Incongruent Feeling States in Psychoanalysis

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Analysts occasionally find that we have dreamt of a patient or experienced feelings in sessions that appear to have nothing to do with the feelings or content presented by the patient. This can be disturbing or confusing, but is always fascinating. This paper defines and illustrates these phenomena, grapples with their meanings, and attempts to understand how they came about.

Introduction

One of the more intriguing aspects of our work occurs when our feeling states appear not to match the verbal content or feeling states presented by the patient.

> Countertransference is incongruent with the content to the extent that there are no evident similarities, parallels, or analogies between the countertransference and the content. Whereas congruence is a source of information about the relationship between the content and the countertransference, incongruence is a source of puzzles and questions. In general, the analyst's confusion--both emotional and intellectual--is directly proportionate to the degree of incongruence in the countertransference. (Geltner, 2013, p. 65)

This experience is most perplexing and sometimes unnerving. We are accustomed to using our feelings, in life and in our work, to inform us about reality and about the

relationships we are in. When there is a discrepancy between what we feel and what we observe, it can feel crazy making and induce self-doubt. This is an excellent area for study in the psychoanalytic setting. These feelings are not as commonly experienced as those we consciously feel (precisely because they come from the unconscious) and there are no signposts of content to guide us. However, I noted while writing this paper that once I became tuned in to thinking about these strange events, I began noticing them more. It was as if lines had been drawn around otherwise amorphous shapes that began to delineate those shapes. It didn't help me understand the feeling state that much better, but it did sharpen my focus in looking for corroborating material from the patient or supervisee that could make sense of the mystery at some later point.

Geltner (ibid, p. 66) points out regarding such feelings, that "Their origins are rooted in the earliest phases of preverbal development and underlie the most tenacious repetitions. Although they are incongruent with material the patient has consciously verbalized, they are actually congruent with unconscious feelings, impulses or memories." Since these experiences originate during the preverbal stage, the patient himself is not only not conscious of them, but also cannot have words to put to them. This puts us in the position, as receiver and reactor, of having an experience that we ourselves are hard pressed to put words to, if at all. It can take considerable processing on our end to begin to recognize that something is being communicated by the other, has not originated from us, but nevertheless we pick it up and it registers in us. In fact, given that our experience is incongruent with the content of the session, the initial tendency will be to impute their origin as coming from us, that is, from some unanalyzed part of ourselves. As preverbal phenomena, these experiences may manifest as feelings, per se, or as physical sensations

(e.g., hunger, nausea, coughing, yawning, a tic, tightness in chest, changes in heart rate, pain, a tear falling, unbidden, from the eye), psychological sensations (e.g. feelings of derealization, depersonalization, changes in body image, feeling larger or smaller, etc.), hard to grasp ethereal fantasies, dreams, impulses, cognitive problems, or behavioral enactments that feel out of character, and more. My personal experience over the years has been impacted by a growing trust in my own instincts. Even though I am not done analyzing every unconscious pattern in myself, I believe my reactions to patients are most likely giving me information about their inner lives. That does not rule out that I possess unanalyzed cans of worms, as referenced in Geltner's second case example in this journal. But even subjective issues once triggered and sorted from the personal, can still proffer information about the patient.

As these situations are usually the result of very early, deeply buried feeling states or relational patterns from the unconscious of the sender, they are not amenable to exploration. It may even take years before they make sense. Therefore the person experiencing the incongruent feelings must make do with holding and tolerating the feelings, waiting, and watching the feelings themselves while being in a state of "not-knowing." Dreams may or may not emanate from the preverbal. Of course they are always sources of information, and the work is to observe and study what that information may be, consider what may have prompted it, and decide how to use it, whether silently or in collaboration with the patient.

These experiences are not necessarily static. They may ebb and flow, or stick for some time and then evolve into something new. A feeling state can change dramatically or subtly over time. As the relationship changes and the patient grows, new and different

patterns emerge. Regardless of the process, a change in feelings in the analyst is a harbinger or marker of a change in a transference state, and in the therapeutic relationship.

