Psychological Research (in the Balkans)
Volume 25, No 3, 2022, 183-196
ISSN 1311-4700 (Print); SSN 2367-9174 (Online)
http://journalofpsychology.org; E-mail: psy_research@abv.bg
DOI: https://doi.org/10.7546/PsyRB.2022.25.03.01

A DAY IN A LIFE: THE MIND OF THE ANALYST AND THE THERAPEUTIC PROCESS DURING THE WORKING DAY[1,2]

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Abstract. *This paper presents closely and directly as possible the therapist's everyday work with several patients, within the framework of a working day. The clinical material is accompanied by ongoing reflections, simultaneous and after the fact, on the development and specificity of the therapeutic process. The author advances the idea that the exploration of the working day, viewed as interactional mental field, is a legitimate and useful tool for the study of the therapeutic process, particularly those aspects related to the therapist's professional and mental functioning, referred here as "the mind of the analyst"***.**

The focal point is the possibility to see how untransformed psychic experiences produced between patient and psychotherapist during a particular session, create "mental residues" in the "mind of the analyst" and to study their fate all through the day. Although, the approach is predominantly therapist-centered, according to the concept of the field, it also presents important information on the workings of the minds of the patients, the vicissitudes of therapeutic interactions and ultimately, on the nature of psychic transformations. In the conclusive section, some broader applications for the clinical practice and research, related to the study of the working day are suggested.

Keywords: mind of the analyst; case load; interferences between sessions; therapeutic field and psychic transformations.

[1] **About the paper**
Written originally in English by the author. Not previously published

[2] **Protection of patient's privacy:**
The disguise used in the paper is, by omitting concrete characteristics of patients (names, age, physical features, profession and other easily recognizable features). No compromise has been made with accuracy of therapeutic process. None of the presented personalities are currently in treatment, and none of them are colleagues, two patients though, are related to helping (medical) professions. Oral permissions obtained by both of them.

The article can be cited as follows:
Todorov, O. (2022). A Day in a Life: The Mind of the Analyst and the Therapeutic Process during the Working Day. *Psychological Research (in the Balkans)*, Volume 25, Number 3, 2022, 183-196. ISSN 0205-0617 (Print); ISSN 2367-9174 (Online). DOI: https://doi.org/10.7546/PsyRB.2022.25.03.01

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Received: *September 30, 2022*
Accepted: *December 26, 2022*

The author has read and approved the final manuscript.

A Day in a Life: The Mind of the Analyst during a Working Day

Psychotherapists, as almost all other professionals, use their personal abilities to work in the most common socio-economic temporal setting - the working day. With few exceptions, under the headings of caseload (Greenson 1974; Spero 2010; Tögel 2009; Waugaman 2003) this setting is seldom discussed or studied in detail in the psychoanalytic and psychotherapeutic literature.

This article is an attempt to present a therapist's everyday work in an experience-near kind of way, accompanied by reflections on the working process, both as they occur simultaneously during the working hours and as afterthoughts.

Trained as a psychoanalyst, I am using language commonly used in psychoanalytic conceptualizations of the therapeutic process, but I believe the described phenomena have wider applications.

In this preliminary study I am looking at the working day as a mental field, broadly defined in analytic field theory (Brown 2019; Civitarese and Ferro 2013; Ferro & Basile 2009) created by subjective and intersubjective experiences between therapist and several patients within the time span of the working day.

Here I am predominantly focusing on experiences of the therapist/analyst in the therapeutic situation, but the approach is sensitive to the experiences coming from the outside of this situation, referred to as "between sessions" (Raphael-Leff 2002).

The focal point of my approach is the possibility to see how raw, unformulated psychic experiences produced between patient and analyst during a discrete session, create "mental residues" in the mind of the analyst (and in the field) and to study their fate. Among various possibilities, I will delineate two general scenarios. The residues are used as important informative elements that after mental transformation serve for the production of meaning, as Ogden (1997, 1999, 2004) has demonstrated, concerning dream states and reveries occurring during treatment. Alternatively, they remain untransformed and thus interfere in the process and take part in various mismatches and enactments (Cassorla 2012; Maldonado 2014; Tuckett 1997).

Whilst this is a predominantly therapist-centered approach, according to the conceptualization of the field, I assume that it also gives us important and reliable information on the workings of the minds of the patients involved in the field (Baranger and Baranger 2008; Schwartz 2013). The following material represents my personal working day, which involves both psychoanalytic and psychotherapeutic sessions[3].

The working day
Monday

Mrs. A (analytic patient) 9 o'clock

The Patient had missed three previous sessions due to work engagements abroad. She paid for the previous month at the beginning of the session as agreed and lay down covering herself in total silence. At some point (after 10 minutes or so), she told me she had dreams she couldn't remember and went back into silence.

It had never been easy for me to keep silent with this patient with a very early separation trauma. My anxiety was mounting; I was struggling with some fixed ideas about broken connections, projected ignorance of my whereabouts, vengefulness for feeling left out… I felt calmer when my mind started wondering around her forgetfulness of dreams. My curiosity prompted me to think about unconscious seductiveness, or better invitation to be curious about her.

[3] The day was chosen randomly (impulsively actually). It happened to be a Monday in mid - January. All the important significations of the first day of the week, closely after the winter holidays, pay day for some patients etc., came into consideration after the fact. All the sessions are reconstructed on the following morning after written key notes taken between sessions.

