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Failure and death in the analytical process[1]

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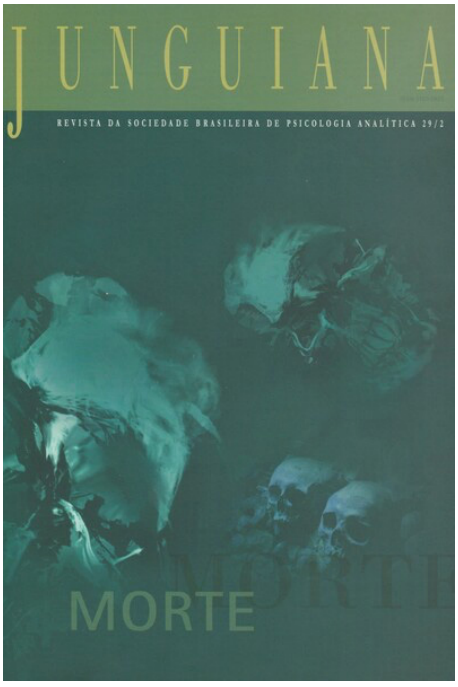
Abstract

This article is about the constellation of the failure complex intertwined with the archetypal theme of death in the analytical process. Through a clinical case, this article deals with some difficulties found in the transference process in psychotherapy with a borderline patient - especially the countertransference feelings of frustration, abandonment and anger related to the impotence of the analyst at the end of the session (analysis). Based on James Hillman and Rafael López-Pedraza, the author searches for elements to discuss the failure-success dyad within the epistemological grounds of psychology, so that it allows to review the limits given to such categories at the psychotherapy field and enlarge some possible meanings to the analytical failure experiences. ■

Keywords
failure, death, transference, counter-transference, borderline.



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Failure and death in the analytical process

> (...) the psychotherapist learns little or nothing from his successes, for they chiefly confirm him in his mistakes. But failures are priceless experiences because they not only open the way to a better truth but force us to modify our views and methods (JUNG, 1988a, par. 73, p. 36).

Introduction

Death as an arquetypal motif may be constellated in the setting in different ways – from the most concrete to the most metaphorical ones – since recurring death processes and transformation intrinsic to life and to psychotherapy leave their marks in this such contemporay and iniciatic process. Being so, the analyst-patient pair is put in a position of facing challenges that demand a certain collaboration throughout the therapeutic process. One of these challenges is exactly to deal with a possible failure in the effort demanded by both in the search of transformations – which is a situation that consists of multiple variables acting by their own. Reflecting about death and failure in analysis means reviewing, among other things, the notion of cure that guides the analyst practice and for being so, some epistemological and ideological elements must be discriminated in a way that it may be possible to notice from which place the analyst listens to the patient and from where he positions himself as a therapist.

The dyad failure-success in the analytical field

James Hillman (1981) points out that depth psychology came across the failure phenomenon since its origins in a way that psychotherapy finds itself historically crossed by a kind of "failure complex," beginning with the failure of the doctor's approach at the end of the 19th century. They could not explain the suffering of the hystericals based on their biological theories not even could deal with the hystericals'symptoms in a more effective way. Similarly, the psychiatrists of that time could not understand the importance of the content of the psychotics' delirium, restricting themselves to categorize diseases. Hillman also said that Freud, Bleuler and Jung (followed by their collaborators) created psychological theories exactly when the medical theories were failing in relation to those pathologies of that moment.

Rafael López-Pedraza (1997) also discusses about failure and success relating it to the contemporary cultural anxiety. He identifies a certain ideology in the Western collective consciousness that associates the notion of success to the competence and gaining of positive results that may influence the therapeutic setting even in a subliminal way. The author points out the necessity of developing, nowadays, what he calls "a consciousness of failure" as the obstinated search for success, encouraged by the collective consciousness (that is strongly marked by narcissistic, compulsive and maniac traits), avoids a dialogue with the necessities of the soul constellated by failure.

It also has to be considered Freud's (1996) worries about the difficulties of leading a psychoanalysis with some success. To this end, he clears up the goals of the treatment: decrease the disqualification of the unconscious repressed contents and, at the same time, fortify the patient's egoic defenses in order to put the scope of the force of the symptoms and instincts into perspective.