The very effort the analyst exerts in processing incongruent feelings constitutes a transformative aspect of the therapeutic process. We have an innate tendency to move toward synchrony.

> Synchrony is viewed as a process towards which we are ... driven and appears to be a part of our evolved survival mechanisms. Achieving synchronous states appears to be beneficial to the patient and the therapist, a stage that may lead to progressive communication. [Marshall (2017), p. 19]

The cases that follow are illustrations of dissonant feeling states in the analyst that seem to bear out the idea that there is buried gold in noticing and attending to them. In the case of Ben, the analyst forgot certain crucial aspects of the patient's history and current life, and would lose his ability to access words and to express meaning, which usually was not a problem for him. In the case of Robert and Jake, the analyst experienced an overtly idealizing patient as covertly full of contempt for him and assumed, incorrectly it turned out, that he was just projecting his own feelings. In Martha and Josh, the supervisor felt uncomfortable about being judgmental of the supervisee who ostensibly idolized the supervisor. The Tori case tells a story in which a supervisor experienced sadness while the supervisee was relaying content about her work in an agitated and overwrought state. Mrs. A, my control case, comprised almost everything discussed in the section above on manifestations of preverbal phenomena. The cases of Melinda and Bahira illustrate a different phenomenon through the use of dreams. Both came from the life of the same analyst, though in the first she was the patient, and in the second, she was the treating

person. The first dream, that of her own analyst, replicated an incestuous event in her life involving her father, about which she had not yet spoken. Years later, the same person, now as analyst, had an erotic dream about her patient that shed light on the patient's early incestuous relationship with her mother.

Case 1: Ben

An analyst found himself forgetting crucial things both from the previous week, like a current illness, and from the patient's history, like whether Ben, a photographer well known for his creativity and originality, had siblings. The analyst began to worry about his aging brain and attributed the memory lapses to his own failings. He had just misplaced his keys that very morning! At the time he also felt competitive with Ben-- about his own command of language, vocabulary, metaphor, beautifully articulated understanding-- something in which Ben excelled. Uncharacteristically the analyst suddenly found that he could not access the language he sought in order to convey his meaning. He forgot words, stumbling as he talked. He felt inferior, stupid and humiliated. He was embarrassed to note that he was concerned about Ben's judgment of him and he assumed it was all related to his own deteriorating brain and inherent inferiority. In the meantime, unfazed, Ben was talking blithely about events of daily life.

Then Ben shared some interactions he had with his mother in which she demonstrated the same qualities, e.g., forgetting important, crucial pieces of information about him. It was extremely perplexing as to why the mother would forget a major event in Ben's life. Was it hostility? Brain damage? Some form of cognitive dysfunction? Extreme self-absorption? Ben had experienced this aspect of his mother's personality for many years. Upon hearing this, and particularly the tremendous emotional

impact it had on the patient, the analyst concluded that he was inadvertently replicating the mother's behavior. It seemed that somehow the mother was uncannily being "channeled" through Ben into him and that inexplicably he was compelled to repeat the mother's behavior. Shortly after these realizations took place, the pattern that was so painful for the analyst, disappeared. It is not clear how this came about. Perhaps because of the analyst's silently noting, and mentally becoming able to make the pattern more objective, Ben moved into a new and different state. Previously, he had anxiously and carefully attended to the analyst's every vicissitude of mood. Subsequently, he became more at ease and was able to focus on himself. The analyst of course was less self-conscious, which must have positively impacted the treatment as well.