Well into the middle of the session, she did say in an apologetic way that she was surprised of that silence, but she could not help it. I said, that there had to be some contradictory thoughts and feelings she was struggling to resolve, after some missed sessions. This intervention did not bring any visible change and we plunged into silence again.

Suddenly my anxiety gave way to a calm desperation as if I had given up on linking with parts of myself. I did not feel persecuted, excited or tormented… I had a reverie[4]. I was looking out of the window (in reality, I cannot do that from the position of my chair) straight into the neighboring concrete buildings and in the gray cold morning the opposite rooms looked poor, uninviting and too brightly lit by naked bulbs. The moment I became aware of my reverie I started associating with themes of loneliness, aloofness, and then with an industrial, socialist, hostile environment. Furthermore, even with torture[5]. I felt that in my isolation I started coming closer to my patient's experience in this session. In the session, I did not speak but she did.

"Do you know I looked at "Google earth" to see what is in the middle of the Pacific? I would never go there, to the Island of Palmerston, all surrounded by water, in the middle of nothingness…" Then she sighed loudly.

I spent the remaining few minutes of the session amazed by the overlapping of our dream processes, a situation close to what some analysts refer to as „dreaming together" or "having dreams-for–two" (Andrade De Azevedo 1994; Cassorla 2012). I felt somehow satisfied and relieved. When the time was up, she got up energetically from the couch, smiled and took her leave.

Between sessions:

I wrote some brief notes from the session, which on its own, accumulated some additional pressure, perhaps including quite a few aspects of what after Ron Britton (Britton 1994) we can call pre-publication anxiety. Moments before I opened the door to the next patient, I received a text from Mrs. C, my 11 o'clock patient texting that she would be unable to come.

Ms. B (analytic patient) 10 o'clock

This session started unusually for both this patient and me. On her way in Ms. B. looked at me and asked formally how I was. I smiled politely and answered – fine, thanks – she looked back at me and smiled. I felt we were both surprised by this interaction.

She did not mention explicitly this initial situation after lying on the couch and started to speak about her weekend.

I, on the other hand, noticed my being too polite and accommodating with Ms. B and started wondering about the significance of this mutual enactment. For my part, I thought it could be related to something from the previous session (still unknown to me) as well as with uneasiness coming from the just received text message, stirring anxiety as to why the next patient was not coming. Of course, I was mainly curious about the patient's unconscious motivation for asking how I was.

Ms. B was speaking about a situation that had dominated her life and analysis for quite some time. She had started an impulsive and passionate affair with a married man. Her internal situation was all about very mixed feelings: triumph over an important and in some respects admired rival (the wife was a public figure); guilt toward everyone concerned, the couple, their children, etc. She was talking about being defeated by "a very greedy part of herself", causing her restlessness, psychic pain and somatic troubles. She was fearful that things were going out of control and she was becoming reckless in her expression of this needy love, she felt a jealous and horribly selfish person… She feared that this af-

[4] All through the text I am using the term in the original Bion's sense (Bion 1962, pp. 35-36), strongly influenced by Ogden's adaptation (Ogden 1999)

[5] Recently I have read "My life in Stalinist Russia" (2002) by Mary Leder, the image of a naked bulb there is associated with torture.

fair would become visible and there would be serious consequences. At one point in the session, she said that all this might threaten her analysis and I would have every right to *stop seeing her*.

As a punishment? I intervened.

She calmed down and said – don't I deserve that? Then paused.

In previous sessions, I had interpreted her affair as acting out in relation to transference issues in analysis, but this interpretation so far had produced only rationalizations. Here again I felt some urgency to interpret the transference, but I found myself not knowing exactly what to say. I clearly felt lost within too many thoughts rushing through my mind. I was angry and frustrated and gave up the interpretation, to avoid giving way to those feelings. I felt too engaged and I knew I needed some space to think.

From previous experiences with Ms. B. I knew the pressure to respond to two basic roles (Sandler 1976), the forgiving and supportive therapist/father, or the accusing, angry therapist/mother. I thought about how I was identified with the fantasy (or belief) projected in me, that beside all possible understanding and interpretation, her "greedy for love and triumph part" would always win, and there was no normal depressive solution (Steiner 1996) for this patient.

Then I heard in the new key how my patient was speaking about these same matters, in her typical thoughtful, open, and rational way. It dawned on me that her very openness and capacity for "honest thinking" were her ultimate line of defense against loss and differentiation. In the same way, as, being sympathizing and understanding (including generously producing interpretations), was mine. A little later, I came to thinking that those were the basic reasons for our mutual enactments, with a tendency of chronicity (Cassorla op.cit.).

The session ended in a calm silence. The patient paid for the month, but accidently gave me more money. I noticed this and returned the surplus. She left and I found myself in a good mood, musing for a while on this last enactment, or parapraxis if you will.

Between sessions:

I entertained some thoughts about the payment parapraxis: a possible compensation for what she felt as badness and for my difficulty to deal with it, unconscious need to keep me happy in a seductive way...? I wrote down a few key impressions from the session.

Mrs. C (analytic patient) 11 o'clock

As announced in her text message Mrs. C did not come.

