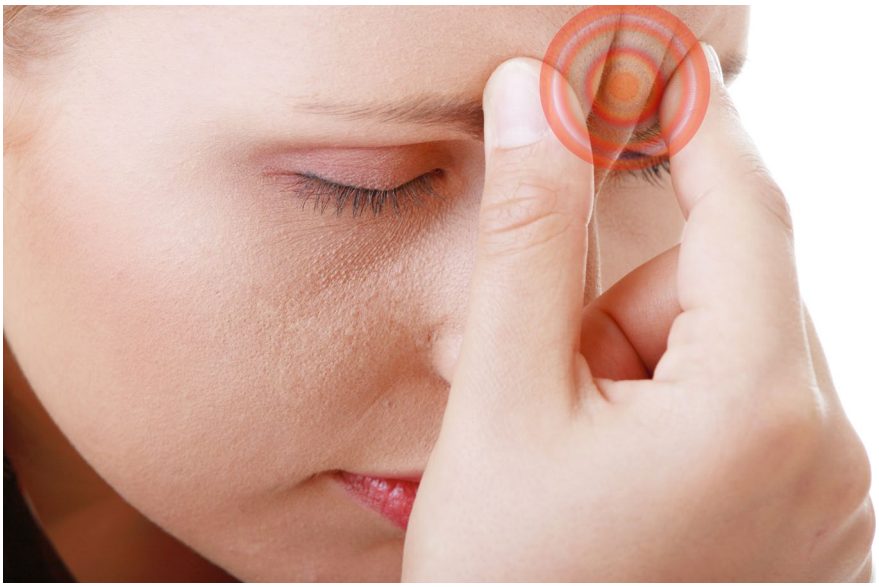
Practitioner Perspective

Love, Hate & Health Professionals

By Dr Coleen Jones



At present we are confronted by a world-wide pandemic, which has placed psychotherapists and other healthcare professionals in a most challenging and demanding situation. The current situation often requires more of caring professionals than what they are effectively able to give. In one way this quarantine period is a creative void, allowing some individuals to rest and reflect, while others are stretched to breaking point.

I have worked for over 44 years in the field of psychology, counselling and psychotherapy. Half that time again I have worked training therapists at university postgraduate level. I currently supervise the work of 'caring' professionals in a wide range of disciplines. What concerns me now is the extent of burnout, loss of life and the tragedy of suicide in a wide range of professionals working under the umbrella of the 'mental health' services. My own training in psychodynamic psychotherapy has alerted me to the implications of caring - caring too much and caring too little – often at the expense of the counsellor, therapist, social-worker, psychiatrist *inter alia* losing their life, sometimes through suicide. Let me refer generically to all 'caring' professionals in all disciplines in this article as 'therapists' and their patients as 'clients'. This discussion is about the shadow side of 'caring'. Often it is a simple misunderstanding of what 'caring' really means. It is a misunderstanding of how the mental state of seriously ill and troubled clients impacts on the well-being of the therapist.

We live in a Western world purporting charitable, philanthropic and altruistic intentions in relation to others. This is a denial of the full range of emotions contained within our palette; both love and hate are present, and they are essential to our work. We need to have access to our fullness of being. It is my belief that we concern ourselves with understanding both love and hate, generically speaking.

We are not living in the realm of *rainbows and unicorns* when we *magically* work with seriously ill or troubled clients, but rather face the blood and guts of turbulent emotions. There is no place for sentimentality. It is dangerous for both therapist and client, and in excess can lead to death. This means understanding what thoughts and emotions get stirred up in the therapist by the client; thoughts and emotions which are often denied. Mostly the hour goes by pleasantly and swiftly. It is the longer-term impact of the work that needs to be understood.

For this reason, I am turning to the seminal paper written by Donald Winnicott called *"Hate in the Countertransference"* (1947, p. 194). If you are reading this for the first time, please consider making a copy

for every professional whom you know including your GP as it may save lives. It is equally useful to parents and practitioners.

Following the atrocities committed during the 20th century particularly the second world war, we have turned towards being 'nice' to others. When what we really need is to be 'real' and grounded as parents, workers and carers. Significantly, Winnicott writes this paper immediately after the war as a powerful reminder. When Winnicott talks of 'love' he is talking generically of those feelings of compassion, admiration, fondness and liking, we mostly have towards our clients. While 'hate' generically includes a range of emotions such as irritation, loathing, weariness, envy or even pure hate. How does the therapist feel when the client arrives late, forgets appointments or does not pay them, but then arrives hungover or flaunting all recommendations relating to his/her health and wellbeing Winnicott says:

> *"the analyst's own hate [needs to be] extremely well sorted out and conscious…however much he loves his patients he cannot avoid hating them and fearing them, and the better he knows this the less will hate and fear be the motives determining what he does to his patients."* (1947. p. 194)

