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***Transcending the Dangers of the Dyad: Enhancing Therapeutic
Triangulation
By Working Individually With Patients in Relationships***

Jean Hantman & Donald Carveth

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Abstract

We wish to address two taboos characteristic of both past and present psychoanalytic practice: (1) the taboo against analysts giving serious consideration to the ways in which psychoanalysis may at times be destructive; and (2) the taboo against having simultaneously in individual analysis with the same analyst people in ongoing relationships with each other. We suggest ways in which violating the latter taboo by working individually with people in relationship may serve to prevent some of the potentially destructive consequences of the traditional practice of referring spouses, relatives and close friends of current patients.

I. Theoretical Rationale

In *Psychoanalytic Theory, Therapy, and the Self*, Guntrip (1973) wrote: "The critics of psychoanalytic therapy usually ignore the implication of their views, which is simply that persons *qua* persons, who can and do so obviously influence each other for ill, cannot influence each other for good; a conclusion that would nullify all that is most important in parenthood, friendship, and marriage, let alone psychoanalysis" (p. 176). But if the critics of psychoanalysis ignore the fact that persons *qua* persons can influence each other for good, then psychoanalysts, assuming that their efforts are of precisely this sort, are often guilty of ignoring the fact that, however fine their intentions, analysts sometimes influence their patients

for ill rather than for good. We suggest this happens far more frequently than we want to know. We say this not to devalue psychoanalysis, of which we are enthusiastic consumers and practitioners, but because it will only be through the study of the ways our various practices may be harmful that we can strive to become more helpful to our patients.

We are addressing what we think is a taboo in psychoanalysis against studying the ways in which various of our standard practices may be harmful to patients. We want to focus on one such standard practice: namely that of referring spouses, children, relatives and friends of current analysands to other analysts, rather than accepting them into our own analytic practices. Despite the obvious benefits to the patient of being treated by an analyst who knows and works professionally with those others who are most significant in his or her life (Hantman, 1999), there is a taboo among conventionally trained psychoanalysts against this practice, against working individually with patients in relationships. And there is a taboo against looking at the harmful consequences of *not* working with patients in relationships--i.e., against looking at the negative consequences of the privacy of the analytic dyad in which the analyst is insulated from all information about his analysand other than that which the analysand chooses, consciously or unconsciously, to convey to him.

But isn't this dyadic privacy a good thing? Not if we agree with Grotstein (1996), as we do in this case, who said not long ago that "the problem with us analysts is that we tend to believe our patients." Naturally, we are not suggesting we should *disbelieve* our patients, for a real world exists in which they may really have suffered various sorts of deprivation, trauma and abuse and it is important for us to know this and at times to validate such realities. What we are suggesting is that having disengaged from our earlier overcommitment to ideals of neutrality and objectivity and from an excessively skeptical attitude, we may have allowed the pendulum to swing too far in the other direction: nowadays it seems we may be inclined to be insufficiently skeptical and too ready to uncritically believe, validate and even embrace our patients' belief systems.

The self-conscious and strategic employment of joining and mirroring techniques by modern analysts in work with patients who lack sufficient observing ego to be able to be interested in and benefit from standard interpretive technique (Spotnitz, 1976) in no way requires the analyst to personally embrace or identify with the attitudes and beliefs that, for technical reasons and while maintaining an attitude of inner reserve, he

chooses to join or to mirror. On the contrary, the tendency to believe and overidentify with our patients is not a consciously considered technical strategy but an unconsidered and unconscious enactment of countertransference credulity. We feel such credulity and its enactment are encouraged by newer models of the analytic cure that conceive it less in terms of disillusion, insight, enhanced reality-testing, mourning or separation-individuation, than in terms of the building of an essentially reparative therapeutic relatedness (Carveth, 1998).

In seeking to redress the classical overemphasis upon insight and underemphasis upon relational factors in the analytic cure, we seem currently to have swung to the opposite extreme. In many quarters, the building of a therapeutic relationship is now viewed almost as an end in itself, as the cure itself, rather than as a necessary means to the end of promoting self-understanding and change in the patient. Because the forging of a therapeutic relationship is seen as the essential task, analysts are increasingly willing to bend themselves, and the conventional analytic frame, entirely out of shape in order to reach hitherto unreachable patients and to take pride in the professional flexibility that permits them to do so. In this context, the analyst's open-mindedness, willingness to negotiate the terms of the relationship, and openness to unconventional methods (such as, for example, abandoning the use of personal hygiene products, perfumes, etc., and removing the eucalyptus leaves and the fax machine from the office at the insistence of a patient who believes she suffers from "multiple chemical sensitivity"; or purchasing a painting from a patient who lacks sufficient confidence and self-esteem to believe in the value of her work) are seen as virtues. Sometimes, in the midst of this celebration of relational flexibility, openness and "optimal responsiveness" (Bacal, 1985), mixed with hostility toward older analytic ideals of neutrality and objectivity--is this a struggle between the imagos of the good, warm, responsive mother (or father) versus the bad, cold and rigid father (or mother)?--the sort of inner reserve that keeps in mind the possibility that the patient might be distorting reality to various neurotic or even psychotic degrees is discouraged. In the thinking of the so-called "intersubjectivist" school (Stolorow, Atwood & Branchaft, 1987), any resort to the notions of patient "resistance" and "distortion" are considered signs of empathic failure and negative countertransference on the part of the analyst.

