

## **A PSYCHOANALYTIC MEMOIR: THE ANALYST ENABLED AND DISABLED BY WHAT IS PERSONAL**

**H**ow do we become analysts? In this essay I will present a trajectory of my use of my self and my understanding of the mutual influences my patients and I have had on each other over my professional life. The use of my self and the mutual influences my patients and I have on each other, of course, are about the patient-analyst match. I believe our engagement reflects a process of working through for me, as well as for each of my patients. Events in our lives also affect who we become as people—sometimes only in subtle ways and sometimes more significantly. Changes in our selves have reverberations in our work with patients.

When I began my psychoanalytic training in 1968, we were taught that analysts were meant to be “blank screens.” Patients could and would project their difficulties onto us. Who we were, our conflicts and character, were to have been smoothed out in our personal analyses and our personalities purged of the tendency to appear in our offices. Analysts were assumed to be interchangeable. I know this sounds like a parody of analysis. I also now know that many analysts, even then, were not like this, but it is what we were taught. I admit to having been incredulous. Really? Who we were as people would not enter our work with patients? Before my training, I had worked primarily with children and been relatively free in using my self intuitively in the work.

My classical analytic training did help to provide a discipline for my spontaneity that was useful, but the idea that I, or anyone, could be grayed

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down sufficiently to be a “blank screen” defied both my imagination and my personal experience. The impression I got as a candidate was that an analyst should listen and understand but not influence the way an analysis proceeded apart from providing insight. This belief may explain why there was a period of time in which the “silent” analyst reigned—as though silence were a neutral state. The amount I spoke lessened as I went through analytic training, but I rebelled against the idea that who we are as people could be expunged from our work.

I thought then, and still do, that we can learn to curb our judgments about how to live a life. We will do better work with some people than with others because of who we are, especially when our conflicts and character mesh or clash. This is what I have called the patient-analyst match, which inevitably affects the nature and outcome of our analytic work. Since we are inevitably part of the process, we need to find a way to be mindful of our influence without being constricted by arbitrary rules.

The psychoanalytic world has changed since the 1970s, when I was trained. In the early 1980s, James McLaughlin (1981) wrote about analysts’ transferences to their patients; Irwin Hoffman (1983) proposed that patients were interpreters of their analysts’ conflicts, not just the other way around. I performed a pilot study (Kantrowitz et al. 1989) that showed that patient-analyst match—the effect of overlap in character and/or conflict—was the variable most related to analytic outcome. By the 1990s, there were many psychoanalytic papers about what we called the analyst’s countertransference and the inevitability of the analyst’s personal characteristics as contributing to what transpires in an analysis. The pendulum had swung. Soon the person of the analyst, rather than the patient, became the center of psychoanalytic attention. Then postmodernism, in which truth, objectivity, and subjectivity are all called into question, frequently led to the “disappearance” of a focus on the character and conflicts of either patient or analyst, as the concept of “the third” ascended (e.g., reverie as a co-construction), obscuring important distinctions between self and other. The belief that one could stand neutrally outside of transference and countertransference faded.

This sort of dialectic seems inevitable in our thinking. We swing one way and then the other: a focus almost exclusively on the patient, then a central scrutiny of the analyst, and finally a merger of the two making them almost indistinguishable. While we cannot obliterate who we are as

people from our work, we need to be careful that our characters and conflicts do not dominate our interactions. We need to try to catch ourselves when our personal characteristics intrude, leading to personal judgments, and damp their expression when they threaten to obscure what we and our patients are trying to understand. We, the analytic dyad, are two people, each with our own intrapsychic issues, involved in an interpersonal relationship in a world that impinges on both of us (though how we perceive that world and our engagement with it may in some important way be different). Today many analysts—perhaps most—see a value in being more welcoming and transparent; some engage in a Ferenczi-style mutual analysis (Wolstein 1989), the obverse of what I was taught in the 1970s. How do we negotiate these boundaries of self and other, keeping our patients as our focus, being real and humane while trying not to let our judgments and values intrude, as they try to find who they are and who they want to be? Who we are influences how we work. So, picking up on Theodore Jacobs's felicitous phrase, "use of the self" (1991), I will try to illustrate what I have understood about this concept in relation to my work with patients and in relation to the complexity of our intersubjective match.

