**Nancy McWilliams on Mental Health, Transference and Dissociation**

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Nancy McWilliams, M.D., Manal Piracha, David Puder, M.D. do not have any conflicts of interest to report.

# Introduction

In today's episode of the podcast, I speak with Nancy McWilliams, Ph.D, a renowned psychologist-psychoanalyst. She has authored several books, including, *Psychoanalytic Diagnosis* (1994; rev. ed. 2011), *Psychoanalytic Case Formulation* (1999), *Psychoanalytic Psychotherapy* (2004), and *Psychoanalytic Supervision* (2021). She was also the Associate Editor of the Psychodynamic Diagnostic Manual (2006; 2nd ed. 2017).

We discuss different aspects of mental health and how it pertains to relationships. We also discuss qualities that make a strong therapist and the ideas of dissociation and transference in therapy.

"The psyche is not of today; its ancestry goes back many millions of years. Individual consciousness is only the flower and the fruit of a season, sprung from the perennial root beneath the earth" (Jung, 1959, p. 42).

# What does mental health look like?

Since the 1980 edition of DSM, the conversation of mental health has mainly revolved around a symptom's checklist instead of the overall aspects of mental health. Nancy McWilliams defines mental health in terms of certain capacities that exist on a continuum of healthy to unhealthy, rather than a finite list of symptoms.

The overall aspects of mental health include:

- **Sense of safety and trust in oneself, others, and the world.**
    - The ability to feel safe with other people and in the world
    - The sense of basic trust in the world and the capacity to evaluate whether you are in a safe environment or relationship.
    - Attachment security

- **Sense of Agency**
    - Similar to self-efficacy, self-agency is the idea of an internal locus of control. It is the power and ability to make your own choices in a situation, such as being able to decide whether you want to say yes or no.

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- **Sense of continuity**
    - The ability to look at the good and bad parts of yourself and consciously see both sides of yourself as a whole. “To have empathy with who you used to be and imagine who you may be in the future.”
    - Feeling a sense of continuity with your body and understanding that you are your body. It is the idea of showing kindness to your body and imperfections rather than participating in destructive habits to hurt yourself.
    - A sense of continuity would mean to see yourself as one person—the good and the bad aspects of yourself—instead of “dissociating from aspects of yourself,” sometimes seeing yourself as wonderful and sometimes seeing yourself as a villain.

- **Self-esteem**
    - Self-esteem bridges the gap between expectation and reality. It has two components: reality and reliability.
    - Reality is having reasonable standards for yourself, not being overly critical, perfectionistic or overly inflated.
    - Reliability is the capacity to stay composed in response to criticism or idealization. It is the ability to not fall apart when you are being criticized or feel overly proud when someone compliments you, but being able to count on your own self-evaluation to carry you through and having a balance between the two components.

- **Affect tolerance**
    - The capacity to tolerate the whole range of human emotion and affects.

- **Self-Preservation and Altruism**
    - This is the ability to stand up for yourself while at the same time sacrifice your time for family and the community. It is the combination of self-love and self-sacrifice.

- **Acceptance**
    - We all have circumstances and situations that can’t be changed, but the ability to grieve and keep moving forward rather than being stuck in a state of complaint and victimization is the idea of acceptance. It is being able to eventually forgive and find gratitude.

- **Capacity to love, work, and play**
    - We love our partners, kids, and family members. The capacity to love is to engage with others, open our hearts and be ourselves.

    - The capacity to play is letting the kids run around freely and engage in rough play. Play helps form friendships and relationships as kids grow. For adults, the capacity to play is to participate in group activities such as dancing, singing, and sports.
    - The capacity to work doesn't necessarily mean to only make progress in careers, but also the capacity to explore our passions and find meaning in our work. It is the ability to work and impact others.

As a therapist, these are qualities you want to see increase in your patients.

# What is mental health in relationships?

Mental health in relationships is depicted through showing love and devotion to another person by accepting them as they are. This includes several other capacities, such as:

- Being fully emotionally honest.
- Being able to acknowledge when you've hurt the other person and having the ability to fix those problems.
- Being able to apologize to your partner, taking responsibility for what dysfunction you bring to a relationship.
- Having gratitude for who your partner is and accepting them for their perfections and imperfections.
- Fully committing to the relationship and being able to vocalize what you need.

# Understanding Mental Instability

It is important to not just re-name or rebrand mental health issues. In doing so, we lose the continuity of clinical and historical significance.

Historically, personality health has been seen on a continuum, from:

Healthy → Neurotic → Borderline → Psychotic

It is important to not confuse "borderline" or "psychotic" here with borderline personality disorder or psychotic illnesses like schizophrenia.

