Dr. Abigail Golomb
24 Nezach-Yisrael St., 6436105 Tel Aviv, Israel
Tel: 972-3-6964720; Fax: 972-3-6969485
Mobile phone: 972-54-4283967
e-mail: agolomb@post.tau.ac.il
abigail.golomb@gmail.com

How we use Defenses, Time and Words to Cope with the Unbearable

Abigail Golomb(Tel Aviv)

Introduction:

"Unbearable" is a very relative word. As anyone working with trauma knows, we sense trauma differently, and we feel something is unbearable very differently. So we cannot generalize and say that such and such an event is unbearable, because there will always be someone who disagrees. And what we might generally think is just a problem, an issue that can easily be dealt with, could be totally overwhelming and unbearable for someone else. In our profession, we must suspend our own definitions and comprehension and even feeling of what is unbearable and see these only in the eyes, emotions and context the patient sees them. This is one of the most difficult tasks of therapy, as it means taking nothing for granted and inquiring about everything.

But is there no possibility of generalization? Perhaps not about the cause of the unbearable, but about the feeling itself. Starting with the premise that "unbearable" is a feeling, not an objective, quantitative entity. It is a subjective feeling that has a number of attributes: it is overwhelming, it is attacking, and we want to get rid of it. We feel it as an uncontrolled entity, something that takes us over without any possibility of destroying, avoiding or controlling it. The basic urge, which defines itself by its negativity, is that we want to get rid of it. We do not want to maintain it, perhaps not even want to understand it – we want it go away, to be gone, not to burden us, not to envelop us.

This is the issue I will try to deal with in this paper: how do we deal with the unbearable? This question is often asked about trauma, and for many the immediate association with the word "unbearable" will be "trauma". The main difference is that trauma is indeed an event, a happening, a memory – also defined by how one feels about it, but still

beginning with a traumatic event. Whereas “unbearable” is totally an emotion, something that can be connected to an event but also stands on its own. I could spend the whole paper on the connections and differences between trauma, which often creates an unbearable situation or feeling, and the actual feeling that something is unbearable. But for the purpose of this paper, I will again emphasize that I am dealing with the emotion, and how we deal with it, and not with the cause, the original trauma (when such a trauma existed). Unbearable is usually used as an adjective, but in this conference we are dealing with it as an entity, a state, a state of mind and emotion, something that exists on its own, and not just an adjective describing something else.

Unbearable has a sense of time. We probably would not use this word when dealing with a sharp, short-lived event. We do talk about “unbearable pain”, but if the physical pain is indeed short-lived, then it can become unbearable mainly by fearing its return. Our sense of time, when something is unbearable, can be distorted, individual, “out of time” and maintaining a weird existence of its own, refusing to relate to actual, physical time. We can talk of an unbearable memory, but in a sense this is a contradiction in terms, because were the memory indeed relived on the emotional, and not just on the cognitive level, we would not talk about a memory but about an actual, present sense of the unbearable. It is often said that if women really sensed the pain of childbirth, not just as a cognitive reliving or remembering but as the actual physical pain, there would be no second births.

So for the sake of this paper, I am talking about an actual, physical and emotional sense of something being unbearable NOW, and that sense of the unbearable is taking over our whole being, otherwise we would be talking of a specific pain, threat or fear that could be contained and overcome. It is a bit like the difference between fear and panic. And indeed, this would bring us to one of the first defenses against the unbearable, which is trying to transform it into something we can see, contain, deal with, rather than something that overwhelms us.

Patients and therapists alike can feel something is unbearable, and of course this feeling is not unique to the therapeutic setting. People often enter therapy <u>because</u> something has become unbearable. The urge to get rid of the unbearable can be a driving force in life in general and in therapy in particular. Still, there is a certain uniqueness in our role as therapists: <u>we must be able to work with the unbearable</u>, whether it means containing what

is unbearable for the patient or it is containing what is unbearable for us - and the two are not necessarily identical. In other words, many of the defenses against “the unbearable” are denied to us as therapists, leaving a high degree of vulnerability and the necessity to be more honest with ourselves they we might like to be. We cannot repress, deny, dissociate from or disregard this overwhelming feeling; we cannot even “dilute” it in the therapy room, as a means of coping with it. We have to be able to allow it to exist. We can express our difficulty, suffering, empathy, identification - but “the unbearable” has to exist and not be expulsed, in order to do our job.