On the other hand, Freud emphasizes that physiological and biological aspects would probably be insusceptible to psychological influences

– for example, as "the constitutional force of the instincts". He also suggests the relative "weakness of the ego" due to physiological causes like puberty, menopause and physical disease. However, according to the author, the most powerful deterrent factor of success in analysis would be the death drive – responsible not only for the resistance to the treatment but also for the supreme cause of the psychic conflicts.

On the other hand, Hillman lists some themes that would be of a difficult therapeutic approach, like alcoholism and chronic depressions and mentions some adverse situations external to the setting that could lead to the failure of the analysis: a fatal disease, suicide, or even a great countertransference on the part of the analyst. I would add the financial difficulties that are normally presented as a concrete reason to cease the treatment, although there may be other difficulties to continue the analysis.

Taking these basic definitions into account, some conceptual questions may gain more specific considerations. How can we reflect upon failure without considering success in opposition? Also, how can we define such categories in psychotherapy?

Hillman (1981) discusses three interfaces of this dyad "failure-success". Concerning "failure in analysis" he promptly warns that the opposition "failure-success" empties a reflection about failure as one of the images that may be constellated in analysis based on their own arquetypal limits. Because the antinomy failure-success engenders a difficulty or a trap as it leads to believe that failure may be conceived as deprivation of success, understood as the most absolute possible remission of symptoms. Being so, "failure in analysis" ends up being evaluated on the basis of some normative criteria of success – also defined in terms of "an excellent health, psychic order and integrity" (HILLMAN,1981, p. 116).

Being so, Hillman puts the scope of the opposition failure-success into perspective when they are thought as antagonistic polarities of a continuous, suggesting that they may be reconsidered as sides of the same coin, however with their own identities, being that: "(...) each element of the analysis is right and wrong; it is leading and misleading, constructive growth and destructive elimination – what implicitly means that for an analysis succeed it must fail" (HILLMAN, 1981, p. 116).

About the "failure in analysis", the author calls his roots in a more general perspective, remembering that "some kind of failure also occurs in analysis and it would make us ask if there wouldn't be any generic component in the analysis that would be responsible for the failure" (HILLMAN, 1981, p. 116). He goes on problematizing this question, explaining that as some studies research the failure of some cases in analysis, others emphasize the failure of analysis as a whole as it is not possible to define it as cure for all the evils. Specially because it is impossible to equalize the meaning of cure in the different psychotherapy approaches not even look for approval in "scientific" and universal terms for some clinical cases, groups of pathologies and so on.

Finally, and as the most important discussion in this issue, Hillman proposes "failure as analysis": psychotherapy could take failure as the source of its praxis, as the psychological field per se, since the feelings that lead people look for analysis – weakness, defeat, failure, frustration, besides feelings of lacking or incompleteness – are all crossed by some idea of failure. So, failure could be put not as a ghost to be avoided during analysis, but as its own archetypal matrix. Being so, it could be taken as an image that calls the emergency of other forces and archetypal motives, other symbols and gods of the inferior world, in a way that clinical situations would emerge and affect the analyst properly, leading him to attend some patients in a "given up and depressing" perspective.

Thanatos is so, called upon by Hillman because this deity would be as worthy taken as Eros in the analysis field:

> If analysis considered its historical origin (conceived as an answer to failure) also as being its archetypal basis, its perspective would change, bonding more to Thanatos. It is from the death point of view that the analysis explores failure, being created as an elective instrument of the psyche, exploring failure as the sum of forces opposed to life, i.e., to question from Thanatos and its archetypal dominants, where life is being blocked, defeated, unsucceeded and failed (1981, p. 120).

With this statement, Hillman offers elements to consider failure as an archetypal dominant typical of analysis – which would allow a less oriented analytical posture in the erotic search for integration and success. Since because when the analyst identifies himself with the awareness or heroic attitude of cure in a perspective of forces opposed to death, in an unbridled search for life, he still finds himself identified with the thought of medical philosophy of the 19th century. There would be an illuminist heritage in this heroic approach: if the unconscious is "well interpreted" and "well worked on" and if its contents are integrated into consciousness, both patient and analyst would be protected from failure. As a consequence of this discourse, we can see the shadow of failure being constellated – for example when the therapist unconsciously acts, making a kind of blackmail based on technical arguments that point to possible dangerous consequences if the patient interrupts the analysis in that exact moment – which is a hypothesis normally grounded in resistances or complexes that are not yet worked on.

