The loss of illusions. How does the analyst mourn?

Marc Hebbrecht[1]

In 2001, an Italian film came into circulation that nicely illustrates today's theme. What does a psychoanalyst experience when he is suddenly confronted with a traumatic loss in his private life, and how does it affect his professional functioning? This is a first question that will be addressed in this presentation. Next I will address the question of what specific loss situations and disillusions psychoanalysts face during their careers?

First something about **the film *La stanza del figlio (The room of the son)***, in which the director Nanni Moretti plays the lead role of the psychoanalyst. Giovanni is a successful and renowned psychoanalyst. Together with his wife Paola, they lead a harmonious family life with two adolescent children, a daughter Irene and his youngest son Andrea. Giovanni has achieved a nice balance between private life, family time and his career. A minor crisis arises in the family when it is revealed that the son has stolen a fossil in the university which his father Giovanni finds hard to believe. Giovanni also regrets that his son is not competitive enough without being derogatory about this, but he cannot hide the fact that he is prouder of the eldest daughter who wins beautiful victories with her basketball team. One Sunday morning, Giovanni was supposed to go jogging with his son but because a patient of his is acutely appealing to him, Giovanni decides to cancel the appointment with his son and visit the patient at home, a decision we would consider a countertransference enactment. The son Andrea goes diving, which becomes fatal for him. Andrea's accident is a shocking event for the family with major consequences: the daughter is devastated by the loss, breaks up with her boyfriend and cannot control her aggression during sports games. All family members are less available to each other because of their suffering. The family fails as a container for each other and for the psychoanalyst. Giovanni is not able anymore to do his analytic profession as expected. With some patients he becomes over-involved, bursting into sobs when a patient expresses her sadness because of lack of children. With another patient, he

[1] Dr. Marc Hebbrecht (MD) is psychiatrist, psychotherapist and psychoanalyst. He is the president of the Belgian Psychoanalytical Society since 2022. He is a training analyst working in the University Psychiatric Center of the Catholic University of Leuven (KUL) and in private practice. E-mail: marc.hebbrecht@telenet.be

reacts angrily. The loss causes an impairment in his professional role that is keenly felt by some patients. A schizoid man who was not really in touch with his emotions feels grief for the first time. Another patient places himself in the role of therapist for the analyst. Yet another patient remains silent because he does not want to burden the analyst with his emotions. Finally, there is the patient who does not accept that Giovanni can no longer cope with his work and reacts angrily. Giovanni can't stand a patient any longer because of the constantly alluding to his son's death and then apologising for hurting his analyst, a quite typical symptom of obsessive-compulsive personalities. To solve his problems Giovanni seeks advice from a colleague but he fails to maintain analytic neutrality and cannot offer sufficient containment to his patients anymore. Giovanni is not able to adequately contain, metabolise, or symbolise his grief. He becomes emotionally incontinent and fails to reflect on what is going on inside himself. A turning point comes when a former girlfriend of the deceased son, asks to visit the family and revisit the son's bedroom. She symbolises the reunion with the son. The entire family takes the girl and her new boyfriend across the French border by car. The car journey is their way of mastering the trauma of loss; now they master the departure of the girl. The psychoanalyst and his family are no longer passive victims of the loss that has overwhelmed them.

Psychoanalysts, like other people, are not immune from traumatic losses such as the death of a child or the unexpected departure of a partner. Apparently, psychoanalysis does not immunise against pain when reality breaks in relentlessly. Illusions are undermined such as those of invulnerability and the fixed belief in transmission to the next generation. Often colleagues enter psychoanalysis because they hope to gain mastery over painful feelings and to achieve an omnipotent position in relation to loss and disillusion, only to discover that through psychoanalysis emotions become more intense but can also be contained or shared with others. An analyst cannot place himself complacently above grief and loss but must acknowledge how dependent he is on others, subject to passionate feelings and powerless about the transience of existence. He cannot deny this universal truth. Giovanni's illusion of living on in his only son and thus become immortal is undermined. The film portrays the consequences of a traumatic loss for an analyst and his patients. The analyst is involved with his totality as a person in his professional functioning, which will inevitably affect his patients when faced with a traumatic loss. Our professional

