

Before the unexpected break, therapy with B was slow and ponderous, with nothing new coming through and I was wondering if we had travelled as far as we could at this stage. When I had telephoned after my discharge from hospital and explained the situation, B seemed appropriately concerned, but accepting. As with all clients, I offered the opportunity for a session or sessions with an alternative therapist should that be helpful. She did not take up that offer.

When we recommenced therapy I found B's mood was very depressed. She was abusing alcohol, had put on weight which she hated, and felt bad about herself. She wept with a kind of desperation and said, "I realise you could have died and I still need you so much".

I struggled silently with a sense of guilt at deserting her. I again felt overwhelmed at the neediness of those I was working with and a dull resentment that it was not me that would be missed, just the needs I could not fill. I felt just a function. The warmth, understanding and insight of colleagues in supervision was helpful. I recognised not only my countertransference issues, but also the elements of projective identification I was absorbing. I suspect B was also struggling with guilt, neediness and resentment, and her "clutch" of negativity joined forces with mine!

In subsequent sessions, B has begun to look in a new way at the quality of her life and the notion that one day she too will die. This has occupied many sessions in a fruitful way. She has made remarkable progress in valuing herself more and is no longer abusing alcohol. She is exercising and beginning to lose excessive weight, she is requesting more from her husband, and having more fun with her children. B has made remarkable progress in contrast to the relative lack of progress prior to our break in therapy.

### *Client C*

C began psychotherapy with an advanced somatisation disorder, with loss of balance and inability to walk more than a few steps. She presented in a wheelchair, wearing dark glasses because of photophobia and appeared to be very unwell. In psychotherapy C has worked through well-repressed early trauma and from a physical aspect is now healthy, walking normally, without dark glasses, with her health well recovered.

In our first session she began immediately updating me with all the events that

had happened over the period we had been apart, without referring to the significance of the break and its meaning for her. Finally, I commented to C: “It’s been four months since we were together here and I’m wondering what that has really felt like for you?”

C: (Said breezily): “Well, when I first heard what had happened to you, I was brassed off, because there’s still a lot of work I want to do with you. But then I thought, ‘Oh well, c’est la vie!’

Later, I dismally reflected to myself that the resolving of the somatisation disorder does not necessarily shift the rigid pathology of the personality structure. I suspect C’s affective awareness and response could not penetrate her defence structure.

### **The view from the canyon’s rim**

These vignettes serve to describe some of the effects on both participants in psychotherapy when transference and countertransference responses occur in reaction to unexpected illness. This is especially so when the therapist’s fallibility and mortality occupy the foreground and the safe, symbolic womb has indeed failed.

I am sure there is still much to be observed from my vantage up here on the rim of the canyon! I have gained valuable insights as I have reflected on the impact of the break in therapy and the response of clients to that situation. I have become more aware than ever of how closely our lives are interwoven in transference and countertransference. Through my personal experience I am grateful for the timely reminder that, although we may live as if we have forever, the reality for all of us - therapists and clients - is that “our life, our existence, will always be riveted to death, love to loss, freedom to fear, and growth to separation. We are, all of us, in this together” (Yalom:1991:14).

The final words must come from Morrie Schwartz, a man who used his dying experience to teach fundamental lessons about living:

Learn how to live and you will know how to die

Learn how to die and you will know how to live. (Albom:1997:82)

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