So, failure or success become facts with reference not from the analytical setting properly, but from its outside, from the one who observes extrinsically and reflects upon what would happen inside, in the therapeutic relation between patient and analyst. This always occurs based on theoretical and methodological references guided by ideological discourses that are not always in line with the experience lived by the analytical partners and with its own characteristic archetypically oriented by this universe called psychotherapy.

Failure as analysis, therefore, allows a rescue of the psychic forces which work under the alchemical perspective of the dissolution of the chronic aspects of the ego, so unilaterally developed and stimulated in the search of pre-established meanings for life. Just because life, in its archetypal dance with death, is marked by uncertain movements that interlink different aspects of failure-success.

Case study – scene 1: Preamble

Julia abandoned analysis after a year and two months – what is common to patients that unilaterally interrupt the treatment: at the beginning, being absent and justifying her absences through objective reasons (other commitments, sickness, etc.) up to the moment that she simply didn't justify anymore and disappeared. This is common on the route of any therapist, as well as frustration for the work being done by both.

She had been sent to a psychiatrist that I didn't know and when she looked for me, she showed symptoms of deep depression. Her pitiful tubercular appearance easily confirmed her state of soul: it showed a 42 year-old woman, approximately, with tousled and dirty hair, shoulders slumped as if the whole body couldn't support the overwhelming weight (tubercular and psychic) that she was carrying; her gaze was like a dead fish look; distorted face with withered lips curved down. She kept in silence most of the time, avoiding looking straight to me. In short, everything in her referred to hopelessness, splitting and pain. She reported that "she had tried to finish with all", taking medicines because everything she wanted was to "die in peace", but she survived to all the suicide attempts.

After some sessions in which, according to her "few things were happening", she said that she didn't believe that the analysis could help

her – as she didn't have anything else to do in life. So, it would be a waste of time for both of us.

She raised the hypothesis that the analysis could even worsen her depression. I carefully listened, considering her hypothesis, although I didn't entirely agree with her.

I knew that something could be done – even because she had come to me and besides her strong resistances – veiled or declared – she continued coming to the sessions.

Scene 2: Social and family environment

Julia was married and she had two adolescents. The family had moved from Minas Gerais to São Paulo years ago. Her husband was an engineer and she was a lawyer. Both worked for many hours a day – as many as possible in order to escape from the marital and family relationship that was overwhelmed by conflicts most of the time.

At work, differently from home, Julia said that people liked her, looking for her as a confidant – although she could not indicate anyone who with she had any engagement a little bit more intimate – either at work or out of it. She justified the lack of friendships through generalizations, saying that, for example, "the *paulistano* is too closed, differently from the *mineiro*"[1].

Such comments denounced some projective aspects of her personality (probably she could not admit that she was a closed person), besides indicating her highly prone to questionings that came from the other, as in general, she took them as criticism. Later, I could notice that it was common to Julia say that people were "aggressive" with her. However, when she gave any example it was possible to see that, in fact, she was being questioned for any arbitrary act, considering that she showed many, especially when she didn't feel herself understood in her narcissistic wishes. Such attitudes indicated secondary gains and attempts to manipulate the environment – which were not always unconscious – so that she could wriggle out of her conflicts and avoid frustrations.

Scene 3: The diagnosis

After some sessions with the patient, I called the psychiatrist – who referred to Julia as a "15 crosses borderline," showing her worry about "the patient's suicide actions." Based on the psychiatrist's diagnosis, I tried to go beyond the limits of the borderline patient (SCHWARTZ-SALANT, 1997; HEGENBERG, 2000), as I wanted to avoid clinging so promptly to this aspect – although I recognized its importance – preferring to stay with the living experience of the meeting with that woman. I wanted to stay with the image of that devitalized body-soul that was presenting itself to me for weeks, without framing the patient's suffering into prior meanings.

In fact, Julia showed many registers of relationships in which she had abandoned the other, indicating intense attachment conflicts – what could justify a borderliner diagnosis. She was not conscious about that. Crossed by many projections, she accused the other of having abandoned her or having done something punctual that had motivated her leaving.

After having talked to the psychiatrist, I began imagining the limits that Julia built between the world and herself – either subjectively or objectively. I thought about the borders and so, I quickly had my method guided by an image: "eating by the edges" – as a popular saying wisely instructs us. If it was difficult to reach the center, I stayed on the periphery, waiting for opportunities to enter Julia's world. It happened sometimes: between a week and another it was possible to go ahead a little bit, to have a closer contact with her ideas and fantasies. However, she suddenly drove me back, missed the session or attacked me verbally when she came to the next session. She made it clear that I had been too far. On such occasions, it was better to "withdraw" and wait for another opportunity.