## Neurotic

In her book, *Psychoanalytic Diagnosis, 2nd Edition: Understanding Personality Structure in the Clinical Process,* Dr. McWilliams defines neurotic as "a high level of capacity to function despite

emotional suffering" (McWilliams, 2011 p. 54). The neurotic-level patient is able to rationalize his/her emotions. These individuals are in touch with reality and can feel a sense of continuity with their past, as well as look into the future, having the ability to collaborate with the therapist to look within themselves. These patients are ego-syntonic in nature. They are able to see the internal conflict within themselves.

For example, a compulsive person in the neurotic-range may recognize their repetitive activity of locking, unlocking, and relocking the door as unhealthy, but they feel they must do it or else anxiety will ensue. These individuals do not seek validation from the therapist and they are able to agree with the therapist when he/she states that these repetitive activities are unnecessary.

## Borderline

The borderline patients, one step up from the neurotic range, are more troubled. This term developed out of experience with patients that were a step above neurotic but not psychotic. These individuals have a hard time defining themselves and lack the ability to make connections with their child-self and present-self. They have difficulty describing their own personalities and trouble explaining their relationships with important figures in their life in a meaningful way. Individuals who fall into this category are often very black and white thinkers (they are "all good" or "all bad"), have very intense reactions, and tend to feel abandoned when they are separated, yet engulfed and controlled when they are close to others. We often see victims of trauma fall into this category.

Unlike the neurotic person, who is able to appreciate the unique features of their significant others or parents' personalities and qualities, the borderline patient is short and dismissive in their expression. If asked to describe their mother, they may reply with something like, "She's a regular mother," versus, "My mother is supportive of me and cares for everyone around her. She has a way of making me feel better." When these patients are in therapy, they tend to react with hostility towards their therapist and become easily agitated, alternating between clinging and idealizing you with transference reactions. They may not be able to differentiate you from people in their past.

## Psychotic

Individuals on the psychotic end of the spectrum are more internally disorganized and have trouble with self-identity, as well. "They are often confused by and estranged from the assumptions about 'reality' that are conventional within their culture" (McWilliams, 2011 p. 60). These individuals may even question their own existence. The psychotic-range individuals have a dysfunctional understanding of self, similar to schizophrenic patients.

A psychotic patient may have trouble differentiating what is on the outside versus what is on the inside. For example, if they are angry, they may believe someone is out to get them and not actually be conscious of their anger. They may feel brutally attacked when offered statements of empathy.

# The Therapist in Psychotherapy

In "*The Great Psychotherapy Debate,"* Wampold argues that there is no one best therapy, but rather there are common factors that make a huge difference in therapy. Empirical data suggests that therapy progress depends about 80% on the individuals involved and their relationship rather than the techniques.

These common factors include the client's subjective experience and the therapist's ability to provide a safe and supportive environment, but more so the connection the therapist makes with their patients. The therapist and patient relationship is highly dependent on the therapist's curiosity of getting to know the patient. As therapists, empathy and willingness to understand the unique qualities of the patients are what help progress the patient-therapist relationship.

## Common Pathways for Therapists to Grow

In the journey of becoming a better therapist, one of the most important qualities is to have undergone one's own therapy. When therapists have had their own therapy they can more completely understand the process and the results. This gives therapists the opportunity to internalize the success and their confidence in the therapy process, as well as the ability to convey hope. In the absence of their own therapy, beginning therapists often suffer greatly from imposter syndrome and struggle to deeply convey an authentic sense of being able to help.

Another important quality of a therapist is to have a genuine interest in their patient. They should show interest and curiosity in the patient's life and stories about their childhood and environment, not only about their mental state. This allows the patient to feel comfortable and it builds trust in the therapist. Patients are all unique and the therapist should be curious about their individual life experiences such as their upbringing, culture, and family dynamic. The eagerness of a therapist to want to know more about their patient shows that they genuinely care.

Being willing to be taught by the patient is important in the therapeutic relationship. The therapist should be able to admit that they are not experts about the patient, although they may be an expert in the patient process. They should teach the therapist about their experience.

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An essential feature of being a strong therapist is to have compassion and empathy for the patient. Without these, and normal kindness, the relationship will struggle to survive when the patient displays toxic behavior (which is an important part of the therapy process) that may provoke your own triggers. The most significant defining factor of the therapeutic relationship is that the patient exposes their worst parts in therapy and despite that, you as the therapist are still there for them.

