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PSYCHOTHERAPY CONSULTATION: TAKING THE TRANSFERENCE

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As Dr. Tillman has reported, *she* initiated the process of psychotherapy consultation. Her words about this are interesting, and reflect, I suspect, the gap between her inner experience and her actions with her patient. She describes the treatment situation as "nearly intolerable" for her, but with her patient, she "propose(s) (an) idea." The affect and the action do not match. If consultation works, it works first of all for the person requesting it (and so Mr. B would not necessarily return from it "a changed man"), and it works toward both the therapist's greater ability to contain experience formerly considered intolerable as well as her greater ability to get it *into* the work.

Mr. B's initial rejection of the proposal for consultation, as well as his regular attendance at sessions, suggested to me that the evolving transference-countertransference relationship might well be in a direction necessary to the patient's growth, therefore progressive, even if deadly and deeply inarticulate. I think here of Nina Coltart's (1986) brilliant reflections on Yeats's poem: "And what rough beast, its hour come round at last, Slouches toward Bethlehem to be born?" (p. 186) "Some people have seen this as pessimistic," she says, adding in a tone so collected and willfully independent as to seem almost regal, "you will gather that I have seen it differently" (p. 186). She continues:

> However much we gain confidence, refine our technique, decide more creatively when and how and what to interpret, each hour with each patient is also in its way an act of faith; faith in ourselves, in the process, and faith in the secret, unknown, *unthinkable* things in our patients which, in the space which is the analysis, are slouching towards the time when their hour comes round at last. (p. 187)

Mr. B's silence and self-described shittiness constituted a new depth of

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assault on his therapist. Dr. Tillman brings all of this, along with her patient, to her clinical team, and in response to the male team leader's recommendation, Mr. B agrees to the psychotherapy consultation. He then misses his sessions for a week and a half, returning to tell his therapist how cold and mean she is, and how useless therapy is since he will be psychotic for the rest of his life.

My two meetings with Mr. B were low-key and relatively uneventful. He knew me from my role in the Therapeutic Community Program and from an important interaction very early in his stay. At about 8 A.M., while I was doing paperwork in my office, someone knocked on my closed door. This is a rare event given the fact that patients quickly learn to make appointments and even more quickly learn that knocking on a closed door may constitute a serious interruption. When I said "come in," there stood this very large, quite mad-looking man, whom I recognized to be the new patient. My first reaction was fear; I felt cornered with someone unpredictable and for the moment speechless.

I asked him who he was, and he told me. I asked him if he knew who I was, and he did. I asked him to come in and sit down. He did and seemed to relax a bit. I asked why he had come to see me. He told me that he was afraid, and I immediately realized that my fear related to his. He told me that he had been walking down the street in front of my office, had heard church bells, and thought that he should become a priest, even though he eventually wanted to marry. He thought he should tell this to someone, and so he found me.

I told him that I was glad he told me, that he sounded like a person who was in conflict about his life, and that the Center might be a good place to sort that out. I added that it must be frightening to be in a new place with so many new people. He said that it was. I told him that I had some work to do now, so I could not talk with him any longer, but that I hoped things would work out well for him here. He thanked me and left. It was this interaction that led him to occasionally call me "Father Fromm" in the patient community, apparently a condensation of his spiritual and familial aspirations, as well as a transference paradigm for what was to come.

So, five months later, we met again because I was the assigned psychotherapy consultant. He told me that he was angry at his therapist because she could not fix him, but it became quickly clear that he felt his psychosis to have been a catastrophic experience, a set of losses that no one could fix. I fished around for what he might have gotten or learned from his psychosis. He understood me, but did not understand his psychosis yet at all. He had learned from it, however, that he remained angry at his father. He dated this to the time after his mother's death, when he "still needed raising, but my father didn't want to be bothered." This spoke to my immediate experience of needing something from Mr. B, on behalf of Dr. Tillman, and of Mr. B's not wanting to be bothered.

I worked hard to get at what *he* might want from this consultation, and with some animation, he said he wanted Dr. Tillman to stop pushing him and to stop telling him what he thought. He said that with me as a mediator, she might listen. I found myself thinking that he must have felt left too alone with his mother during her illness, as indeed he had throughout his life. We ended this meeting with our agreeing that we would both bring this discussion to Dr. Tillman and that he would call me if *he* wanted another appointment.