When I began working as an analyst this issue did not occupy my thoughts. I was trying to learn my trade and do my job. Self reflection centered a great deal on grading myself – had I been good enough, had I met the criteria of my superego, composed to a large degree of the superego of my supervisors, teachers, the whole analytic society. Of course I was also busy wondering if I had helped the patient, but the “real” superego derived from my training. So “unbearable” then would have related to my feelings of failure. When I began preparing this paper, I suddenly was taken over by a series of memories, over a few weeks, all dealing with extreme sadness and helplessness, all dealing with events from 30 to 40 years ago.

To give one example: one of my first patients had a severe phobia of driving, that began after the birth of her second son. She was sure she was a dangerous driver and was afraid she would run over someone, run into someone, and had stopped driving. After 2 years of intensive dynamic psychotherapy it became clear she had terrible issues with her femininity and was terrified by her aggressive castrating drive. She learned to enjoy her femininity, began to drive again, and in her last session happily described her pleasurable desire to have a baby girl, and thought she was pregnant again. A month later she called to say she had had an ectopic pregnancy – of a baby girl – and had had an emergency total hysterectomy. The result was early menopause and of course no chance of having a daughter. She actually called to say that if she hadn’t been in psychotherapy she was sure she would have gone crazy when all this happened - and wanted to thank me. At that time I was grateful to her and felt good, though a little sad for her. But as this 45 year old memory came back it was with unbearable pain for her loss. And an extreme emotional reaction that the therapy was useless and even cruel if it prepared her to enjoy something that was then snatched away from her. The sense of “unbearable” seemed to be a mixture of my present sense of helplessness and the past sense of futility. And – there was nothing I could do. Obviously nothing I could do in the present - but also nothing I

could have done then. It was as if I had buried the futility until a present event revived completely repressed feelings, feelings I had not been aware of then.

This is not the kind of event we would normally think of in connection with the word “unbearable”. Our more common associations would be with much more dramatic and consciously overwhelming events and/or emotions. But all the memories that came back in those weeks were seemingly “small”, as if I suddenly had permission to mourn feelings (how do we mourn feelings? Don’t we mourn people? Losses?) I could not permit myself when they occurred.

Another such example came from my last year of medical training, when I was already aware I wanted to work with children. A baby had been abandoned in the maternity ward – a very beautiful and healthy baby except for a haematoma (a big, red conglomerate of blood vessels) on one cheek. It was inoperable because it was composed of so many blood vessels. I had no sympathy for the parents at the time, certainly no empathy or even an attempt on my part to understand them. I was furious. But it wasn’t my problem – I was just a student – and this baby was someone I hadn’t thought of for years, though occasionally I used this as an example of how different things are sensed as trauma. But now, plunging into the unbearable, I suddenly felt the total grief, fear, and sense of unbearable pain the parents must have felt.

The Therapist, Parent, Child Triangle

A lot of my work has been with children, and for many years I ran a Unit for pre-school children, that catered to two groups: the developmentally traumatized and the family traumatized. We started working dynamically with autistic children when the concept that therapy (of all kinds – speech, art, occupational therapy, etc.), if done intensively enough, could change the development and prognosis of the child, even if the diagnosis remained. In parallel, we assessed children and their families for adoption, removal from home, and high conflict divorce cases. There was an interesting movement in the staff: when they felt they could no longer deal emotionally with the severely disabled toddlers they took “a break” and switched to working with the seriously harmful families, perhaps idealizing that there was more chance of change there, or simply wanting to be able to really talk to the children, and feel what they felt – a major difficulty when working with autistic children. But after a while they would switch back, feeling they