How I use my self is something that has evolved over time. Always it is the clinical interaction that stimulates my reflection. Rather than provide a single case example, I will present a number of brief illustrations reflecting different parts of me at different times in my professional life. My aim is to show a process of how I use my self and work through what is stimulated by my patients.

Early in my professional life, I could be characterized as working intuitively. I tried to follow my patient's affect and thought and used my own (not always so clear or nameable) affects and thoughts that resonated to formulate what I was hearing. My analysis and analytic training supplied a discipline that helped me achieve greater asymmetry, to stand back more, rather than automatically mirror the patient's state. Theory, when I found it meaningful, helped organize my affect and broadened my thinking. I continued to learn a great deal about myself in the process of trying to understand my patients' conflicts and states. I present this first example specifically to illustrate work with a patient that lifted my own repression as well as his, as I located similar conflicts we seemed to share. It was in the early 1970s, not long after I had terminated my training analysis, very early in my career. I repeatedly dreamed of a patient—just

his image. My patient, when only four, had been left to babysit for his two-year-old brother, who fell from a second-story window and sustained permanent brain damage. His mother accused him of pushing his brother out the window. My patient did not believe he had pushed him but suffered intense guilt nonetheless, as if he had. I tried to analyze my dream but seemed stymied about its meaning. My dream of him—his image—recurred until I imagined telling my former analyst about the dream and had an image of myself standing in front of a summer house when I was four; I also recalled the memory of my mother's miscarriage. At that moment I had an intense awareness of how much I didn't want a sibling. These memories of my mother's miscarriage and the house were not new, but my associated thought and affect were. Until then, I had thought it was simply that I bemoaned being an only child. My guilt was buried in this reversal of my wish. Following this realization, I could much more effectively address my patient's sense of guilt. I didn't dream about my patient again. My dreaming of the patient—an uncommon experience for me—had stimulated my self-scrutiny. My associations enabled me to find a similarity to my patient—our common sense of guilt in relation to fantasies of harming a sibling that had occurred at the same age. My guilt had not been conscious, while his was, and I had been trying to lessen his guilt—focusing on his self-criticism—rather than analyzing it, until I discovered that I was avoiding facing guilt in myself. My patient had been ready to explore his guilt, but I had been defending and moving away from my own experience of guilt (see Racker 1957). Once I was ready to inhabit mine, we shared a state of affective distress that we could explore. A different and increased focus on his guilt opened the way for exploring his aggressive fantasies (Kantrowitz 2009).

Over the years, I learned more about my characterological tendencies—tendencies I would not welcome recognizing—stimulated by discoveries of overlapping character issues with my patients. Engagements involving patients' fury or perceptions of me as withholding and mean would lead to my own fury and intense feelings of experiencing myself as someone I would hate and fear. When these experiences first occurred, I did not think in terms of projective identification, though the experience could, of course, be conceptualized that way. My understanding of patients who stirred these intense affects in me was that they were externalizing one half of a relationship, in most cases a sadomasochistic one, most often with me as the sadistic abuser. I understood that I needed to tolerate being

in this role for them to understand it. I didn't think of it as just providing a holding environment, because I felt so acutely the intensity of the affect with my patients in our interactions. To contain what I felt, to find a resonance, I needed to understand what was stirred in me—an exploration of affective memories of being on both sides of the conflict.