I do not follow any specific routine during the missed sessions. Usually I read a bit, answer e-mails, listen to the radio, rarely run some errands. I try to leave the building, only when patients have informed me that they would be away for days. While doing such mundane things, I try to be aware of my patients' absences and have developed a way to be sensitive for thoughts, feelings, fantasies that may pop up in my mind. Those I find informative, part of my receptive attitude, influenced by Casement (2002).

Well into the time of the session, I was answering some e-mails. There was a particular e-mail that struck me as important. I found myself putting quite a lot of efforts to persuade a colleague at the university *to look from a different angle* at the thesis of a student of ours. I thought the work had quite a few good qualities. It was about clinical research with *addicted* patients and I had been consulting this student at various stages of the study. The objections of my colleague were purely statistical, but I wanted to emphasize the clinical usefulness of the study. After I noticed my state of mind, I remembered that this student had phoned me a few days earlier to discuss some final feedback and had ended the conversation in an informal way, saying, "If those people at the department continue to give me such hard times I might stress out and stop breast-feeding my baby." At this moment, I stopped writing the e-mail and started thinking about my patient Mrs. C.

Mrs. C. had very pronounced identity issues with many features of an *addictive* personality. She had given birth to her first child during the analysis, at the quite advanced age of 38 and now was struggling with a serous

dilemma how to wean off her slightly over 3-year-old child. The breast-feeding had recently been experienced by this patient, as a total domination of her child, who used and abused her breasts at any time and in any place, while she'd been unable to maintain any boundaries. Interestingly enough, during our sessions, I never felt such violent boundary confusion. There had always been quite a rational and mutually respectful (emotionally shallow) dialogue, without strong feelings of dependency.

Thus, my unusually strong defense of a breast-feeding mother (the student), my sympathy for the problems of dependent people in general, alerted me to give some further thought to my relationship with Mrs. C., or if you will, to *look from a different angle.* In that particular moment, I actually felt her absence but no longer as something trivial, determined by some mundane event. Behind the screen of the nice occasion for me to pause and relax during a stressful working day, her absence emerged as something painful, difficult and threatening. Like a pending loss of serious stature.

12-12.30 Lunch break on the way to the clinic

Twice a week I work psychotherapeutically with patients in a psychiatric clinic, specialized in dual disorders. Monday is one of those days when I change consulting rooms from a typical private practice office, to a working environment with several consulting rooms, a waiting room and a reception desk. The patients there enroll in a comprehensive treatment comprising of different levels of interventions including different members of a clinical team (Todorov, 2009). I am having a snack and driving to another part of the city for a rescheduled session with Mrs. D**,** whose usual time is 3 pm.

Mrs. D 12.30 -1.15 pm (twice a week psychotherapy)

This patient had had some turbulent times lately, a month ago she had spent a short time in hospital on her own accord in order to stop a very problematic drinking episode. The situation ensued around the Christmas therapeutic break and this was not the first instance of acute acting out for this extremely vulnerable histrionic patient.

The session (second after the break) started with her telling me about a working seminar she had attended during the weekend. These seminars are part of some long-term qualification program and I've been hearing about them quite often. In our sessions, they were used as mental scenes representing various relationships with colleagues (mainly erotized male figures), lecturers (mainly idealized male figures) and the people left outside these activities (father, mother, husband, son) often jealous and forbidding. In the transference, depending on the emotional situation, my position has been fluctuating between those three.

Mrs. D. described this particular seminar as very psychologically oriented, with organizational psychologists working on the good practices of consolidation and communication among various medical specialists. I was also hearing about jealous reactions (possibly augmented by massive projections) of her husband, "not talking to her when she is leaving for seminars" and of her son "having a tantrum after she asked him politely not to play on her computer". Mrs. D. maintained that on other occasions, she would feel hurt and neglected, but this time she was calm and balanced. The seminar on the other hand went very well; she was pleased to interact with colleagues, did not think much of the past, and did not feel different or inadequate. "I suppose I am learning not to act so fast on my impulses" – she said - "and most importantly not to impinge on people, to give them space…"

Then the patient took an apologetic stance, combined with a lot of shame and guilt. She talked about the episode of her drinking and hospitalization, about her strong wish for recovery and the need to repair some of the damage, including "the grave disappointment she's been for me, for her parents and for her colleagues".

She had also mentioned her gratitude for accepting her at an earlier hour, which due to her changed work shifts was the only possibility.

Overall, the patient was tense, vulnerable; she spoke fast with almost no pauses. I think I made one interpretation, directed to the mentioned wish for reparation, but later, while writing my notes, I was unable to remember it.

What I remembered distinctly was that during the whole session I was trying to reflect on my subtle feeing of anxiety and uneasiness. Firstly, I noticed that I was quite "grateful" to this patient for coming today in such a composed and balanced state of mind, after previous turbulent events. Then I remembered my cautious approach from a few days back, concerning her demand for a session at a different time. On one hand, I didn't want to create a feeling of dangerous urgency by responding immediately to her demand, on the other I was careful to avoid rejection. In hindsight, I realized that just like my patient, I was frightened by impulsivity, unconscious jealousy and vengefulness. I felt restricted, almost immobilized in my ability to think and obviously to speak in this session. Thus, I had remained silent for most of the session, expressing acceptance, understanding, and perhaps obvious anxiety through lively body language.

Between sessions:
When writing my brief notes after this session I had an association with Ms. B from this morning, who perhaps had stirred similar, still undigested feelings, which interfered with the ongoing situation.

