Working at the “Intimate Edge”
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Abstract: In this article I 1) provide some very brief context for the history of the differences between the relational/interpersonal and classical analytic perspectives; 2) give a brief overview of my own position, which is based on the view that an appreciation of the power of unconscious communication between patient and analyst, and of the interactive/intersubjective nature of the analytic field, requires a radical reconceptualization of how we conceive of the data of analysis, the analyst’s role in the process, the nature of the analytic change process and the nature of therapeutic action; and 3) elaborate how working at what I call the “intimate edge” of the analytic relationship can extend the reach of psychoanalytic interaction not only with more traditional patients, but also with patients who traditionally were considered “unanalyzable.”

Keywords: “intimate edge”, deconstructing enactments, therapeutic action, unconscious communication, transference-countertransference, new experience.

I WAS PLEASED TO PARTICIPATE IN THE PANEL, “Minding the Gap: Freudian and Relational/Interpersonal Psychoanalysts in Dialogue,” and to have been invited to spell out my own position. Before doing so, however, I noted some historical considerations that I thought important to keep in mind as we aimed to establish a meaningful dialogue.
What about this “gap”? The panel brought together psychoanalysts trained within the institutes of the American Psychoanalytic Association (ApsaA) and relational/interpersonal psychoanalysts who had been excluded from training by the institutes of the APsaA because they were not M.D.s. The latter group included analysts who were trained at the William Alanson White Institute (WAW), which was formed as a result of a split from the New York Psychoanalytic Institute (NYPI) in the early 1940s. This split was related to concerns about achieving intellectual freedom from the constraints of both “orthodoxy” and the political issues in play at the time (Thompson, 1955; Crowley and Green, 1968; Eisold, 1998; Lionells, 1998; Richards, 1999). The relational/interpersonal analysts also included analysts trained at the NYU Postdoctoral Program in Psychotherapy and Psychoanalysis (NYUPD). The NYUPD program was established originally by analysts trained at WAW to provide analytic training for Ph.D.s in an intellectually free academic context (for details see Kalinkowitz and Aron, 1998). Many of the same relational/interpersonal faculty members now teach at WAW, NYUPD, and also at the new relational/interpersonal institutes and groups that have developed and continue to develop in New York City and throughout the world.

Relational/interpersonal analysts trained outside of ApsaA, beginning with the original programs at WAW and NYUPD, and in this increasingly expanding community, study Freud and the work of the classical analysts, but they also study other points of view and interdisciplinary work where it is relevant. The range of study includes the work of Sullivan, Ferenczi, Rank, Fromm, Fromm-Reichmann, Horney, Searles, Thompson, Rioch, existential analysts in Europe and America, object relations theorists including

1 The M.D. versus Ph.D. issue in the ApsaA was more or less brought to a close when the American Psychological Association (APA) brought a successful lawsuit against the ApsaA in the 1980s for excluding Ph.D.s from training. (Before that non-M.D.s could be accepted for training only as researchers and if they were willing to sign a waiver agreeing that they would not use their training as a basis for engaging in clinical practice.)
Winnicott, Khan, Bion, Klein, Fairbairn, Guntrip, Little, Heimann, Laing, the work of Kohut and many others in the areas of self psychology, and infant research, attachment theory, gender theory, linguistics, neuropsychology, and the list goes on and on. Dialogue and debate continue to be staples in this environment committed to intellectual diversity and this has been reflected in the relational/interpersonal journals. The result of this is that even those relational/interpersonal analysts trained in the same institutes do not share a unified theory (Ehrenberg, 2006) and draw on different analytic forebears. Even those on the same side of many of important controversies within this group, differ from each other in significant ways.