For example, one patient was intensely preoccupied with me: She wished to call and share her daily experiences, to accompany me on vacations and professional trips, to have me read what she read, see what she saw. She had felt neglected by her busy professional mother. The problem for me in the treatment was that she would become depressed or paranoid in response to my interpreting her longings for more from me. She felt I was rejecting her when her literal wishes were not granted. I felt pressured; my reaction was an anxious, angry stiffening and wish to pull away. Though I manifestly contained these reactions, I am sure she sensed my feelings, and this increased her pressure on me. One day she requested that I be designated in her will as the guardian of her children. She realized I might consider this a conflict in my role, but since she would be dead, she pointed out, that would not be so. Who better than I would know her wishes? I felt the familiar stiffening in myself in response to her push for more, but having spent much time exploring in myself how it felt to be on either side of such conflicts, I invited her to do the same. After much exploration got us nowhere, I asked her how she would respond if a patient asked this of her (my patient was herself a therapist). She became very thoughtful, and then said she wouldn't want to say no; it would be hurtful. But it would be such a huge responsibility; she wouldn't really want to do it. But she would feel she had to or injure her patient. She wouldn't want me to say yes if I didn't want to. I said I knew she wished I would want to do this, but if I didn't and said no, she had put me in a position where she would experience me as being hurtful to her in a way she knew she didn't want to be. Following this interaction, she began to recognize her role in what she had experienced as others' meanness. I had used the discomfort I felt in being "the mean one" to find an empathic way to help her see her role in our interaction.

It was Sandler's concept of role-responsiveness (1976), more than the idea of projective identification, that resonated; he was very explicit that there needed to be something in us that got hooked by the patient's conflict for this to occur. Enactments as compromise formations, sometimes more influenced by the patient's issues and sometimes more by our

own, made a great deal of sense to me. I offer this example to illustrate the recognition of my own struggles with feelings of helplessness and difficulties in accepting my own limits, a recognition that emerged from my countertransference enactment. I vividly recall a time in the late 1980s when a patient was railing against the limits of reality, refusing to accept any possible solution to a situation that caused her acute narcissistic injury. In one session I tried every way I could think of but failed to provide any soothing effect or insight for my patient. Our time was up, or so I thought. But in fact I had ended the hour ten minutes early. I felt intensely guilty! But it wasn't only guilt I felt. I recognized that I had been unable to tolerate my own sense of helplessness, a feeling similar to my patient's. My patient had stimulated in me the very feeling she was experiencing. My patient dealt with feeling helpless by throwing a tantrum, while I, once out the door and realizing my error, knew a familiar experience of feeling unable to master something and wanting to throw up my hands. I had dealt with my helplessness by walking out on it, as I often fantasized doing without allowing myself to do. Clearly, containing both my own and my patient's sense of helplessness had been more than I could tolerate at that moment, and I abandoned both of us—a clear example of reciprocal impact.

In the last few decades, I would say, I have been more actively mindful of how I offer my self to be used by patients. I welcome and embrace negative transferences, finding them a rich avenue for exploration, and am not usually thrown into states of self-criticism by them. I've come to appreciate that with some patients not only half of a conflict, but half of an internalized object relationship, is externalized and extruded. When there is no representation for the patient of what is extruded, it is the analyst's capacity to contain, and to empathize with, both the patient's conscious experience and all that the patient disavows—including registration of the disavowed "other's" subjectivity—that enables the patient both to reinternalize the extruded, conflicted parts and to accept "otherness" itself. This conceptualization emerged from work with traumatized patients whose distrust, fury, and sense of deprivation can make them unable to take in the point of view of others. When I have been able to find a place in myself that can resonate and tolerate the intensity of feeling unseen, deprived, frightened, or abandoned, and a reactive emptiness, greed, fury, and neediness, we can find a place of subjective meeting and the work can deepen. But my conscious willingness to let myself

participate with such malleability to my patient's needs is not always sufficient.

A severely traumatized patient resisted all work in the transference and experienced any observation I made about her as competitive and demeaning. Anything beyond empathy evoked her anger or withdrawal. I knew she was frightened and feared humiliation. Observations produced both of those responses; she dreaded and resisted this experience. I finally said to her that she was willing to go places with her own patients that she was unwilling to go with me. She said she heard that as an invitation; I agreed it was. I can't really tell you what happened next because for the following month she bombarded me in a way that my mind became paralyzed. I tried everything I knew how to do—took copious notes after hours to try to get perspective, talked with several colleagues about what was going on, tried to analyze my dreams. Nothing I learned or that I said to my patient changed her assault on me. The content seemed less relevant than the intensity and its unrelenting flow. Finally, I said I could only think that she was communicating to me what her experience had been growing up. Not long after, she said, "Enough—being so rageful isn't good for me," and stopped her assault. Try though I did, I concluded we were not a facilitating match. I believe I was unable to tolerate the extent of her fury. To survive, I dissociated as she had done in childhood. I took on her state, and she became the abuser of her childhood. Since I was unable to offer her a place in myself of empathy and containment for her state, I was abandoning her to being someone she hated and feared and could not tolerate being. The split was repeated but not repaired. I felt regretful but accepting of my limits. We worked together for a while longer, talking some, but not adequately, about what occurred between us, and ended the treatment several months later. We both recognized we could not work further on our experience. I have not heard from her since.