Mr. E – 1.15 – 2 pm (once a week psychotherapy)
The patient was a few minutes late. I noticed, but didn't mentally engage with the fact. He rushed in the consulting room and still in a hurry, started talking about how many things he had done this morning. Emphasized how he was taking good care of his grandfather, fresh from bringing him to see a doctor this morning. Then he concluded that he was certain that grandpa was very sick and probably would not last longer, it had to be the heart…

Mr. E had recently lost his grandmother, a significant mother figure to whom he had been dearly attached. She had a stroke and passed away. The emergency team came very late (forty minutes after the call) and everything happened while he was calling and waiting and staying with her until her last breath, less than a month ago. Since then, the whole family were in shock and my patient was coping with the situation mainly by being very agitated and active to ensure that he could protect himself, his mother and grandfather from anything unexpected or unforeseen, dangerous and stressful (including emotional) events.

There was a manic atmosphere in the consulting room. The patient used many action verbs and performative utterances. In the countertransference, I immediately wished to calm him down and asked him how he felt. At one point, I tried to suggest that, since from the medical examinations of his grandfather there was nothing of serious concern, perhaps we could talk about his own feelings, which "stress his own heart". The moment I said this, I reproached myself for using the metaphoric expression. From our experience, I knew this particular patient hated vagueness.

Instead of his usual "stop playing the doctor and say something human"; his reaction to my intervention was different. He told me about a dream he had had recently: There is a storm over an island in the middle of a huge river that runs near his grandparents' hometown. He and grandpa are in the eye of the storm. It is frightening, but he hears the voice of his granny "you will gather together the whole family and will drink and eat on the 31-st of January." That voice had been so relaxing and calming in his dream.

I was having some thoughts about his being so frightened and alone, about his wish to remain in touch with the lost grandmother, while Mr. E. went on telling me that indeed there would be such a gathering and that he wondered about this coincidence between dream and reality. He quickly added that he did not believe that dead speak to us in dreams.

I was pleased that my patient was actually allowing some doubt in the concrete presence of the lost object. Obviously, I was worrying about a more pronounced psychotic reaction, still remembering how Mr. E. was referred to me as being a good candidate for a few psychiatry diagnoses.

Near the end of the session, E. spoke about recently meeting my colleague Dr. K, the head of the clinic, who had agreed to reduce his fee for a period of time in relation to some difficulties in his mother's business (who was paying for the treatment of her unemployed son). He expressed a gratitude to the doctor and the institution as a whole, for being always strict about medications, schedules as well as compromising when needed. He knew many people being in methadone treatment, who only took their medication to sell it on the street. There was an acquaintance of his in some other clinic, who was dealing drugs and every time he needed a rise of dose, he would simply offer more money to his doctor, but here he claimed, it was different.

Listening to that last bit, I sensed some uneasiness and wondered about a corrupting and corrupted part of the self, split off and projected in other bad patients. I started thinking about possible risks for this young man. Finally, I simply asked him if he thought that an increase of dosage could be helpful in these difficult times and if there was a danger of illicit use of drugs. He replied in a similar straightforward fashion that of course this had been his first thought, but he had decided that it would not be a solution and for the moment and I did not have to worry.

Suddenly he was calm and silent. For 2-3 minutes, we stood still and silent.

During that silence, I remembered my own granny, who had passed away many years back. I too had lived with my grandparents during my childhood and adolescent years, strangely enough I had seldom thought about this extremely important, loving figure in my life. I felt so glad to have had reconnected with one of my good objects. I smiled to Mr. E. He smiled back. The session ended.

Mr. F 2-3 pm (once a week psychotherapy)
My next patient had called the secretary to tell her that he would be 15 minutes late.

Between sessions:
I had used the pause to write down key notes from the previous session and started waiting on his arrival. Mr. F was in the last phase of his treatment, he had reduced the intake of medication to a very small dose with the intention to stop it completely and to end his overall treatment in the next few months. The reduction of opioids below stabilizing levels and the very idea of ending treatment had made him moody and impulsive. Like many other patients with addictions, he had a traumatic history of previous unsuccessful treatments. This one had been his longest continuous treatment and a lot was at stake. For the last month or so, he had been very regular in his sessions with me and his lateness today put me on the alert. In the meantime, he had left another message with the secretary and on my mobile, saying that he was doing his best, but perhaps he would miss the session. Because of the change in my schedule for Mrs. D. I did have a free hour at 3pm and asked the secretary to call and offer him that possibility. She told me that he accepted. I felt relieved from the immediate situation with Mr. F. for the moment.

I used the remaining time from this session for a short walk in the nearby park.

Mr. F 3 pm
At 3 pm I was waiting for the arrival of Mr. F, but some thoughts brought me back to my previous patient Mr. E. I felt a wave of sadness. Just like him, I grew up in my grandparents' home and the loss of my grandmother was an important event in my life. My granny's image had always been a very strong internal support in my mind and I caught myself wishing the same to be true for my patient. I pondered for a while on the occurrence of these thoughts and memories and hypothesized that they came also in relation to Mr. F partly related to his absence, as a continuation of the grieving process around his wish for termination of the treatment. I also reflected a bit on the feeling of danger coming both from Mr. E's session and from the absence of Mr. F. I connected my thoughts with memories of how the clinical staff usually reacts with mixed feelings of pride, sense of achievement and stagnant fear toward patients with dual deceases during the termination phase. More than half an hour had

passed into the session and F. wasn't here. Almost at the end of the session Mr. F called for a final cancelation.

