

**A Slave For Two Masters:  
Countertransference of a Wounded Healer in the  
Treatment of a “Difficult to Treat” Adolescent**

by

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## **A Slave For Two Masters: Countertransference of a Wounded Healer in the Treatment of a “Difficult to Treat” Adolescent**

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### **Abstract**

The aim of this case study is to analyze intense countertransference experienced by a therapist while treating a “difficult to treat” adolescent patient. During treatment, the therapist struggled to recognize much of his subjective countertransference and its impact on the treatment. This paper will discuss the reasons for this and the manner in which both subjective and objective countertransference played a role. In doing so, the therapist discusses how his childhood experiences and the subsequent assumption of Carl Jung’s wounded healer archetype fueled the countertransference in ways that were concurrently beneficial and detrimental to the treatment. The patient’s symptoms, behavior, and family system are also examined to illustrate how they uniquely contributed to the intense feelings evoked in the therapist. Topics of abandonment, omnipotence, curative fantasies, Borderline Personality Disorder, biblical myth, and childhood trauma are explored throughout this paper, as they uniquely intersected to create a complex web of psychodynamics between therapist and patient. This is demonstrated primarily through an interpretation of the patient’s final session and the therapist’s dream following treatment. Finally, implications for wounded healers’ self-disclosure are examined, reflections of the treatment are offered, and suggestions made for the recognition and management of countertransference wounded healers are prone to feel while working with ‘difficult to treat’ patients.

*\*Privacy Disclaimer: The names and identifying details of the patient and his family have been significantly altered to protect the privacy of the individuals.*

*“What is to give light must endure burning.”*

*-Viktor Frankl*

The referral seemed straightforward enough, a “softball,” I thought. A woman named Ruth called my office seeking counseling for her fifteen-year-old son. He’d recently returned home, blackout drunk after his girlfriend ended their three-month relationship. Teenage breakup was a subject with which I had become quite familiar. Having worked with hundreds of teens, I had listened to countless tales of woe. Lending an ear and the passage of time was usually enough to mend the young heart. Not this time. And that softball...well, it clocked me upside my head and brought me to my knees.

This paper has arisen out of a desire to understand the countertransference reactions I experienced while working with the aforementioned patient; most of which came in hindsight long after treatment ended. During treatment, I struggled to recognize much of my subjective countertransference and its impact upon the therapeutic relationship. This paper will discuss the reasons and manner in which subjective countertransference impacted the treatment of the patient. In doing so, I will discuss how my childhood experiences, and subsequent assumption of the Jungian wounded healer archetype, fueled the countertransference in ways that were both beneficial and detrimental to the treatment. The patient’s symptoms, behavior, and family system will be examined to illustrate how they uniquely contributed to the intense feelings stirred up in me during the treatment. This will be explored primarily through an interpretation of the patient’s final session and a dream that occurred after treatment ended. Finally, the implications of wounded healer self-disclosure and stigma are discussed, reflections of the treatment are offered, and suggestions are made for exploring intense countertransference reactions wounded therapists are prone to experience while working with “difficult to treat” patients.

Carl Jung first coined the term “wounded healer” in 1951. It is a phenomena that philological and psychological scholar Karoly Kerényi (1959) referred to as the ability “to be at home in the darkness of suffering and there to find germs of light and recovery with which, as though by enchantment, to bring forth Asclepius, the sunlike healer” (n.p.). The archetype suggests that

healing power can derive from the healer's own woundedness. It is based in part on the mythical Greek character Chiron. Chiron, a centaur, born half man-half horse to sea-nymph Philyra and Olympian God Cronos, was rejected at birth. Considered too disfigured, Chiron was abandoned by his parents, and raised by Apollo, who educated him in the art of medicine. As an adult, Chiron was revered as a wise teacher and mentor, and for his child rearing qualities. Accidentally shot by a poisonous arrow, he sustained a wound that, ironically, he could not heal. This wound did not prove fatal, however, due to his god-like immortality. Thus, Chiron was forced to live his life in endless pain while continuing to serve and heal others until bargaining his death with Zeus.

The wounded healer archetype is a prevalent yet seldom researched and discussed theme within the mental health field. The archetype proposes that a healer's own pain can have a curative effect on patients. Viktor Frankl (1965) writes, "I believe that my handicap will only enhance my ability to help others. I know that without the suffering, the growth that I have achieved would have been impossible" (p. 179). Psychotherapists are often drawn to the mental health field by personal experiences of emotional turmoil and pain. Anna Freud once said, "The most sophisticated defense mechanism I've ever encountered was becoming a therapist" (Norcross & Guy, p. 1). Many mental health practitioners use the profession as a way to heal their own psychic wounds (Russell, Pasnau, Zebulon, & Taintor, 1975). Sussman (2007) reports that therapists cite childhood experiences of woundedness as a primary motivation for entering the profession. This notion is supported by research that psychotherapists, as compared to the general population, come from emotionally withdrawn and unstable homes (Burton, 1972; Ford, 1963; Groesbeck, 1975; Racusin, Abramowitz, & Winter, 1981). Chu (1998) furthers that the reasons therapists get into the mental health field are personal and related to their own painful feelings of having been lost, disenfranchised, or victimized. Wounded healers are also commonly represented in the substance abuse field, many having struggled with addiction themselves (White, 2000). It is well documented that several esteemed psychological theorists including Carl Jung, Lawrence Kohlberg, and Marsha Linehan have suffered from mental health issues. Given the frequency with which the wounded healer archetype exists within the mental health professions, patients would be hard pressed to

find a therapist who has not had a diagnosable mental disorder at some point in their lifetime. One only needs to look as far as Adjustment Disorder diagnoses in *The Diagnostic and Statistical Manual of Mental Health Disorders, Edition 5 (DSM-5)* to validate this claim. It is likely, too, that patients would go unaware of this, as a majority of therapists choose not to disclose such information. It is neither good nor bad when a therapist has struggled with mental health issues, emotional trauma or psychic wounds, but rather it is their ability to draw on their woundedness in the service of healing that is important (Zerubavel, Wright, & O'Dougherty, 2012). Therapists who can successfully navigate challenges and have processed their pain and identified their strength as a result of their wounds are in a better position to ensure more positive treatment outcomes in their patients

For these reasons, investigating the wounded healer archetype and its dichotomic nature is essential for understanding its impact on the therapeutic relationship. Gilroy, Carroll, and Murra (2001) assert that wounded healer therapists may have a greater ability to empathize with their patient's pain, can have a more profound understanding of that pain, and show more patience and tolerance during treatment. Research further indicates that the wounded healer's countertransference can have a positive influence on therapy as well. Gelso and Hayes (2007) cite that wounded healers who have sufficiently addressed their mental and emotional health issues can make uniquely talented therapists. However, there are also caveats to consider when a therapist fits the wounded healer archetype. Briere (1992) cites decreased ability to be emotionally present, poorly managed countertransference, overidentification, and projection as common negative aspects that impact treatment with patients. Cain (2000) illustrates this in his qualitative study of therapists with histories of psychiatric hospitalizations,

I started working rather heavily with people with multiple personality disorder. And, for the most part, they were like other clients for me except that I had a phenomenal ability to shift with them. But then I got one particular case, and it turned out that the girl had a background that was very, very similar to my own, that I myself had multiple personality disorder. It had been buried since I was 10 years old, and it suddenly reemerged...I was

spending just ungodly amounts of time working with this girl...But it was a negative instance. Had I known that I was in a sense working with myself. I was giving her what I would have wanted and didn't know it. I didn't know that I was MPD. (Anonymous, p. 25)

This testimony speaks to the fact that particular patients are capable of triggering the wounded healer's pain. Patients presenting with similar childhood history, experiences, and trauma to the therapist's are more likely to elicit countertransference reactions from their therapist. As you will come to read, this was true in my treatment of a patient named Luke. Despite any resemblance in symptomatology, there were similarities between us that caused an overidentification with him during the treatment. This had a profound impact upon the therapeutic relationship and continued to affect me long after treatment ceased.