could cope with something nature had created, but couldn't deal with the terrible wrongs some parents were inflicting on their children. The main cry was "how could they do this???" They felt that the most unbearable parts were their helplessness to change the parents or other caretakers, and the strong feeling that this destroyed some kind of basic order in the world in general and the psychoanalytic world in particular – which assumes that a love for your child and the drive to protect your child are ingrown, basic axioms. Somehow there was the hope that if we showed the parents, if we explained to them, if we uncovered their own traumas and "freed" them they would then become good parents, or at least express a desire to mend their ways. In a way, the most difficult cases were the divorce cases of seemingly normal, everyday people who could be our next-door neighbors – when the conflict between them became so narcissistically invested that the children disappeared from their inner space and often from their daily care. Everything was invested in the hate for their erstwhile partner, and the children only served as a conduit for this or even as weapons to be employed against "the enemy".
"Ordinary" concepts of honor and respect went out the window. To give some examples: one couple was capable of leaving a four year old in kindergarten and not picking him up, even when the teacher rang up, because it was the fault of the other parent; or having a 5 year old undergo a gynecological examination every time she came back from a visit to her father; or pressuring a child to lie to the other parent; or never praising or criticizing a child but only the other parent: "I was the one who helped you succeed in the exam – tell your mother how negligent she was!" or "your miserable father is the cause of all the failures and now you are getting to be like him or defend him". I am purposely giving only examples of emotional abuse and not physical; in these cases we sometimes longed for physical abuse so we could prove to the court the child should be removed from home. Each of these examples was seen as a nonsignificant event by "outsiders" – and we began to treat everyone who didn't see the damage as we did as an outsider. We dealt with these unbearable situations by closing ranks, feeling we were the only saviors, and were helpless, useless saviors at that.

The possibility of reacting as a group, of having group support, of sharing your feelings and knowing that others feel as you do – is a common way of dealing with the unbearable. Unfortunately, this is a luxury denied to us in the therapy room. We can share later, up to a degree, but there is not the feeling of belonging to a group. The best we can do as individual therapists is share the loneliness, which means first of all admitting the

loneliness and secondly admitting that this makes the unbearable all the more unbearable, as there is no one to share the burden with. One can talk about it – in fact, one should talk about it, but this is very different from living it with other people. This is one of the major difficulties of our profession – having to be the recipient of the patient, the reactor to his feelings, the analyser of the interaction, the metaboliser and the responder. And in all this to remain at exactly the right distance from our own emotions – a distance that permits us to transmit them in an authentic, convincing way but not so close that we are caught up in the emotion, at the risk of being enmeshed with the patient. Jonathan Sklar discusses this a great deal in "Landscapes of the Darkness". This is not unique to "the unbearable", but almost by definition the unbearable means that we have difficulty dealing with it, otherwise it wouldn't be unbearable.

Working with children adds a conflict of hope that there is still time to right things, with the pain when a child is damaged and cannot be fixed. Any chronic condition, especially in a developing child, is a burden, and any burden has to be borne. Also, the immediacy of work with children brings us constantly into more immediate contact with primary feelings, undiluted by words, which are less used with children, making the whole process much less consciously intellectual.

So what happens when we work with autistic children? This is entering therapy with a preconception of something unbearable – it is not something that hits you suddenly during therapy. And there are always the parents, and how they are dealing with the unbearable situation of having a severely damaged child, with the particular difficulty of not being able to communicate with him, not getting the normal responsiveness that makes us feel good when we comfort a child, or hit the nail on the head understanding him. The parents feel basically helpless, as there are no clear criteria when they are doing the right thing, and they react on a spectrum beginning with overactivity and filling every crevice of the day with "something" – to underactivity and nothingness: becoming depressed, hopeless, inactive and seemingly distant and uncaring. Basically, the therapists have the same mechanisms at their disposal. Some are constantly doing, both in intensity and timewise; and some use the definition of therapeutic neutrality to neutralize their feelings, when these are too unbearable. There is also a tendency to project the part that is unbearable – the parents onto the therapist and/or the therapist onto the parents; and the child is often a recipient of these projections, when we assume that he is feeling all the things we intellectually expect him to feel, from suffering to indifference. We certainly assume that the situation is unbearable to the child, even though we

intellectually know that the very definition of autism in some way protects him from feeling loneliness, being different, etc.