Ms. G 4 pm (initial interview)

In the next session, I was charged with the task to interview a new patient for psychotherapy.

The patient was punctual and we started the interview, but in a while, I was somehow distracted. During the initial minutes, I had a vague impression that Ms. G looked familiar to me. When she later told me some details about herself, I recognized her as the daughter of an old family friend, a renowned physician who had taken care of me and members of my family in the very distant past and with who I was still in touch on celebratory occasions. I hadn't seen the young lady in front of me since she had been a teenage girl (now 31 years old), but the possibility of a thorough interview seemed compromised already. It didn't take long for her to recognize me as well and finally we clarified the fact of our acquaintance. Her immediate reaction was to warn me that she relied on confidentiality and discretion. No one knew of her difficulties and she hoped it would stay this way. I confirmed the patients' privileges and asked whether she would like us to continue talking or perhaps we had better stop right there. She felt reassured and told me that she had chosen this clinic after serious explorations, that she was making good progress, so she would do as I suggested. Slightly overcoming my initial surprise, I decided to conclude the interview by giving some additional information and to help her reschedule with a colleague. In my mind, I had chosen an excellent therapist for her. Then I asked her whether my presence in the institution could be of some concern. She replied that, on the contrary, it was very reassuring and since she did not have to work with me directly, she would be glad to know that there was a familiar face around. We agreed on the immediate details and stopped the interview. During the greater part of the interaction with Ms. G, especially after the initial awkwardness had resided, I felt warmth and care. I thought about transference to my old family doctor, her parent. I saw this patient out, both worried and hopeful.

Mr. H 5 pm (twice a week psychotherapy) last session for the day

The patient was on time. With almost no exception, he came 10-15 minutes late when, in his words, "things are normal" and was punctual when "there is a problem".

He sat down and immediately told me that he was very tense, angry and frustrated. He feared a coming panic attack. I noticed that I didn't feel anxious and invited him to continue. He told me about an incident with a neighbor who had blocked his car for quite a while and though the neighbor was apologetic, my patient was relentless and had a fantasy of beating him to pulp. He even went in some details about a fantasized use of instrument to smash the other person's car.

Without much reflection, I told him that the fantasy scene looked like a manly duel with car tools. Mr. H started laughing nervously, then visibly relaxed and added – "you mean penis fight, very Freudian".

I too detected a smile on my face and thought of this quick interaction where feelings and imagery perhaps did not reach sufficient transformation, but brought somatic emotional discharge.

Mr. H continued, about him and his wife going to see a famous doctor to discuss an in vitro procedure. This topic had come recently in his therapy and for the moment, in the patient's words was a "tough subject". His wife needed to undergo some minor operation and Mr. H felt that she was the one who suffered for that baby while he was not doing enough. He feared she could lose hope if they failed for the second time.

I was having a thought about how for Mr. H. "not doing enough" could easily become, "not having enough"… and then I thought again of his violent fantasy fight. I had an impulse to interpret in the context of transference, but discarded the thought.

Instead, I said that thoughts and worries like these were frustrating and could make one quite angry. I noticed that I chose a weaker interpretation.

He continued. During the weekend, they went to an important dinner, a high-end event with a real Prince. "Not only was I the poorest of all, but my wife decided to be late. I hated it amidst the entire glamor."

I did hear "being poor" and "being late" as symbolic expressions of the situation with the delayed pregnancy but once again, I thought such an idea could be confrontational or humiliating.

Suddenly in my mind, I was outside of the room, so to speak. I did think about my previous encounter with Dr. P's. daughter. I wanted to do something nice for her, to help her in a more direct and immediate way, it was more like feeling without concrete imagery.

I did take this as a dream, a reaction to my frustration, fear and helplessness in the session. Perhaps a reaction to some split off and denied need for warmth and confirmation in the field with Mr. H. I formulated for myself the idea, that the sadistic scene of beating and projected grandiose need for power, money and masculinity had a blocking effect on my empathy and analyzing capacity.

Mr. H was telling me about a friend of his, an extremely talented and successful entrepreneur, who had recently had a child, but felt unhappy, drank heavily and had surrendered to his constantly nagging and criticizing wife. My patient thought that his friend was in danger of suffering a break down and told the friend about his therapy, in the hope of encouraging the friend to seek help.

After a pause, I said – "perhaps for you to be in therapy today means to have a place where you can share this horrible feeling of stagnation and may be, even the fear of a break down."

My patient showed a convulsive movement; his eyes became wet, then he shrugged, stretched and said, "I have shown my pain today, haven't I? Time to go." Then he looked at the clock and this was the end of the session.

Discussion of Clinical Material

Now, I wish to share some after thoughts and observations on the "mind of the analyst/therapist", based on some discoveries, made during assembling the clinical material.

Looking at the material, it becomes very apparent that *there is a common topic* in the entire working field – the major developmental and clinical theme of separation and loss (Akhtar 2012; Bloom-Feshbach & Bloom-Feshbach 1987). Its various manifestations reverberate all through the field and engage the mind of the therapist on different levels and with different intensity.

Now let me continue with a few words about each session in order to offer additional conceptualizations and to connect other focal topics, active in the mental field of the day.