Why was the issue of “intellectual freedom” versus “orthodoxy” such a divisive one for so long at APsaA? And why does it continue to remain so? In his presidential address to the ApsaA in 1982, Arnold Cooper (1984) identified the roots of this conflict as dating back to Freud’s “insistence on establishing psychoanalysis as a movement of adherents to his ideas, rather than allowing, as Bleuler wished, for free scientific interplay to determine, over time, the correctness of his views” (p.252). Cooper, in that same paper posed a challenge to many of his colleagues when he noted,

“\begin{quote}
It would be folly to attempt to define psychoanalysis on the basis of a technique or practice. Techniques change over time and the essence of psychoanalysis lies in its ideas concerning the nature of its inquiry and its views of man, not in its technical procedures. Where Freud's concern with analytic identity helped advance the early cause of analysis, an excessive concern with protection of its boundaries may retard our future development. . . . .We will most benefit from our current scientific debate if we pursue boldly the implications of our differences. It would be astonishing, and disturbing, if the psychoanalytic situation and the psychoanalytic technique we devised more than half a century
\end{quote}

\textsuperscript{2} Historically, the classical journals would not publish papers by authors writing from other points of view. This situation has since changed.
ago were never to develop further. . . . we should welcome any developments that speeded (sic) the achievement of analytic results and made the benefits of analysis available to larger numbers.” (Cooper, 1984, p. 258).

Cooper’s remarks address the vigorous tensions that continue within the APsaA over this issue. Many APsaA members hold fast to traditional ideas and this continues to be reflected in many of their training programs even as others have become more interested in relational/interpersonal perspectives and relational interpersonal analysts are now invited to speak at some of their meetings.

In light of this complex psychoanalytic history, that our panel was held at the invitation of NYPI in an effort to foster dialogue between those on each side of the “gap” is of historical significance.

Given these considerations I think it is important to note that because the same words—words like transference, countertransference, intersubjectivity, and projective identification, as well as many others—often are defined quite differently not only between but also within the groups on both sides of the “gap,” if we are to be able to engage in meaningful communication, it will be necessary to be clear how words are being defined as we use them. The word “intersubjective,” for example, is regarded as a given by some (including me) and as a developmental achievement by others (see Beebe, et. al. (2005) and Ringstrom, (2009), who spell out some of these and other important differences).

At the “Intimate Edge”

Although the way of working I describe draws on the work and thinking of a wide range of both classical and non-classical analysts, it also differs in important ways from each of these. Freud (1915) observed that, “It is a very remarkable thing that the Ucs. of
one human being can react upon that of another, without passing through the Cs.” (p. 194), Ferenczi (1915) wrote about “dialogues of the unconscious” (p. 107, see also 1933) and Sullivan (1953) wrote about how anxiety is transmitted nonverbally—nevertheless, analysts of all persuasions, including those who were attempting to address the interaction, generally failed to appreciate how much goes on unconsciously between patient and analyst, and the bidirectionality of what transpires in the analytic interaction. Even those who were attempting to address the interaction generally failed to realize the inevitability of their own unconscious entanglement, no matter how “well analyzed” they were.

I hold that recognizing the power of what goes on unconsciously between analyst and patient, and the inevitability of enactment in the analytic relationship, no matter how “well analyzed” the analyst may be, has important implications for how we conceive of the data of analysis, the analyst’s role in the process, the nature of the analytic change-process, and the nature of therapeutic action, no matter what our theory. This position is consistent with observations in science about the influence of the observer on the observed, and vice versa in any context.

In my work, beginning in 1974 and continuing thereafter, I have stressed that an interactive view of the analytic field has some theoretical and technical implications that bridge all psychoanalytic perspectives and that cannot be ignored by any of them. Central to my position is the recognition that analyst and patient simply cannot avoid having an effect on each other, even if both are totally silent. Thus we are required to acknowledge that even if a treatment is productive or successful, we cannot be clear whether this outcome is related to our deliberate technical interventions or to aspects of the interaction that have eluded our awareness. For this reason it is useful and necessary to distinguish between theory of technique—which relates to what we do with awareness and intention—and theory of therapeutic action—which has to do with what is healing in the psychoanalytic interaction whether or not it evolves from our “technique.” Doing so can allow us to expand our knowledge of the complex and subtle factors that account for therapeutic action and can become the most effective basis for refining and developing our understanding of how to best use ourselves to help our patients grow and change no matter
Recognizing the power of what transpires unconsciously between patient and analyst requires us to reconsider the concepts of transference and countertransference. Viewing transference and countertransference as an interlocking unity and studying the intersubjective process that accounts for transference or countertransference developments allow for exploring questions such as, What do varying transference-countertransference developments achieve, and what do they prevent, or avoid? Does the development of a particular transference-countertransference prevent certain possibilities of mutual recognition and, if so, why? What are the interactive dynamics involved? From this perspective the contextual meaning and function of transference and of countertransference, and the ways either involves denial or negation of the other, or failure to appreciate or recognize the otherness of the other, must also be appreciated. Clarifying what is not seen and why, can then be as crucial as clarifying what is seen and why.

