A SUPERVISEE REPORTED A SESSION in which she found herself feeling like she was having a "stroke." Her experience was that she could not follow what her patient was saying, the words were all in a jumble in her mind, and she could not comprehend at all. She felt she could not go on listening. With some trepidation, but emboldened by her work with me, she decided to take a risk and told her patient, "I have to share with you what is happening because I don't understand it"; she then described to her patient how she found herself unable to comprehend, that she felt confronted by a jumble of words and didn't know what was happening to her mind. To her surprise, her patient's mouth fell open in response. The patient then reported with great emotion, "you have just described to a T what I experience most of the time." The patient went on to say that this has been characteristic of her experience for as long as she could remember, and that she has always struggled to present a semblance of being able to function coherently, even when her own experience remained a jumble. She elaborated that she sometimes remained in this state for long periods—days, weeks, not just moments—and expressed her relief in being able to talk about it. The patient went on to say that she had never discussed this with anyone before, and how much the therapist's revelation meant to her. She felt "safe" for the first time in the treatment.

My supervisee was relieved and surprised. She was even more surprised when, in the weeks following, the patient was able to deal in treatment with very painful material she had never been able to deal with before, now sobbing with emotion where before she had "felt nothing." She was also surprised when her patient reported that for the first time she was no longer spending part of every day crying, and that in addition, despite having been totally "blocked" as an artist for a couple of years, she was suddenly working creatively again. The supervisee observed that the patient seemed not only to be feeling, but also looking as though she had a totally "new lease on life"; in fact, she now seemed to actually be "coming to life." The therapist also reported her amazement at how engaged she herself was now feeling with the patient, whereas before her mind had often wandered when she was with her.

In sessions following, the patient described how she had felt a validation of a part of her experience that went beyond articulation when her therapist shared her own experience of feeling as though she were having a stroke. The patient cried as she described the tremendous effect on her of realizing that something so vital about herself could be seen without her having to articulate or explain. Her associations here were to feeling that no one in her family was ever there to respond to her, and she described how what had happened between them in the treatment enabled her to develop a new understanding of how depressed her mother had been when she was growing up. This led the patient to yet another insight: she sometimes feels her desire is "blasphemous, as though I am tempting god—acting in a blasphemous way that will bring
retribution, yet I can't stop myself from wanting—it's the wanting that is the blasphemy." She then was able to articulate her fear of treatment. "This is the first therapy that has a chance, but at the same time I can't allow myself to hope for it. I can't do it. I sense it will end badly." She noted that she usually leaves therapy when this starts to loom as possible, and elaborated that she was afraid to stay in treatment because "I need you to do this and I hate admitting it. It frightens me to recognize that I need this and that I am this dependent right now. It makes me want to flee in a million directions."

There were further insights about the extent of her own conflict, i.e., that to go further now, to let the treatment work for her, was to open herself to the pain of what she had done internally by killing off the desirous part of herself. There were associations to a past abortion, and to the realization now that that may have been her only chance for a child. There were also associations to the seeming deadness of family members, detailed associations to violence and even attempts at murder within the family, and an articulation of her feeling that it was her responsibility to breathe life into a dead family. In her view, to confront the fact that she could have a different life was not a gift, it was a torture. The sense here was that if she holds herself back she betrays herself, if she goes forward she betrays her family. Her own intense conflict about whether she could go further was thus dramatically illuminated for the first time, as was her terror of what it meant to be alive, and the degree to which she had heretofore tried to avoid the pain of her experience by "stroking" out.

I must say I was not amazed nor even surprised at the level of what thus unfolded. I had been there before, and I had learned from my patients what my supervisee was now learning from hers.

How do we understand what happened here, in the patient, in the therapist, and in the interaction? Though I will try to keep my focus on the analyst's inner experience and the analyst's vulnerability, I believe this example opens onto the question of the nature of "therapeutic action" as well as onto issues of technique and of how we best use ourselves as analytic instruments.