Whatever progressive effects such newer perspectives may have had, they have at the same time contributed to the creation of a professional climate that is a breeding-ground for countertransference overidentification with

patients. And we think that such countertransference overidentification is greatly enhanced when, as in standard practice, we are insulated from all information that could potentially open our eyes to the complexities of the case, the contradictions in our patients that we seldom or never get to see, the various Mr. Hydes (or Dr. Jekylls) who never appear in our consulting rooms, isolated from any appearance before us as they often are.

Many of us have had the scales fall from our eyes when, in situations of *extremis* of one type or another, we have felt forced to agree to seeing, say, our patient's spouse or parents, with the permission and in the presence of our analysand (as is our practice in these circumstances). On more than one occasion this has been a real eye-opener for us, as we have witnessed, in such conjoint interviews, an entire aspect of our patient's personality and life of which we had been entirely ignorant emerge before us, or been informed of important facts of which we had been entirely unaware, or encountered the three-dimensional quality of "objects" regarding whom we had, or had been induced to have, an entirely one-dimensional image hitherto.

Is the emergence of such truths, leading to a more complex and multifaceted awareness of reality, a good or a bad thing? Those postmodernists who view analysis as the conjoint construction of a healing narrative, or as a semiotic investigation of the text the patient brings or produces, may feel such exposure to "extra-textual" sources is entirely irrelevant to the analytic task. On the other hand, those who share, as we do, Bion's (1959) belief that truth is the essential nutriment of the mind and that "Psycho-analytic procedure pre-supposes that the welfare of the patient demands a constant supply of truth as inevitably as his physical survival demands food" (p. 99), or who accept, as we do, Christ's injunction "And ye shall know the truth, and the truth shall make you free" (*John* 8:32), or who agree, as we do, with Freud (1937), who wrote "we must not forget that the analytic relationship is based on a love of truth--that is, on a recognition of reality--and that this precludes any type of sham or deceit" (p. 248), may feel, as we do, that techniques that enhance the likelihood of the emergence and analytic consideration of important truths that might otherwise remain obscured can only be a good thing.

Exposure to information about and alternative views of the analysand from other analysands who are in relationship with him--which, after all, is the usual situation for training analysts who analyze candidates who are members of the same analytic class--may help the analyst guard against

countertransference overidentification with the patient. We may envisage a "complemental series" of such overidentifications, ranging from appropriate empathic immersion and trial identifications at one extreme, through various states of "narcissistic countertransference," twinship experiences or mergers with the patient, to "projective counteridentification," all the way to outright *folie-a-deux*. It was to phenomena approximating the latter extreme that Grinberg drew our attention when, in 1957, he first coined the term "projective counteridentification" to refer to "a specific and differential aspect of countertransference, based on the unconscious analytic interaction between the patient and the analyst, and which is brought about by the particularly intense use of and psychopathic modality of the mechanism of projective identification of the patient. As a result of the pathological quality of the mechanism, the patient is able to induce different roles, affects and fantasies in the analyst, who unconsciously and passively feels himself 'carried along' to play and experience them" (Grinberg, 1979, p. 169). He continued:

"Projective identification and counteridentification" phenomena are frequent in the analysis of narcissistic and borderline personalities, and give rise to a pathogenic interaction between the analyst and patient which is not easy to resolve. One might say that what was projected, by means of the psychopathic modality of projective identification, operates within the object as a parasitic superego which omnipotently induces the analyst's ego to act or feel what the patient wanted him to act or feel in his unconscious fantasy. I think that to some degree this is similar to the hypnotic phenomenon as described by Freud (1921) in which the hypnotist places himself in the position of the ego ideal and a sort of paralysis appears as a result of the influence of an omnipotent individual upon an impotent and helpless being. I believe the same idea applies, sometimes, in the process I am discussing. The analyst, unaware of what has happened, may resort to all sorts of rationalizations to justify his attitude or his bewilderment just as the hypnotized person does after executing hypnotic suggestions (p. 180).

In "Is There A Future in *Disillusion?* Constructionist and Deconstructionist Approaches in Psychoanalysis," Carveth (1998) recently described such

projective counteridentification processes underlying the credulity of colleagues who bought into, colluded with and sometimes even, as our anthropologist friends say, "went native" and entirely embraced their patients' phantasies of having multiple selves, of suffering from "environmental illness" and "multiple chemical sensitivity," of having been subjected to satanic ritual abuse or abducted by aliens. Such hysteroparanoic phenomena have been lucidly discussed in Showalter's (1997) *Hystories: Hysterical Epidemics and Modern Media* so we need not elaborate on them here, or on the current lawsuits directed at those among us whose countertransference overidentifications led them to be drawn into such psychopathology instead of analyzing it.