He did soon thereafter. When we met, he told me that things had gone better in therapy; there had been more "dialoguing." He told me that he did not understand therapy. As it turned out, he did understand that therapy was about coming to know and tolerate and express feelings. The new idea he took from me had to do with a person's tendency to relive important, unresolved aspects of his life. He did not recall much about our first meeting, except that he felt bombarded with questions. He did not come out of it liking Dr. Tillman, as he had hoped. Rather, he was angry with her and did not understand that.

He then added an important, specific reaction: He felt that she saw him as a "crybaby" and he thought she held herself back from that. Again he thought of his mother's death. He remembered feeling terribly sad at that time, but he refused to show that to anyone, for fear of being shamed as a "crybaby." (A note about history: Mr. B was an only child of his parents' marriage, considerably younger than his half-siblings. He was very attached to his mother and easily embarrassed about his relationship with her.) At this point in this second consultation, the point of maximal emotional contact, Mr. B said, rather defiantly, that he thought he had a lot to cry about, and I said indeed he did. He made it clear to me that he did not want to change therapists. I simply encouraged him to put into words the thoughts and feelings he was having with Dr. Tillman, for example, the "crybaby" feeling.

As I said, these sessions were in no way dramatically productive. I tried simply to bring the patient out, to hear his understanding of the problem, to make emotional contact, and to find his language. That he initiated a second session I took to be a good sign. Overall, I feel that the importance of these sessions was not in what happened, but in *that* they happened, that a third person inserted himself into an ailing treatment dyad and found a way to frame and hold the treatment task.

In my meetings with Dr. Tillman, we talked about the patient's nonattendance as representing a narcissistic injury in response to her request for a consultation, which he took to mean her refusal to be with him during a difficult time. His wish for a note certifying a permanent remission from

psychosis seemed transparently related to painful temporary improvements in his mother's condition and to the patient's enraged disappointment and fearfulness about help and hope.

In the transference-countertransference matrix, he seemed to be living out with Dr. Tillman a profound paradox, the task, as Masud Khan (1974) put it, being to sustain the paradox and prevent it from degenerating into irreconcilable conflict. That paradox seemed to have to do with a terminal situation that was not supposed to change at all. Dr. Tillman and I talked about various ways of sticking with the patient and of listening to his "technical" suggestions. Most importantly, this former EMT and I talked about simply accepting her feelings and letting them be, simply holding and going into the countertransference, particularly the helplessness at being unable to save someone wasting away in front of you. From that starting point, some kind of understanding might eventually come.

As I look back on it, my talk with Dr. Tillman was about one of the most basic and powerful, if least written about and understood, aspects of psychotherapy. Neville Symington (1986), in his "Last Lecture," a Credo to what for him is central to his life's work, puts it this way:

> Each new patient . . . challenges the analyst to further his emotional development. . . . It is for this reason that I have stressed that the most difficult matter for the analyst is to "take" a transference. The interpretation of it is relatively easy, but taking a transference has a special difficulty . . . for the transference is a distorted truth about the analyst [p. 321]. . . . The analyst cannot make an interpretation when he is too anxious about the topic [p. 322]. . . . What is he to do *before* he becomes conscious of [his difficulty]? [T]here is the patient and the analyst in the consulting room, but there is also a process. This is the third term in which trust is ultimately placed. The process of analysis is the master of both analyst and patient [p. 324]