Conceptualizations of conflict and affect states, any theories that increase appreciation of how and why people struggle, help our patients and us feel understood and contained—but they are not always enough. When theory helps, it is not just intellectual. The ideas become integrated as part of ourselves and are then used in a more spontaneous fashion. I don't think I'm apt to be listening for a process of projective identification and projective counteridentification with patients, though I think for the most part I recognize it when it occurs. I'm sure all I do is influenced by what I've learned over the years about human psychology

and disturbances in others and myself. So in a sense I find myself less conscious of myself—still operating intuitively, but now having absorbed so much cognitively and having gained increased affect modulation. It feels seamless until there's a disruption. Then I return to self-scrutiny and try to untangle what has happened between my patient and myself that has interfered with our work.

Another consideration in how we use our selves concerns our attitude about self-disclosure. I don't mean telling our patients about our private lives—though I realize some analysts find this is a productive way to work—but our willingness to use our own feelings about what goes on between a patient and ourselves as a way to help patients recognize that they have extruded parts of themselves that they find unacceptable, and by so doing help them access those parts. The intimacy of the therapeutic situation permits patients, when they are able, to find a freedom of thought and expression. If I introduce my life, my pain, my fears, I believe I distract them from themselves; they may hear or sense my revelation as an implicit request for a response—our contract is to focus on their needs, not my own. Disclosing deeply personal feelings in a presentation, or even a published paper, is different from disclosure directly to my patients—though, of course, disclosures in these formats, if our patients learn of them, will likely stir many reactions. When I was younger, I thought the actual information presented a potential interference in our work, but I no longer believe this. It is not the information itself that interferes with patients' transferences to us—though such information may delay the development of their fantasy use of us for their needs. But, of course, we do reveal personal things all the time. Our offices reveal our taste. It is apparent when we are sick, tired; we make slips. We may sometimes answer questions about why we go away, where we go, and certainly we always tell for how long. There are many ways in which we convey information about ourselves about which we are not aware. Anything a patient learns about us can be understood in terms of its meaning to the patient. We need to be able to explore together what the information has stimulated in them, how it has altered their perception of us, and, if it has, how they believe this might change our work. Such inquiry is part of our work. The internet also has changed what personal information can be discovered. But I think that even without this easy source for finding personal facts, I would feel the same. We can explore the meaning of anything that is learned about me, but when the information comes



*from* me, I have also introduced the meaning of my telling, a meaning that may not even be conscious to me at the time.

Answering personal questions when they arise in the course of our work together is a related matter. While there are occasions where answers may be necessary, or possibly even desirable, answers can confuse patients about boundaries. I am not an affectively distant analyst, but I have both seen, as well as know of, too many patients whose therapists have not remained clear about their place in their patients' lives. They may assume multiple roles. No matter how such shifts in stance or role are rationalized at the time, entering into dual relationships, such as when the analyst becomes a personal friend, or, most dramatically, when the analyst enters into a sexual relationship with a patient, is likely to have untoward reverberations over time. I treat many patients who, were they not my patients, could have been my friends. But I feel very clear even when we end the treatment that my role remains as their therapist or analyst, someone to return to should they ever feel the need.

Although who I am in the world may not be so different from who I am in my professional roles, who I am to each patient is also influenced by who each patient needs me to be and so perceives me. If I consciously chose to introduce myself, my own needs and foibles, I believe this could complicate and confuse what my patients take away and what they need to mourn. My everyday, out-of-the-office self can muddle this process. Who I am as a person is inevitably present to some extent in the work, but that is different from the choice to actively bring these personal aspects in. Over time, I have come to accept seeing how my own character and conflicts, when they interdigitate with those of my patients, may be played out in ways I wish they hadn't. I regret when my ignorance about some issue or blindness to my conflicts complicates our work, but I feel less ashamed about such intrusions occurring. These disruptions seem inevitable from time to time, and while I am unlikely to reveal the content of my own issues, there are times when I feel it is important that I acknowledge with patients that I have introduced such complications. Sometimes interferences that limited our work are not recognized until many years later.