A huge part of being a therapist is encountering and navigating multiple toxic affects each day, ranging from suicidal patients, walking on eggshells around paranoid patients, worrying about a child who could be beaten when they leave, and when to report a borderline case of child abuse. Empathy, love, support and compassion are essential to carrying us through.

## Therapists and Listening

"Listening in a professional capacity is a disciplined, meditative, and emotionally receptive activity in which the therapist's needs for self-expression and self acknowledgment are subordinated to the psychological needs of the client" (McWilliams, 2004, p. 133).

Before a therapist experiences their own therapy, this may seem like a foreign concept. To have someone listen without agenda, without an “advice-giving” mentality or competitive or envious needs is refreshing, and, in turn, it is refreshing to be able to offer this capacity of listening to a patient. It is a very different type of listening when there is an awareness of the desire for self-expression or self-acknowledgement, and instead of pursuing these desires, the therapist is able to willingly subordinate them.

Listening in therapy is not much different from some types of meditative activities, such as trying to interpret a painting. It’s using a right-brained skill to take things in. The focus is on analyzing what is in front of you. In therapy, the therapist is implementing a similar skill of absorbing and taking information in while the patient speaks.

## Intent

Intent in therapy can be felt instinctively at a mirror neuron level. If the patient perceives that the therapist is for them and has their best interest at heart, chances of successful therapy outcomes are increased. Even if patient situations may be impossible to truly understand, for them to feel the intent to understand makes all the difference.

"Most of the ways that therapists talk during the clinical hour are intended to demonstrate that they are listening" (McWilliams, 2004, p. 134).

We all need to be heard and listened to, including children. Many patients come in and describe being brought up by well-intentioned parents but who didn't understand the importance of listening to them, instead tending to have their own agenda for the child. That could look like pushing them into sports they do not want to participate in or onto career paths that are not of their interest.

Instead, children would benefit greatly from parental curiosity, perhaps being asked how they experience the world and being taught to name their feelings. It is a shift from a parental-agenda perspective to one of focusing on understanding what the internal life of their child is like and discovering their temperament and talents and what brings them joy.

The anxiety and fast pace of today's culture requires people to adapt to cultures they didn't grow up in. This makes it much harder for someone to experience a life where they are explored as an individual versus being treated en masse to those around them. It is profoundly healing when someone takes the time to listen to a person's story and helps them make sense of their world, experiences, and reactions to these things.

## Do therapists have a harder time experiencing anger?

In her doctoral dissertation, Dr. Judy Hyde found that depressive personality type was the most common personality type among therapists. She found that therapists tend to be more self-critical and worried that they did the wrong thing, leaning towards introjection instead of projection. If the patient is doing well, they credit the patient's capacity, and if they are not doing well they blame themselves. Because of these things, these therapists tend to have a difficult time finding their anger.

Although it isn't usually appropriate for a therapist to express their anger towards a patient, it is important for a therapist to be able to communicate boundaries with their patients to keep a healthy frame that allows for the work to be done long term for the benefit of the patient. This can be difficult for therapists, most of whom are naturally empathic, because it requires them to access a certain degree of their own aggression. Exerting boundaries is a form of anger. But they should be able to tell their patient the fee that is required or specific times they are unavailable to talk. Therapists generally have a harder time doing this because of their personality.

# Dissociation

Dissociation, like most aspects of mental health, could be considered to exist on a continuum. While it is a mechanism of self-preservation during times of trauma, it could also be considered a form of dissociation when we get lost in our thoughts while driving down the highway. We are

all subject to brief experiences of dissociations. “Researchers in cognitive psychology (e.g., Hilgard, 1986; LeDoux, 1996, 2002) have described simultaneous, coexisting trains of thought in both patient populations and ‘normals’” (McWilliams, 2011, p. 334).

Dissociation is a common, extraordinary ability the mind has to cope with traumatic events. The “glucocorticoids secreted during traumatic experience can shut down the hippocampus, making it impossible for episodic memory (the memory of *being there)* to be laid down in the first place” (McWilliams, 2011, p. 334). The brains of trauma victims develop the ability to dissociate; in situations where these individuals can’t physically get away, their brains dissociate to protect them from the distress. For example, a victim of trauma may, during the trauma, see themselves floating above and witnessing the act of trauma instead of being present in their body and recognizing it is happening to them.

When a patient has been exposed to enough trauma, their brains can shift to long-term dissociation as a coping mechanism. Ultimately, these patients can develop an altered personality, and, in extreme cases, develop dissociative identity disorder where they shift self-states and experience amnesia during the alterations.