[1] Paulistano is a person who is born in São Paulo city. Mineiro is a person who is born in the state of Minas Gerais.

I dared inviting her to make some drawings that, in general, showed few elements, some very small, on the lower-left part of the paper. That wide blank space on the middle of the sheet presented itself as a concrete register of Julia's own animic world. Empty, very empty. Or transparent – as she desperately tried to position herself towards herself and the other.

The absences were regular, alternated with weeks when she could come more frequently to the sessions. She justified these absences with the worsening of some physical and psychic symptoms. In these occasions it was as if the water of the sea came to dismantle the small foundations of a sandcastle. After some months, I thought about giving up: why not? Analysts have the right of giving up but something on me resisted to this idea. In a remarkable supervision, I heard a sentence that saved me from the discouragement it was falling upon me: "in order to understand this patient you "must stay yourself 'quitted' and 'depressed'." This changed my attitude and the course of things. Surely, the best to do was to quit also – from any hopeful attitude. I'd better assume the poor state in which I stayed before and after the sessions.

Being with Julia was as being in the presence of a great and heavy shadow. The best was to give up, assume the failure of my methodology: not from the edges or the center; neither from drawings. The truth was that nothing seemed to work on. Quitting with the anxiety of having things integrated or balanced really worked and the treatment continued ahead – marked by the absences, discouragement, apathy. Nothing new. Only regret, crying, passivity, reactivity. It was only darkness around! I realized that I should stay darkened, also, a little bit more opaque, less hopeful, less, less... Because to assume any ideal or expectation was to expect too much from this process.

Final scene: An unfinished analysis

At the end of a year and two months, Julia showed some different signs, indicating a small improvement. In the sessions, she tended to be more reflexive and capable of realizing that "she was not an easy patient at all." Also, in an attempt to check the limits of the therapeutic bond, she admitted that "it must be difficult for a person to like me" – as if she waited an answer from me that could deconstruct such a negative idea about herself. She also assumed having worked more than necessary – in financial terms – and because of that, the difficulties of relationship with the children and her husband. More than once she thought about breaking up with her husband, but whenever she arrived near to any decision about it, she gave up. She needed him more than she could imagine. Both, in a deadly unconscious pact, needed each other a lot. Julia had difficulties with the topic "dependence" and showed herself ambiguous about this issue: she hated having to depend on the other and at the same time, hated the other because she realized that depended so much on him as well. Of course, that this would be repeated in the transference process. That was what hapenned with the previous analysts with whom she had tried psychotherapy before. Generally, she did not finish the analysis personally, indicating that after some signs of negative transference, she simply "gave up."

So, finally she began to stage, in the transferential relation with me, the same script that she had staged with the previous analyst. She missed the sessions for "health problems" – although she referred to physical symptoms that, in fact, were frequently present in her daily life. I commented that "it seems that they (the symptoms) make you company", pointing out how she carefully talked about the diseases. The symptoms were characters with whom she staged her own private tragedy; the ones who ensured her to get some gains – either in the family or in the professional field – as they helped her to justify her distance from the relationships when conflicts emerged without having to deal with her own aggressiveness. Guided by the rationalist logic of arguments taken as evidence in the med-

ical appointments, Julia stayed slightly irritant, beginning to repeat, exhaustively, the scientific details of her diseases as if she were in an audience. Also, she remained deaf to the metaphorical meanings of the symptoms that talked about the pains of her soul materialized in the body.

So, she decided to make a trip. Julia rarely traveled as she always had to work or she was sick! When she came back from this short trip, she began missing the sessions often justifying it with physical symptoms. One day, finally, she stopped coming. I had called her many times before that. In one of these sessions, Julia said: "It is like that. It was not until I traveled that I blamed myself and got sick."

Even if I cannot know the level of her capacity to internalize what she had said (because I did not see her anymore) it was interesting to hear from her own the confirmation that the diseases that made her company through punishment were like forces that reminded her that "she could not be happy" – as if they were all jailers of her own fantasy.

After these telephone calls, I decided not to insist, as in general, when a patient announces directly or indirectly his/her intention to stop with the analysis, I receive the decision and propose a dialogue with this impulse or wish.