functioning is partly influenced by the quality of our relationships, the stage of life we are in and our life circumstances. It is an illusion that our analytical instrument would be an immutable and constant fact. Our analytical function is a variable which is influenced by factors such as trauma, loss, passion, relational well-being, the holding function of a family and the atmosphere within one's own analytic society.
How can we emotionally survive when we ourselves as analysts are faced with the illness of a child or a close family member? How does it affect our work attitude and countertransference? Close contact with colleagues from one's own analytic society can offer support and reduce the feeling of isolation. When the analyst himself is in crisis, at times he feels disengaged with the patient. Often this is subtle, he does not consciously feel this, but it is keenly felt by the patient. As in the film, a therapist can become resentful when he must take care of another person and needs help himself. Our patients unconsciously sense how we function or dysfunction in our profession. Sometimes dreams of the patient bring the therapist's dysfunction into focus as Van Lysebeth-Ledent (2016) and Ferro (2019) have described. The analyst's receptivity is often more crucial than his verbal interventions. It makes a lot of difference whether the analytic stance is receptive and concave or convex and dismissive. The quality of the psychic functioning of the analyst is a variable in the analytic field and will help determine whether the patient will develop or dysfunction.
It is a difficult and delicate issue to what extent the analyst can be self-disclosing when faced with personal suffering. It will partly depend on the personality organisation of the patient. If the patient is very vulnerable to abandonment, maybe it is better to honestly say what is wrong with us and refer the patient to a colleague. If we become seriously ill ourselves, inevitably we are anxious and preoccupied with our own physical health which makes us less available to the patient. But it is also difficult to be honest with our patient when the medical doctor of the analyst has not yet decided on a clear diagnosis, prognosis, or treatment plan. Can we burden our patients with our own uncertainty? It is important of being able to consult with a colleague in these circumstances. Some patients will ask us pointed questions about our functioning and availability that we find difficult to treat as analytical material because we are too preoccupied with our own condition.
Therapists and psychoanalysts inevitably face loss experiences such as retirement, ageing, loss of status and illness. Our losses include not only deaths and divorces but also the conscious and unconscious loss of our romantic dreams, impossible

expectations, illusions of freedom and power, illusions of security, the loss of our young self that thought to be wrinkle-free, invulnerable, and immortal. Sometimes psychoanalysts underestimate the impact of losses. It is not rare to look for comfort and reassurance from the patient, which is understandable, but which reverses the relationship. This is a real ethical problem when the patient becomes the therapist of the analyst.

Let me also briefly address **mourning over lost illusions**.

A disillusionment is like falling out of the world, no longer feeling solid existential foundations which is accompanied by a deep sense of groundlessness. The crisis of falling away from foundational illusions is the hallmark of trauma. In trauma, the security assumed to be true of interwoven illusions is torn. The sudden loss of supporting illusions confuses people, the holding is no longer there, the world cracks open to reveal a fundamental lack of coherence. As we face the future, we wonder anxiously: where will we land? Will it be like this forever? What we firmly believed in turns out not to be true. Psychoanalysis deals in illusions and so mourning the crumbling of illusions is a typical theme in our work. Our patients can only discuss this if they can maintain the illusion that we are invulnerable and constantly available.

Psychoanalysis as a profession also faces painful disillusions that it must bear, process and work through. For instance, there are analyses that fail or do not produce the expected results. This may have to do with self-overestimation of the analyst based on rescue fantasies. It may also mean that the patient's demand and personality dynamics have not been properly assessed.
Until the 1970s, psychoanalysis was in a smug intoxication of being at the centre of psychiatry. We have painfully abandoned this centrality illusion. The current reality is that psychoanalysis has lost a lot in the multidisciplinary scientific debate and mostly at the university. Physician assistants in psychiatry are often told that psychoanalysis is detrimental to their careers. But it is striking and hopeful how psychoanalysts remain enthusiastic, vital, and active into old age.
Patients increasingly demand psychoanalytic therapy with an analyst after several disappointing experiences with short-term therapies, while they find it difficult to find a psychoanalyst who has a place at short notice.

Another disillusionment has to do with unrealistic goals about what is achievable and what is not. Illusion and disillusion are central concepts in psychoanalysis. An illusion is about a dream image or notion that we believe corresponds to reality or that we would like to see realised. Illusions as hopes are more appropriate for youth. As we get older, it is not uncommon to face disillusions and mourn the loss of wishes that have not materialised.

Disillusionment is a universal theme, peculiar to human existence and have to do with loss experiences and the abandonment of omnipotent fantasies.

Psychoanalysts may be weakened in their professional role by illness or shocking life events with a resultant incapacity to provide the patient the necessary holding and receptivity.

For example, an analysand's suicide is an extremely painful event for a psychoanalyst. In our current times, there is a fear that the family may initiate legal proceedings because they think of the possibility of a mistake and want to hold the analyst civilly liable to get financial compensation. This is extremely stressful.

Moreover, the analyst also faces specific disillusions that the work entails. The therapist may get stuck in identifications with certain patients and their inner objects. With psychotic and borderline patients, it is sometimes difficult to find the right balance between being terrorised (then we are too close) on the one hand and feeling pity on the other (then we are too detached). John Steiner (2016) advocates an ironic view. According to him, during our therapeutic work we constantly alternate between participating in and observing the drama of others while at the same time living our own drama. An ironic vision implies that we appreciate both sides of the conflict between reality and illusion, that we can occupy both points of view simultaneously: we sympathise, reflect, want to know the truth and we accept illusions to which the patient clings just as we do. An ironic stance presupposes sufficiently mature defences. Irony, however, can also degrade into cynicism, sarcasm, and ridicule.