We project not only emotions but expectations. We often build up an inner image of how parents should be feeling, based on what we feel and cannot accept, or what we feel we should feel but are not feeling, due to our defenses. We are then pleased with the parents or furious at them for living up to or not living up to our expectations. Thus we dilute the unbearableness of the child's situation into a more intellectual one with the parents, who often do the same with us. This is not just "common" transference-countertransference. It is an expulsion of an unbearable feeling. Is it unbearable because we feel spectator's guilt? That they have such a child and we do not? That we are not sure how we would deal with this, and don't want to look into ourselves? Or are we projecting existential anger that such things happen to a child onto the parents, the world (often the gynecologist, the health services, the doctor who did or did not diagnose the condition)? Anything to avoid dealing with the unbearable thought that we may achieve nothing, in other words the unbearableness either of our own individual helplessness or the helplessness of our profession.

Again an old memory intruded: a mother whose child had been diagnosed as autistic when this was considered untreatable. When we began intensive work with autistic children her son was invited to join. The parents were completely poker-faced, where we had expected joy, gratefulness, or perhaps anger and depression that they had not been able to give their child treatment earlier. They were very cooperative but the mother continued her "blank-face" communication. I finally asked her what she was feeling. She responded: "I'm angry at you because you've given me hope! We had finally come to terms with the hopelessness of our son's situation, had done our mourning. And now you have put us in the territory of not knowing! We have hope but no certainty, and I have to open up all the wounds I thought I had closed!"

In general the staff had two prototypes of reactions. There were those who needed a messianic approach, a kind of religious inner belief that they could and would cure the child. If they didn't have that kind of personal narcissistic belief they projected it onto the Unit, believing and proclaiming that this was the best, sometimes saying the only, therapeutic unit that could save the child. The opposite extreme was setting very small, almost microscopic aims, saying we would achieve that and then go on to the next microscopic step, thus creating aims that seemed achievable and bearable, rather than so overwhelming that it was impossible to even start work. When therapists worked with parents, it was much easier when the parents had the

same defense patterns, otherwise it was fair ground for endless criticisms and projections. It seemed as if the dyads with the same defenses were a good working partnership, but often this was just collusion aimed at denying the unbearable. The words seemed to be of a sharing, comforting quality, but in effect they were a coverup. And this brings us to a major difficulty in our profession: the use of words. These are our tools, and we become very proficient using our tools. True – the preconscious and unconscious world are seen as our main field of expertise, but we can express them and deal with them almost exclusively through the use of words.

Working with the parents, or seeing the parents through our eyes, or imagining the parents through the child's eyes – all these create a "third" presence that can help to examine the intimate dyad of the therapy room. I am using it here to examine the defenses we use, as they often get exposed through the tryadic relationship, whether through recognizing them in ourselves or seeing them in the parents. It would seem that parents of autistic children, who have such a clear and "objective" burden placed upon them, are quite different from abusing or neglecting parents, who have themselves placed a burden upon their child. Each situation enables us to create our defenses and externalize our own very difficult reactions to the unbearable situations we are presented with. These defenses are no different from the ones we develop and use with all our patients, and therefore can serve as a kind of mirror, a laboratory that enables us - in fact, forces us – to look at our defenses instead of just hiding behind them.

Parents will often verbalise what patients won't. They will throw their anger at us, they will attack and criticize and even threaten. My first lesson in dealing with this came from work I did as a young intern in a cancer ward. I had become very attached to a couple in their forties; the woman's mother had lung cancer. They were very devoted to her and seemed genuinely grateful for my interest in her and my willingness to listen to them too, and not concentrate only on drug dosage etc. They often shared family stories or the chocolates and cakes people brought to the hospital. When the mother died, they attacked me verbally, in a combination of rage, fury and despair. I fled in tears to the Head of the department, who said in a very down to earth tone of voice: "does anyone pay you a salary to be thanked? They have nobody else to be angry at! They don't believe in God or have any other belief to sustain them! So your job is to hear their despair – really hear it!!". This was my first lesson in containing and bearing – and I remember it better than any analytic text I have read since. But it also emphasizes the narcissistic aspect of our work, and how often what is unbearable also has a narcissistic component.