Events in our own lives can have a powerful effect on our work with patients. In the mid-1990s I suffered a loss in my personal life that greatly affected me and my patients. My loss had reverberations both inside and outside my analytic work; it both disabled and enabled me. Twenty-one

years ago, vacationing in the south of France, my husband and I returned to our hotel imagining many more glorious days ahead. As we entered our room, the phone was ringing. I picked it up to hear our twenty-six-year-old son say, “Mom, I have some bad news. I have a brain tumor.”

We flew home the next day. Our older son was already by his side. Our daughter, who was on safari in Africa, was not reachable for several days. Our son was operated on two days later. The diagnosis was an astrocytoma. The tumor was debulked but could not be completely removed; it overlapped with his motor functions. When he reached us that night in France, my husband, who is a physician and very wise, said, “He will die.” I knew it must be true, but I could not, would not, accept living emotionally with that reality. He was too young. We were too young. I had to have hope—for our son, for me, to go on living and finding pleasure in whatever time he had. I held dearly to the thought: “There has to be a time that someone will find a cure for this kind of brain tumor. Maybe it will be now. How can we know that it won’t?” This is the doubleness of knowing and not accepting what you know. How do you sustain hope, optimism about a future, when reason tells you it won’t exist?

It was early August. I was not scheduled to see my patients again for more than a month. I could therefore attend visits to his doctors and be at our son’s side as he began a course of radiation, all without canceling patients’ appointments or considering what I would or would not tell them. Surely, I tried to say to myself, the doctors wouldn’t plan all this if there was no hope, even though I knew—you always do what you can, that the doctors were proceeding as if what I clung to was true: a possibility might still exist that he could be cured.

In the weeks that followed, I began to think about my patients and disruptions in my schedule. What, if anything, would I tell my patients? I know, and still believe, that if I were the one who was ill, I would tell them of my illness. I have witnessed too many colleagues who did not inform their patients about serious, often life-threatening illnesses. Some of these analysts—many who were older, but not all—had died without any chance to say goodbye, leaving their patients shocked and bereft. Even when death is not the outcome, patients struggle with what they think they perceive as changes in their analysts, worrying if they could or should address it, burdened not only by their own concern and anxiety for their analyst, but also anxious that they might be intruding, exacerbating their analyst’s concerns, especially as they age. I thought if I were the

analyst who was seriously ill, I would want to deal with the effect of my illness and possible death on my patients. But would it be the same for them and for me facing my son's life-threatening illness? What would my patients perceive in me? How would it change our work together?

I thought about each of my patients: their histories, their vulnerabilities, their relationships and transferences to me. I was fortunate at the time that most of my patients were people I'd worked with for a considerable period and were engaged in intensive work. I knew them well. As I thought about each one, I decided that there would be time in the future to deal with the meaning of my son's illness to them—again a reflection of my “knowing” the outcome of his illness while simultaneously refusing to accept it. But one patient made me pause. Her view of me was so often of my being distant and withholding, as she had experienced her mother. Would it be worse for her to find out from others rather than from me? But as I considered her response, I recognized that my thinking of telling her was a way of protecting myself from her anger, which she'd likely try to hide. But I knew her well and thought I would be able to help her bring it to the surface. The more I thought about it, however, the more I thought I should try to protect all my patients' treatments for as long as I could. I knew I would need to be vigilant to attend to what they might not be conscious of or might not be willing to risk seeing or saying if they suspected something was wrong, or if they actually knew. Trying to protect my patients from the reality I was facing, to make it easier for them, for me, all, I realized, was as impossible as saving a child. On some level, they inevitably would be registering my changed and upset state.