The first session contains an example of a reverie as a part of the transformative process – an unconscious attempt on the part of the analyst to react in his idiosyncratic way to the fantasy co-created in the analytic situation. This dynamically created fantasy and the ensuing reverie, tormenting in its content and intensity, was actually a first of many attempts for representation, and re-enactment of an early separation trauma, inflicted during the patient's long hospitalization without parental presence at the age of three.

The patient from the second session has a similar psychic functioning as the patient in the fourth session and we see that the therapist has difficulties to interpret in both cases. We may hypothesize that those difficulties are related to seductive, jealous and vengeful transference/countertransference experiences. They create particular interferences[6] in this working day's field, but most probably are specific for the therapist's regressive profile and developmental history. The session demonstrates a kind of impasse in the process, accompanied by repeating enactments that have a tendency to become chronic (Cassorlla 2012). In his thoughts concerning the first

[6] The metaphor is based on term interference as used in physical science, a combination of two or more electromagnetic waveforms to form a resultant wave in which the displacement is either reinforced or cancelled.

enactment, the therapist notices his mounted anxiety, related to the absence of a next patient. In hindsight, it is clear that the first case of Mrs. A. has left residual untransformed active elements concerning separation and loss, perhaps reinforced by more pronounced themes of the session – intrusiveness, jealousy and guilt. Let us not forget that the latter are intrinsically related to the former.

The third session is a missed session. It engages the therapist reflexive capacity to deal with emotions activated from the background process with Mrs. C, identified with another breastfeeding mother, and from active residues of the previous two sessions. I think the residues here are entering the field under the rubric of dependence/differentiation. Another missed session several hours later serves the similar purpose of reviving the untransformed psychic residues from previous sessions, mostly related to dependence, separation and loss, while promoting a transformative process via emotional linking and symbolization.

The fourth session is first from several within a different clinical context. It is mainly an attempt on reparation of the therapeutic process after an acute acting out, provoked by separation issues. The therapist is quite stuck by his fear of impulsivity, jealousy and vengefulness, perhaps augmented by residual elements from previous sessions. In relation to impulsivity and acting out, in this session we may deduce a disturbance in the overall capacity for containment in the therapist's mind. Consequences of this "crack" could be observed from now on, but most conspicuously in the next session, when the therapist actively engages his patient with questioning about possibility for impulsive intake and relapse[7].

In the fifth session, the basic topic of the field is expressed in the tone and register of a melancholic - depressive experience. Patient and therapist are dealing with recent actual loss. It is astonishingly clear how the dream of the patient creates a forceful emotional situation engaging the therapist's psyche to rely on a deep identification with its good objects both as a defense and as an attempt to revive the need and the capacity for mourning[8].

The sixth session is another missed session. The theme of separation enters the field by the pending termination of the treatment with Mr. F. A couple of postponements and rearrangements of the hour with this patient create suspended tension and uncertainty in the analyst's mind, active in the duration of the next sessions. The actual absence of the patient, perceived as imminent danger, is represented by fantasy of an accident. After reflecting on the catastrophic anxieties, the therapist continues the work of mourning, through the memories of his own childhood, already started in the previous session (Volkan 1981).

The next session (seventh) is uncanny in regard to the therapist's internal process of remembrance and mourning of the good granny object, by bringing into actual presence the daughter of a doctor from the therapist's past, who knew and occasionally took care of the same granny. Only with hindsight, we can appreciate the debt of surprise and confusion in the therapist. The professional taboo of seeing acquaintances in the consulting room, puts additional strain on the therapist and brings forth new unconscious dimensions of the topic of separation, with restrictive and neurotic features. It is of little surprise that frustration, helplessness and confusion accumulated in this session will interfere in the next session in the form of a reverie.

The last session is dominated by narcissistic defenses. The grandiose part of the patient's self is maintained by projective identification. The felt threat of a breakdown in this

[7] The remark is intended without relevance to technical correctness or clinical usefulness of such interventions in psychotherapy of dependent patients

[8] Retroactively the work of mourning can be seen in the third session in relation to the psychic script "loss of the breast".

patient, if such a primitive threat existed, is related to serious obstructions in the capacity for mourning and grieving (Searles 1985). The not grieved infertility issues obviously invade the therapist's mind through projective identification and he is unable to conceive any interpretation for a long time in the session. The therapist is overwhelmed by the patient's omnipotence, but we must forward the hypothesis that some of the difficulties in this session are also a reaction to untransformed residues related to separation and loss accumulated in the field of the entire working day, which "help" the therapist to identify with the patient's projections. It remains questionable, whether we may see a transformative process at the end of the session, leading to partial recovery from projective identification, and regaining some ground for therapeutic relating to the patient, as the therapist is inclined to read the situation.

Conclusive Remarks

In this paper, I wished to further the assumption that the exploration of the working day seen as a specific interactional mental field must be a legitimate and useful tool for the study of the therapeutic process. Particularly, aspects of the process related to the analyst's professional mental functioning referred to as *the mind of the analyst* (Arlow 1993; Baranger 1993; Birksted-Breen 2016; Cohler 1996; Jacobs 1997; Ramzy 1974).

The working day provides a more complex field for observation than the usual forms of case studies, like vignettes and single session presentations. As a setting, it offers the bonus of multiple transferences/countertransferences (Bleiberg and Baker 2008) and inter and between session influences (Raphael-Leff 2002) observed in a unified framework.