I consider with true respect what she had to say about the reasons to stop with the analysis: "It is not working. You didn't solve the problem. I am tired of coming here, talk, talk..." and etc.

In Julia's case, I've got to admit that the first idea that came up to my mind was the expression "swim, swim and die on the beach." Naturally, feelings of incompetence and failure fell on me and raised questions that I joined in the modus operandi of my clinical practice. I confess that I felt a great relief. I considered that I could not be the right therapist to attend her. I also tried to comfort myself, considering that it was a very difficult case and regardless the short period of the treatment, something may have been built, in psychological terms, during that process. But what exactly? How could the progress be defined? Taking into account so many withdraws motivated by the patient's resistance and lack of egoic resources or even by the therapist's countertransference questions, to whom or to what attribute the abandonment of the therapy: to the analyst, to the patient or to the therapeutic relationship?

Some final considerations

Failure in its interface with death – was already implied in this process since the initial interviews – as the more I actively searched for an objective referential to deal with the obstacles of this process the more I distanced myself from any "positive" resolution. Instead, there was a negativity that should be recognized and valorized all the time. In these terms, Jung (1988b) is very clear: there is no cure for life and individuation follows tortuous and mysterious roads which sometimes pass along the clinic and flourish in the less expected places.

So, it is the ego that must be healed: in the patient's case, either in her fragilities so that she could deal with the forces of the instincts and the pression of her unconscious images or in her rigidity in order to soften her parameters allowing her to become a continent able to receive the metaphorical meanings that underly the literal force of the chronical meanings of her symptoms. After all, a neurotic sometimes suffers from the literalism of the notions that cause anguish and hold him hostage of the repetition of symptoms – as well as a psychotic entangled by his fantasies and imprisoned in the limits of his delirium.

Likewise, the analyst's egoic expectations should be reviewed as he may be taken by weakening feelings when he cannot achieve the ideals of success highlighted by the dominant discourse of the science that reflects upon psychology.

It was interesting that by being frequently visited by the failure in this analysis I was driven to put success at issue – what is to notice its deadly and mortifying perspectives.

Probably the most clearly grieving aspect of my analytical attitude was the death of this so polarized dichotomy failure-success. Something of a heroic desire combatant and combative to the possibilities of this encounter had to be sacrificed towards a more plural attitude as far as there was an opening to different nuances of failure and success, in more humanized measures. Perhaps, micro cells in the daily life of the therapeutic process since "it would be more fair to the failures *of* and *in* the analysis if we considered it (the analysis) as a process in the failure", as Hillman (1981, p. 120-121) warns. ■

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Resumo

Fracasso e morte no processo analítico

O presente artigo discorre sobre a constelação de um "complexo do fracasso" em sua interface com o tema arquetípico da morte no processo analítico. Por meio de um recorte de caso clínico, problematiza algumas dificuldades encontradas no manejo transferencial do processo psicoterapêutico de uma paciente diagnosticada como borderline, em especial os sentimentos contratransferenciais de frustração, abandono e raiva relacionados à impotência da analista diante do fim da análise. Tendo por referência textos de James Hillman e Rafael López-Pedraza, buscam-se elementos para discutir o estatuto da díade "fracasso-sucesso" nas bases epistemológicas da psicologia, de modo que reveja os limites dados a tais categorias no campo da psicoterapia e amplie os sentidos possíveis para as vivências de fracasso analítico ■

Palavras-chave: fracasso, morte, transferência, contratransferência, borderline.

Resumen

Fracaso y muerte en el proceso analítico

El presente artículo discurre sobre la constelación de un "complejo del fracasso" en su interfaz con el tema arquetípico de la muerte en el proceso analítico. Por medio de un recorte de caso clínico, problematiza algunas dificultades encontradas en el manejo transferible del proceso psicoterapéutico de una paciente diagnosticada como borderline, en especial los sentimientos contratransferenciales de frustración, abandono y rabia relacionados con la impotencia de la analista ante el final del análisis. Teniendo por referencia textos de James Hillman (1981) y Rafael López-Pedraza (1997), se buscan elementos para discutir el estatuto de la díada "fracaso-éxito" en las bases epistemológicas de la psicología, de modo que revise los límites dados a tales categorías en el campo de la psicoterapia y amplíe los sentidos posibles para las vivencias de fracaso analítico. ■

Palabras clave: fracaso, muerte, transferencia, contratransferencia, borderline.

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