And then I began to recognize that I wanted and felt I needed to preserve my work space for myself. I wanted it to be a respite from the anxiety and grief I was fending off by an illusion of hope. I could be there for our son, supporting and loving him, but I could not really be effective in helping him, in changing the heartbreaking reality that he was likely to die. I recognized my work as a place where I was not helpless, and where I could be effective in helping others. I could not know whether I could keep my patients from knowing the reality of our son's illness. I did not plan to keep it secret from my friends and colleagues. Relationships bring me comfort. Many of my colleagues' and friends' lives overlapped with my patients'; I did not want to impose on them some sense of secrecy about our life—but would they preserve my privacy? What if they didn't? I would manage later. With these considerations, I decided I would not

tell my patients. Throughout my career as a psychoanalyst, I have turned to a colleague-friend to be an ear for me, to process with me what went on in sessions with my patients, to listen for what I might be missing. Now I felt an acute need to be told if I was concealing from myself distress my patients might be perceiving in me or expressing themselves. Having an outside listener gave me a way to feel I could trust I would be less self-deceptive. I was grief-stricken about our son, but I was feeling more settled about how I would approach my work.

In the first hour of my first day back, a patient told me that she had been told about my son's illness in early August. So much for careful planning. The person doing the telling had no idea she was talking to a patient of mine; it was just a sharing of tragic reality about the life of someone who was part of the patient's community. My patient said to me, "I am *so* sorry I have intruded on your life." I said, "On the contrary, my life has intruded on your analysis." But of course, it was not the contrary. I realized that both were true and actually inseparable. I did not mind that she knew the information about my life, but I knew it was likely to be a burden requiring greater vigilance for me in our work. I quickly lost the illusion that I would be able to preserve my work as a place to escape my worries about my son. I knew my patient had a close enough relationship with another patient and anticipated that she too would soon know my situation. So I impetuously told this other patient, thinking—but not really thinking it out—that it would be preferable to come as information from me. As it turned out, the first patient never told the second, so I had compounded my own need for extra scrutiny—now two patients, not just one, knew my son had a brain tumor and that they had an analyst who was in state of anxiety and grief, even if she could try to put it aside in the context of analytic work. Trying to work, putting my distress aside, was my way of managing my grief.

I had adult analytic children who were physically healthy, whom I hoped I could help to grow and develop into their best selves. I wanted, I needed, to bring my best, most effective self to our analytic work, to not be thinking and feeling about the dread of impending loss of our son. I knew I had to be alert for signs that my patients would try to avoid their worries about me and my worries about my son, but that I must also avoid reading what they said or didn't say as thoughts about me or him when they were not present. I had complicated their transferences and their treatments. When the second patient ended analysis, I apologized for having added this burden to our work.

After a period of remission, our son's tumor recurred. I continued to try to keep my work as a respite. I talked with two colleague-friends about what was going on with my patients and me. I was trying to be self-scrutinizing but would not have trusted myself to not be self-deceptive. Not only did I want to continue believing, against all odds, that our son could survive; I also wanted to, needed to, believe I could still be effective in my work. I analyzed my dreams where fears and grief intruded, disrupting my need for mastery. My husband respected my defenses and did not continue to impose his realism on me; at times, indeed, I think he was comforted by joining me in thinking and hoping that the next treatment would work. My close friends—some of them colleagues, others not—provided nurturance in so many ways, staying attuned to my mood, what I wanted to talk about, what I didn't. But, of course, some did not maintain this sensitivity and so a few friendships did not survive the stress of my son's illness. These were other losses. But mostly my friendships provided me a source of support, helping me stay available for our son and for my work with my patients.

Our son died a little less than four years from the time of his diagnosis, a week after he turned thirty-one. When you have a brain tumor, unlike other cancers, there is no pain. He became increasingly diminished and spent the last month of his life in a nursing home near us where we visited several times a day. Our son was a journalist, so when he died my patients were informed not only by people in the analytic community, but by a lengthy obituary in the *Boston Globe*, the most prominent of the local papers, telling the facts of his all-too-brief but adventurous life. His funeral was a celebration of that life, people recounting stories of his antics—like taking ten round trips on the air shuttle to New York in the course of a single weekend to earn a free trip to Europe. He was a character, and our memories of him still make us laugh and bring us joy. Apart from the two patients who knew about his illness, it turned out that none of the others had known. My colleagues had protected my privacy—patients, me, and our work—and yet. . . I don't know what they may have known without consciously knowing.