It is my contention that the extended time/mind observational framework of the working day can give us an additional perspective on the therapist's internal processes of containing, psychic transformation and working through (Brown 2019; Casement 1992; Jacobs 2002; Steiner 2000). It can be a good tool for the study of openness, vulnerability and defensive makeup of the therapists (Kernberg 1996), as well as the capacity to maintain symbolic function and third position (Birksted-Breen 2012; Zwiebel 2004).

In particular, it could be very useful for the study of the typology and nature of enactments, as situational interactional events (Aron 2003) in the particular session, with particular patient, or as typified chronic reactions (Cassorla 2012) to repetitive psychic events, interactional issues and developmental themes.

Notwithstanding the fact that this is more micro process and micro functioning-oriented approach (Ornstein 2004) it can be useful for the observation of some universal topics in the mental functioning of the therapist such as closeness, loss and separation, trauma, triangulation, etc., as hopefully shown in the present discussion.

The working day setting could be a suitable aid for the study of memory, time and narrative structures in psychotherapeutic encounters (Bellin 1984; Fonagy 1999; Sabbadini 1989; Schafer 1992) especially if one choses to recreate an entire working day out of key notes and memories[9].

With some developments and formalization, it might be used as a validation procedure, particularly if we choose to validate therapeutic work through transformations of emotional experience (Andrade De Azevedo 1994) in the clinical process.

Finally, yet importantly, this approach should not be confined to a single theoretical perspective, intersubjective field theory, for example. Looked from another perspective, the study of the entire working day could help the observer to distinguish between what is "brought into the room" and "what is made in the room" (Tuckett 2011), among other possible applications.

[9] Recording equipment can be used of course and that will definitely bring more details for consideration.

References

1. **Andrade De Azevedo, A.** (1994). Validation of the Psychoanalytic Clinical Process: The Role of Dreams. Int. J. Psycho-Anal., 75: 1181-1192.
2. **Akhtar, S. (ed.)** (2012). The Mother and Her Child: Clinical Aspects of Attachment, Separation, and Loss. New York: Jason Aronson.
3. **Arlow, J. A.** (1993). Two Discussions of 'The Mind of the Analyst' and a Response from Madeleine Baranger. Int. J. Psycho-Anal., 74: 1147-1155.
4. **Aron, L.** (2003). The Paradoxical Place of Enactment in Psychoanalysis: Introduction. Psychoanal. Dial., 13(5): 623-631.
5. **Baranger, M.** (1993). The Mind of the Analyst: From Listening to Interpretation. Int. J. Psycho-Anal., 74: 15-24.
6. **Baranger, M. & Baranger, W.** (2008). The Analytic Situation as a Dynamic Field. Int. J. Psycho-Anal., 89(4): 795-826.
7. **Bellin, E. H.** (1984). The Psychoanalytic Narrative: On the Transformational Axis Between Writing and Speech. Psychoanal. Contemp. Thought, 7(1): 3-42.
8. **Bion, W. R.** (1962). Learning from Experience. London: Tavistock.
9. **Bion, W. R.** (1965). Transformations. London: Tavistock.
10. **Birksted-Breen, D.** (2009). 'Reverberation Time', Dreaming and the Capacity to Dream. Int. J. Psycho-Anal., 90(1): 35-51.
11. **Birksted-Breen, D.** (2012). Taking Time: the Tempo of Psychoanalysis. Int. J. Psycho-Anal., 93: 819-836.
12. **Birksted-Breen, D.** (2016). Bi-Ocularity, the Functioning Mind of the Psychoanalyst. Int. J. Psycho-Anal., 97(1): 25-40.
13. **Bleiberg, J. R. & Baker, M. N.** (2008). Working Through Co-Transferences in Inadvertent or Unavoidable Multiple Relationships. Int. J. Psychoanal. Self Psychol., 3(4): 465-487.
14. **Bloom-Feshbach, J. & Bloom-Feshbach, S.** (1987). The Psychology of Separation and Loss: Perspectives on Development, Life transitions, and Clinical Practice. San Francisco: Jossey-Bass.
15. **Britton, R.** (1994). Publication Anxiety: Conflict Between Communication and Affiliation. Int. J. Psycho-Anal., 75: 1213-1224.
16. **Brown, L. J.** (2019). Transformational processes in Clinical Psychoanalysis: Dreaming, Emotions and the Present Moment. London and New York: Routledge.
17. **Casement, P.** (1992). Learning from the Patient. New York: Guilford.
18. **Casement, P.** (2002). Between Patients in Raphael-Leff J, editor. Between Sessions and Beyond the Couch, p. 29-32. University of Essex, Colchester: CPS Psychoanalytic Publications.
19. **Cassorla, R. M.** (2012). What Happens before and after Acute Enactments? An Exercise in Clinical Validation and the Broadening of Hypotheses. Int. J. Psycho-Anal., 93(1): 53-80.
20. **Civitarese, G. & Ferro, A.** (2013). The Meaning and Use of Metaphor in Analytic Field Theory. Psychoanal. Inq., 33(3): 190-209.
21. **Cohler, B. J.** (1996). Panel Report - Psychic Reality and The Analyst: The Inner Working of the Analyst's Mind. Int. J. Psycho-Anal., 77: 89-95.
22. **Faimberg, H.** (1988). The Telescoping of Generations: Genealogy of Certain Identifications. Contemp. Psychoanal., 24: 99-117.
23. **Ferro, A. & Basile, R.** (2009). Eds. The Analytic Field: A Clinical Concept. London: Karnac.
24. **Fonagy, P.** (1999). Memory and Therapeutic Action. Int. J. Psycho-Anal., 80(2): 215-223.
25. **Greenson, R. R.** (1974). The Decline and Fall of the 50-Minute Hour. J. Amer. Psychoanal. Assn., 22: 785-791.
26. **Jacobs, T. J.** (1997). In Search of the Mind of the Analyst: A Progress Report. J. Amer. Psychoanal. Assn., 45: 1035-10.
27. **Greenson, R. R.** (2002). Once More with Feeling: On Working Through in the Analyst and Its Role in the Analytic Process. Psychoanal. Inq., 22(4): 599-616.
28. **Kernberg, O. F.** (1996). The Analyst's Authority in the Psychoanalytic Situation. Psychoanal Q., 65: 137-157.
29. **Lichtenberg, J. D. & Slap, J. W.** (1977). Comments on the General Functioning of the Analyst in the Psychoanalytic Situation. Ann. Psychoanal., 5: 295-312.
30. **Maldonado, J. L.** (2014). A Mismatch of Meaning and Intentionality between Analyst and Analysand. Int. J. Psycho-Anal., 95(4): 641-662.
31. **Ogden, T.** (1997). Reverie and Metaphor: Some Thoughts on How I Work as a Psychoanalyst. Int. J. Psycho-Anal., 78: 719-732.
32. **Ogden, T.** (1999). Reverie and Interpretation. London: Karnac.
33. **Ogden, T.** (2004). The Analytic Third: Implications for Psychoanalytic Theory and Technique. Psychoanal Q., 73: 167-195.
34. **Ornstein, P. H.** (2004). The Elusive Concept of the Psychoanalytic Process. J. Amer. Psychoanal. Assn., 52(1): 15-41.
35. **Raphael-Leff, J., editor** (2002), Between Sessions and Beyond the Couch. University of Essex, Colchester: CPS Psychoanalytic Publications,
36. **Ramzy, I.** (1974). How the Mind of the Psychoanalyst Works: An Essay on Psychoanalytic Inference. Int. J. Psycho-Anal., 55: 543-550.
37. **Sabbadini, A.** (1989). Boundaries of Timelessness. Some Thoughts about the Temporal Dimension of the Psychoanalytic Space. Int. J. Psycho-Anal., 70: 305-313.
38. **Schafer, R.** (1992). Retelling a Life: Narration and Dialogue in Psychoanalysis. New York: Basic Books.
39. **Schwartz, H. P.** (2013). Neutrality in the Field: Alpha-Function and the Dreaming Dyad in Psychoanalytic Process. Psychoanal Q., 82(3): 587-613.