In milder ways, of course, we all fall victim, and necessarily so, to countertransference overidentification with our patients. This is inevitable. We are in no way suggesting that it is avoidable or in and of itself a bad thing. It is a bad thing only if it remains unconscious and leads to chronic countertransference states that remain unanalyzed. As our Lacanian colleagues might say, we are inevitably drawn into Imaginary, dyadic identifications with our patients, but it is our responsibility to find ways to re-triangulate the analytic situation and return from the Imaginary dyad to the Symbolic in which the analytic third (the analytic goal of putting everything into words or other symbolic forms) is reestablished. Our point is that given the ubiquity of such countertransference overidentification, the experience of *disidentification* and re-triangulation that can be derived from exposure to people, including other patients, who know the patient in other contexts, who are in relationship with him or her, can be therapeutically beneficial--as can seeing one's patient outside the dyad of the consulting room, as happens when training analysts see their candidate analysands in the classroom setting, or modern analysts see their individual patients also in modern analytic group therapy together with their other patients, and so on.

To be aware of the danger of Scylla one need not be blind to the threat of Charybdis. In drawing attention to the pitfalls inherent in the private analytic dyad, we are in no way blind to the difficulties entailed in working with people in relationships especially, to take but one important contraindication, in work with borderline couples who will allow the analyst no therapeutic space for analysis, but insist on struggling to have her endorse their paranoid-schizoid conviction that it is the spouse who is the bad object and who, if the analyst seeks to maintain analytic neutrality, come to view her as the bad object (and who as a result may for a time

enjoy a fragile alliance based upon mutual projection of the badness into the analyst-alien). Here the principle is that since the badness cannot reside in me, it must reside in my spouse, and if not in my spouse, then in the analyst. But if working individually with a couple of this type may be doomed, so may attempts to analyze the partners by the conventional method of having a different analyst for each, unless the strong tendency for the individual analysts to be drawn into significant countertransference overidentifications can be avoided.

As we have indicated, the contemporary reaction against older psychoanalytic ideals of neutrality and objectivity in favor of newer ideals of empathic immersion, intersubjectivity, optimal selfobject responsiveness, mutual construction, open-mindedness and willingness to significantly modify the analytic frame and engage in various supposedly therapeutic enactments in the service of negotiating a corrective therapeutic relationship, have intensified our vulnerability to such countertransference overidentifications. It is as if we have lost sight of the fact that the analytic cure is about moving toward the Symbolic (putting everything into words), not about establishing supposedly therapeutic Imaginary dyads with our patients, and that while an open mind is a good thing up to a point, our minds can be too open, in which case they can easily be filled with the very psychopathology the patient came to have cured.

It is true that if he succeeds in inducing his misery in us the patient at least has company. Related to both Searles's (1959) insights into "the effort to drive the other person crazy" and Langs's (1985) "cure through nefarious comparison" in which the patient feels better through recognizing that the analyst is crazier than he is, we must now add "cure by contagion or conversion" wherein the patient feels better by inducing his madness in the analyst, thus helping him to avoid seeing it, and thus himself, as mad. Our point is that exposure to alternate sources of information about one's patient may offer some protection against these pitfalls.

II. Treatment Considerations

In "A Labyrinth of Connections: When the Patient Generates an Analytic Community," Hantman (1999) has described her work with two communities of patients, work that grew out of two initial cases, women who, as the matriarchs of their respective family networks, began referring daughters and sons, sisters and brothers, nieces and nephews, spouses and grandchildren, all of whom Hantman accepted into individual treatment. Let us begin by discussing the contraindications to this practice, to taking

on as a patient the partner, child or parent, other relative, friend or neighbor referred by a current patient:

a. when the current patient is painfully conflicted *consciously* about the referral and reports that he will not be able to tolerate the simultaneous individual situation.

b. when the patient is *unconscious* of this conflict but induces a feeling in the analyst that employing this approach will threaten rather than enhance the current analysis.

c. when the analyst has a feeling she will not be capable of tolerating the referral; when she senses she will act on without considering her countertransference urges to mediate and take sides, or be unable to remain emotionally intact herself. This occurs most frequently with patients diagnosed as borderline or any patient whose narcissism will not be able to tolerate triangulation of the transference.

When the patient is consciously conflicted (a. above) he is able to predict verbally that sharing the analyst with someone he knows will unproductively shift the focus of the treatment from the analyst/analysand dyad to the triangle. This patient is able to warn you that sharing will bring the analysis to a halt. "My husband wants to see you, but I know if he does I'll be paranoid all the time about what he's saying about me." "If my sister becomes your patient, she'll become your favorite the way she was to Dad... I think I'd have to quit."

The patient who is somewhat self-aware (b. above) cannot put into words the specific reasons for wanting to avoid sharing the analyst. He may say "I don't know why, I'm just not comfortable with it." Alternatively, the patient may *say* it is a great idea (the altruist, the humanitarian and the martyr sound like that), but the induced feeling in the analyst is anxiety.