An appreciation of the power of unconscious communication and enactment, and the bidirectionality of unconscious influence in the analytic relationship, also requires us to recognize that interpreting by the analyst and “free-associating” by the patient may be more interactively influenced than either can consciously grasp at the time. Interpreting and free-associating may be ways of pulling out, detaching emotionally, or generating distance. Conversely, interpreting and free associating may be ways of moving in and penetrating or impinging on the other. Interpreting and free-associating also can be ways of harassing, demeaning, patronizing, violating, gratifying, supporting, or complying, among a multitude of other possibilities.

From this perspective also, a patient's and analyst's assuming that the analyst is in a position to be an objective interpreter of the patient’s experience may actually reflect a form of collusive enactment and a convergence of the needs of both to see the analyst as an authority. If patient and analyst both have needs to believe that the analyst is an omniscient other or a benevolent authority to which one can entrust
oneself, this kind of structuring of the relationship might obscure recognition of the fact that such a drama is being enacted. Such enactments, in which analyst and patient are engaging in this kind of hierarchical way, are particularly hard to discern where the enactment dovetails with the analyst’s theory (Barratt, 1994; Ehrenberg, 1995).

No matter how we are involved, whether we are involved in what we might think of as some reflective kind of analytic “reverie” or in some attempt to address the interaction, or when we engage in some deliberate and carefully thought out form of disclosure, we may be unconsciously involved in subtle forms of interactive enactment and collusion. Even our efforts to monitor for unconscious enactment and collusion may involve enactment and collusion on another level. The same applies in reverse. What we see in our patients is often in response to our own participation.

In contrast to the idea that by being silent we allow a “purer” transference to develop, such a perspective requires us to recognize that being silent influences the transference as much as any other way of responding does. At times, our being silent may be cruel and traumatizing and integral to our participation in a sadomasochistic enactment. Winnicott (1947, 1969) noted in this regard that silence can sometimes provoke a suicide. Especially with more disturbed patients, the traditional idea of the analyst's being silent to allow a transference to “unfold” can be potentially dangerous. This is probably why such patients traditionally have been considered unanalyzable.

A critical point here is that with any patient, not just with more disturbed patients, although at times the analyst’s silence can be respectful and facilitating, at other times it has as much impact and carries as much risk of negative iatrogenic consequences as does active intervention. Furthermore, even our silence, like any other response, may be interactively influenced without any awareness on the part of either party of the degree to which this is so.

Because we and our patients are always affecting and being affected by one another, even when silent, we must be alert to the fact that so-called negative
therapeutic reaction may be an iatrogenic reaction to an aspect of the analyst’s participation of which the analyst may not be aware. The same, of course, applies to idealizing or any other kinds of patient responses. Of course, the analyst’s reaction, which may have evoked in the patient the negative reaction or the idealizing reaction, might itself have been in response to something provoked by the patient, given the dialectical complexity of what is always in play.

From this vantage point, when the patient’s perceptions of the analyst are plausible and even valid (see Ferenczi, 1933; Little, 1951, 1957; Levenson, 1972; Searles, 1975, 1979; Gill, 1982, 1983; Hoffman, 1983), we must consider that these perceptions may be the result of the analyst's being caught in some interactive enactment. He or she may be playing sadist to the patient’s masochist or reacting in some other way that is specific to the intersubjective moment; or the analyst's reaction may involve some form of concordant, complementary, or other kind of identification, including projective and introjective forms of identification. Thus, although patient and analyst each will have unique vulnerabilities, sensitivities, strengths, and needs, we must consider why particular qualities or sensitivities of either patient or analyst are activated at a given moment and not at others. At such time, patient or analyst might be involved in some kind of collusive enactment (see Racker, 1957, 1968; Levenson, 1972, 1983; Ehrenberg, 1974, 1982, 1984, 1992, 1995, 1996, 2000, 2003, 2005a; Sandler, 1976; and the literature on projective identification (in all its definitions), including the work of Bion, 1967, 1983; Ogden, 1979; Grotstein, 1981;, and McDougall, 1979). These considerations help illuminate why clinicians often seem to practice in ways that contradict their own stated beliefs and theoretical positions.