### **Luke Harper**

My work with Luke began on a Thursday afternoon in the late fall of 2010 and continued weekly for the better part of one year. I opened the door that day expecting to find a teenage boy sitting next to his mother, as was the norm for an initial appointment. Instead, I saw Luke sitting alone in the far corner of the waiting room. He was hunched over with his head down, his eyes gazing at the floor in front of him. His bangs covered his forehead in a Beatle-esque shag. Having just finished school, he was still dressed in his uniform: a blue oxford shirt and a patterned maroon necktie adorned with his school's crest, which he would wear to all of our subsequent sessions. His ill-fitting khakis draped over his long skinny legs. I welcomed him in, and with that, he slung his backpack over his left shoulder and walked past me into my office without making eye contact or saying a word. This weekly reoccurrence would come to represent the defeat and exhaustion of our therapy for the next year.

The following week I arranged to meet Luke's parents, Ruth and Warren Harper. Upon entering my office, they sat at opposite ends of my couch, leaving a gap between them, with just enough space to fit Luke had he been present. Warren was a computer programmer at a Fortune 500 company and Ruth, a stay-at-home mother. They had one other child Mandy, age six. The Harpers lived in an affluent town just down the road from

my office. Like most families I met with from the area, Warren worked very long hours while Ruth cared for and scheduled the children, who attend private schools. During the session, Warren said very little and usually deferred to Ruth to answer even the simplest of questions. He wore a grey suit that seemed to mirror his demeanor. His face showed very little range of emotion, his slow, deep voice never changing in inflection or pitch, even when discussing his primary concern, Luke's grades. Ruth looked tired and somewhat unkempt. She wore a grey sweatsuit and no makeup, with her hair pulled back into a short ponytail.

Ruth was considerably more animated than Warren, her voice modulating with the ebb and flow of her emotions. At times, her facial expression was tense, with jaw clenched, especially when discussing Luke "not working to his potential." Other times, she looked distressed, on the verge of tears, stating that she was the "bad guy" having to set rules while Warren got to be the "fun parent." "The problem is they don't talk. He will take Luke to a movie once every few weeks, but that's not communicating with your son!" Ruth said. Warren remained deadpan unresponsive to the assertion.

As the session progressed, Ruth began to share detailed information about Luke's childhood. She said, "Luke was very fussy as a baby. He was an angry child. He would have these really bad temper tantrums where he would scream and flail his arms and legs. We took him to a therapist for a few months when he was six." She continued that Luke never had many friends, and struggled to maintain close friendships. "He has just always been unhappy...sad," Ruth lamented.

The Harpers reported an extensive history of completed suicides on both sides of the family. Two maternal aunts, and a paternal aunt and uncle had all committed suicide as a result of struggles with mood disorders. Ruth admitted that she had impulsively attempted suicide by taking a cocktail of psychotropic medications when Luke was eight. She was hospitalized for two weeks following the attempt, while Luke stayed with his father. When I questioned Warren about how he explained Ruth's absence, he replied, "I told him that she'll be back in a few days." But Warren never explained her whereabouts. "Luke played in the driveway the whole time I was gone. That's what you told me," Ruth exclaimed, glaring at Warren. He nodded silently in agreement. Ruth recalled that Luke was angry with her upon her return from the hospital. "That lasted a few weeks," she said. Ruth reported that they never told Luke

what happened, but believe that he now knows. She continued that she was worried that Luke might try to take his life at some point. I felt a knot cinch in my stomach as she said this. Based on Ruth's description, I, too, felt he was at risk. The last thing I said to the Harpers that day was, "I will do my very best to help Luke and your family. It could take us some time, but I am confident that things can get better." The former was true, but looking back, I am not so sure about the latter.

Luke would challenge me weekly for the next year, proving to be the most difficult patient that I have ever treated. The majority of sessions were spent in triage, devoted to processing the latest in a number of intense altercations at home, discussing a new incidence of self-injury or his most recent suicide attempt. It felt like Luke was always drowning and that I was desperately trying to save him. Treading water just to stay afloat, he would repeatedly push me below the surface with each new crisis he brought to session. I often say, "You can't fish when your boat is sinking," and it felt like Luke was always sinking. There was never an opportune time to analyze or explore the dynamics of our relationship and the transference. His ego needed to be buoyant enough to do this, and I struggled just to keep us both afloat. Despite my best efforts, and the cocktail of psychotropic medications he was prescribed, any attempt to do this felt futile. As a matter of fact, it seemed like Luke was becoming more symptomatic and increasingly prone to act out his aggressive impulses as treatment progressed.

I would be remiss if I did not mention how Luke's symptomatology impacted the treatment, and although I do not intend to frame this case around his diagnosis of Borderline Personality Disorder (BPD), it is integral to understanding what transpired between us. It has been argued that countertransference reactions are the most reliable indicator in making a Borderline Personality Disorder diagnosis (Solomon, Lang, & Grotstein, 1987). Given the intense feelings Luke regularly induced in me, combined with his behavior outside the treatment room, I am confident that Luke suffered from BPD. Borderline Personality Disorder is a mental illness marked by unstable moods, behavior, and relationships (National Institute of Mental Health, 2013). The *Diagnostic & Statistical Manual of Mental Disorders, 5<sup>th</sup> Edition* lists nine pervasive symptoms that mark the disorder (American Psychiatric Association, 2013). Luke exhibited seven of these during the course of our work together. He frequently self-injured via cutting and

experienced angry outbursts at home that he directed at his parents, destroying furniture and family possessions in the process. He attempted suicide three times during treatment and was subsequently hospitalized after each. Each attempt was impulsive, without a preconceived plan, and occurred within the hour of an argument or break-up with a girlfriend.

Initially, when I made the decision to write about Luke, I did not understand my motivation for sharing our story. What I was aware of, however, was the emotional toll the relationship had taken on me. It has been through the process of writing that I have come to understand some of the dynamics that were at play during the treatment. Ruggiero (2011) writes that countertransference difficulties predominate the treatment with BPD patients due to the impending threat of destruction of the therapeutic relationship. I unequivocally believe that this is true of my work with Luke. I was in constant fear of our mutual annihilation. Time and again, I was subject to the crises of Luke's life and the accompanying anxiety that if I did not help him it could lead to his death and my professional and emotional disintegration. I can recall periods of catastrophic thinking where my ultimate fear of patient suicide was activated, along with the potential everlasting consequences: an enormous sense of guilt, and loss of my professional license, reputation and livelihood. As a result, I continuously struggled to manage the self-destructiveness of Luke's aggressive behavior. When they occurred, I felt inadequate, as though I should have been able to prevent them. I was continuously plagued with questions of how to stop these acts from occurring and why I had been unsuccessful at previously stopping them. I felt like a lifeguard ill-equipped to save a drowning victim.

In the unlikely event that a session was not spent in triage, I experienced some relief in the "pseudo-security" that Luke was emotionally stable. I use the term "pseudo-security" because I do not believe there was ever a time during the treatment when Luke was not prone to impulsive acts of self-destruction. This contributed to a vacillating pattern of annihilation and omnipotence that emerged in the treatment. I now recognize that my narcissistic aspiration to help Luke was in part induced by his unrealistic wishes, and a shared belief that I was omnipotent and he helpless. This resulted in two "narcissistic snares," a faulty aspiration to know all and heal all (Maltsberger & Buie, 1974). When I failed to

achieve this, I would feel hopeless, just like Luke. Unbeknownst to me, I could never live up to Luke's omnipotent aspirations. Similar to the Greek mythological character Sisyphus, whose hubris led him to believe he was cleverer than Zeus, I maintained an omnipotent fantasy that I could heal Luke. And just like Sisyphus and his boulder, my efforts ultimately ended in exhaustion, repeated frustration, and with pervasive feelings of inadequacy each time progress would backslide.

### The Last Session

"How's it going?" I asked as Luke placed his backpack on the floor. As he sat down on the couch, he began to speak about his relationship with then-girlfriend Jenna, whom he had met during his latest hospitalization.

Luke: I haven't broken up with Jenna.

Therapist: You mentioned that you were thinking about it last session. Seems like you're still struggling with that.

Luke: I don't want to sound narcissistic, but she needs me. She needs someone.

Therapist: I don't think that sounds narcissistic. But there is a difference in her needing you and her needing someone. No?