My consultation may well have helped Dr. Tillman trust the process, giving it communicative form and allowing her to let go a bit into it. Certainly a change occurred in the patient: a first dream, curiosity, playfulness, in Dr. Tillman's words, "use of the psychotherapy to examine his experience." Dr. Tillman felt that I had "saved" the therapy. But on reflection, she realized that the material seemed very much the same; while he had indeed changed, Mr. B was not a "changed man." Rather, Dr. Tillman had changed. "In retrospect, it appears that the consultation served to shore up my discouragement and confusion about why my interpretations could not make this deadly transference-countertransference interaction abate." I would underline the verb *make*. As Dr. Tillman said to me, she found herself in the midst of the patient's transference assault, looking for the interpretation "that would make it all stop." In other words, Dr. Tillman's emotional burden was leading her to the use of interpretation not to understand the transference but to refuse it. Hence the act of interpreting indicated to the patient her jeopardized survival and therefore could not be used by him. In my experience, this is a common phenomenon for therapists, regardless of training level, when working with very troubled patients. In a recent paper, Grinberg (1997) writes of "the analyst's possible fear and concealed rejection of the transference" (p. 4). But, as with any crisis, this situation holds both danger and opportunity.

Elsewhere I have described variants of psychotherapy impasse as reflecting what I have called pathological transitional relatedness (Fromm, 1989). I focused in particular on two technical functions of the analyst: the establishment and maintenance of the frame and the offering of the analyst's emotional responsiveness and total mental functioning as a medium for metabolizing and articulating the patient's heretofore unconscious experience. This concept of medium was developed by Marion Milner in various papers, including her autobiographical work *On Not Being Able to Paint* (1957).

In this work, she wrote of the problem of reciprocity between one's own need and the need of the other. She described a developmental failure in which the child "had lost hope of making any real contact with the outside world" (p. 116) and the possibility that in creative activity might be found "an experience of togetherness with one's medium lived through together" (p. 118), an experience of "pliability yet irreducible otherness" (p. 118). Thus, "the 'other' that had inevitably had to fail one at times in one's first efforts to realize togetherness" (p. 118) might be rejoined from the position of a newly revived subject.

It is indeed this transformative, becoming-conscious, lived-through togetherness that was at stake between Dr. Tillman and Mr. B, given the burgeoning demand on Dr. Tillman's capacity as medium. This demand—to be with him as he dies, to accept helplessness, to feel guilt, despair, and rage, to never leave, and to hold on to her strength in the face of assault—was thoroughly embedded in Mr. B's experience of himself and his mother at the time of her illness and death. Most of all, nothing was to change, then or now, since underneath his whistling-in-the-dark grandiosity, change meant only loss and guilt for his destructiveness.

This is the problem of serving as medium when that term carries its connotation of facilitating contact with the dead. The transference-countertransference relatedness felt like a death grip. To the extent that Dr. Tillman's interpretations were in fact a way of leaving the patient, a way that his ailment, like his mother's, was not survivable, the content they delivered could not be integrated. Even more, they enacted and repeated the patient's early experience, the "let-me-out-of-here" that never actually worked, and the "take-this-to-make-me-feel-better," which did not either. A

therapist's being used for what she really has to offer can only happen, says Winnicott (1969), when the therapist has become placed outside the patient's projective field, placed there by the patient's destructiveness and the therapist's real survival with technique intact.

Is this what happened through the consultative process? Mr. B announces in his first therapy session that the problem will be grieving his mother's death. His first reaction to the therapist is to feel hurt that *she* "dis-owns" *his* feelings, as though rupturing a oneness he wants with her. He goes on to lament that Dr. Tillman is too this or too that, like an inconsolable child or a child whose skin sensitivity makes *any* contact with reality a source of irritation. He cannot stand it that he affects Dr. Tillman's technique, and then he takes sadistic pleasure in the effects he cannot help but have on her. In response to her interpretation of what both he and his father need from doctors, he speaks angrily to what he was promised, what he is owed, and of course what he has been deprived of.

This *is* the work of grieving. Dr. Tillman interprets to "abate" a process, but ironically interpretation deepens the process if the interpretation is accurate, and escalates the process if it constitutes a transference refusal. One or the other seems to have been the case at this juncture of Mr. B's treatment. He becomes silent. He watches television. He thinks of murder. He smells. There is a moment in his history, as his mother comes home from the hospital, when he watches TV rather than visit with her in her sickroom. She comes out and says, "Can't you even come in to speak to your mother?" He confesses to his sister that he wishes she would die already. I wonder how she smelled.