When I returned to work a few weeks later, all my patients knew the reason for my absence—they had been informed of it by a colleague. They expressed their sadness for me. But the death of a child defies expectations; responses are different from the death of an elderly parent, a more emotionally expectable sequence. With each patient, I felt the

continued need to remain vigilant to what he or she might be avoiding. At the same time, I was also trying not to read in a focus on my son's illness and my distress when it wasn't there. I believe for some of my patients my son's death made it harder for them to terminate. Perhaps they felt a need to stay with me, possibly, as replacement children—and I tried to be vigilant about monitoring my wish to keep them.

When I am distressed, unhappy, confused—any state of emotional disturbance—I write. Writing helps me clarify what's going on with me. Dreams bring unconscious facets of myself to my attention. Writing helps me sort them out. But I didn't write about my son then, not until now. I told myself I didn't want to use him that way: surely I could have written just for myself. But I didn't. Instead I continued to plunge myself into my work, and my husband did the same. We talked about our son a lot together, retold stories about him that made us laugh—we missed him terribly, and this was a way we kept him present. I talked about him with others, so it wasn't that I moved away from feelings or thoughts about him. But I didn't turn to writing.

Mourning, grieving, takes so many different forms. I began a project exploring how analysts thought about and chose to write about their patients. I interviewed 140 analysts, and it took me several years to put the material together. Then a colleague-friend asked, "So why did you do this project? It's not what you usually think or write about." I hadn't asked myself this question; I was just doing it. Instantly, I knew the answer. My son was a reporter, by preference an investigative reporter. I had unconsciously been continuing his life, living out his role in my research. I had found another way of keeping him alive. The realization brought tears to my eyes.

About eight years after our son's death, a former patient of mine returned. She had been in analysis with me as a young adult in her late twenties and early thirties—the age of my son's illness and death. There had been occasional check-ins over the years, but now she returned because she was frightened by the emergence of hostility she did not know how to contain. She was both surprised by and did not understand her unmodulated anger. We worked for several years putting together pieces of herself, her relationships, of affects that she had split and knew of in what she described as "separate stripes." Our work was intense and demanding—gratifying to each of us. We had begun to talk about ending

when she was suddenly diagnosed with pancreatic cancer, a disease that statistically gave her two more years, if that. I was grief-stricken. My analytic child, whom I had known over thirty years—how could she die? She had worked so hard, was so vital, so alive, so much younger than I! How could this be? And while I knew her expected survival time was just a statistic, it was now difficult for me to again wholeheartedly throw myself into hope for a medical cure. But there was work for us to do—and I think I wanted to keep her close, to help where I could. We had explored the vicissitudes of her aggression and her fear of being destructive, and now she was terrified that she had brought this illness on herself. I kept at our task of untangling her fantasies about her power and powerlessness, to try to help her live as fully as she could while she could. Although my patient had not been in treatment at the time of my son's illness, she knew he had died and now his death was alive in her treatment. She was frightened she would drive me away, that she would make me think of him and his death, of my own death, that I would not want to be with her, to work with her. She feared all she would bring to me would be memories of pain and, much as she wished it, she did not really believe I could protect her from dying. If I had those powers, I would have saved my son. So what was the point? Yet she knew she wanted to be with me, to express her fear, her anger, her regrets. She had a good marriage, and her children came to be with her, showing their concern and love. She wept with a newfound sense of intimacy. She had felt unseen by her mother and was intensely self-critical for not attending enough to her own children. It was only in her hours with me that she felt free to say all this.

Her fears and thoughts about dying did reawaken for me the hope and despair of those years of accompanying our son through his treatment. I struggled to keep my focus on her, but of course it was inevitably also on him, my lost child. My grief was revived and intensified. Loss compounds loss. And now I was, of course, older too. Although healthy and energetic, I also thought of my own dying.

Before each three-month scan, my patient was overcome with anxiety; she could not help anticipating a recurrence. Her cancer had been diagnosed early and it was hoped that her chemotherapy and radiation would shrink her tumor, but the statistical likelihood of her survival was so slim. I felt as if I were reliving my son's course of treatment; I knew I had to contain my anxiety if I were to help her contain her own. She did well, resumed teaching part-time, and began an ambitious research study.