My response hinted at what was transpiring in my relationship with Luke. It was a projection of my ambivalence. I was asking Luke to question his role of rescuer, as a manner of unconsciously questioning my own. In recent sessions, I encouraged Luke to consider my treatment recommendation that he attend an initial assessment for an intensive outpatient program. It had taken several weeks and a considerable amount of personal processing before I could recommend this to Luke's mother. Unfortunately, the idea did not go over well in their discussions, with Ruth reporting that Luke was resistant and argumentative. "He won't go. He says he won't talk to anyone else but you," she told me. Luke idealized me, and the impending threat of separation resulted in anxiety and desperation. Perceiving me as omnipotent, he would naturally resist termination and perceive it as abandonment. Because he felt helpless without me, he would need to find a way to maintain a fused relationship. I wonder if Luke's suicide attempt on the night of what would become our final session was a last

ditch effort to prevent our separation. At the time, however, I believed that I was making some headway with Luke, as well as with my own resistance to terminating his treatment. I was beginning to come to terms with the notion that Luke needed a greater level of care than I could provide with once per week sessions. There would be relief in no longer having Luke as my patient. Several colleagues had previously suggested termination after hearing about the repeated crises that sprung up in the treatment. But the very thought of termination had evoked personal guilt. "*Luke would feel like I'm abandoning him...that I don't care,*" I thought. Gabbard (1993) notes that in these situations, therapists may criticize themselves for a lack of professional ethics and make amends to patients by professing undying devotion through continued sympathetic discharge in the therapeutic dyad. This is precisely what occurred in the treatment. I felt great sympathy for Luke, and I could see his enormous suffering as he grappled with overwhelming emotions that seemed to consume him. The more I felt sorry for him, the more each new crisis would impact me, and induce feelings that I was not doing enough and would need to increase my efforts to help.

Gabbard (1993) writes of borderline patients that "the anxiety the patient will commit suicide is ever present and the sense of guilt and responsibility induced by the borderline patient amplifies such worries" (p. 11). This dynamic is co-constructed in the treatment. Luke was obviously not sitting alone in my office. I was a contributor to the relationship, and like all therapists, brought my past conflicts into session. Bollas (1990) writes, "In order to find the patient we must look for him within ourselves. This process inevitably points to the fact that there are 'two patients' in the session and therefore two complementary sources of free association" (p. 202). Although I thought plenty about Luke and the effects we were having on each other, I failed to recognize much of my subjective countertransference. There was, however, much we shared in common just below the surface.

Luke continued about Jenna, "She doesn't have anyone else."

"Sounds like you feel responsible for her," I answered.

Luke insisted that he liked spending time with Jenna but felt he was obligated to do so. I could clearly relate. I often looked forward to our weekly sessions. But, needless to say, the work was often incredibly frustrating. *Wouldn't my time*

*be better spent elsewhere, helping someone more amenable to treatment?* But Luke was my proverbial ball and chain. I was determined to help him. How much of this was induced by Luke, and how much by my past conflicts, is hard to discern. Natterson (1991) asserts it is important for clinicians to see themselves as patients whose own issues enter into the treatment with their patients. I was unable to recognize how my personal struggles crept into treatment. My countertransference was less obvious with Luke than it had been with other patients, thereby making them easier to contain and control. Gabbard (1993) notes that the interactions between therapist and patient are “so inextricably bound up with one another that what is initiative and what is reactive may be next to impossible to dissect” (p. 13). In the treatment of Luke, our individual contributions to the countertransference were terribly opaque. I only have an understanding of this now, after some time to differentiate from him and the treatment. By focusing solely on the objective countertransference, I had created a blind spot, disavowing my conflicts and the impact they were having on the treatment. This comes as no surprise now, given a professional history of mostly working with healthier or more neurotic patients where subjective transference is more easily identifiable (Gabbard, 1993). What transpired between Luke and I was a result of his projections and their interaction with my interpersonal compromise solutions. By solely focusing on Luke’s behavior and its effect on me, I lacked the gestalt necessary to understand my countertransference in its entirety.

As the session progressed, the conversation segued from Luke’s relationship with Jenna to somewhat uncharted territory, his parents’ relationship. This was a topic that seldom came up in session. Most often we would speak about his relationships with each of his parents separately. Initially, it seemed as if the conversation would take this course until Luke said, “My parents’ marriage is fucked up! They don’t even love each other. They just share the same space. I fucking hate him [Warren]. I wish he would just leave. I fucking hate him!” Then he went silent. I watched Luke’s eyes scan the room as if he were searching for something, something new that he had not noticed before.

Luke: We read a cool story today in religion. Do you know the Bible?

Therapist: Ah, vaguely. I know some of the Bible’s more popular stories.

Luke: Then you know Noah...It’s a pretty far-fetched story. Don’t you think?

Therapist: What do you find far-fetched?

Luke: Well this guy builds this big ass boat and manages to get every animal in the world on there.

Therapist: I do agree that seems unrealistic. Impossible, really.

Luke: Think about how big that boat would need to be.

I gazed up at the ceiling pondering this for a moment, immediately realizing that I had no idea how to gauge the size of something so massive. All I could envision was based on childhood recollection from Sunday morning religious television. The arc was brown, wooden, boxy, aesthetically unflattering, but functional. Where was Luke going with this? I wondered. I allowed myself to drift in the current he was stirring; instinctively knowing this would be another entrée into his turbulent world. Havsteen-Franklin (2007) writes that by using myth, patients have the opportunity to find a place where they can gain freedom for thinking that includes awareness of, rather than being overwhelmed by, unacceptable feelings of their internal world (p. 60). The story of Noah could be a subliminal and less threatening way for Luke to express his feelings.

It was too overwhelming for him to talk about what was really going on in his family. The image the Harpers portrayed to the world was quite different from the reality. They lived in a nice house in an affluent town; Luke attended a prestigious private school, Warren was upper management at a financial firm, and Ruth maintained an immaculate house and cared for the children. Luke wanted me to hear the untold story, his story. This was a double binding invitation however, and an impassable test. If I chose not to climb aboard and weather the swells with him, he could experience this as a rejection or abandonment. On the other hand, by accepting his offer, I ran the risk of failing or disappointing him. I was aware that I could not treat the family pathology, as it was not within my purview, but I was fully committed to helping Luke. Thus, I accepted his invitation. Hunter S. Thompson

(1971) writes,

Buy the ticket, take the ride...and if it occasionally gets a little heavier than what you had in mind, well...maybe chalk it off to forced conscious expansion: Tune in, freak out, get beaten. (p. 89)

Oh, how these words ring true in retrospect. There is a masochistic streak in me that revealed itself while working with Luke. I felt a duty to accompany him despite the emotional rollercoaster ride he had me on. I had willingly taken him on as a patient, not knowing the extent to which he would test me. I felt obligated to securely hold anything he put forth, no matter how emotionally draining; the running away, regular self-injury, the suicide attempts, a sexual assault (to be referenced later in the paper), all of it. At times, I would feel overwhelmed and anxious, and at other times completely drained. But I made a promise to help Luke and his family. Only now have I come to realize that I conveniently repressed my anger toward Luke for what he was putting me through. How could I have been angry with him? He was in so much pain and his family was ripping apart at the seams. I was so blinded by his emotional distress that I often did not acknowledge my own. When I would discuss Luke with my supervisor, he encouraged me to terminate treatment due to a great liability he posed to me professionally and the group practice where I worked. A colleague had once asked why I did not “just refer Luke out” during a conversation about difficult cases. I remember feeling like this would be abandonment. I believed Luke would have interpreted it that way, too. I felt it was a cop-out. I had often heard stories of therapists referring out BPD patients because they were too much work. I could not bring myself to do that. So, I remained present and attentive, 100-percent on board, despite doubts that treatment was hurting rather than helping.

### The Slip

Luke bent down, unzipped his book bag and pulled out a large textbook. He flipped through the pages, stopping at the passage he wanted. “You know the ark was three-hundred cubits?” Luke said. I had no idea what a cubit was, so Luke gave me a detailed explanation of what he learned that day and the size of the ark.

Luke: Just think of all the work that would have to go into building that thing.

Therapist: Yeah, it’s a lot of work. I wonder if Noah felt a sense of responsibility for everything?

Luke: I wouldn’t have done it. Too much work...F that! I’d be like screw you.

Therapist: OK. So, if you were Moses, you’d let the world flood?

Luke: Yes. But you mean Noah?

Therapist: Yeah. What did I say?

Luke: You said Moses. You know...he was the guy who parted the Red Sea and saved the Jews from the Egyptians.

Therapist: Ahhh, right. I knew that...I’m not sure why I said Moses.

*Luke giggled.*

Luke: It’s cool. They’re both dudes with long hair and beards.