Often, disillusionment with treatment has to do with rescue fantasies or fantasies that psychoanalysis is the royal an only road to professional self-fulfilment. Based on my own experience, I think of a talented young psychiatrist who is analytically gifted and asked for 50 sessions of learning therapy, kept very precisely to the number of sessions agreed, and ultimately chose not to go into further psychoanalysis. I felt disappointed. On closer inspection: why should anyone be passionate about the

project I was obsessed with as a trainee? The colleague concerned wants something else and I should respect this. It is not easy to accept that the next generation chooses a different path. Analysts who invested a lot in their training and their professional development are much tempted to conceive and to raise analytical children for a long time. This illusion keeps us young.

Similarly, it is an exaggerated expectation that psychoanalytic treatment provides lifelong immunity against future psychological suffering. Not all difficulties that crop up in life are repetitions of past dynamics. Analysis can mitigate the painful and unexpected disillusions that life inevitably brings only to some extent. But it can lead to a more courageous attitude that helps one face reality and not just be enchanted by illusions.

In his latest book, André Green (2010) describes 12 clinical cases of long analyses (some lasting more than 20 years) that disillusioned both the analysand and the analyst. Often these were socially isolated people with narcissistic problems, whose analysis was the only meaningful relationship. Sometimes these patients had not been recognised in their individuality as children because they had to replace another child who had died shortly before they were born. Or they had to play a therapeutic role for a psychotic, depressed or self-destructive mother. There was often a masochistic attachment to the mother and very few memories of a good relationship with the mother.

The situation occurs when, parallel to the therapeutic process, an illness process takes place that is progressive and not yet acknowledged: think of schizophrenia, dementia, or addictions. If someone does not get better despite psychoanalytic treatment, we should not only seek supervision but also question our diagnosis and check whether there are physical, psychiatric, or social influences at play that psychoanalysis cannot control. The relationship between psychoanalysis and nosology is ambivalent but nosological reassessment is necessary when analytic processes stagnate or lead to regression.

The training situation may underlie disillusions. A famous training analyst refers a patient who is heralded as particularly gifted while the training candidate feels he will not be able to work with the patient in question. Training candidates then face a dilemma: how to treat someone with whom there is no good match? Does he dare refuse the patient or does he fear upsetting the training committee? Being able to disillusion the analyst is necessary during the analytic process. The patient who is the

son of a father who constantly belittled and humiliated him will be tempted to disappoint his analyst in a paternal transference.

It is also an illusion that good care will be rewarded with gratitude and progress of the patient. The analyst is less neutral than he wants to admit. He is also human and may experience the parting of some patients with whom he had an intense and long-standing analytic relationship as a deep loss and therefore not be immediately available for a next patient. Sometimes we underestimate the strength of very vulnerable patients and keep them in treatment longer than necessary. When I left the hospital, I gave a few patients who seemed very vulnerable an exception and assured them that they could continue in my private practice. It did require more effort from them. To my amazement, they let go of me without much difficulty and appear to be quite well.

There is not always agreement between the goals of the patient and those of the therapist. A manager with recurring problems in relation to his employees may come to therapy with the hope of acknowledging his difficult position towards employees he calls incompetent. While the psychoanalyst's main aim is to explore and understand his narcissistic issues.

Some analysts cherish the illusion that they can work into old age and only get better with age. Illness can lead to the therapist not working properly and no longer being able to assess one's own abilities realistically and critically. The patient may suffer as a result. The sicker one is, the less responsible one feels for one's patients. Signs of dysfunction include falling asleep, forgetting, or cancelling appointments, boundary blurring, taking poor care of oneself, discussing private matters with the patient, or making statements about colleagues. There is a danger of using the patient to satisfy one's own needs resulting in boundary violations. Major illness is often denied and conversely, we see a role reversal developing where the patient wants to take care of the sick or injured therapist as I illustrated in the clinical vignette. Because of the power of transference, the patient cannot face the fact of the illness of his analyst. Out of loyalty or guilt, he does not dare to abandon his therapist even when the therapeutic relationship is over.

Fortunately, this problem has been intensively discussed in psychoanalytic societies in recent years (Junkers, 2013). But the fact remains that the evaluation of fitness to practice is done more rigorously at the beginning of the career while at the end of a career, there is no examination of whether a therapist is still fit for the profession

unless serious boundary violations occur. The psychoanalytic profession is increasingly becoming a profession of late adulthood; most of us have already had a career as a psychotherapist before applying for psychoanalytic training. Now it often happens that someone waits too long to apply for analytic training and regrets not having done it earlier. Especially in Western countries, candidates apply too late for psychoanalytic training which is unfortunate because it leads to an aging of the profession.

To prevent disillusionment, we must consider who may benefit from psychoanalysis and which patients are indicated for psychoanalysis. It is advisable for the analyst to recognise patients who can create impasses. Even if they contribute to disillusions, these patients too are entitled to treatment. However, it is advantageous that the analyst can foresee to some extent what developments can be expected. He should reflect on goals, question the evolution of patients, and seek a second opinion in case of deterioration. It is not always about negative transference. The main message does remain that psychoanalytic work is not possible without disillusionment. The psychoanalytic method challenges people's illusions, which hurts... pain against which they defend themselves by disillusioning their analysts.