How do we cope?

It is essential to look at two concepts we see as basic to our work: identification and empathy. These are seen as tools of our trade (along with words, which I will address later). I will not discuss these terms, for lack of time. I am sure we do not all have exactly the same definitions, and certainly don't have the same emotional attitude to these terms. But we all accept them as positive attributes, something a therapist must have in order to do his work. Overidentification, enmeshment, lack of boundaries, rescue fantasies – these are all negative concepts that are an "overdoing" of our "good" therapeutic position.

We function in a territory of uncertainty and not having clear answers. Combine this with constantly being on guard for our boundaries and also constantly having to absorb/contain/accept and we are *a priori* in a situation that can become unbearable. Add to this an "objective" situation that is frightening or hopeless – and our coping and containing are at risk before we've even started developing a therapeutic relationship. This is why "Helping the helpers" has become a major component of work with longterm, traumatic situations or overwhelming ones. For instance: the mental health professionals who accompany people who identify their loved ones in the morgue; those who give first line emotional support to people pulled out of a destroyed building; those that work regularly with dying patients or severely disabled ones or children suffering from cancer – all these mental health professionals have a major difficulty with emotional boundaries. They have to keep their perspective in order to be able to do their job - not to be compassionate onlookers saying how terrible everything is. They have the task of containing, of making sense out of the unbelievable, of taking part of the unbearable burden upon themselves. They have to feel contained in order for them to contain others. Often containing is the only thing we can do – something we hate to admit, even though we are supposed to be a supporting rather than a doing and controlling profession. Supporting workers in the morgue may be easier because death is such a clear fact. But supporting indefinite unclear situations makes people want to turn them into clear situations – and part of our job is to help them (and the helpers) accept that clarity is not the reality - uncertainty is. And reality cannot be changed by oversimplification, overidentification, or saying the right words and not meaning them. It is impossible to maintain this position without a very strong outside support system. One of the things that happens to us when we are overwhelmed is that thinking is attacked and

emotions take over. We can encourage the patients/clients/victims to allow their emotions to flood them, but we cannot allow ourselves this, and yet we must remain feeling, empathic, understanding, authentic – but at a distance. Creating this distance can be unbearable in itself, and needs outside support, containing and objectivity.

These are also social issues. How do the nuclear family, enlarged family, society deal with these issues? What is accepted behavior and what is considered crazy or frightening? One could take funerals as an example: are people quiet? Do they weep loudly? Do they tear their clothes? Obviously, if you are silent and restrained when the culture expects loud expressions of grief people will criticize you, and if you are extremely distraught when everyone else is silently communing with themselves you might be thought crazy. But these extreme examples extend to the therapy room itself, and to the reactions of colleagues to our behavior. Do we comfort a grieving patient? Is this human empathy or a breach of boundaries? Are we doing what is best for the patient or are we doing what enables us to deal with an unbearable situation?

What about words?

There are two components in our work, that apply equally to bearing the unbearable: what we think and feel, and how we convey this. In our work and in talking about our work we use words and we put great emphasis on choosing "the right words", at the right time. In recent years there has finally been a lot more emphasis on how we convey these words, what emotion underlies them, how we pick up on the patient's state of mind and how we communicate ours. The nonverbal communication is a major element. When addressing the unbearable, the split between words and emotions and the need to integrate them is even more extreme. Words are necessary for us to organize the world; words are necessary for us to communicate with others; they are one of the most emphasized achievement of mankind. But as analysts we should know that anything we become skilled in using we also become skilled in misusing.

When a child is presented with a statement and an incongruent emotion he will always react to the emotion: a mother and child, hand in hand, walk down the street and see a dog. The mother grips the child's hand tightly, shaking a bit, and says: "there's nothing to be afraid of!" you can be sure the child will learn to fear dogs….. if we say "no" to a child in a playful voice, he will be sure it is a game and not a forbidden act.