I did not think too much of it either. But then I would make the same slip again moments later. As I sat there in my chair, my mind was adrift thinking, *He’d let them die*. This would free him; the flood could just wash them all away. He would not have to deal with his critical mother and a stoic, detached father. *It’s too much work for him*, I thought. I now realize that it was all too much work for me, too. Treating Luke was emotionally taxing enough, but thinking about the overwhelming pathology of the family was enough to make me wish they were gone, too. After all, he was a mere teenager. It was hard to imagine that his aggression and difficulties regulating emotion were nothing but a direct result of childhood trauma. This perception clearly contributed to the blocking of my anger toward Luke. Luke was a product of his environment, shaped by relationships and attachments fraught with ambivalence and anxiety from the outset. This is a familiar theme I recognize from my own life. As a child, I had grown accustomed to suppressing my anger toward persons I perceived as victims. I split off the reasons for their behavior, absolved them of fault, and made excuses for them like, “it was their illness,” “they don’t know any better,



this was the only way they knew how to cope.” This pattern was playing out in my relationship with Luke, yet I could not see it.

This dynamic was further compounded by two factors. The first is an overidentification with Luke. I understood the experience of preoccupied parents with mental health issues, and the pain and confusion this can cause a child. A safe adult to empathize with my experience would have been invaluable at that time. My desire to support Luke through this period of his life was rooted in a wish that someone would have done the same for me. Secondly, my relationship with Luke had a familiar air to it. Like my mother, Luke suffered from severe psychopathology and just as in my relationship with her I hoped he would get better. Logically I knew this was not possible, but was driven by an unconscious wish to fix him. This was an unachievable task for a child with a sick mother and would prove to be so now with Luke. Yet, I continued to try to rescue him despite continuously falling short.

Therapist: There’s a house on the ark, right?

Luke: Yeah, for Noah and his family. To protect them from the storm.

Therapist: I think it’d be pretty rocky in that house? You know with the wind and the rain...the swells.

Luke nodded in agreement.

Therapist: It reminds me of your house. It’s pretty turbulent at times. The arguments you have with your mom and dad. When you tell me about cutting yourself, destroying furniture...the place where all this stuff happens is in your house.

Luke: Are you saying I’m like Noah?

Therapist: What do mean?

Luke (*scratching the back of his head*): I don’t know...like I have to deal with all this shit and just like hold on, no matter how bad it gets or how bad I feel?

Therapist: That’s an interesting way to look it at. What are your other options?

Luke (*laughing*): Jump ship!

Therapist: Well, occasionally you do. You’ve run away a few times.

Luke (*smiling*): It’s like I’m a man overboard, and I keep getting pulled back onto the boat.

Therapist: That’s an interesting metaphor. Who pulls you back?

Luke: You do. You always talk me into going back.

I paused to reflect on the latent content of Luke’s statement. Did he see me as a rescuer or as some sadistic bounty hunter who was sending him back to his jail cell? I believe Luke was incapable of simultaneously experiencing me as both. At times, I was the idealized, omnipotent object, and at others a cruel, scheming therapist making demands of him, and colluding with his mother. Luke ultimately experienced me as a controlling force, “manipulating [him] for either good or ill” (McGlashan, 1983). In reality, however, Luke had a choice in these situations despite any options or suggestions I offered. Luke interrupted my reflection.

Luke: You know...I never told you my favorite part of the story.

Therapist: About Moses?

*A big smile swept across Luke’s face.*

Luke (*chuckling*): You did it again!

Therapist: Did I say Moses again?

I was slightly embarrassed. What was going on? Why had I made this slip a second time? Surely I could identify with Moses, the rescuer, as I was attempting to guide this lost, helpless boy through a desert of emptiness; fantasizing that I could part the sea, and protect him from the tidal wave of emotions that routinely crashed over him. My identification with Moses would run much deeper than this, however. My parapraxis had “a meaning and can be interpreted, and that one is justified in inferring [from them] the presence of restrained or repressed impulses and intentions” (Freud, 1925, p. 46-47). As a baby, Moses was abandoned by his mother, and set adrift in a basket on the Nile River in order to protect him from the murderous Pharaoh. Through my own psychoanalysis, I have come to discover that I, too,

felt abandoned as a child. Freud writes that certain conditions are particularly conducive to repressed material “to penetrate into conscious...whenever recent events produce impressions or experiences which are so much like repressed material that they have the power to awaken it” (1939, p. 121). Without question, my own memories and fears of abandonment were triggered in the treatment of Luke. My parents were inadequate in providing the emotional security that I required. My mother was extremely unhealthy throughout my youth, which caused me to fear her imminent death. Preoccupied with the symptoms of her psychosis, she projected her anxieties on to me, thereby sabotaging any attempt she made at creating a secure environment. Thankfully, I was able to find refuge in my maternal grandmother and aunts, whose affection gave me respite from the distress I often felt when alone with her.

My mother’s health greatly strained my parents’ marriage, too. And, although I do not attribute the demise of their marriage solely to this, I can imagine it contributed greatly to my father’s emotional and physical disconnection from her. My father, like Luke’s, was barely home, traveling extensively for work. He would live with us periodically, and with the exception of my latency years, never seemed to be fully engaged with our family. Undoubtedly, this had an impact on me, as I believed that I was left alone to ensure my mother’s well being. My father would routinely tell me, “Make sure you take care of your mother.” This was extremely frightening, as I did not know how nor would I ever be able to meet her needs. Not unlike my mother, Ruth was chronically ill, and in spite of a deep love and concern for her son, it was clear that she was easily overwhelmed by life and continuously struggled to regulate her emotions. Prone to episodes of rage and depression, Ruth could insult Luke without provocation and withdraw her love if he did not comply with or appease her.

Given the parallels between our experiences, the slip of Moses was a verbalization of my projected wish. Being deeply conflicted about the choices my father made when I was a child, I unconsciously picked the persona of Moses, whose description gratified my unconscious wish (Appelbaum, 2012). I wished that my father had rescued me from the anxiety I often experienced in the presence of my mother. In retrospect, I can see how this wish I had for my father impacted countertransference reactions in the treatment and stood in the way of terminating treatment

with Luke. His parents had already emotionally abandoned him, and I knew all too well what this was like. Instead, I would respond to Luke’s need as I wished my father had, and how a hero like Moses would have done. Freud (1939) says, “A hero is someone who has the courage to rebel against his father and in the end victoriously overcome him” (p. 12). By trying to rescue Luke, I was unconsciously attempting to overcome my father. I could rise above my unmet childhood need for protection by playing the hero role for Luke. Perhaps I could save him from the pain I felt as a child. Shaffer (2006) writes that unconscious motivation “manifests in a strong conviction about what people need to get better” (p. 353). This is a quite common countertransference reaction among many wounded healers who vicariously seek to heal personal wounds by helping patients through similar life obstacles. A quote from the novel *The Catcher in the Rye* echoes this sentiment through alienated, teen protagonist Holden Caulfield.

Anyway, I keep picturing all these little kids playing some game in this big field of rye and all. Thousands of little kids, and nobody’s around – nobody big, I mean – except me. And I’m standing on the edge of some crazy cliff. What I have to do, I have to catch everybody if they start to go over the cliff – I mean if they’re running and they don’t look where they’re going I have to come out from somewhere and catch them. That’s all I do all day. I’d just be the catcher in the rye and all. I know it’s crazy, but that’s the only thing I’d really like to be. (Salinger, 1951, p. 224)

Holden is trying to save innocent children from the suffering he has come to know. He is the potential hero in the wings, with an ability to prevent others from experiencing the pain he has felt. I felt a kinship with Holden in my desire to keep Luke just far enough away from the cliff’s edge. His parents were either too preoccupied or dismissive to do so, which left Luke alone to navigate powerful emotions that often seemed too much to bear. Seeing aspects of my teenage self in him, I empathized with his experience and knew there was hope for adult life that was more emotionally stable.

Unfortunately, I did not have the opportunity to shepherd Luke safely into adulthood due to the untimely ending of treatment following Luke’s third suicide attempt. Like Moses, who died before crossing the Jordan River, I would never see Luke

make it to the proverbial promised land of adulthood. Although Luke failed to end his life, he did succeed in killing our relationship. Luke had left me prematurely before our work was finished. Like Humbert Humbert in Nabokov's *Lolita*, who felt his second chance at love was inexplicably taken away, I was cheated of my redemption, my second chance to make things right. Had I been able to rescue Luke, perhaps the repressed wish to heal my mother could be satisfied.