Therapists have their own unresolved, developmental issues which are mostly repressed and/or only briefly touched on in training; mostly because they think they have been drawn to the work in order to 'help' others. In fact, we are drawn to the work because we, sometimes, have our own deep unresolved issues. Jung's idea of 'the wounded healer' (CW16, par 422) archetype comes to mind. We may be trying to fix ourselves, fix a cold mother relationship or attend to our unmet childhood needs. We need to establish a safe space and a secure relationship where reactions that are evoked in working with clients can be processed. How we feel in response to what the troubled client brings us is called the countertransference. Winnicott writes that the therapist must:

> *"be so thoroughly aware of the countertransference that he can sort out and study his objective reactions to the patient."* (1947, p. 194)

It is important that the therapist is in touch with and has worked through issues relating to his/her own sexuality, as it will probably be acted out in some or other way

Donald Winnicott was a paediatrician for most of his life and therefore worked with children who were sick rather than troubled. He had a deep understanding of normalcy and play. It is the idea of creative play occurring in process supervision and in the therapeutic space. Supervision which follows is the essential engagement. The space where clarity emerges, where the therapist can express and understand why she feels irritated by a client who displays grandiosity and eschews the need for therapy and who may even imply that it is the therapist who needs the therapy more! The supervisory space is very delicate though. It can take us into deep, old wounds and can be exposing unless the relationship is totally confidential, well-grounded and the supervisor, a person who has attended to their own old wounds. According to Winnicott it is not possible to be exclusively nice and loving in relation to the work, in relation to others and in relation to clients. The 'nice' clients might stir up envy when they finish therapy/treatment and leave the therapist who is by now tired and drained. A bit like the parent who sees their 20 year-old bouncing out the door on a Friday night for a night of fun, pleasure and sex, with money in their pocket, while the parent is left tired and drained after a week at work providing the backup and where-withal for that pleasure; note that the envy and resentment is denied and hidden under the guise of generosity - "we were like that once". In the case of the 'not so nice' client, the therapist mostly hides the fact that they are overjoyed when the client does not show up or leaves therapy. The therapist may avoid the task of contacting or "grasping the thorny nettle" and working through difficult issues with the client. It is perplexing, for example, when the therapist feels sexually aroused by the client and is pulled into a confusing erotic transference. The therapist might feel mortified to express and work through this reaction with anyone else, but a private and trusted supervisor. In the supervisory space the therapist can begin to understand that the client is probably acting out, acting seductively as a way of avoiding his/her early childhood pain and confusion. It is important that the therapist is in touch with and has worked through issues relating to his/her own sexuality, as it will probably be acted out in some or other way. We may now understand how teachers and

coaches etc have strayed over this line.

Ambivalence is the experience of simultaneous and contradictory attitudes or feelings (such as attraction and repulsion) toward an object, person, or action. According to Winnicott the neurotic client experiences ambivalence as an either/or phenomenon and experiences the therapist as splitting, sometimes loving and sometimes hating them. A healthy individual has the capacity to hold both love and hate simultaneously. A healthy individual might *love* their sister for being warm and personable and be able to tolerate, and at the same time *hate* the fact that she is mostly late or forgets things. Whereas for the neurotic it is an either/or. The psychotic struggles with a confusion of coincident love-hate and flicks between the two states. He/she might be thrilled and grateful for the session but arrive the next time fired up with rage. *"If the analyst is going to have crude feelings imputed to him, he is best forewarned…hate that is justified in the present has to be sorted out"* (Winnicott 1947, p. 198). While unjustified (unconscious) accusations and imputations must be tolerated and not reacted to until enough work has been done with the client. It is obvious that some of the clients' dark or challenging responses and behaviours are active symptoms and usually unconscious. The therapists must dig deep within themselves to tap into a reservoir of compassion for himself/herself, find patience and then work to understand the client objectively while not taking it personally. However, if there is a deep chamber of unprocessed issues within the therapist, the client's behaviour might be like lighting a match in an old coal mine - explosive. Or alternatively take the therapist into realms of dark despair, feelings of incompetency and self-loathing which are implosive.

What my experience has shown me is the fact that in most institutions, supervision degenerates into case management

It is the therapist's responsibility to ensure that resentment does not creep into the therapeutic space. This may happen when the therapist goes seriously over time with the client. In a way the therapist is indulging in the grandiosity of "*aren't I so nice and generous, so as to give this poor wretch more of me*". Or the ego manifests in the attitude "*it's OK with me if you don't call, show up or pay, because I'm really so nice and accommodating*". When the work becomes a charitable or patronising affair, this is dangerous territory. When the therapist is working late and has not enough money to adequately maintain himself/herself, have a proper holiday or engage in refreshing CPD (Continuing Professional Development), this has a deleterious effect on the work and on the mental well-being of the therapist. Where there is over-niceness, too much accommodation of the client, grandiosity in the form of the therapist seeing herself/himself egoically as an expert, points to danger.