The groundbreaking work of Sullivan (1953), Searles (1975, 1979), Fromm-Reichmann (1950), and others who had struggled in daring and creative ways to be able to work with more disturbed patients usually considered “unanalyzable” was

3 Groddeck, Jung, and others also attempted to work with a broader range of patients very early on.
particularly inspiring for me. Encouraged by their work, I found in my own work that being able to establish a “safe” connection in which toxic developments are dealt with before they can escalate out of hand, and shifts in presence and absence and in closeness and distance are acknowledged and studied, is valuable with all patients.

I particularly began to see that closely attending to the moment-by-moment interactive shifts and studying the unique calculus of relatedness that develops in each analytic dyad allows for deconstructing how each one’s participation is affected by and affects that of the other. The paradox is that looking at what is happening in this way leads to change, whereas if we press for change it usually has the opposite effect (Ehrenberg, 1996, 2003). Our pressing for change can be experienced as coercive. It can also be dangerous. I stress this because in my experience pressing for engagement when a patient is resistant to it, especially when the patient seems to rely on “deadening” defenses, fails to appreciate that such resistance and such defenses often are desperate efforts to protect against feelings that are too painful to bear or to manage and fears of the possibility of interactive developments that could potentially become catastrophic. Where there are dangers of potential breakdown or violence, including possibilities of murder or suicide, or the vulnerability to “losing it” in any other way, it is not the unwillingness to engage or the “deadness” per se but how to help our patients with the vulnerabilities that these are protecting against that becomes key (Ehrenberg, 2003). Pressing for movement in such instances gets away from the important issues rather than allowing them to be fruitfully engaged.

Deconstructing potentially toxic developments, particularly with regard to boundary confusions and violations, before they can escalate to dangerous proportions is precisely what creates a context of safety and allows both patient and analyst to take risks that would not have been possible otherwise. I describe this kind of process as an effort to work at the “intimate edge”:

By “intimate edge” I mean that point of maximum and acknowledged contact at any given moment in a relationship without fusion, without
violation of the separateness and integrity of each participant. This point is not static and may fluctuate from one moment to the next, so that being able to relate at this point requires ceaseless sensitivity to inner changes in oneself and in the other, and to changes at the interface of the interaction, as these occur in the context of the spiral of reciprocal impact. (My concept thus encompasses spatial as well as temporal dimensions). More often than not this optimal point is over-or undershot so that there is some kind of intrusion or else over-cautiousness. In either case there is a failure on the part of psychoanalyst and patient to meet at the “intimate edge [Ehrenberg, 1974, pp.424-425].

Identifying the difficulties or problems that become revealed this way creates a unique trajectory of new experience that becomes both the medium and the measure of the work. In addition, it allows for working with more primitive and dangerous feelings, yearnings, fantasies, and wishes without fear of destructive or dangerous consequences, not only with more troubled patients (usually considered unanalyzable) but with traditional kinds of patients as well.4 I have repeatedly found in my own work that simply tracking the moment-to- moment shifts in feeling in the analyst, as well as in the patient, helps to identify what such shifts in feeling are in response to, and allows for deconstructing enactments in which we ourselves have become players in scripts of which we have no understanding. Opening such enactments in this way is crucial to the extent the interactive process between patient and analyst becomes the

4 Though a frequent assumption about my early papers was that I was working with very “disturbed” patients, they were the same patients who had not been able to get to the same levels of exploration and the more primitive aspects of their own experience with prior analysts. Being able to detoxify the immediate interaction seemed to allow them to feel safe enough to take risks they would not have dared to otherwise, and this very process became an important medium of the work.
canvas on which problems in engagement and process issues are manifested—issues that the patient has no way of communicating to us otherwise.

Even if we cannot always clarify how unconscious collusion occurs, simply asking questions—Why are we fighting now? How did we get into an argument? Why are we both getting sleepy or quiet or frightened or intellectualized? Why do we now feel so close?—can be extremely useful.