After treatment had ended, I struggled with feelings of guilt and inadequacy. Despite my efforts to suppress these feelings, they were stronger than any I experienced in working with patients before. There was a sense that I had done something wrong. Personal reflection would inevitably lead to self-doubt. *"I should have been more empathetic. I should have been awake to receive his text message at 2 a.m. Perhaps I should have incorporated more Dialectical Behavioral interventions? I should have referred him to someone who could help him."* These were just some of the thoughts that periodically made their way into consciousness after my work with Luke. Goldberg (2012) maintains that it is terribly difficult to separate a perceived failure from the moral judgments that often accompany this evaluation. This was certainly true of my experience both during and after the treatment. In reality, Luke's acts of aggression may have had little to do with anything I did wrong. Many patients manifesting with borderline personality traits seem to unravel as treatment progresses (Gabbard, 2003). This phenomenon was unfamiliar to me during the treatment, but I now know this was true in the case of Luke. The more he decompensated, the more guilt I experienced. Gabbard (1993) writes, "Borderline patients often present themselves as Dickensian orphaned waifs who need the therapist to serve as a 'good' mother or father to make up for the 'bad' or absent parent responsible for victimizing the child" (p. 4). Periodically I filled the "good" father role for Luke, standing in the place of his emotionally detached father. Periodically my role would expand to husband, too, supporting and providing guidance to Ruth while Warren remained impotent and absent in his parenting. This role ultimately caused what Freud dubs a "return to the repressed" in which Luke would reenact an Oedipal conflict with me. Returning again to my identification with Moses, who Bernstein writes, "symbolizes the 'great man' father figure – the figure of authority" (1998, p. 73), I would come to represent the "good" father, and inevitably Luke

would respond by rebelling against me in an Oedipal reenactment. In *Moses and Monotheism* Freud says, "I have no hesitation in declaring that men have always known (in this special way) that they once possessed a primal father and killed him" (1939, p. 100-101). Little did I realize I contributed to this dynamic by regressing into a primitive struggle with Luke. Winnicott (1974) writes of this phenomenon,

At such moments the patient is likely to become unconsciously equated in the therapist's mind with the adversary mother of his anal stage; he will be tempted into a fight to "show her who is boss." When the therapist is drawn into a fight, the patient plunges into a hating, panic-like frame of mind in which survival or annihilation seems to be the issue. (p. 631)

Luke unconsciously experienced this struggle as my attempt to control him, and would retaliate by trying to destroy himself, abandoning me in the process. The suicide note Luke wrote to his mother evidences this: "Please tell Ralph I'm sorry. I know I was supposed to call him if I was going to do this, but he would have tried to stop me." Had Luke succeeded in suicide he would have killed me, the symbolic "good" father.

### **The Castration of Noah**

With a greater understanding of my affinity for Moses and its relevance to the treatment, I would now like to turn to the story of Noah. God and Christianity were themes that were discussed several times during the course of our work. Luke would report heated arguments with his mother regarding Catechism class attendance and his completion of the Roman Catholic sacrament of Confirmation. Luke once told me, "I don't want to lie to the priest when he asks me if I believe." Ruth, on the other hand, felt it her duty to have Luke confirmed, telling him, "I've decided for you. I have to do everything I can to keep you out of hell." These harsh words only served to anger Luke and intensify his resistance to the experience. Yet, there was something about the biblical story of Noah that resonated with Luke and motivated him to bring it to session. It was not the usual session fodder he brought in each week – the arguments with his parents, incidents of self-injury, girlfriend woes, and friendship disputes. It was quite different in that it lent itself to interpretation. Havsteen-Franklin (2007) writes, "A

contextualization of the image in a myth can be an aid to illustrating the internal world of a person struggling [...] The narrative enables a sense of personal positioning in relation to what is otherwise overwhelming” (p. 68). The story of Noah was symbolic of the power dynamics at play between Luke and his father, and in his relationship with me. Themes of control, punishment, and retribution are all depicted in the Noah myth, and parallel Luke’s interpersonal patterns during the course of treatment.

Therapist: OK, so what’s your favorite part of the story?

Luke (*smirking*): Noah gets shitfaced after it’s over. He saves the world, and the first thing he does is get drunk. His son finds him passed out, naked in a tent.

Therapist: What does Noah’s son do?

Luke: Well, he has three sons. The youngest son is Ham. That’s the one who sees him.

Therapist: Uh huh, what does Ham do?

Luke: He just looks at him and leaves.

Therapist: What do you think Ham was feeling in that moment?

Luke: Weird! Awkward.

Therapist: I bet. Do you think he was disappointed in his father?

Luke: I’m not sure.

My question stemmed from a Freudian notion reflected in his essay, *Some Reflections on Schoolboy Psychology*:

From his nursery the boy begins to cast his eyes upon the world outside. And he cannot fail now to make discoveries that undermine his original high opinion of his father and which expedite his detachment from his first ideal. He finds that his father is no longer the mightiest, wisest and richest of beings; he grows dissatisfied with him, he learns to criticize him and to estimate his place in society; and then, as a rule, he makes him pay heavily for the disappointment that has been caused by him. (Freud, 1914, p. 244)

Luke was extremely disappointed in his father. Warren was not living up to the expectations Luke had of him. He was not present and attuned to his son, was emotionally distant with a hypoaroused affect. This angered Luke immensely, and he wanted to punish Warren for it, going so far as to tell me about fantasies of killing him.

“It seems like Ham just wants to get out of there. So he goes and tells his two older brothers. They cover Noah, but they turn their heads away, so they do not have to see him naked,” Luke said.

“Huh, wonder why?” I asked.

“Well...who the hell wants to see their father naked?” Luke replied.

“Good point!” I concurred.

Luke’s description of the myth was accurate, but he stopped just short of explaining Noah’s reaction to being discovered. The King James Bible reads, “When Noah awoke from his wine and found out what his youngest son had done to him, he said, ‘Cursed be Canaan! The lowest of slaves will he be to his brothers’” (9 Gen. 24-27, King James Version). This passage implies that Ham performed an action, but the Bible leaves its reader guessing, never elaborating on what Ham did. There are several scholarly interpretations of what Ham really did to Noah, as seeing a father naked was not typical or sufficient ground for eternal servitude. One common interpretation claims that a sexual crime, specifically castration or sodomy, occurred (Goldenberg, 2005). The assumption is that Ham must have done something so inexplicably cruel to Noah that it warranted a curse upon Ham’s descendants. In following with this interpretation of the text, Ham commits an aggressive sexual act, one motivated by power. Whether Ham castrates or sodomizes Noah, it is an attempt at taking power from him. Ham shames and emasculates his father, the assault serving as a display of dominance. Winnicott (1974) explains that suicidal patients can experience deep regressions that involve impulses to destroy through “anal sodomy in an attempt to render a person helpless and then to dirty and injure him and to enjoy his agony” (p. 630). Interestingly, Luke had been in two physical altercations with his father around the time of this session; one of which involved a pocketknife that Luke used to threaten Warren. “I’ll chop your dick off,” Luke told Warren during that altercation. Luke desperately sought to control, and perhaps annihilate his father, whom he believed did not give him or Ruth the attention they deserved. By acting out aggressively, Luke was successful in

assuming power and getting Warren's undivided attention via destruction. Luke would continuously get my attention too, sucking me in with each aggression. Winnicott (1974) asserts, "Unconscious masochistic trends may also be activated in the therapist as he attempts to deal with the primitive aggression of his patients. Under the guise of being loving and tolerant, he may allow the patient to attack and punish him" (1974, p. 631). Luke enslaved me by using my empathy as a means of control. Patterson (1982) writes, "Perhaps the most distinctive attribute of the slave's powerlessness was that it always originated (or was conceived of as having originated) as a substitute for death" (p. 5). Powerless to help Luke, I was shackled by his acts of rage. He was slowly killing me off, as I worked harder and harder in the treatment. Our relationship was akin to slave and master. I was to be controlled and submissive to Luke or be nothing at all. He would have it no other way.

Luke (*glancing up at the ceiling*): Oh, fuck I didn't tell you...I found my dad's stash of porn movies. Fucking fag!

Therapist: No, you didn't tell me. Where did you find them?

Luke: In his bedroom drawer. Fucking gross! He had a butt plug, too.

Therapist: That's quite a find. Sounds like you were looking for something. What do you think?

Luke: It's just fucking weird. He's a fag.

Therapist: A-ha. What makes you say that? Was it gay porn?

Luke: I don't care. He's fucking gross!