Winnicott draws attention to three categories of clients i) those who have had adequate early experiences, ii) clients who have had traumatic experiences; what I call acts of commission, to use a legal term, in other words trauma; bad things done to them. He also refers to clients who missed out on experiences iii) what I call acts of omission. This means that these clients are unconscious and do not know what they don't know and don't know what they are missing or where the gaps are in their lives. This means that they are often developmentally delayed. They present as competent adults but in fact feel inside like terrified teenagers and are often as vulnerable as children. The therapist may be the first person to meet and address these gaps. The therapist therefore needs to stay contained, not go beyond or over-manage boundaries and having access to both the therapist's love and hate; able to hold both and tolerate the ambivalence. It is so important for the therapist to know, name and express their hate in supervision or some safe space, whilst keeping it from being flung back at the client; in other words, being reactive. There is an enormous strain on the therapist who must hold, contain, without lashing out at the client or flinging their pent-up emotions/thoughts back at the client. Winnicott said that it was important to hold on and 'survive the hour' until things could be processed in supervision. For all individuals in the caring professions (that includes police, those in prison and probation services, and paramedics), I personally believe in external private supervision. What my experience has shown me is the fact that in most institutions, supervision degenerates into case management. This happens because it is too threatening to admit to a colleague, a senior or a line-manager in supervision that

one is feeling incompetent, stupid or furious with a client for fear of censure. However, it is those very counter-transferential feelings that need to be aired in order to allow the work to proceed and for both the client and therapist not to feel he/she must be on her/his best behaviour. This allows the client to express vicious, fearful and nasty thoughts and know that the therapist will be able to contain her thoughts, process her emotions and her *bad* behaviour and yet still be empathic, warm and caring.

Winnicott ends the paper by drawing an analogy between the experience of the therapist and a mother, whose young baby (unknowingly and unconsciously) treats mother as a slave, who refuses her carefully prepared meals, bites and slaps her, invades her sleep or private life, chews her nipples, spits things out, expels excretions, drags her off in other directions and yet smiles sweetly at strangers. According to Winnicott *"a mother has to be able to tolerate hating her baby without doing anything [retaliatory] about it."* (1947. p. 202). The parent must eschew sentimentality, not be saccharine, but be willing to hold a line, hold things firmly in place. It is important for the parent to realise that as they set boundaries for the child, that they are providing security and a safe base from which the child can explore the world; such is the nature of good attachment. As the parent monitors their own hate – irritation and exhaustion- it leaves them free of guilt and free to truly love the child. Surprisingly sometimes therapists have the opportunity of seeing a client at a distance in a social context, who is full of beans and laughing excitedly, when all the therapist has seen in the therapeutic space is tears and irritation.

The therapist may believe that they are somehow immunised against illness by virtue of having been through an analysis or having experienced an extended period in therapy during their training

Conclusion

I have distilled some of Winnicott's wisdom as a way of addressing and alerting 'caring' professionals to the dangers of suicide, burnout or death from ill health. At this time of a worldwide pandemic it is absolutely essential that healthcare workers are careful to protect themselves mentally and emotionally from the demands of the work, demands of their seniors and demands of their clients. In some instances, they may feel irritation, exhaustion and frustration. They are unlikely to lash out at the patient or client, but more likely to take it out on themselves by working and pushing themselves too hard. All healthcare workers need to be cognisant of the importance of caring for themselves and their mental and emotional wellbeing.

"It is a struggle to apprehend and articulate the dualistic/ holistic tension and adequately express it in words. Splitting happens so "naturally that it goes unnoticed. These are slippery convolutions of thought, difficult to hold and not unlike R.D. Laing's *Knots*…for example, the therapist may believe that they are somehow immunised against illness by virtue of having been through an analysis or having experienced an extended period in therapy during their training. Therapists appear to have a somewhat omnipotent belief that they are immune to the range and effects of organic diseases and psychical turbulence manifested in the general population." (Jones, 1997, p. 4).

Dr Coleen Jones

Dr Coleen Jones is a psychotherapist and supervisor in practice in Cork. She has worked in the field since 1976 in Johannesburg and in Ireland since 1990. She worked at University College Cork in Applied Psychology for 15 years and subsequently was on the board of ICP (Irish Council for Psychotherapy) and represented Ireland on the board of the ECP (European Council for Psychotherapy) as well as time spent on the accreditation committee and governing body of IAHIP and the supervision committee of IACP.

coleen@coleenjones.com

www.corkpsychotherapyandcounsellingcentre.com

www.coleenjones.com

References

Jones, Coleen 1997*: Psychotherapists and their health; a qualitative analysis of awareness as expressed by a random group of psychotherapists:* University College Cork.

Jung C.J. 1944: The Psychology of the Transference: *The Practice of Psychotherapy*: CW 16.

Winnicott, Donald, 1947 *Through Paediatrics to Psychoanalysis*: Collected Papers: London.

Hogarth 1975: Reprinted by Karnac 1992.

Winnicott, Donald (1971) *Playing and Reality*: London: Routledge.

Winnicott, Donald (1990): *Home is where we start from*: London: Penguin.