In my view, the kind of emotional joining that occurred between patient and analyst here merits careful consideration. It certainly seems as though this was a truly therapeutic moment, a moment that was transformative, and that the "analytic" insights followed from the power of what was thus touched off internally by the actual experience, not the reverse. The therapist noted, in this regard, "It didn't come out of what felt like the intellectual part of the work—it wasn't understanding, it wasn't linear, it was not insight. It had to do with the experience of the moment."

What was the experience of the moment? Though we could speak about what occurred in terms of the analyst's constructive use of "countertransference disclosure" and its impact on the patient, my concern is more subtle. It has to do with the degree of emotional availability and vulnerability her response reflected, i.e., with the level of what we ourselves are willing to risk emotionally in relation to our patients. More specifically, I believe there are ways in which we permit or preclude certain kinds of emotional contact with our patients, and that this is something that must be addressed explicitly, because this often defines the level of analytic work that will be possible.

The significance of our own emotional availability in relation to our patients, in our silence as well as in our words, and of the fact that we all listen differently and are present differently, even if we say nothing, has been especially brought home to me by one patient who reported that even when I was silent he could feel my "relatedness." He described his

prior analyst as very "clinical" and as having treated him as a "patient," always keeping him "outside" of himself. His image was of the analyst wearing "psychic rubber gloves," and he noted that in response he felt too isolated and alone to be willing to take an emotional risk. In contrast, he felt my openness to contact with him, my not being afraid of it, and his sense of my willingness to receive his thoughts and feelings, to allow them to penetrate me and to mix with my own, allowed him to take risks with me he never would have dared in his prior treatment. Though I never would have thought about this myself, since it was so
integral to how I work, I realized that, in fact, my patient was right. I was willing to receive his material, I was emotionally receptive to him, I was vulnerable to his impact.

The kind of vulnerability and availability I am focusing on here can involve being "closed" as well as being "open." I emphasize this because I think it is important to distinguish between "closedness" or "openness" as a potential reaction to something the patient evokes or provokes in us, and "closedness" or "openness" as an assumed stance. Being closed or open as a spontaneous, authentic reaction, based on a willingness to permit ourselves to be truly responsive and touched by our patients, is different from being closed or open because we think it is the correct thing to be. An assumed stance is unrelated to the moment-by-moment experience with the patient and as a result is basically detached. Being "empathic," for example, because we feel this is how we should be, can be patronizing, a way of keeping ourselves at a great distance from our patients, even though the ostensible intent is to be "connected." Furthermore, the assumption implicit in taking any such stance is that we know what is best for our patient. This presumes an authority (Renick, 1995) and an objectivity that I don't think we can fairly presume. The fact is that we are as human as our patients and as vulnerable to unconscious influence as they are (Ehrenberg, 1994c), (1995b). Any stance we consciously take may involve some form of inadvertent countertransference enactment that eludes our awareness at the moment, no matter how conscientious we are striving to be.

From my perspective, being emotionally available and then being sensitive to whatever we feel, no matter how strange or bizarre or irrational it may seem at the time, becomes the basis for the most profound kind of analytic work. At times we may want to be explicit about our experience, as was true in this instance for my supervisee; at other times we may feel this would be inappropriate. There are always multiple options to consider.

In an earlier paper (Ehrenberg, 1984) I noted that this view of the importance of the analyst's affective availability is consistent with a growing body of data from all psychoanalytic schools of thought, suggesting that the analyst's more direct affective engagement not only can be constructive in advancing the analytic effort without compromising its integrity, but may be essential. What I stressed at that time, and still believe, is that analytic rigor in the context of a vital, personal, affective engagement is crucial, and that either without the other is insufficient. In effect, each becomes the condition for the other, as the safety of the analytic rigor allows for taking greater emotional risks, and the emotional risk allows for deeper levels of analytic exploration. The emphasis is on the degree to which analytic work actually takes place within, and is a function of, the two-person interaction and the new experience, particularly affective experience, that is generated within it.