Polite society uses euphemisms, encourages not speaking the whole truth, avoiding unpleasant issues. We all come from a certain society, had family unwritten laws which words were acceptable and which were not, and what subjects were dealt with directly and which were adapted to a different language. Again, the words used for death vary not only from language to language but from culture to culture, from family to family. We often don't realize to what extent children take us literally; they look for their dead father out of the window of an airplane, because he is "in the sky". And when they are taken to the cemetery and explain that dead bodies are eaten by worms the adults are horrified and the child doesn't understand why. I worked with children whose homes had been bombed out during the Gulf War. We encouraged them to draw – a classic technique with children – and they all drew pictures of the the rockets and Sadam Hussein and destroyed houses. But when I asked a group of 7 year olds what had destroyed their homes they looked at me in amazement that I even asked and said "the thunder and lightening!" (most rocket attacks occurred on stormy winter nights). Obviously, we had been giving them a technique but not dealing with their trauma…..

Children and patients alike pick up on any incongruity between our tone and our words, between the structured sentences and the accompanying emotion. Patients will often resent "neutrality" – usually when neutrality is not a state of mind but an emotion, that they feel as our defense, our denial, our lack of ability to contain them. Or we express ourselves badly, feel we couldn't find the right words, review a session and feel that our words were not organized or elegant – but the patient got a great deal out of this session. Probably those were the authentic sessions, where we were truly groping for contact, understanding, sharing – and not presenting a highly polished finished product.

My last example is from a trial of group dynamic psychotherapy in a class of clinical psychologists. They described this as a very moving experience, and "measured" the emotion by the degree of tears in the session. No tears equaled a "bad" session and everyone crying meant it was a "good" session, in their words: an emotional one. They felt they were really "exposing" themselves. But gradually they could reflect that each one of them had brought a very significant experience from their past, but something they had already worked through in their individual therapy, something they related but did not relive. In retrospect, they made no personal discovery from relating their unbearable situation in the past. And the tears seemed to be no different from reading a sentimental book. The

stories were "true", they were "authentic", but the emotions were not immediate but retold.

In other words, we digest and incorporate events and emotions into something that we can live with, but in telling about it we are not at the acute, overwhelmed, unbearable stage. We remember it was unbearable but we no longer feel that way. The words sound the same; in fact, they are usually better organized and more clearly conveyed. But they do not really convey any sense of unbearable, and our listeners – the patients – can sense this and sometimes feel betrayed.

In Hamlet, Claudius, his wicked uncle who had killed his father is communing with God. This is portrayed in many ways on the stage, from a sarcastic dismissal of remorse and retribution to a real sense of doubting. He finishes his monologue with the words: "My words fly up, my thoughts remain below. Words without thoughts never to heaven go". (Act 3, Scene 3). To paraphrase in analytic terms: "words without thought never to patients go."

Our use of words is our best tool and our most dangerous defense. We can use them for denial, dissociation, projection, etc. We discuss the use we make of words – with words, making it doubly difficult to really critique and review ourselves. We have to learn to put them in their place and combine them with the emotions they are meant to express or accompany. Gerald Moore, a famous pianist who accompanied some of the most celebrated singers, wrote an autobiography he titled "Am I too Loud?". It combines a respect for his profession with a degree of humility and a strong sense of boundaries….. something I think we could all learn from.

Epilogue:

This is really a work in progress, where the theme of the Summer School made me think, associate, despair, give up, and then conclude that maybe that is what I should write about. There was something in writing for the Summer School that allowed me to be vulnerable, to let memories and feelings and ideas and associations just flow, hurt, surprise. Part of it was probably missing Tamara and feeling the frustration that she couldn't see this project to its end. Part of it is the atmosphere of really thinking that I have experienced over the years in the PIEE: not reciting or teaching or preparing learned texts but having to come to terms with the essence of psychoanalysis, with the questions what makes it work, when doesn't it work, and how we survive in this weird and demanding profession.