In the third exceptional situation (c. above) the analyst has been given cues that the patient will not be able to tolerate sharing without acting in a destructive way. This is because this type of patient can tolerate barely anything inherent to the analytic situation, for instance the couch or consistency of sessions. This is the treatment-destructive patient who, for the most part, acts rather than talks. She has trouble distinguishing her

wishes from calls to action. Instead of thinking, "I wish I could stay home today" or "Dr. M. really hurt my feelings," but coming to her appointment *to discuss* the wish or the feeling, she actually misses her appointment. This type of patient usually waits until the problem with husband (or others) is at the brink of catastrophe before handing it over to an analyst, so the analyst is from the beginning caught up in a crisis. The analyst who takes on as a new patient the spouse of the acting-out analysand will find that, at every turn, both members of the couple will unconsciously thwart the treatment.

There are some analysts who can continue to contain this type of situation. (The various schools of non-analytic family and conjoint therapy attempt to address such problems by refusing to see couples individually from the start and for the duration of the treatment.) Our recommendation is for the analyst to be very conscious of the existence of this type of couple, so that he can recognize them before he takes on particularly unconscious patients, and so he is in a position to have a planned approach designed specifically for them. Those who do succeed with the treatment-destructive couple (the couple engaged in a negative bond) are analysts who have both unlimited patience and optimism, and a commitment to ongoing supervision. Psychodynamically it is possible that this kind of generous analyst had been parentified as a child and grew up feeling comfortable overseeing and regulating the histrionic couple.

Modern analysts customarily take on couples conjointly if that is the request of the patient, and family therapists always see the couple together. We regard conjoint analysis as group analysis (more than two people in a session is a group). We do not address this modality of treatment here, other than to suggest that while the analyst can do successful conjoint couple or family therapy, this is not recommended until each participant has had at least a year of individual analysis. After each partner has been in individual analysis for a year, the beginning of the development of a language for communicating has been learned. The language of communication involves the capacity to consider thoughtfully what another person is saying. In most cases, people who have not had any experience in analysis--the place where a person starts listening to *himself* for the first time in his life--does not have enough emotional vocabulary to be able to make use of conjoint sessions, at which listening to an *other* is required.

One typical impetus for taking on the partner of a patient is that the patient has changed and begins to see that his partner (the one not in analysis) is not only *not* changing with him but is becoming increasingly antagonistic

to his analytic growth. However there are several distinctive ways both partners become patients.

- *Old patient--new relationship.* For the patient who has been in a long-term analysis and starts a new relationship the prognosis for the relationship is excellent if the new lover comes quickly into analysis. Like others who have have experimented with this technique, we have observed that when a patient has been in analysis for a long time, then begins a new relationship with someone who refuses to consider analysis, the prognosis for the relationship is poor.

Mary, a single woman who had been in analysis for five years started up a number of relationships during that time. When each relationship passed the infatuation phase and problems arose she encouraged the new boyfriend to begin analysis. As each one refused, at the same time as Mary's own capacity for a mature relationship was growing, the relationships didn't last. She was able finally to be attracted to a man who wanted a successful relationship and was also interested in looking at his emotional history. He became a patient and the relationship continues.

- *New patient--old relationship.* It is a different scenario for the new patient in an old relationship. Often when someone who has been married for a long time starts analysis he and his wife appreciate him being the only one in treatment for years without there being a threat to either the analysis or the marriage. This might have to do with him having been the identified patient in the marriage for so long already that occupying this role in the analysis is comfortable for a long time too.
- *Old patient--old relationship.* The patient who has been the only member of the couple to have experienced analysis, for a long time having been content to be the identified patient, is no longer willing to be the carrier of pathology for the couple. This is the most difficult of all situations in the time before both partners are in treatment. In our experience the treatment at this point has a fifty-fifty chance of surviving this crisis of growth. So fixed has the fantasy been that the current patient is the one who has the problems (way beyond

the time when it is apparent to everyone that she is indeed not the sole bearer of problems), it is typical for great emotional upheaval to occur in the couple's lives before the unanalyzed partner steps into analysis.

At this time it is common for the patient to start having regressive fantasies that there is a war going on between his analyst and his wife and that he must now choose between the two of them. He has projected the unrecognized intensity of hate towards his wife into the analyst, but he doesn't hate the analyst. He needs to imagine that the analyst hates the spouse. In other words the fantasy is that his spouse hates and the analyst hates but he is innocently in the middle loving everyone while the other two are fighting for his loyalty.

He fluctuates between periods of lucidity when he recognizes the projections (observing ego, depressive position) and periods of regression (unconscious, paranoid-schizoid position). In reality the actual conflict is between (1) his own new unpleasant awareness of the darker elements of his marriage and (2) his regressive wish, supported by the unanalyzed spouse, that life return to splitting and pretense.