What I want to stress here is that honestly felt detachment can be more present than inauthentic "relatedness" if it is used in some sensitive analytic way. Whether we find ourselves closing off, becoming defensive, guarded, or detached, not comfortable and not willing to be open, or feeling angry and unempathic, constitutes important analytic data about what is going on interactively. I am thus arguing that in the moments when we close off responsively, we may be more related than when we are acting "open" and "caring" because we think we are supposed to. More specifically, my view is that working from what we honestly feel in a moment-by-moment way allows for a very different kind of process than working from what we think we should feel. The former involves placing ourselves in an emotionally touchable range and becomes a way of making contact and keeping the work alive. The latter involves relating from a protective distance and remaining inaccessible emotionally to our patients. In my view, without the possibility of affective consummation of some kind the relationship will remain sterile.

The challenge, from my perspective, therefore, is not to get past our own disturbing feelings, but to recognize that these constitute an important part of the analytic field and data (Ehrenberg, 1995a), and to find ways to tap into the margins of our own sensitivities, their most subtle nuances, as a vital analytic resource and as essential for the kind of affective engagement that defines the most profound analytic work.

What I am thus stressing is that feeling anything unfamiliar or even strange, or feeling detached, or
even feeling negative feelings, as a reaction to the moment-by-moment experience with our patients, is not the same as being a detached or hostile analyst. We can be very present and very sensitive with our detached or hostile feelings, if we are able to use them in an analytic way. Finding some way to use these feelings analytically, even something as simple as saying "I find myself feeling detached and I don't understand what is happening, and I am concerned about this," is very different from being detached as an assumed role, or from simply enacting our countertransference detachment. In this regard, my supervisee sharing her experience of feeling like she was having a stroke, and expressing her concern for what this might reflect about what was going on, was different from just "stroking out." In my experience, patients are generally touched when they realize we are not simply (passively) giving in to our feelings of wanting to detach or distance (i.e., enacting them), but are willing to hang in and explore with them in an analytic (and emotionally engaged) way whatever might be happening, particularly when it means opening ourselves to pain. In many instances, sharing my feelings of wanting to distance rather than acting on them, when others simply would have let themselves be pushed away, became the basis for turning points in the work.

I often cite an example in which admitting that I felt distracted when I felt it was inappropriate, and that I was concerned about it, allowed for exploring very subtle interactive and intrapsychic issues the patient would not have had a clue about otherwise. Pretending I was not distracted in that instance, or ignoring it and pulling myself back once I became aware of my own distraction, which would have been easy to do, would have foreclosed the kind of exploration that then became possible (see Ehrenberg, 1992). Simply saying I am distracted, without framing it in some analytically constructive way, however, would not have been constructive either. It might have been hurtful.

In general, I have found that my willingness to make the effort to talk about feeling "cold" in some constructive analytic way, when I do feel that way, often leads to things becoming very "warm." In effect I am saying that trying to be a "good" object, defined by some preconception of what is a good or desirable way to feel, is different from being a real object and then using our genuine feelings in a "good" analytic way. To pretend to feel what we think we should feel not only is dishonest and patronizing, it also cuts us off from ourselves and from our patients. As we saw with my supervisee and her patient, the most subtle aspects of our own experience, however inappropriate or threatening they may seem at any given moment, can become our best guide to how to open the work and to how to make contact in a meaningful way. What I am arguing here, therefore, is that our very vulnerability often becomes our most sensitive instrument, and paradoxically thereby, a source of analytic power and strength.

Apropos of Winnicott's (1960) stress on the limitations of work based on the patient's "false self" (with which I fully agree), what I am stressing here is that if the analyst works from false self, or is cut off from himself or herself, it is even more problematic. It precludes the chance of ever finding and connecting with the patient and of helping the patient realize when he or she is not affectively present, where this is an issue. When the analyst is not emotionally present and available there is a certain level of connection that simply will never occur and a certain level of work that may never be possible.