40. **Searles, H. F.** (1985). Separation and Loss in Psychoanalytic Therapy with Borderline Patients: Further Remarks. Am. J. Psychoanal., 45 (1): 9-27
41. **Spero, M. H.** (2010). After Hours: Temporal Developments at the Edge of the Analytic Session. Psychoanal Q., 79(2): 395-419.
42. **Steiner, J.** (2000). Containment, Enactment and Communication. Int. J. Psycho-Anal., 81(2): 245-255.
43. **Steiner, J.** (2000). Revenge and Resentment in The 'Oedipus Situation'. Int. J. Psycho-Anal., 77: 433-443.
44. **Szasz, T. S.** (1956). On the Experiences of the Analyst in the Psychoanalytic Situation a Contribution to the Theory of Psychoanalytic Treatment. J. Amer. Psychoanal. Assn., 4: 197-223,
45. **Tögel, C.** (2009). Sigmund Freud's Practice: Visits and Consultation, Psychoanalyses, Remuneration. Psychoanal Q., 78(4): 1033-1058.
46. **Todorov, O.** (2009). Psychotherapeutic Experiences with Methadone Maintained Patients in the Framework of Multidisciplinary Clinical Institution. Heroin Addict Relat Clin Probl 2009; 11(1): 35-40.
47. **Tuckett, D.** (1997). Mutual Enactment in the Psychoanalytic Situation. In: Ahumada, J., et al. The Perverse Transference and Other Matters: Essays in Honor of R. Horacio Etchegoyen. New York, London: Aronson, pp. 203-216.
48. **Tuckett, D.** (2011). Inside and Outside the Window: Some Fundamental Elements in the Theory of Psychoanalytic Technique. Int. J. Psycho-Anal., 92: 1367-1390.
49. **Volkan, V.** (1981). Linking Objects and Linking Phenomena: A Study of the Forms, Symptoms, Metapsychology, and Therapy of Complicated Mourning. New York: International University Press
50. **Waugaman, R. M.** (2003). The Analyst's Caseload as a Family: Transferences to Fellow Patients. Psychoanal Q., 72: 575-614.
51. **Zaslavsky, J., Nunes, M. L. & Eizirik, C. L.** (2005). Approaching Countertransference in Psychoanalytical Supervision: A Qualitative Investigation. Int. J. Psycho-Anal., 86(4): 1099-1131.
52. **Zwiebel, R.** (2004). The Third Position: Reflections about the Internal Analytic Working Process. Psychoanal Q., 73: 215-265.

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