Case 2: Robert and Jake

Robert, who was in group and individual analysis with Jake, idealized him. He presented with a problem of being perceived as judgmental by others and as critical and contemptuous in his relationships and at work. His part in this was unconscious. Jake only knew of it because of Robert's descriptions of interactions in his outside life. The actual dynamic had not yet become evident within the analytic relationship. He "worshiped" Jake and everything he did in the group and individual treatment. If Jake attempted to elicit any negative feelings toward him Robert would become protective. Nevertheless, particularly in group Jake strangely experienced silent but palpable contempt and disdain emanating from Robert. Jake always felt completely on the spot, and "wrong". This feeling continued to haunt him outside the session, and he would shudder when re-experiencing the scenario. It was perplexing and painful because of the extreme disjuncture between Robert's overt presentation and the covert communication. Since Jake knew Robert's relationships were

a major problem in his history and current life, he did not believe that he was having paranoid feelings, although initially it certainly felt that way. He understood he was experiencing some transmission of feeling and judgment deeply buried in the patient. As Jake did not yet know much about Robert's history, he was only able to glean from Robert's current descriptions of his functioning that what he, Jake, was experiencing was a deeply repressed repetition that he knew was also happening more overtly outside the room. At the time, Jake had to make do with silently noting and storing away for the future his understanding of Robert's relational troubles.

Case 3: Martha and Josh

Martha, a supervisor, had a supervisee, Josh, who idealized her. Josh always expressed great delight in the relationship and would wax rhapsodic about how much he loved Martha, how helpful she was, and how perfect their relationship was. Surprising to Martha, her own response evolved over time from feeling nurturing, helpful and protective to feeling extremely judgmental of Josh. Martha felt critical of practically everything Josh said about his life but more so what he reported about his work with his patients. This was disturbing to Martha, extremely baffling, and made the relationship feel dissonant. Josh was effectively ecstatic, almost manic, while Martha would uncomfortably have to mask her physical reaction and monitor her verbalizations so Josh would not pick up her negative attitude.

Josh tended to focus as much on his personal life as on his cases, in spite of efforts on Martha's part to redirect him, whether gently or more actively. Josh would delightedly take complete credit for any of his patients' accomplishments. Martha felt this indicated a kind of enmeshment between Josh and his practice, with little boundary between the two.

Martha thought that the dynamic between her and Josh was also a revealing diagnostic sign about Josh's fixation at an early level of development.

Several years into the supervisory relationship, Josh became a father. To Martha's astonishment and distress, Josh reported treating his infant daughter in brutally derisive, sadistic ways. He would punish her for "transgressions" like spilling juice by putting her in the crib for a time out at only a few months of age, revealing an utter lack of understanding of the very early developmental level of the child. In addition to the punishment not fitting the "crime," Josh interpreted his daughter's frustration as an insult to him that deserved of punishment for lack of respect. It was then that it dawned on Martha that she had been experiencing Josh's own mother's early feelings for him, channeled through Martha, which turned out to be blatantly and cruelly externalized and reenacted on Josh's daughter.

It seemed that Josh was apparently fixated at an early level of development, evidenced in his merging with his practice and his lack of awareness of his effect on Martha and on others. Each of them had a wildly different perception of their relationship. His lack of understanding of his own baby's developmental level and the early traumatic repetition was being unconsciously enacted with his child. It helps explain, in part, the disjuncture between the surface content of what transpired between supervisor and supervisee and Martha's feeling reactions. Martha was most likely attuned to the early critical mother Josh carried inside him, about whom he was completely unaware. Perhaps because of this realization, or because the negative attitude was externalized and enacted, Martha found herself becoming more compassionate toward Josh.