Phillip Bromberg writes “Dissociation, like repression, is a healthy, adaptive function of the human mind. It is a basic process that allows individual self-states to function optimally (not simply defensively) when full immersion in a single reality, a single strong affect, and a suspension of one's self-reflective capacity is exactly what is called for or wished for" (Bromberg, 1993, 1994).

Dissociation is a mechanism through which humans can maintain a continuation and organization of the sense-of-self. We all have different self-states and part of mental health is being able to stand between those self-states. Self-states can look like the state of being a teacher, the state of being a mother and the state of being a friend, all experienced by the same person. These are all slightly different states of self for one individual person, and “health is the ability to stand in the spaces between realities without losing any of them—the capacity to feel like oneself while being many" (Bromber, 1993, p. 166). “Standing in the spaces” is the capacity to shift to a different “self” or version of “me” given the situation or subjective reality at any given time. But some people are unable to “stand in the spaces” of their different self-states and these individuals’ *self* is organized more by dissociation than repression.

## The “Shoulds” versus Entitlement

If a person is raised by parents who superimpose feelings of what the child *should* be doing, they can begin to dissociate by living in a façade from their true selves and live in what Karen Horney, in her book, *Neurosis and Human Growth*, calls “the tyranny of the shoulds.” This

becomes a “harsh superego” that constantly tells them they have responsibilities and duties that *should* be completed. Most of the time these aren’t responsibilities they want to do but feel the pressure that they have to do. There is this critical internal voice telling them they need to get things done.

McWilliams also sees the other end of the continuum, where the attitude is one more of entitlement, with these individuals believing that the outside world should adapt to them. Because they have been or feel they have been victimized, they feel entitled to the world taking care of them. Rather than having a “supercritical” voice, these individuals express a rather narcissistic element in their attitude, feeling that it is someone else’s responsibility to fix their situation. This attitude lacks the idea of gratitude. Instead of being thankful for what is good about their life situation, they display an attitude of complaint. When gratitude is present, there is less room for complaining.

Our culture today tends to feed these narcissistic tendencies. Using television commercials as an example, admakers used to market toward our sexual side, but today ads often tell us that we deserve certain things and we have the right to give ourselves a break. It feeds the primitive desire to make the world into whatever we think it should be for us.

It is possible for people to enter a space of gratitude from a place of narcissism, but it is a process that takes time. Eventually, these attitudes can be replaced by a sense of agency over their lives instead of resigning themselves to being a victim of circumstance.

# Transference

Transference is when the patient unknowingly conveys feelings towards a person or figure from the past onto the therapist. Transference is very common in dissociative patients. “A person who has been severely mistreated lives in constant readiness to see the abuser in anyone on whom he or she comes to depend” (McWilliams, 2011, p. 346). When treating these patients in therapy, it is essential for the therapist to clarify how different they are from the expected abuser. These patients often confuse their past and present and can have intense reactions towards the therapist.

Transference that comes from the trauma may also present in nonresponsive bystander transference. The bystander in a situation of trauma may be the mother that doesn’t engage or help the child that is being abused by the father or stepfather. These patients often show more anger towards their mother who was the bystander than the father who was the abuser. The refusal to have a relationship and the willingness to disengage is actually more damaging than the abuse itself because, as far as the mind is concerned, at least the abuser is engaging with them and has a relationship with them.

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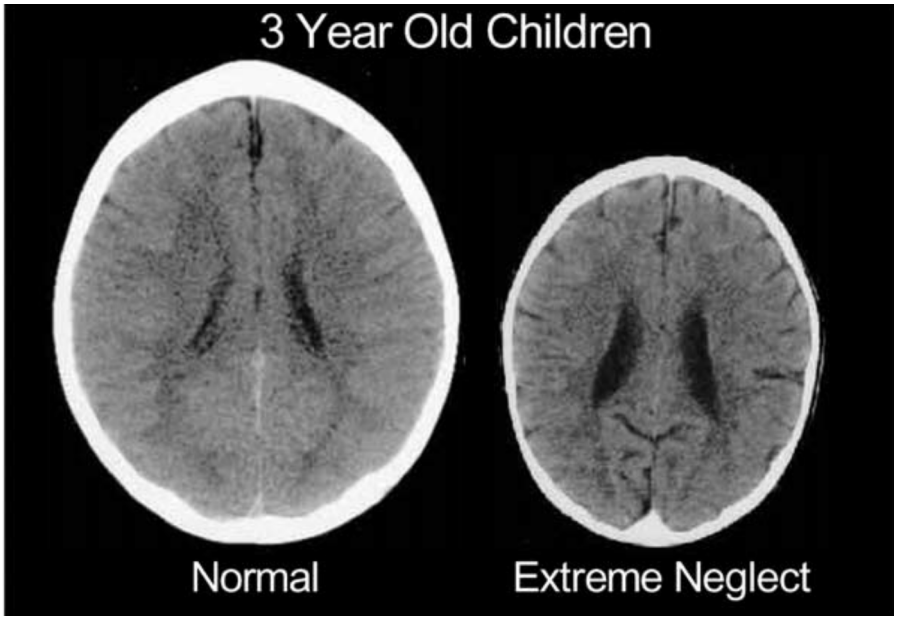
## Is there transference of the nonresponder bystander?