The spouse not in treatment enthusiastically supports the fantasy that the war is between the analyst (container of hate) and the marital dyad. Formerly unexpressed hostility towards the analyst by the partner not in treatment is out in the open. It is notable that this destructiveness (spouse sabotaging treatment) occurs for patients who have given up their willingness to be abused but still do not believe that they won't die if they lose the spouse. Despite the advancements they have made in terms of self and other awareness, they continue to confuse anger with action which, in their fantasy, will lead to dissolution rather than intimacy if expressed.

These patients are characterized also by an inability to become conscious of any negative transference just as, prior to analysis, they had been unconscious of any anger in the marriage. When through analysis the patient becomes conscious of rage towards the partner but not

towards the analyst the treatment is threatened because if she can't feel it in the transference she will likely not be able to express anger toward her partner. In this situation, the analyst can predict fairly well that the patient will discontinue. Despite the analyst's acuity and best attempts to analyze the split-off negative transference rather than collude with the fantasy that no such negative transference exists, the patient is so threatened by the loss of the marriage that he discontinues treatment. Although she is now very aware of her anger, still believing she would die if she were to express it and the marriage ended, she needs to continue to placate her partner as she has always done. The patient at this point still depends on the contentment of the partner, to paraphrase Meadow, "more than life itself."

Dara, a 50 year old woman had been treated for anorexia and other phobias for five years. Her analytic focus now turned to the troubles in her marriage, which had been formerly concealed by her being the identified patient in the marital dyad. As she began for the first time to be consciously aware of marital dissatisfaction her husband began to attack her analysis. He most enjoyed the times when Dara, in an attempt to avoid confrontation, evinced signs of her former pathology in order to placate him. At no time was she able to defend her analysis to her husband or even to tell him to back off. (In our opinion this timidity is the direct result of the analyst's powerlessness to engage the patient's negative transference.) Even though the analyst could think of plenty of reasons for Dara to be discontented with certain aspects of the treatment, the patient was not conscious of anything but positive feelings for her. In effect her transference had become what her marriage had been, except that her analyst was prepared to respond to aggression while Dara's husband would not. In a commonly observed dynamic, the more she hid her anger at her analyst, the more unable she was to defend her analysis to her husband. So Dara and her husband had both become antagonistic towards the analyst, the

husband openly and Dara unconsciously. Also manifest at this time was an increasing connection between the patient's newly conscious hatred towards her husband and her fear of losing him, in the fantasy that being real would destroy the marriage. Dara discontinued treatment, having been cured of her 'individual' symptomatology but choosing to stay stranded in interactional dysfunction.

- *Old patient--old relationship II*. The patient most likely to succeed at integrating his marriage (of many years) with his analysis (of at least two) is the one characterized by a willingness to discuss negative transference. He can now yell at both his wife and his analyst. Discussion of divorce at this intense time does not signify divorce. It only signifies the analysand's new feeling that the world, rather than any one irreplaceable object, is a good place. Psychodynamically what has been gained is the knowledge that anger is not action, anger is simply a topic for discussion. The patient, his wife and the analyst have not died as a consequence of the expression of dark feelings. This patient has the best prognosis for helping his or her partner to come into analysis no matter how hostile the partner has been towards analysis or the analyst.

Mrs. G, a patient of three years with six children and a history of depression had become able to separate her internal troubles from the troubles caused by the man she had chosen to marry. She started to dismantle her depression, which led to the diminishing of the split: "I'm a depressed bitch / He's a great guy". Her husband, an alcoholic high-functioning corporate executive, was unable to be alone with Mrs. G without being drunk. He spent the weekends sleeping it off on the couch while she took care of the children. The less harsh ('it's all my fault') she became towards herself the more she longed for a more connected marriage. The difference between Mrs. G and Dara (the case above) is that Mrs. G became more than willing to express real aggression towards the analyst, exploding frequently in accusations of his unhelpfulness, to which the analyst listened and responded seriously. The more Mrs. G was able to experience the relief

of having been listened to by her analyst when she had been the most enraged, the more she was able to envision life without her emotionally dead husband. Meanwhile Mr. G spent a lot of time cursing the analyst in many bars throughout San Francisco, to friends and family and to his wife. "He'll never come to see you, he hates you, he called you a _____", reported Mrs. G to the analyst. Very shortly after that session Mrs. G began to look at the real estate market in her neighborhood and mentioned to her husband that she was thinking of taking the kids and moving out. Mr. G called the analyst that week and began analysis.

We keep in mind that patient-generated referrals fall into two groups: (a) those who were willing to become a patient; and (b) those who feel they were forced into treatment. In either case, the analyst begins as he would with any new patient (any form of the question, "What has brought you here?") For those who feel forced the answer to that question will be, "She made me come. I told her I could work on this problem myself but she's so (e.g. impatient.)"

In every situation the most important task for the analyst at the beginning of treatment, if he does decide to take on the case, is to give the new patient the feeling that he is alone with you and always will be; that the two of you will be creating a relationship separate from any other; that he can count on you to be sympathetic to his individual goals no matter what his partner's goals are. (Conversely, the analyst may do the opposite of all of that if he does not want to take the case, consciously or unconsciously.)