Winnicott's (1949), (1969) observation that the unflappable analyst may be useless when it is essential for the patient to know that he or she can have an impact seems relevant here. He cautions that there are times when an implacable analyst may provoke destructive forms of acting out, including suicide. What I am stressing is that we need to go one step further. We need to focus on the subtleties of what goes on at this level in an explicit way. In my view, this kind of attention to the interactive subtleties is not only essential in order to maintain analytic integrity, it also allows us to study the ways in which getting affectively involved becomes problematic. This in turn allows for a kind of new experience of working through that can be potentially transformative and liberating. The emphasis is on moving through the affective moment, finding out what happens if we enter it and struggle with it analytically. Struggling to sustain an analytic process in the context of intense anger, for example, can lead to dramatic emotional shifts, including, at times, very intense feelings of affection and gratitude. For some patients, the opportunity to experience getting into a toxic interaction and moving through it to another place can become a revelation, the most important aspect of what occurs and the medium of working through. The
goal is not to stay outside the danger zones, but to help identify the danger zones and to find ways to safely enter them so that the potential time bombs can be defused once and for all. For some patients the new experience—that it is even possible to touch and be touched in a positive way—allows for an experiential kind of insight by creating a new perspective that throws old assumptions open to question. Fears of contact as being inevitably dangerous to self, to other, or to both, and conflicts about it, can be addressed and worked through as they are challenged in the live experience of the moment. If there is no possibility of real contact this simply cannot occur.

If we do risk opening ourselves, how we manage the countertransference feelings that arise, particularly in those instances where closeness inevitably does become toxic, of course, becomes crucial. For example, if the patient is worried about his or her potential to destroy or be destroyed by any touching or closeness, and the analyst is unable or unwilling to be involved or touched, there is no opportunity to determine whether touching can be survived. If the patient fears that he or she is someone who could drive other people crazy, bring out the worst in them, turn them into murderers, the analyst's ability to be affected and still survive can be critical. In contrast, the analyst's affective detachment may affirm the patient's despair. It may be interpreted as a confirmation to the patient that he or she is perceived by the analyst as too dangerous to engage with.

In stressing the importance of emotional openness and contact, and of respecting our own feelings and using them analytically toward achieving this, I want to be clear that I do not mean using our feelings recklessly (see Ehrenberg, 1995a). An indiscriminate introduction of the analyst's free-associative expression, for example, can be a way of precluding contact, because what looks like openness can mask a real closedness. It can be seductive, deceptive, a way to seem available and yet remain untouched, a form of opening a crack and then quickly shutting the door. In some instances, filling the analytic space with the analyst's "stuff" can actually become a form of violation. Sensitivity to this level of what is going on, however, can be a way of opening the analytic work. The challenge is to stay close to the most subtle aspects of our own experience, however inappropriate or threatening they may seem at any given moment, and especially when they seem inappropriate and threatening, and to use this experience in an analytically sensitive way. The emphasis here is on "analytically sensitive" and on a willingness to question our own responsiveness, whatever form it takes, based on a recognition of our own vulnerability and susceptibility to unconscious influence and to engaging in enactment unawares.

Let us return to my supervisee and her patient. Certainly, sharing that she felt as though she were having a stroke while with the patient was not a standard "analytic" intervention; yet it seemed to advance the analytic work in a way that more standard responses would have been unlikely to achieve. What did she do? She did not interpret the patient's behavior. She did not try to analyze her own response. She did not blame the patient for doing this to her, nor did she burden the patient with her own associations or an explanation of why she herself was vulnerable in this way. She did not invade the patient's interior space. She did not crowd out the patient or try to analyze away their mutual experience. She stayed with it. In simply sharing her response and her own puzzlement about it she opened an analytic door that the patient could then walk through. In addition, by sharing the experience that she (the therapist) felt like she was having a "stroke, " one of the things she conveyed to her patient was that she was vulnerable to the same experience her patient was. My sense is that for this patient this in itself had critical impact. It enabled the patient to feel that she herself was not as "alien, " or out of the human realm, as she herself had come to think. Had the analyst said something to this effect in the form of an interpretation, I do not believe it would have had the same impact as the confrontation with the analyst's experience had in enabling the patient to come to this realization on her own. In effect, the analyst's self-revelation permitted the patient to look at both herself and the analyst in a new way. The analyst thus detoxified the field in a way that allowed the patient to feel "safe" for the first time. Once this occurred, instead of remaining locked in a struggle with her feelings and fears about whether she was "weird" or "defective, " she could begin to look at these feelings from a totally new perspective, and become
analytically curious about them as the analytic process thus moved to a new level.