Case 4: Tori

While working in an agency, I had a supervisee, Tori, who was known to be a workaholic. She seemed overburdened with work and always felt overwhelmed, staying late, engaging in unnecessary phone calls with clients after work hours and on weekends. Her co-workers found her annoying, because although she seemed to be responsible, she would refuse to collaborate with them around agency tasks that involved teamwork, even though they were a necessary part of the job. She would come to supervision agitated. She repeatedly pleaded her case, saying that she had to be assigned less work and requesting my help to do so. She would embark on long garbled and confusing descriptions of the work she was doing as a way of convincing me how impossible the job was. I found myself becoming confused and unable to find an entry point to facilitate concrete problem solving that might have helped provide some organization and stability. We just seemed to go around in circles, week after week. At the same time, I felt an underlying strange and profound sadness that had no basis in the content of the discussion. Overtly, she was a whirling dervish. Eventually, the problem was "solved" by her sustaining a back injury, staying at home lying prone on her back for two weeks, slowing down, and deciding to leave our agency to take a part time job. I had the feeling that the problem probably was not sufficiently resolved.

Over a year later she contacted me, updating me on her new life. The combination of part time job with a well-delineated set of responsibilities and the benefit of having had more treatment had given Tori some space to reflect. The frenetic activity turned out to be a defense against the trauma and grief she was experiencing unconsciously following her mother's suicide two years prior. This insight provided an explanation for her behavior. The purpose of the "activity" defense shed light on my inexplicable feelings of sadness.

Until then I had had no way of knowing what was underlying the frenzy, but now it all made sense.

Case 5: Mrs. A

While in analytic training, my control case was a psychotic, somatizing patient. Working with her was one of the most painful, regressive experiences of my life in trying to manage excruciating affect, unconscious in both the patient and me. Some of her communications took a somatic form. She gave dramatic expression to her physical pain during sessions such as coughing fits, squirming on the couch, and repeated readjustments of her body position in response to muscle spasms. Outside the room she had frequent illnesses. In response I became distracted by feeling tortured, experiencing obsessive food cravings during and after sessions. I had never before encountered these kinds of reactions to a patient.

On the intrapsychic level, the patient suffered from confused thought processes and bizarre ideation, obliterating me by never contacting me, in fact treating me as though I did not exist. My reaction was to semi-escape her by nodding out or falling asleep outright, only to awaken guiltily minutes later to find, unfortunately, that hardly any time had gone by.

After 7 years of treating Mrs. A I never fully came to know or to understand her history and what had led to the extreme pain, physical and emotional, that this woman suffered. I knew early on that both her husband and son had attempted suicide, and I analyzed my reaction of sleeping from many points of view. One of my hypotheses was that it was a subtle form of killing myself off ("putting myself to sleep") in the room with her, as well as possibly acceding symbolically to her wish that I sleep with her, which she

in fact verbalized several years into the treatment. The whole treatment could almost be said to have taken the form of two people speaking two different languages, taking place in a physiological realm. Amazingly, the patient improved, bettering her relationships with her grown children, reducing her illnesses and therefore her work absences to a minimum, and showing a rudimentary attachment by continuing with me privately after my graduation and allowing me to finally increase her $15 fee by $2.50, without threatening to leave! I understand the improvement to indicate that in the interaction between the two of us, somehow my efforts at processing the primitive feelings, though never verbalized to the patient, and correspondingly reflecting back a change in the dynamic, had an ameliorative effect on the patient. How this occurs on a molecular level, I do not know, and see it as an area for further research in the field.

TWO DREAMS/one analyst/two cases

The following two cases involve Melinda's report of an event early in her own treatment in which her analyst had a dream about her. The second case details an illustrative dream that Melinda, now an analyst in her own right, had about her patient, Bahira. As these situations are similar, we may speculate about the connection between the two in understanding the subjective element from Melinda's life. In addition, we see how Melinda's subjectivity may have added to her receptivity to an objective piece of her patient's dynamic.