I was struck by Luke's use of the word "fag." He had never used this word in my presence before, not even when very angry. Having worked with many teenagers, it is common to hear the word "fag" traded as a barb between heterosexual males. Pascoe (2005) writes, "The term 'fag' has as much to do with failing at the masculine tasks of competence, heterosexual prowess and strength or in any way revealing weakness or femininity, as it does with a sexual identity" (p. 330). It was clear that Luke felt Warren was incompetent as both a father and husband, and, by extension, a man.

However, I think there is more to Luke's use of the word than this. About midway through the course of treatment, Luke was sexually assaulted at a bus station. A middle-aged man verbally intimidated and coerced Luke into performing oral sex on him. Luke did not report the assault to the police or his parents, and waited several weeks before he would tell me. Luke expressed that he felt angry for passively allowing the assault to take place without a physical struggle. "I should have stabbed him. I had my knife with me and didn't do anything!" Luke felt emasculated and ashamed. He asked me not to tell his parents. After careful consideration and legal consultation regarding my ethical duty, the assault was kept confidential. I remember asking Luke if he hoped that by telling me that I would be obligated to inform his parents. Despite his denial, I believe Luke may have had an unconscious wish that I would have protected and cared for him. When I did not fulfill this wish, Luke resorted to aggressive action as a way to restore his power. Luke would identify with his perpetrator, and physically attack his father, threatening him with castration. Although this is pure speculation on my part, I believe that Luke was sexually violated long before this assault. He never disclosed this to me, but Ruth had once implied as much during a telephone conversation. Looking back, I wonder if Luke thought that I would violate him, not in a sexual way per se, but as an emotional invader. In order to defend against this, Luke would have to exert power over me. This would relegate me to the role of slave, and any attempt at connection or help was rebuked in order to preserve the status quo of the slave-master relationship.

### The Dream

Months after treatment ended, I found myself still thinking about Luke. Residing in the area where Luke attended high school, I occasionally daydreamed about running into him in the mall or a chance encounter on the street. These fantasies would inevitably spark questions and more elaborate visualizations. "What would Luke be like?" "Would he even acknowledge me?" "How would I react and respond to him?" "Will he be so full of rage that he verbally chastises me in public?" In these fantasies, I hoped Luke would nod or wave to give me a sign that he was OK, and so were we. More elaborate fantasies involved a conversation where he would share how he was doing and thank me for my help. I have come to realize that I was still feeling responsible for Luke long after

our work together ended. I was preoccupied with whether I had helped, and concerned that he may resent me for a perceived abandonment. Clearly, my fantasies of having helped Luke were still very much alive. So much so that one night several months after the treatment ended, I had a vivid dream that would jar me from sleep. So as not to forget, I immediately wrote it down.

The dream began with me sitting on Luke's bed. I was aware that Luke's parents were not home. His room was unlike anything I had imagined during our conversations. I had always pictured it to be somewhat messy with posters of rock bands tacked to the walls. In the dream, however, the walls were bare, and the room was impeccably clean with an earth tone color palette, uncharacteristic of what one might expect from a teenage male. Luke stood several feet away from me. I stood up and said, "Luke, you need to help me figure you out." He smiled but did not respond. I looked down, and to my surprise I was not wearing a shirt. I was bare-chested. I immediately looked back up to find that Luke had left the room. I was alone. I feared the return of Luke's parents. How would I explain my presence in his room? I walked over to Luke's bed and proceeded to lie down on my side. As I lie there, the door to Luke's room slowly swung open. It was Luke's sister Mandy. "Who are you?" she asked. I did not know how to answer. But I was worried that she would tell her parents that I had been in Luke's room. I replied to Mandy, "I know your brother. We are friends. But please don't tell your parents I was here. OK?" With this, she swiftly turned away from me and ran out of the room. Suddenly, and without explanation, I was kneeling in the center of the room, facing away from the doorway. My hands were clasped behind my head. Someone entered the room. I looked over my shoulder and saw that it was Luke. He was holding a long, electric extension cord. I did not move or speak. Luke began to whip my back mercilessly. After several lashes, I knelt over in agony and placed my hands on the floor. I screamed out in pain. But, I did not try to run or stop Luke. Then, I awoke.

My dream is what Whitman, Kramer, and Baldrige (1969) call a "countertransference dream" and typifies my internal struggle both during and after Luke's treatment. With this in mind, I will attempt to make sense of the dream's manifest content and its relevance to my understanding of the case. At the time of the dream, I was in psychoanalytic treatment. I had recently made the transition from sitting upright in a chair facing my analyst to lying on the couch,

where he was no longer visible to me. Luke's bed represents the analytic couch, and my desire to better understand my unconscious. There is a palpable anxiety present in the dream, ambivalence evidenced by my moving back and forth between the couch and a standing position. In reality, I was concerned that my analysis would evoke powerful emotions and uncover past conflicts and trauma that I would be unable to manage. In the dream, I make an appeal to Luke for help. I want his assistance to better understand his emotions and behavior. Luke's image, however, is but a representation of myself, reflecting back a man who is struggling to make sense of a troubled childhood and its connection to his career as a therapist. Perhaps if I were to recognize my subjective countertransference, then I could begin to understand what transpired during Luke's treatment. Luke may not have honored my request in the dream, but he unknowingly did so in reality, inspiring me to analyze our work and the role my personal history played in its outcome. Luke allowed me to be acquainted with my own shadow by helping to "lift the repression and denial of my personal wounds" (Kirmayer, 2003). He had evoked such strong emotions in me that I was forced to question the reasons for why this was so.

The theme of self-exploration emerges yet again, later in the dream when Luke's sister Mandy asks, "Who are you?" Despite many distinct differences, there are several parallels between Luke and my teenage self. The most easily identifiable is that Luke, like me, had attended a parochial high school. I recall feeling a kinship with him in our early sessions as he talked about school life; a world where most of your teachers are priests, adolescent dick humor is commonplace, and the only females in sight are Sister Mary Francis and the lunch lady. This was likely an initial trigger for early countertransference reactions in the work. As treatment progressed, I learned more about the dynamics of Luke's family. But I would somehow fail to recognize critical similarities to my own: a mother struggling with depression; a father working excessively, rarely home, and presumed to be having an extramarital affair; a son desperately seeking comfort in various girlfriends who could buttress him during times of intense and overwhelming emotion. Luke's parents were clearly preoccupied with their own lives, only taking notice when he acted out his sadomasochistic impulses. By contrast, I never behaved in a manner that resembled Luke's. His

family situation, on the other hand, is strikingly familiar to me now, but comes in hindsight as a result of my own psychoanalytic treatment and the writing of this case.

The theme of innocence emerges twice during the dream. Both the color palette of Luke's room and the appearance of Luke's sister Mandy are significant in that they represent purity. Despite the chaos of Luke's everyday life, his room appeared as a calming sanctuary. In stark contrast to the metaphorical darkness that Luke often occupied, the room symbolized a projected hope for something better, something more tranquil for both of us. It also represents a longing to return to the time when life was less complicated and encumbered with the suffering that accompanies growing up. The appearance of Mandy is an extension of this theme. She symbolizes the Jungian archetype of the "Divine Child," the most innocent version of the self (Jung, 1951). Young, innocent, and in need of care, the "Divine Child" is also a representation of strength and power, having to overcome great odds in order to survive into adulthood. This archetypal figure, based on biblical and Greek mythology, is like Moses, who was rescued at birth, and later became a powerful adult, entrusted with leading the Jews to the Promised Land. Mandy is but another representation of myself in the dream. She is curious, asking, "Who are you?" It is a question I am unable to answer in the dream, but it is clear that I saw myself both as savior and in need of saving during Luke's treatment. I know now that I felt a responsibility to save Luke, and in the process opened old wounds that left me vulnerable in our relationship. I implicitly express this by making a plea to Mandy not to tell her parents of my presence. Defending against this exposure was my way of maintaining the persona of omnipotent healer, while concealing the very wounds that have allowed me to heal. I was unable to recognize and integrate a version of myself where I am simultaneously vulnerable and powerful. My inability to do so is signified by Mandy leaving the bedroom.