From this perspective our most bizarre and puzzling feelings, those most confusing or seemingly inappropriate, become vital analytic data. Though we may not know how to read our experience, attending to what is often only at the margins of our own awareness as we listen can become key to knowing when the words are “empty” or “full” (Lacan, 1953, 1958), or when something is “off” and should be looked at more closely; or when what is going on nonverbally and affectively may not be consistent with what is going on in the verbal dialogue. Sometimes disclosing our confusion or specific feelings of puzzlement can be useful. At other times, we can use our feelings to help formulate questions without revealing specific feelings at all. The point is to engage in a collaborative exploration with our patients because often it is only our patients (not even an analyst or supervisor) who can provide the information that will make it possible to deconstruct the interactive issues in play.

Tracking when either patient or analyst becomes more coherent or less, more present or less, more frightened or less, more protective or less, more brilliant, or unable to think at all—and monitoring for when patient or analyst feels more or less open, more or less vulnerable, or willing to be vulnerable, more or less empathic—can help illuminate the exquisite subtleties of what is developing interactively in an ongoing way and becomes a medium through which toxic ways of engaging can be deconstructed and worked through.

What is critical here is that, instead of acting and reacting, patient and analyst begin to engage collaboratively in the effort to figure out what is going on. The new
experience of being able to work collaboratively is the change and also the “insight.” Where the collaborative effort is derailed or not able to be achieved, deconstructing why and how can then become the heart of the work.

We know something important has happened in such an instance if the patient responds with emotionally charged associations to the past and begins to bring in dreams that would not otherwise have been accessible. The associations and the new access to dreams are the result of the change, not the reverse. They become possible to the degree that past, present, even future can be seen through new lenses and with new degrees of freedom and agency. Such shifts account for why the history that a patient presents at the beginning of an analysis is usually not the same as the history that might be presented at the end of a successful analysis. In this kind of process, patients usually are the ones who make the critical connections and achieve the crucial insights. It is not the analyst’s interpretations but the lived, new, collaborative experience, and the opportunity to (re)claim a sense of power and agency, that often become the basis for profound kinds of internal shifts.

Attending to what is in play interactively allows for clarifying wishes and longings to be “taken over,” or to be controlled, or to have all decisions made by another, or the reverse. The same is true for varying forms of denial of boundaries by which patient or analyst may maintain an illusion of some kind of “oneness” or merger. It may also help to clarify the extent to which patient and analyst may feel internally “colonized” or “co-opted” by each other. Helping to deconstruct enactments in which either is not able to say “no” or feels invaded or at risk allows for recognizing the ways power can be disavowed without awareness. These are mutative “insights” to the extent that they relieve paranoia and feelings of helplessness and open the way for new experiences of agency that feel empowering.

Deconstructing enactments can also bring to light the extent to which taking a helpless role may be a way to seduce the other into taking a helpful role, a way of asserting power or manipulating the other, with or without awareness. Where the
relationship is eroticized, bringing erotic undercurrents into explicit focus can change the nature of the erotic tension and generate new experiential and relational possibilities (Ehrenberg, 2005b). The same is true if there is a power struggle in play. Being able to look at and lay bare the power structure changes that structure and changes the interactive tension. Once the collusion is exposed, it cannot continue in the same way. Something “moves” and changes for both patient and analyst in relation to each other in the immediate moment, as they begin to look at what is in play collaboratively. Every such change then opens the way for yet other possibilities in an endless progression.

As the boundaries are clarified, and boundary confusions are cleared up, as projections and introjections become undone, there is a reclaiming of power and agency and a chance to explore conflicts about having power or agency or access to one’s desire. There is also opportunity to clarify those moments when one is assuming that one has powers one does not, and one assumes too much responsibility or guilt. Establishing the limits of one’s helplessness and one’s omnipotence makes it safer for patients to go deeper into their own experience, especially when there is a risk of a potentially paranoid or other kind of fantasy or impulse escalating out of control. Patients' fears that they are at the mercy of the other, or that they are toxic and dangerous and that opening to their own experience will inevitably be dangerous, can then be worked through.