There are two types of couples in treatment: *negative bond* and *ambivalent bond*. The negative bond couple has gotten to a point in their relationship at which they will seem to the analyst highly allergic to each other. No matter what one says or does the other one will respond negatively. This couple is characterized by an inability to tolerate difference; by an unwillingness to consider thoughtfully rather than respond defensively; by attempts to use the analyst as a weapon against the partner rather than a tool for understanding and emotional growth. Both will induce in the analyst a feeling that their partnership has become hopeless. The reason they stay together at all is hard for anyone to imagine, or expressed as "we're staying together for the sake of the children" or "it would be too expensive to get divorced."

These people are problematic for the analyst because *as intense as their hate* for each other, *their obsession with each other is just as intense*. As is the case with all obsession it is difficult for this patient to settle into treatment and form an analytic dyad (therapeutic alliance.) So much of his or her libidinal energy is directed to hating the spouse that there is none left for forming another, healthy, relationship. He and she resists talking of anything but the evil, stupid partner, needing for a time to engage the analyst in supporting the perception that the partner is bad. These couples will typically take anything the analyst says, rush home and brandish it against the partner destructively. The analyst who is new to this modality of treatment will often be induced to respond in treatment-destructive ways, not only expressing what the patient wants to hear, but literally feeling that the one he is with that day is the one who is 'right'. The analyst is confused the next day, when he is in session with the other member of the couple, to find he is literally feeling the opposite, that the one he is with now is completely justified in finding her partner evil and stupid.

Mr. J says, "She is always late for everything. Now Dr. M, isn't that horrible?" The inexperienced analyst is advised to respond with something sympathetic (and true): "I can see how that would be irritating." The experienced analyst can say, even more sympathetically (and true: she's always late and it's inconsiderate), "She's awful," because this analyst knows how to handle the fallout that will probably occur at Mrs. J's next session. "Thanks! Mike came home from you and told me you agree with him!" to which the experienced analyst might reply, "Mike doesn't know anything about helpfulness, does he?" or, "Why would he tell you something like that! What's his goal here? To drive you away in the next week?" The analyst should be prepared to respond to the patient saying, "*MIKE* doesn't know about helpfulness, how about *YOU*?" Among the multitude of things the analytically-inexperienced couple learns from this process is that speaking to each other about their sessions and indeed any of their relationship issues to each other, instead of to the analyst exclusively, makes things worse. What happens after that is they start to forge a more effective bond with the analyst because they find that the analyst is the only one at present who can hear everything without becoming destructive.

When a patient has been displacing aggression towards the analyst onto the partner and manages to overcome the displacement and release it in treatment toward the analyst, she feels relieved of the intensity of anger towards her partner. Becoming conscious of anger and finding that its expression does not end the analytic relationship but enhances it leads to realizing that the same might occur within the marriage. When the patient is able to express her anger toward the analyst and then toward her partner, she becomes hopeful about the marriage once again. Realizing that expressing anger does not mean ending, the burden of having to placate the bad object (the husband or the analyst) is lifted. Gaining inner strength and being less dependent on approval, the patient need not hate as much: she can be real; she can be ambivalent.

The analyst working individually with people in relationships differs from other types of psychotherapist in that, at the beginning of treatment, the only instruction given to the patient is "do all the work with me in session, not with each other." The negative bond couple will have a great deal of difficulty cooperating with this simple instruction.

The reason the analyst who is new to this approach might want to avoid joining the patient's perceptions and stick to safer statements ("That must be annoying") is that she does not realize that in this marriage one of the partners is not good while the other is bad, but that she is being emotionally induced by the couple to choose sides. She keeps forgetting that these two picked each other and that they began treatment to save their relationship no matter how bad each thinks the other is. When she forgets this she finds it impossible to support both partners equally. She is not able to contain both because unconsciously she wants to destroy the "bad" one, the one she has decided is to blame for the relationship troubles. This is a consequence of both subjective and objective or induced countertransference. The analyst's personal regressive potentials have been activated by the borderline couple who induce in him a regression to paranoid-schizoid splitting. The analyst may simply not have had enough experience working individually with couples and understanding induced feelings. (For example, a woman analyst who has a mental concept of women as helpless victims of male power sides with the wife: the analyst whose wife doesn't like sex when he does will bond strongly with the member of the couple who likes sex and is being deprived, etc.)

Another unconscious force operating on the analyst in this tricky situation is that *she feels left out*. In the negative-bond couple's obsession with each

other they both resist forming a real relationship with the analyst, and the analyst develops the unconscious idea that if she pushes one out (the 'bad' one) she will get at least one of the two dyads she has been wanting. The reason this is delusional is that when this does occur, when the analyst unconsciously arranges for one member of the couple to drop out of treatment, typically the couple will strengthen their bond and kick the analyst out instead. The analyst has to remember that the couple's goal is to be helped to stay together, not lose each other and have the analyst's love. Otherwise, to paraphrase Sidney Love, they would have gone to a lawyer instead of an analyst. Unconsciously, then, the analyst signifies to the partners 'successful relationship.' If the actual outcome is the end of the relationship, this signifies 'unsuccessful analysis' to them. It is the experience of many analysts, even those skilled at working individually with couples, that in the rare situation when divorce is the consequence of the analysis, frequently both will leave treatment, even though both swear the analyst has been helpful. On the other hand, if the analyst has been able to demonstrate that analysis is not just marriage counseling and has been able to forge a working alliance with each individual, he might be able to salvage the analysis for one, more rarely both, partners despite the separation and divorce. For this reason, it is advisable for the analyst to very quickly become something more than a marriage counselor in his work with both partners.