Melinda the patient

Two years into her treatment, Melinda's analyst, one who infrequently self disclosed, reported he had had a dream about her. The dream seemingly came out of the blue. He was lying on a bed next to and lower than the bed the Melinda was in, and he

reached out to touch her breast. She pushed his hand away. The analyst explained that he had been intrigued by his dream, and because it was so out of the ordinary, decided it could be valuable to explore together. He told her the dream fragment and asked if she had any associations to it. She was shocked and surprised, saying, "You must have been a fly on the wall of my visit home this weekend to see my parents!" She had mentioned nothing about this visit, before or after it occurred. She said that at that visit, her father had entered her old bedroom in which she was sitting, and skulked around the room, surreptitiously following her around as she uncomfortably moved away from him, from one area to another. Every time she sat down, and especially, she noted, when she was on her bed, he would sit next to her—too close. There followed a flood of incestuously based memories of her father's ongoing sexual intrusiveness throughout her childhood, unspoken before.

Another interesting aspect of the dream was that in real life, just as in the dream, the patient's bed was higher than the father's. It remains a mystery as to how or whether this could have been communicated to the analyst. The patient had a number of metaphorical associations to the bed juxtaposition, e.g., she formerly felt victimized by the father and now felt empowered; she felt inferior growing up and now felt superior in the sense of more emotionally mature than father. Did the analyst pick up the symbolic nature of the dream's communication —and/or might the transmission of the visual be a psychic phenomenon between analyst and patient? De Peyer (2016, p.162) has an excellent discussion of such Psi phenomena.

Melinda, the analyst, and Bahira, the patient

Bahira was a Pakistani professional musician, married for many years, who had been having a seven-year affair. She was extremely conflicted about both the affair and whether to continue the marriage. She was furious with her husband for being a disappointment, even though he performed the culturally prescribed husbandly duties to perfection. The man with whom she was having the affair satisfied her deepest wish to have her mind read. She felt he intuitively knew her needs and interests, and understood how to gratify these needs. She cherished recognition and being treated as special. She liked to generate excitement and joy in the other regarding her accomplishments. Her husband, absorbed as he was in the day to day life of making a good living, and somewhat self-involved, was not up to this task.

The boyfriend was not of her religion which was a major taboo given her upbringing. One particularly compelling attribute of the boyfriend was his ability to mediate between her and her father psychologically (in discussion with Bahira, not with her real father) by acting as an emotionally protective mentor to her in relation to her father's undermining of her. The father was her lifetime manager. The father would criticize her in front of colleagues and even arranged underhandedly to siphon her money to him. Bahira could not see a way clear to separating herself and her business interests from her father. Her boyfriend, also a musician with an insider's understanding of the business, acted as her advocate such that she was enabled to feel more separate from, objective, and empowered about handling the father's devastating demeaning of her, as well as his stealing from her.

Melinda had been struck right away by how physically, intellectually and relationally attractive Bahira was; she was funny and charming. But Melinda was

especially struck by her physical attractiveness and aura of sexuality. By anyone's standard, Bahira was a good looking, a polished and stylish dresser with an athletic body. She was clearly someone who paid a lot of attention to how she looked. At the time Melinda felt her reaction was objectively understandable—probably anyone meeting her for the first time would notice Bahira's outstanding appearance and sensuality. Melinda had not previously experienced herself as bisexual, and didn't give these feelings much thought, other than appreciating and enjoying them. She wrote them off as a function of the inherent bisexuality of the human condition.

About six months into the treatment, the boyfriend ended the relationship with Bahira. That same week Bahira paid for her session in her customary manner, depositing a wad of cash on the analyst's desk. Melinda contained an impulse to say, "How come I feel like a courtesan?" deeming it too provocative that early in the treatment. However, she made a mental note about her experience of the sexual suggestiveness of the gesture. The following week and from there forward, Bahira paid by check even though Melinda had said nothing aloud about the cash. It was as if she had said something out loud. She thought to herself that some kind of ESP must have been operating. Perhaps triggered by the gesture, that night she had an erotic dream in which Bahira was making powerful sexual advances toward her and she was murmuring that such behavior was inappropriate. It felt so pleasurable, so filled with longing, so forbidden, and fraught with conflictual desire to be acted on. Ultimately, her superego in the dream reigned supreme and talked her out of it. She had already been aware of her patient's appeal since their first session. The forces in her own life at the time could underscore what drew her to the patient as she was having a disappointing dating life with men who turned out to be objectionable in one