Studying choices that are made, as they are made, along with the subtleties of what goes on at the boundaries of the interaction, allows patient and analyst to begin also to see how each may be colluding, or permitting, or even inviting cooption. This kind of examination permits clarification of the real dangers to which patient and analyst are both vulnerable and actually perpetuate, in relation to each other, in an ongoing way. As it becomes possible to see, in the moment, the choices that are made—including the choice not to know, not to take responsibility, or to take too much responsibility—both participants gain a heightened ability to become aware of
and begin to deal with fears of, or conflicts about, empowerment or helplessness, and about “knowing” and “not knowing.”

This is an issue particularly with victims of sexual abuse and children of depressed parents. In the context of any kind of history of trauma, this kind of tracking can be especially crucial and can permit, finally, access to the terror of being penetrated, manipulated, or hurt as well as the cynicism and despair that were integral to the resistance to any kind of engagement. It also can facilitate access to feelings that one has been “ruined” or “defiled,” that one is “disgusting” and not worthy of being alive or of being involved in any kind of loving relationships. Accessing such fears and anxieties allows them to be worked through in ways that involve and facilitate the possibility of new experiential awakenings.

The “intimate edge,” over time, becomes the trace of a constantly moving locus, for each time it is identified it is also changed; as it is reidentified, it changes again. This becomes the “growing edge” of the relationship and the point from which experience goes through ever-new transformations; each time we turn the moment “inside out,” the experience changes, and, opening the new experience, transforms the moment yet again. This process is never linear— as the moment “opens,” it opens in all directions simultaneously. The experience of being able to engage constructively, where before this may not have been possible, not only allows for looking at the past through a new lens and with new degrees of freedom but also makes possible a recognition that things could have been otherwise and an acceptance of a painful but necessary process of mourning.

Attending to the interaction requires being alert to the ways that what transpires in a dyad may actually involve triadic or even more complex considerations. The analyst may be the “third” in a triangular relation to a significant other in the patient’s life, or a person in the patient’s life may be in the role of the “third” in a triangular relation to the analyst, or the patient can be the third (in fantasy or in reality) in triangular relation to some real or imagined other in the analyst’s life. This may be the
analyst’s issue not just the patient’s. The same applies where the numbers may be even
greater than three. Patients react to other patients, to phone calls, even those
unanswered, to distractions in the immediate moment. They also react to what they
know about the analyst's personal or professional relationships. These factors often
also apply to “free association,” which can be motivated by a wish to break free of or
even to betray the privacy of an intimacy with someone other than the analyst. The
opposite is often also true. Resistance to “free associating” on the part of the patient
can reflect a wish to be loyal to or to honor the privacy of another (non-analytic)
relationship. The possibilities are myriad. The analyst’s need to maintain privacy,
similarly, may be affected by how this need relates to his or her relationships with
others.

Focusing on the “real” interaction is in the tradition of Ferenczi (1916, 1926,
1932, 1939),5 Rank (1929), Rioch (1943), Wolstein (1959, 1971, 1993), Levenson (1972,
1983, 2000), and many others. My focus, however, is somewhat different from each
of theirs to the extent that I look not only at the interaction and how I might be
participating in it. I try to engage the patient in a collaborative exploration of what
goes on at the boundaries in a moment-by-moment way. I see as crucial what
transpires emotionally and nonverbally as the work proceeds. If I feel there is
something destructive going on, I will take a stand. I see insisting on maintaining a
safe space for exploration and collaboration as essential. And I see my commitment to
establishing and maintaining safety and the process of pursuing this kind of goal not
simply as creating the conditions for the work but as an important medium of the

5 Ferenczi’s interest was in the need for “elasticity of technique”, depending on
the patient’s needs, and for being able to develop a mutual kind of analytic
relationship, in which the very acknowledgment of our issues can be valuable and
helpful in establishing trust and honesty. He was also able to see the extent to which
the analyst was often in need of the patient’s help, given his own unconscious
vulnerabilities.
work. Working this way does not involve “mutual analysis” or “wild analysis,” but it does require that the patient and I have to deal with each other, and with each of our strengths and vulnerabilities, in real time and in real ways.