To summarize the negative-bond couple: their passion has become channeled into pure hate, and instability and explosiveness will characterize the beginning of the treatment for all three involved, the partner, other partner and the analyst. The analyst can take care of himself by remembering that the couple who actually begin treatment with one analyst want to be rescued, not form new love relationships; that even though they appear to be on the brink of divorce or murdering each other or firing the analyst, unconsciously they do not want to do any of those things. Simply, and as in all other analytic situations, the analyst should never forget the unconscious, never simply believe his patients, and should continually and quietly doubt the new patient's conscious perceptions and opinions.

The ambivalent couple is much easier at the beginning for the analyst to work with, as in the case of all motivated and cooperative patients. Whereas in the negative bond couple there *seems* to be not one shred of love left to hold onto and to 'hold' the situation, the ambivalent couple is able to access feelings of love as well as hate. They might not be able to understand that 'difference' does not mean ending, but they have more

conscious motivation to work at understanding the mysterious causes of their troubles with each other. In contrast to the negative bond couple the ambivalent couple, especially when one has been in treatment at least two years longer than the other, will respond powerfully, positively and quickly to the introduction of the other into analysis. For one thing the one who has been presenting her own picture of the couple is now confronted with the knowledge that her partner is for the first time presenting his perceptions, opinions and experiences of the couple.

Mr. A had been in analysis for five years before Mrs. A began. Both had the same precipitating cause for beginning treatment, sudden acute midlife depression in the face of previously thinking each had been living a problem-free forty-five years. After Mr. A's depression had been cured, he looked at his marriage and found it wanting. He had been madly in love with someone else when he was 19 whom he was unable to control, and when his girlfriend left him he met Mrs. A whom he could control because she had a harsh, controlling mother she could never talk to. In analysis he started to complain of marital dissatisfaction and boredom, and constantly criticized his wife, whom he believed 'adored' him and was completely content. Obsessed with cleanliness and orderliness, he had a need to be seen as attractive and a celebrity while simultaneously needing to control every relationship in his life. He had gotten their three children (now adults) to demean their mother and revere him. Believing that his wife wanted the marriage more than he did set the imbalance in place from the beginning. She would never attempt to question his grandiosity because they both believed he would walk out the door while (they believed) she never would, no matter what. As pretense and obsessive competition were Mr. A's predominant defenses, the analyst used these enthusiasms to aid the analysis of the couple. As the analyst became more aware of his omnipotent defenses, he helped Mr. A become even more super-duper to the public by supporting his showing off his new emotional sophistication. After Mrs. A's depression was set aside (during which Mr. A had been a saint of solicitude) he returned to his complaints of marital boredom. However, as his wife had been in analysis a year already, a more complete picture of the marriage had been seen by the analyst. As he had suspected, Mr. A's controlling behavior over the past 30 years had the consequence

of destroying his wife's sex drive for him. In contrast to his belief, expressed to the analyst, that his wife was hot for him, Mrs. A confessed to the analyst (confirming the analyst's guess) that not only was her desire to have sex just about gone but that earlier in the marriage she had gone to other men for sex in the face of her husband's cold and domineering personality. Mr. A, without any details but simply knowing that his wife might now be discussing these topics to the analyst, dropped the story that he was a sexually desired by his wife. In a more emotionally genuine way he was able to realize how his need to be in control had turned his wife off. As soon as it became out in the open that he wasn't the only one lacking desire, he started to desire her. He reported to the analyst that he was upset that Mrs. A didn't seem to want him much anymore physically. The analyst at this point suggested that he ask her which men turned her on. His initial reaction to this suggestion was to say that she would not give him an answer, that she would say he was the sexiest man in the world. At his next session he reported that she immediately answered his question by giving him a list of about nine sexy men. He reported having a feeling he had never experienced before with his wife: threatened, and he didn't like it. But, he went on, "The next day we had the greatest sex we ever had, I mean the *greatest*."

The analyst's belief was that if Mr. A had continued to come to analysis without his wife also coming, or if the analyst had referred his wife to another analyst, splitting the case because of the customary taboos against such practice, this couple would likely not have progressed. Their treatment with the same analyst led to a rapid uncovering of unconscious material and the releasing of repressed memories for Mr. A that he hadn't had before his wife was in analysis. It is important to note that although patients who have been in analysis longer can make use of interventions that the newer patient cannot, it is not necessary for both to be at the same level before certain interventions can be effective. Mr. A, being ahead of Mrs. A, was able to initiate many therapeutic changes in his marriage while his wife, being newer, needed only to provide information to the analyst.