way or another. In addition, her own history with a seductive father lent itself to developing incestuous feelings toward a forbidden object. On the other hand, these were not feelings characteristic of interactions with other patients, particularly attractive ones young enough to be her daughter, like Bahira. That observation led her to deduce that although she might be more likely, based on her own subjectivity, to resonate with the forbidden erotic than another therapist, that it was also possible that the feelings were related to an aspect of the patient's subjectivity. The attraction died down once she got to know more about Bahira, but they were still perceptible to her in the room.

Although the sexual feeling the analyst experienced had waned, she felt it was a potent source of information about some unknown dynamic. She did find it curious, as on the overt level there had been no reference to such powerful feelings between Bahira and her. At this point she had to be content with musing to herself about the meanings of her sexual reactions to Bahira. They were not yet close to more open revelations about the nature of their relationship. Subsequently she learned that Bahira had a penchant for trying out her seductive skills on both women and men that she met at random, even though with Melinda she had not been overtly seductive.

Since the feelings about the affair and unhappy marriage were pressing and torturing for Bahira, Melinda felt pulled to help her move to a deeper understanding of what the affair meant, and how the marriage had seriously devolved, how stuck she was, and how all had come to pass. She assumed that the powerful dream and conscious sexual feelings she had felt contained clues that could be helpful.

It took much more time in the analysis before the history revealed what had been played out in the treatment, subliminally and unconsciously on Bahira's part. There

was a powerful repetition for the patient of going outside the fold into the forbidden that went back much earlier in her life. She loved to sneak "forbidden" foods. She argued with her superiors about the tenets and principles she grew up with and got in trouble for being a rebel. She wouldn't wear a head covering like the other women in her community. She even sought therapy outside the community. When she was younger she had managed an unusual achievement, leaving her insular culture for a year to see the world. She had reveled in foreign languages, cultures, food, and of course, both women and men. At the same time, she loved her heritage, her religion, community and her family and experienced herself as firmly attached. Not surprisingly, her relationships with her parents played into the conflict that had emerged in the marriage. Her mother had allied with her against the patriarchal, rigid father while simultaneously abandoning her daughter to the father's abusive undermining of Bahira's self-esteem and her accomplishments. When the father destroyed a cherished elaborately constructed instrument the patient had designed and created, her mother stood by helplessly. Ultimately Bahira's mother kept herself subordinate to her father, not providing the much-needed protection from her father's competitive and destructive denigration. Later in treatment an erotic undertone that had existed between mother and daughter was revealed, exemplified by Bahira's mother enjoying undressing her until she reached puberty, turning her around slowly, admiring out loud her hair, chest, buttocks, and beautiful face. She recalled how conflicted she had felt, bathing in the admiration (and no doubt, budding sexual feelings) while feeling dirty, ashamed and scared. Her rage and disappointment in her mother's not protecting her from her father now surfaced, making it available to be processed in treatment. The analyst

silently interpreted her sexual feeling reactions to have been a replication of the incestuous dynamic between Bahira and her mother.

CONCLUSION

Incongruent feeling reactions of analyst to patient present baffling and even disquieting experiences as they do not lend themselves in the moment to understanding a case in our customary ways. The examples above illustrate the need for us to trust our instincts and consider the instances in which these strange states occur. We must recognize that there is a good chance we are being provided with information about the case that may be revealed sooner or later. Sometimes "later" can mean years. It is especially true when the puzzling feelings or dreams emanate from the preverbal time of the patient's life and have been deeply repressed. Our work is to notice the feelings, put words to them if possible, and store them away for future reference, thereby alerting us to stay attuned for corroboration by the patient's memories or discussion of everyday life and relationships.

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