In continuing to interpret the dream, I would now like to turn my attention toward the possibility of Luke's parents discovering me in his room. Interpretation brings two thoughts to mind. The first is a fear that Luke's parents might discover my successful infiltration into their home and that I was now privy to family secrets, which, when exposed would cause a spike in Luke's rage, and further upset the homeostasis of the Harper family. My second interpretation directly relates

to the writing of this case study and the conflict that comes in exposing my own family secrets. It is one thing to reveal this information to my analyst, and feel shame and vulnerability in the process, but quite another to share it with a broader audience. Despite its cathartic and professional benefits, and its potential value to fellow wounded healers, how might my self-disclosure impact relationships with family members? Will they be hurt or angered by the sharing of our private lives? Moreover, what will others think of me after reading this case?

This brings me to the image of my exposed torso in the dream. Kirmayer (2003) contends that by being willing to expose one's own wounds, the therapist can activate the patient's own resources. In doing so, the patient can become a participant in their own healing, no longer passive and compliant with the therapist. The torso is significant in that it houses the heart, the bodily organ most often associated with experiencing love and the pain of love lost. The heart is sensitive and vulnerable; most of us take great care to protect it. Exposing it risks great pain, but this is also what allows for the deepest connection. By acknowledging and accepting my wounded heart, I may have been able to generate the potential for Luke's own healing power to emerge.

Jackson (2001) posits that when patients recognize the therapist's duality as both patient and healer, recovery may seem more possible. But as my training taught me, before a therapist makes any self-disclosure, it is imperative they examine their motivations, asking themselves, why am I choosing to disclose this information to my patient? Is it of benefit to the patient? If not, then it is advisable not to disclose. It is a tradition in our field that the therapist be a "tabula rasa," and that the less the patient knows about the therapist, the better for the transference relationship. This leaves the patient to fill in the blanks with their own fantasies, wishes, and desires, which, in turn, fuels the transference relationship. It serves a clear purpose in the treatment. However, this rule affords additional protection to the wounded therapist. It protects them against any negative judgment or misconceptions that may come from patients and their parents (e.g., the therapist is sick too, how can they possibly be of any help?). I never disclosed my woundedness to Luke, as I thought it insignificant to his care at the time. But its profound impact is so apparent to me now that I sometimes wonder if sharing some part of my childhood experiences would have benefitted the

treatment. Perhaps it would have been therapeutic for Luke to experience me not only as his therapist, but also as a successful and empathetic male in spite of a childhood littered with emotional trauma. Perhaps by self-disclosing, I could have instilled hope in Luke. But clearly this was not a guarantee. It could have easily gone in another direction, negatively affecting the treatment. My emotional wounds were not fully healed at the time of treatment, despite a long-running personal commitment to processing them. Sharing these with Luke may have served to further complicate the relationship and obscure his difficulties. Zerubavel and Wright (2012) ask an important question: What does it mean to have “resolved” one’s issues? I would argue this is a subjective assessment only to be made by the wounded themselves. A more pertinent question is: How could one use their woundedness in treatment? Zerubavel and Wright (2012) believe that it is important to make a distinction between impaired professionals, therapists whose distress adversely impacts the treatment, and the wounded healer. But this binary division is problematic because it fails to acknowledge the complexities of countertransference, the uniqueness of each therapeutic encounter, and the particular patient being treated. I propose rather that the therapist may, throughout the treatment, practice in a manner that is at times effective and at others inept. The fluctuation on the continuum of woundedness is dependent upon several variables, including the time of the wound(s), the degree to which the therapist themselves has healed, the therapist’s current life stressors, the patient being treated, and the countertransference that individual induces in the therapist.

It is clear to me now that I could not cure nor help Luke in the way I had hoped. At the time of treatment, however, I maintained a “curative fantasy” that this was possible. Ornstein (1995) defines “curative fantasy” as “a deep, inner conviction that some very specific experiences that were unavailable in the past have to be provided in order for development to move forward” (p. 114). I could not cure my mother or fuse my fragmented family back together. But with Luke, I was granted an opportunity for redemption, a second chance at omnipotence. I was unconsciously motivated by my past experiences to provide the safety and support for Luke that I lacked as a child. However, there was a logical flaw in my thinking. I wished for an omnipotent object, one that could have protected me from the fear and insecurities that I

experienced as a child. If I was able to be that omnipotent object for Luke, I just might be able to save him from self-destruction. Clearly, I was wrong. Schaffer (2006) explains that therapists who believe that certain needs were unmet or missing in their childhood can fall victim to a false notion that these experiences must be provided for their patient’s development to continue. This is true of my work with Luke, which further contributed to the false notion that I was therapeutically ineffective or had caused him to decompensate further.

This serves to support my interpretation of the latter portion of the dream where Luke is whipping me. The imagery is suggestive of a slave who is being punished for a transgression. My inability to protect Luke from self-injury and multiple suicide attempts caused me to feel incompetent during the treatment. With each call from Ruth detailing another failed suicide attempt, another lash of the whip. I punished myself. Based on the dream’s content, Beck (1967) would categorize it as a “masochistic dream,” expressing themes of physical attack and punishment. In reality, I felt partly responsible for Luke’s behavior. I erroneously believed that if I gave him something more, something better, then he would have stopped acting on his rage. Luke’s image in the dream is my shadow self, an unacceptable representation of me, which I, in turn, projected onto him. Shadow selves appear in dreams as the same gender of the therapist and take on negative attributes that the therapist typically defends against (Kron & Anvy, 2003). I was a slave to the notion of rescue, but also a sadistic master who beat myself mercilessly when I could not provide it. I would willingly take the pain because “that’s what therapists are supposed to do. You don’t abandon your patient! No matter how bad it gets!” “You don’t pawn them off on some other unsuspecting therapist either.” Or so I believed at the time. I often found myself questioning if Luke would act out in the same way if another therapist were treating him. As I later discovered, he would. I spoke to Luke’s therapist at his intensive outpatient program in the months following our treatment. He revealed that Luke had self-injured just a day prior to the conversation. Morbidly relieving, it is a consolation to know that I am not alone in terms of therapists who have struggled with Luke’s care.

### **Self-Disclosure of the Wounded Healer**

Despite receiving weekly clinical supervision, I



was uncomfortable and reluctant to discuss Luke because I was ashamed of the lack of treatment progress and believed myself largely ineffective during the treatment. I now realize my resistance to openly process Luke's treatment had a direct link to my woundedness; an exposure that I still believe could have resulted in judgment and a questioning of my competence. This is a common fear among mental health professionals, who fear woundedness may be misconstrued as impairment (Sherman, 1996). This belief is shaped by several factors relating to and interconnected by the stigma of emotional woundedness. The social stigma of being emotionally wounded creates a gap between the wounded and society at large. The emotionally wounded's perception that people may be confused by, humiliate, be shaming toward, distance themselves or experience them as weak, all contribute to the isolation and silence that they are prone to experience. This culminates in self-stigma, and the belief that secrecy is the only means of protection from scrutiny.

Mental health professionals are not immune to the stigmatizing beliefs held by greater society, either. Those placed in supervisory and mentorship roles, despite their extensive training and theoretical knowledge, often subscribe to the same negative biases and beliefs held by those outside the field. Nev Jones (2013) describes this phenomenon when discussing her diagnosis of schizophrenia with colleagues and instructors at De Paul University. She writes,

In the first year of my current psychology doctoral program, for instance, I was told by a program director that 'someone like [me] could never finish a Ph.D.' and that 'while there might be exceptions,' she 'didn't believe I was one of them.' I've had to sit through departmental parties and social gatherings in which groups of faculty or doctoral students (for one reason or another) landed on the topic of schizophrenia, unwittingly evincing not only deeply discriminatory attitudes but also deeply misinformed ones...More generally, both students and faculty have at various times implied that I am either not 'schizophrenic' enough (i.e., too 'high functioning' to understand the 'real' experience of psychosis) or too 'schizophrenic' to ever successfully compete with 'normal' graduate students and researchers. (Jones, p. 4)

For Jones and many others who experience unfavorable judgment by professional colleagues, it begs the question, why is it difficult to embrace our own as we have our patients, with the same compassion, understanding, and empathy? Bloomgarden and Mennuti (2009) believe that the reason is to protect against the doubt regarding professional competence in the mental health field. I agree with this, but it is also the reluctance of some mental health practitioners to see themselves and the profession as a collective of individuals in need of healing and understanding, just like the patients they serve. For some of us, it may be all too threatening to recognize and relinquish the belief that we are not the all-knowing, omnipotent, "the epitome of health," expert, doctor, and therapist. It is enticing to maintain the illusion of separation: health here, sickness over there, and therapist in the chair, patient on the couch. This socially constructed distinction, however, is simply false, elitist and discriminatory.