The scan frequencies were decreased to every six months. We were working hard together in her analysis. Whatever happened, we both knew we were living this work as fully as we could. In the background for me, though, there was sadness as well as this pleasure, for I could not let myself fully believe that with her it could end differently, that she would not die while I lived on.

But over time, as her scans were clear, her energy was restored—three years from the end of her treatments, it seemed she was cured. It felt miraculous to both of us. We wondered if she were ready to think about ending her analysis. First she said no, but then reconsidered; perhaps it was time. We had done this before, but this time it was different. We were both so much older now. She couldn't be sure I'd still be there if she wanted to come back. I am more than ten years her senior. She really knew now that anything could happen. And if she was not here with me, how could she be sure I was okay? And, of course, someday I wouldn't be, and how could she know? How could she leave me? And how will I bear not to know about her ongoing health and life? She is my analytic child, but she is not mine to keep. How do we ever end with our patients who have grown in our presence? With our real-life children, when we are lucky, we know and can share in their adult lives, but our patients we have to let go and may never know of their futures. But she has asked a question of me: If she was not here with me, how could she be sure I was okay? I tell her I have a list of my patients and their contact information that I leave with a colleague, and she is on it. If—when—something untoward happens to me, my colleague would let her know. “But if you were ill?” she asks. “I'd want to know. Would you call me?” Tears are now behind my eyes. I say, “If I am able to.” She cries. The realism brings the poignancy home to both of us.

When we, when our patients, end a meaningful treatment, we grieve the loss of ongoing contact, but we do not lose what we have found in ourselves and in the other: how the relationship has changed each of us. When a beloved person in our ongoing life dies, the ripples of what we lose are more far-reaching. For me, and for my husband, our work, our ability to be helpful to others, to focus on them rather than ourselves, seemed ways to cope. Yet I realize that in being an analyst, I was also keeping my son with me, initially by working against the grain of my own preoccupying sadness through the immersion in the struggles of others, trying to monitor how and when my grief limited my participation, to recognize when my patients were trying to protect me and limiting themselves; later, I more fully



re-entered my experiences of anxiety, grief, and the fear of impending death with my patient's life-threatening illness.

When I presented this paper at a William Alanson White Society colloquium, Ruth Imber, in her discussion, wondered whether my 2014 book, *Myths of Termination: What Patients Can Teach Analysts about Endings*, was also part of my mourning process. Similarly, when my colleague's question had made me aware of the link of my book *Writing about Patients* (2006) to my grieving my son's death, I was immediately aware that of course she was correct. Interviewing former patients about ending analysis and ramifications over time enabled me to vicariously enter their experiences of grief and assimilation of the meaning this important relationship held for them, what they kept alive in themselves after their analyst was no longer part of their daily lives—what they kept and what they had to relinquish and mourn. The experience of loss of a loved one is simultaneously a unique and universal experience. We can find comfort in bridging our existential aloneness. My work with patients and my writing both provided this comfort for me. I feel fortunate and grateful to have found a profession that satisfies so much.

In analytic work, the personal and professional self cannot always be clearly divided in the way I was taught fifty years ago. But I do believe that keeping our patients' needs, distress, and conflicts central in our attention, and trying to maintain a neutrality when our own conflicts, attitudes, and values are challenged, in order to understand another without imposing ourselves, is an analytic responsibility. That we gain personally—grow emotionally through our analytic work with patients—is an added benefit, but we need to be careful not to let this self-benefit dominate our work.

In this essay I have tried to convey my understanding of the analyst's role in the process of analytic work: conscious decisions about what and what not to reveal, awareness of the inevitability of preconscious and unconscious intrusions, and a commitment to keep the focus on the patients' needs and conflicts. Yet even while we are trying to find ways to both modulate and make use of our intrusions when they occur, we know the inevitably that the personal will encroach. Having an external observer, such as a peer supervisor, adds to what we can see. That is the best one can do, but it doesn't erase our potential blindness. So the pleasure and pain in our work inevitably continues, as does our responsibility to remain both inside and outside the process.

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