In addition to working individually with spouses, one may work with, for example, two siblings, or a parent and child, or two friends--or one may work with whole families or groups of co-workers or neighbors. This is a

common occurrence for people who work openly. When the analyst is successful with Jim, and Jim's neighbor Bob admits to Jim that he has been having some troubles lately, Jim will recommend that Bob call Dr. C., the analyst who is helping Jim have a more successful life. Then what happens is that Bob recommends Dr. C to his wife and/or to his college-age son and/or his colleague at work, and that's how the analyst ends up working individually with people in relationships with one another.

The analyst working with larger numbers of people who know each other outside of the analysis will find first of all that the concept of confidentiality becomes less sacrosanct. All of the traditional associations to the words "taboo", "secrets", "inappropriate", "boundary" and other formerly charged experiences in psychoanalysis lose their emotional thrill. In fact, the analyst who works this way is surprised to realize that the frame itself has been used as a countertransference resistance to analytic progress. The absence of nervousness (as well as the absence of destructive occurrences) about frame and boundaries in all other psychotherapeutic approaches besides psychoanalysis is one of the positive consequences of people who know each other sharing the same therapist. This approach, therefore, will be a disappointment to analysts who enjoy concealment, secrecy and the creation of a space in which no one really knows what is going on in the consulting room besides the analyst and the patient.

Analysts who work openly find that the opportunity for sexual and otherwise non-therapeutic behavior is diminished to the point of irrelevance, as is the case for the family and couples therapy schools, whose literature has no need for discussion of "abstinence". Then analysis can take place without danger, as *destructive* acting-out on the part of the analyst will be difficult to conceal from the community of patients sharing the same analyst. Which is why we do not recommend that analysts hastily instruct their patients not to discuss treatment with the other people who are in analysis with the same analyst. Unless patients are obviously intent on destroying the treatment of others by discussing sessions outside, the analyst can refrain from making 'confidentiality' a rule.

Confidentiality is a clinical guideline that is taken seriously when the patient wants it taken seriously. The advantages and disadvantages are explored just as with any clinical issue, such as frequency of sessions. Information received by patients about other patients is always used by the analyst to facilitate other patients' analysis. This might seem a practice that would stimulate paranoia and intolerable mistrust, but it does not have that

effect in reality.

At Ellen's 16th birthday party, Aunt Susan attempted to have a discussion of their father's (Ellen's grandfather) damaging effects on all the daughters. As Aunts Kate, Linda and Melanie agreed and the chat became energetic Claire, who is Liz's mother, stood up muttering, "I can't take this," walked out of the house and went home. Then Aunt Pattie started to cry and her daughter expressed annoyance at Aunt Susan for 'upsetting my mother'. Susan, Kate and Melanie stopped talking and the party broke up with nothing resolved except for a private determination on all involved not to talk to each other anymore about anything except the weather.

Ellen, Susan, Kate, Melanie and Liz have all had analysis. Pattie, her daughters and Claire have had none. The analyst received reports of the birthday party incident from Ellen, Susan, and Kate, and an extraordinarily full picture of this family's pathological avoidance of emotion and reality--what in *The Dark Side of Love*, Goldberg (1993, p.47) calls "pathological niceness"--and their murderous acts against anyone who would disturb the frail façade of civility. Most importantly, the analyst observed, through the reports of all three, that although Susan and Kate had progressed to a point in their analyses where they had become conscious of their family dynamics, they had not yet resolved their resistances to meekly surrendering in the face of their other sisters' angry reactions to them. This realization inspired the analyst to invite Susan into her analytic group, the first of all the sisters to participate, and *this* led to some powerful confrontations by group members of Susan's "martyr" defense in the face of honest emotional communication. Additionally, this is an example of the irrelevance of an assumed need for secrecy to most patients who are much more interested in the work of the unconscious and how it plays out with their loved ones, than in whom the analyst is talking to and hearing from.

It is our observation and the observation of many analysts who do this kind of work (including those who frown on it but in reality participate when their patients happen also to be their students and/or co-committee members at institutes) that, though there seems to be more to regulate in

terms of cross-discussions, outside interferences, diluted transferences (a quaint misunderstanding of the way transference works) and all the other concerns about this particular approach:

(a) these dreaded (as an approach to anything new is dreaded at the beginning) issues are actually quite easy to manage when the analyst is experienced and has developed systematized simple approaches to dealing with them, and

(b) the benefits of one analyst working individually with couples, sisters and brothers, mothers and daughters, neighbors and co-workers far outweigh the disadvantages.

As the number of analysts who are working this way begin to present the advantages to others in the field, confidently rather than guiltily, there will be a growing network of interested supervisors for interested candidates.

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Jean Hantman

Philadelphia

jhantman68@aol.com

[Jean G. Hantman, Ph.D.: TherapyatHome](http://www.therapyathome.com)

Donald Carveth

Toronto

dcarveth@yorku.ca

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