Given the inherent vulnerability that comes with disclosing one's personal struggles, it makes sense that a therapist would remain silent about how their woundedness may be impacting the countertransference and treatment of their patient(s). It is important that we, as a community of mental health professionals, make an effort to encourage openness and support, rather than silence and avoidance (Zerubavel, et al., 2012; Sherman, 1996) amongst our own, which contribute to relapse, continued dysfunction, and the failure to recover from various traumas and mental health issues (Zerubavel, et al., 2012; Chaudoir & Fisher, 2010). A shift in this direction may foster a greater willingness in therapists to disclose past traumas, and present emotional struggles or mental health issues. When disclosure occurs and can be safely held and contained by the supervisor, it creates a trickle down effect, and puts all involved (therapist, patient, and supervisor alike) in a better position to ensure positive therapeutic outcomes. It creates an opportunity to discuss how woundedness is manifesting and impacting countertransference, how it can be used to enhance the therapeutic relationship, and various ways in which the supervisee can address his or her own wounds through support, personal therapy, and self-care. This, in turn, can help wounded therapists to reframe and normalize their experiences, and be more attuned to their reactions and feelings toward patients.

## Discussion

I have come to several conclusions regarding the wounded healer archetype and my career as a psychotherapist as a result of my work with Luke. This was made possible only by virtue of our unique pairing, for each therapeutic dyad has distinct dynamics that create a third entity. It is an imperceptible space where the therapeutic relationship resides, and is nonexistent sans its co-creators. Ogden (1994) refers to such an entity as the “analytic third” emerging from the intersubjective field between psychotherapist and patient. The “third” is the agent by which all therapeutic change and progress are made possible. This change is not one-sided, exclusive to patients, as psychotherapists, too, come away transformed by these relationships. In this case, the therapeutic coupling of Luke and myself resulted in greater self-insight that has since transformed my practice. Largely perceived as a therapeutic failure, the growth I experienced could have only come by way of Luke routinely serving up heaping forkfuls of humble pie. I doubted my therapeutic efficacy in ways I never had before nor have since. This ultimately brought about a steadfast resolve to answer the question, “How and why did this occur?”

Throughout my life, emotional suffering and psychotherapy have brought me closer to my own woundedness. Although I would gladly jettison the turmoil I experienced during more difficult periods of my life, I have come away stronger and with a greater understanding of myself. Acknowledging my childhood pain and the role it has played in my life is clearly a significant factor in my choice to become a therapist. But in the case of Luke, the impact of these factors on my professional practice eluded me, the shadow side of my motivations lying outside conscious awareness until the writing of this case study. I believe the reason for this is twofold. The first was an overidentification with Luke. Despite our vast differences, we shared similar struggles with preoccupied parents who were absent. Although I did not know it at the time, I was rooting for Luke to overcome his emotional battles because I deeply empathized with his pain, a pain familiar to me as an adolescent. My response to the distress I faced as an adolescent was different, however. Equipped with healthier coping skills, a better support network, and a greater capacity to regulate difficult emotions, I managed to navigate this time without self-destructive action. I

desperately had hoped to help Luke to do the same.

Furthermore, traces of early childhood loss and narcissistic injury were at play in my attempt to heal Luke. Barnett (2007) notes that therapists who experience loss and loneliness in childhood can suffer from an underlying grief that can combine with repressed anger toward a patient. This often results in the therapist’s tendency to intellectualize the treatment. I cannot recall ever being consciously angry with Luke during the treatment. Winnicott (1947) discusses that therapists need to be able to hate appropriately, as a function of the real therapeutic relationship. My experiences of loss and abandonment in childhood certainly contributed to my intellectualization of both Luke’s and my own emotions. Unable to acknowledge my anger for the anxiety and incompetence he evoked in me, I instead turned my attention to the most recent crisis and the notion that Luke was a victim who needed me. In order to defend against the feelings of hate that arose in me toward Luke, my ego employed a reaction formation defense, thereby heightening Luke’s omnipotent transference for persistent care and protection. This also speaks more to my dependence on Luke to feel important and appreciated, than the reality of him needing me. The practice of putting Luke’s needs above my own had its origins in the childhood role of having to “parent” my mother. Never being able to adequately meet her mental health needs, I was repeating a pattern with Luke in order to fulfill an unconscious wish to repair my mother. The caregiver role I assumed acted as a defense against underlying rage and guilt (Mander, 2004). This was compounded by the absence of my father in childhood and the belief that I was not important enough for him to remain present during my young life. Needing to be loved, I was not responded to and validated by my father, which ultimately gave rise to feelings of inferiority. My work with Luke evidences a “striving for perfection and a desire to foster an idealized image” of myself in order to defend against personal insecurities and a wish to be needed (Barnett, 2007, p. 261). Overall, my experiences of loss and narcissistic injury may have given me a distinct sensitivity to Luke’s needs, but it is also clear that I felt overly responsible for curing him, feeling like a failure when I was unable to do so.

Although I have spent much of this paper discussing the negative impact of my personal experiences on the countertransference, there are ways in which the same personal factors

positively impacted Luke's treatment. I strongly believe that many psychotherapists, if placed in the position of treating Luke, would have quickly referred him elsewhere given his aggressive acting out behaviors, diagnostic profile and the recurrent threat of suicide. Irrespective of this, I remained committed to supporting him the best way I knew how. I provided him a place where he could express his emotions in a safe forum without judgment or reprisal. I was empathically able to hold difficult feelings and tolerate circumstances of uncertainty without feeling the need to take charge or control the therapy. I was also able to deeply empathize with Luke's experience having lived as a teenager with an absent father and mentally ill mother, with an appreciation for how difficult it can be to reconcile the accompanying emotions. These experiences are what brought me to the profession of psychotherapy in the first place. Without the pain and ambivalence of my childhood, I firmly believe I would be someone very different, less emotionally attuned, and likely in a different line of work altogether.

Colleagues have asked me why I chose to write on countertransference and the wounded healer construct. Why would I openly self-disclose personal information about my life to the public? I have been told things like, "it's risky," that I am brave, "some may not see the value in it," or that I might be judged negatively for my admissions. I can understand these reactions given the information I put forth. But, I did not set out to write about the wounded healer construct and my personal struggles. I only knew that I wanted to write about Luke and the profound impact he had upon me. What emerged during the writing is what you see here, an analysis of our therapeutic relationship and myself in the treatment. Often painful, it has been an exercise in self-discovery and another way to continue to address and heal my own woundedness. It has prompted deep self-reflection, not only in my role as therapist, but in my many roles I occupy outside the treatment room. I have a greater understanding of myself as a therapist and a human being as a result of this experience. At times, writing and introspection exposed old wounds. But it also gave me the opportunity to share feelings of shame and inadequacy that have affected both my personal life and career. This catharsis far outweighs any of the hurt. It has been liberating and part of my journey in healing. It also serves a much greater purpose in that it has the potential to raise some, be it a small amount, awareness regarding the

wounded healer construct and its importance to our field. Acknowledging this hidden yet pervasive phenomenon in our profession can hopefully help to normalize and generate discussion around the "elephant in the [treatment] room."

I would like to close by offering a few suggestions to wounded therapists struggling with "difficult to treat" patients. The first is regarding the recognition of countertransference. If a patient routinely induces powerful feelings in you, where you are spending excessive time thinking about and/or managing crises outside the treatment room, it is a good indication that your subjective countertransference is being triggered and likely having a negative impact on the therapeutic relationship. In these situations, it is of the utmost importance to attend to these feelings in the interest of personal and professional well being. There are several ways therapists explore countertransference, the most common of which is clinical supervision. Taking into consideration the delicate nature and obstacles standing in the way of self-disclosure, choosing a supervisor whom you trust and are comfortable with is essential. If you are assigned or limited to an individual within your agency or a larger practice setting, it is advisable to find someone outside that system to avoid any biases or policies that can impede your self-disclosure. Peer supervision with trusted colleagues is another way therapists can find support and obtain guidance for countertransference with difficult to treat patients. However, the composition of the peer group must be such that members promote safety and openness and do not cast aspersions on the therapist for their disclosures. Personal therapy, be it periodic or ongoing, is also highly encouraged as a way for therapists to continue to heal old wounds and address personal conflicts. Lastly, I have found the process of writing my feelings and reactions to patients invaluable in terms of understanding myself, the patient, and relationship patterns that play out during the course of treatment.

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