In other words, Mr. B may be re-creating the specific elements of this dire phase of his life, including death, sleepiness, and indifference in his therapist. But all of this cannot become interpretable until the destructiveness of it really has been survived. Mr. B's assault may have been *his* effort to place the therapist beyond his projections. Dr. Tillman's call for a consultation may have been *her* effort to get there, to help him find a usable reality by her first finding a third party who might help her survive his death grip.

Nina Coltart (1986) writes of a similar clinical situation:

> We came to see how much, to his own surprise and horror, this man had needed to live out, and have *experienced and endured by another person without retaliation* his primary hatred of a genuinely powerful mother. . . . I had given up trying to "understand" this patient, given up theorizing and just sat there day after day without memory or desire in a state of suspension, attending only with an empty mind to him and the unknowable truth of himself, which had shaped his life, until such a moment as I was so *at one* with it that I *knew it* for the murderous hatred it was, and had to make a jump for freedom—his as well as mine. (p. 195)

Dr. Tillman's "jump" may have been to ask for the consultation. I am suggesting that this action at this time in the treatment began the process of change she notices. There is a remarkable moment while the consultation is occurring when, in response to his physically turning away from her and reporting being turned away from by his friends, Dr. Tillman asks Mr. B "if [he] knows something about turning away from people who are seriously ill." To my ear, her approach is stunningly different: calmer, more settled, more "with" the patient. He responds quietly and with vulnerability: "Me —I turned away from my mother when she was ill. I refused to visit her. I told my sister I wished she would just go ahead and die." He falls into a silence that feels completely different from his earlier provocative withholding.

Dr. Tillman eventually picks up on the way in which his mother's illness must have felt like her turning away from him. Mr. B joins that and speaks of her having lost her will to go on. His own giving up simply follows hers. But Dr. Tillman too is struggling with giving up. She too turns away, toward a consultant, though this turning is in the service of turning back, however painfully, toward her patient. The tone and depth of this exchange suggest to me that the impasse is already resolving.

Dr. Tillman writes (in the unabridged version of her paper) that, "The consultation provided a third to the deadly stalemate, providing a holding context through the act of bearing witness to the pain and despair of both the patient and the therapist." I would accent the deeply therapeutic function of becoming a true witness with the patient to the specific emotional events of early family life. And Dr. Tillman is right to emphasize the "bearing" in all of this, because these truths only become really known emotionally in their actual reliving between patient and therapist. In calling for consultation, Dr. Tillman asked for help with her emotional burden, including perhaps her carrying the mother's unacknowledged and projected burden of wanting it all to be over too. Thus, she opened a path for development that the mother–son dyad, in collusion with a father in denial, had foreclosed. Interestingly, it was a path that included a transference father, whose actual function was to feel the burden with her, rather than deny it (Ann-Louise Silver, personal communication).

Let me finish with a thought about the distinction between consultation and supervision, which for Dr. Tillman in her fellowship was ongoing in this case. Perhaps consultation, precisely because it is not ongoing, does not have a mentoring aspect to it, and actually contacts the patient, can serve two purposes very powerfully. First, it is an actual treatment intervention, the timing of which is in unconscious but direct response to the gathering affective storm between patient and therapist. Second, the consultant is working in this particular treatment moment, and finds himself not only

as third to the patient–therapist dyad, but perhaps third also to the therapist–supervisor dyad. In this sense, the consultant is the double of the patient, speaking on behalf of the patient to what might be thought of as an imaginary and therefore unseeing dimension of the supervisory pair.

Finally, to return for a moment to Grinberg's (1997) recent paper, he writes that, given the confusing welter of theoretical and technical ideas about transference in our literature, "It is difficult not to think that the transference is still our 'cross' owing to the tendency to avoid a committed relationship to it" (p. 5). The cross metaphor belongs to the Freud–Pfister correspondence and captures the notion of transference as a chosen role involving suffering on behalf of others. Grinberg summarizes what I am calling "taking the transference" in the following way:

> The basis of this attitude would be an acceptance of invasion by these projections and of all the consequences, so as to be able to share and feel on a basis of consubstantiality with the patient the affects contained within them whatever their nature . . . , as if they were part of the analyst's own self. It is a matter of offering one's entire availability. (p. 11)

Psychotherapy consultation is one avenue toward such a difficult offer.

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