This is a transference that isn't clearly obvious in therapy. According to McWilliams, as the therapist you can see aspects of this type of transference when the patient shares their stories. It may be noticed as an absence from the therapy; usually the bystander is not mentioned or is absent from the recollections. Additionally, if the therapist looks bored or zoned out, you may be able to recognize the bystander through a countertransference. In order to get back to authentic connection with the patient, the therapist may address the situation head on and ask, “Are you experiencing me as fully there?” Patients may react negatively to this but it is useful for them to even show anger if that is what they're experiencing.

This scenario of neglect and disengagement emphasizes the innate, primitive quality of humans to yearn for attention and attachment and to be protected. If the lack of attachment is severe enough it can be deemed neglect, which is another form of abuse. Studies have shown that neglect can have long-term effects on a child’s brain development (Perry, 2002). The brain requires attention and attachment through relationships for growth and without it there are detrimental consequences.



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We respond to different drives. Freud describes some of these drives in a more dichotomous and oversimplified way, such as the libido and the death drive, but more recent research has found more nuanced and specific drives. Jaak Panksepp identifies seven emotional brain systems :

**Seeking**
The seeking system is associated with dopamine, which mediates our urge for anticipatory rewards, exploration of new environments, investigation of new information, work for resources and motivation to learn.

**Rage/Anger**
The Rage and anger drive is stimulated by the amygdala. It provides the aggressive energy needed to defend our lives and our loved ones. It is also activated in situations of frustration when access to an expected reward is obstructed or delayed.

**Fear**
The fear system is associated with the amygdala and periaqueductal gray regions of the brain and stimulates the “fight or flight” response, activating defense mechanisms and behaviors. The fear system “evolved to protect against predation” (McWilliams, 2011, p. 55)

**Lust**
The lust system is associated with the amygdala and hypothalamus. This system drives sexual behaviors and evokes sexual excitement.

**Care**
The care system is the source of love among humans, such as between parents/parental figures and children. It drives nurturing behaviors. This system is activated by the anterior cingulate and regulated by hormones oxytocin and prolactin.

**Panic/Sadness**
This system consists of sadness and grief that is usually triggered by the distress that comes from separation when social bonds between individuals are threatened or lost. The central anxiety for people in the borderline range has to do with activation of the panic system, which deals with early attachment needs (McWilliams, 2011, p. 55).

**Play**
The play system is the source of joy and pleasure that comes from rough-and-tumble play, interacting with others, exploration, and the excitement of living

These are drive systems that are associated with feeling and affect. Anxiety is associated with the fear system and the panic system. The play system is important for brain growth, mainly in children. Davis et al. found that more kids are being diagnosed with ADD and ADHD because they're not getting the play time that they need (Davis et al., 2019). A study found that martial arts was a non-pharmacological treatment to help counteract the attentional impairment in patients with ADHD with impressive effect sizes (Kadri et al., 2019). The main systems for attachment are the panic and sadness systems.

# Different modalities for expression of self

It can be difficult for some patients to come into therapy and be able to talk about what is going on. Most patients have a hard time being able to discuss their traumas or life stories. However, these patients are sometimes able to express themselves through different modalities such as writing, art, or singing. This is a way for the therapist to reach the real person.

## Important terms:

**Transference**

- When the patient unknowingly transfers feelings towards a person or figure from the past onto the therapist.
- Example: Seeing the therapist as a father figure who was powerful and authoritative. This would elicit feelings of agitation if the relationship with the father was upsetting/negative.

**Countertransference**

- The therapist's reactions to the projections of the patient onto the therapist; a redirection of the therapist's feelings towards the patient. It is often unconscious.
- Example: A therapist who fears anger due to a family history of aggression might then discourage expressing anger from their patient

**Dissociation**

- Experiencing a disconnection and lack of continuity between thoughts or memories.

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