An interaction from which I learned a great deal analytically comes to mind here. It involves a moment when I lost my temper with a patient and thought that my own vulnerability signaled that I was probably not up to working effectively with her, i.e., that I should refer her to someone more competent. To my complete surprise, however, her reaction was one of joy and relief. She explained that my having "lost it" enabled her to feel that she wasn't the only "bad one" in the room. That proved to be a turning point in the treatment, as well as in my own psychoanalytic development.

Another situation from which I learned a great deal was with a patient who had been sexually abused and had given up a child for adoption when she was eighteen. As we began to explore her feelings about having given up this baby, I found myself often moved to tears. At first I was a little embarrassed to be so vulnerable myself (I certainly had been taught not to show such feelings). Nevertheless, as I gradually stopped trying to hide my reaction, I found that my patient was enormously moved and touched by my responsiveness. My openness allowed for a level of emotional contact between us that seemed pivotal. She was able in this context to engage in very intense work she felt she would not have dared to engage in if she felt out in the "cold." (Some of her early images in treatment were of herself floating in space, totally untethered, and at that point she was having out of body and depersonalization experiences.) I, in turn, was very moved by how much my responsiveness meant to her, which led to things only intensifying between us. In the months following, as she agonized over whether to try to find her child, we often would both end up weeping, literally going through boxes of tissues together. Sometimes, when we just simply would greet each other, both of us would become tearful before she even started to talk. Though I myself wondered whether this was a positive or negative development, I came to realize the power of this for her as she expressed feeling validated, understood, and understandable, and connected to me in a way she had never experienced being connected to anyone ever before. In this context, she was able to access feelings she had never been able to express or feel before. The intensity of that experience remains indelible for both of us.

I believe that our own willingness to risk knowing and being known, touching and being touched by another human being, may be far more important than has been recognized. Perhaps our willingness to recognize the terror this holds for us, as well as for our patients, is critical if we are to dare to work at this level.

The complexities of this kind of engagement, of course, are enormous. A situation comes to mind with a patient to whom I was deeply attached, who was dealing with terminal cancer. In that instance, where I was often overwhelmed with feeling, I did not feel that showing the extent of my own pain was best. Though I was often tearful with her, and we were both open with our feelings of how much we cared about each other, as we both dealt with the tragedy of the situation, I would often really only let myself sob with the full intensity of my feelings after she left. In that instance (rightly or wrongly, I do not know) I felt it would be of no help to her to be burdened with the full extent of my own feelings. I felt she would feel she had to take care of me at a time when she needed to be able to worry about herself. This was something we did ultimately address, as it applied not only between us, but obviously elsewhere as well. I raise this only to emphasize how working this way means finding one's way anew each time, since no two situations, or no two moments in time, even with the same person, are ever the same.

There is something about the intimacy of sharing joy, exhilaration, playful exploration, or sadness, pain, grief, or of confronting illness and impending death, and going through a deeply personal struggle with someone that is extremely touching to both. It results in an indelible bond—an invisible thread of knowing what it is to be known and touched, and that it is possible. The key here is the willingness to reach to the other in that way, to allow oneself to touch and be touched without the protection of the kind of "psychic rubber gloves" described earlier. I believe this kind of emotional connection ultimately becomes the key to the most profound kind of analytic possibility.
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