Although aspects of this approach seem to be consistent with Winnicott’s (1969) ideas about the necessity for the analyst’s surviving “destruction,” my position is different from his in an important way. I believe that not only does destructiveness in the interaction have to be survived by both patient and analyst, but also that destructiveness has to be dealt with straight on (Ehrenberg, 1992). This is in the tradition of Fromm-Reichmann (1950) who wrote long ago that allowing abuse is not helpful to the patient, the analyst, or the treatment. It also is in the tradition of Lucia Tower (1956), who noted that standing up to a patient made all the difference in her work—even though she actually did so inadvertently at the time.

Winnicott’s work with Margaret Little comes to mind (Little, 1990). He did not address the enactment between them when she broke a vase in his office. He simply replaced the vase with another just like it. Though there is no way to know if her becoming suicidal and his ultimately hospitalizing her might have been preventable, my experience is that addressing hostility and hostile enactments, or any kind of threatening comments or behavior, as they occur, is essential. Acknowledging that a patient has been able to scare me or arouse my anger or that I am aware there is something going on that is not explicit and concerns me, matters and has often been crucial in preventing escalating kinds of acting out. Some patients have told me explicitly that had I not reacted and shown that I was vulnerable when they threatened me or acted out in destructive ways, they would have kept upping the ante until they were able to provoke my reaction. There is more involved here than simply looking at the provocative behavior and addressing the negative transference. We must explore what may have provoked such behavior or responses to us in the moment. Accepting responsibility for our contribution, and vice versa, allows for boundary confusions to be demystified and for the realization that each is vulnerable to the other. If one fears one’s own potential for destructiveness, learning that one is not omnipotent and that
others can take care of themselves also can be liberating and reassuring. Such insights are not achieved as a result of anything that one can say to the other. They are achieved in the crucible of the actual lived interactive experience in the moment.

Notwithstanding that from the earliest days of psychoanalysis (Breuer and Freud, 1893-1895), analysts have been wary of strong feelings (in patients or in themselves), positive or negative, I believe that the opportunity to explore what occurs when strong feelings develop is a critical medium of the work. Being able to discover that hateful or loving feelings can be talked about and can lead to real communication and understanding of each by the other, rather than threatening the relationship, and that the relationship can deepen rather be destroyed in the process, can be transformative. It can, in fact, open onto possibilities of loving that neither patient nor analyst could have anticipated.

Openness to loving and to hateful feelings in both patient and analyst also allows for discovering how deeply affected each can be by the other, for exploring the anxieties that may be aroused by such feelings, and for working through the relevant issues relating to fears about one’s power or impotence (or both at the same time).

In some instances, the opportunity to discover that one can be involved in a deeply emotional way, and that this involvement can be constructive rather than dangerous, can be a revelation and an “insight” that has transformative impact. Discovering also that one can have access to one’s desire without risk of losing control, that is, without risk of becoming a murderer or suicidal, and without risk of sexual or any other kind of boundary violations, is also powerful.

Just as knowing that we can help others to change their lives is meaningful and rewarding for us, the opportunity for our patients to learn that they can touch us profoundly and help us to grow can be especially meaningful (Ferenczi 1932; Singer, 1971; Searles, 1975; Feiner, 2000). For some, discovering that they have something of value to offer, and that the analyst is happy to receive it, can be the most healing
experience of all. Being able to laugh together, enjoy each other, even waste time and be “bad” together and enjoy being able to be so, can also have great meaning (Ehrenberg, 1992). Those kinds of discoveries, in the actual interactive moment, may be healing. This view of the analytic relationship as the medium of analytic work and also its measure is different from the ideas of Greenson (1965; Greenson and Wexler (1969), Klein (1957), Myerson (1973), and others who have emphasized the importance of the “real relationship” between analyst and patient as a facilitating condition for successful analysis but do not see it as the medium or the measure of the analytic work.

Clinical Examples

John

In a session just prior to my taking off for one week, a relatively new patient, John (Ehrenberg, 1992) talked about quitting. He said that he really did not see any value to continuing treatment unless there was "something going on in his life" that he could talk about. I asked whether he thought his statement might be related to the fact that I would be away for a week. He insisted that it was not. He spoke, not really talking to me but at me, and without any affect. What struck me was my own reaction. I found myself feeling pleased by the thought he might leave and was aware of an impulse to say nothing further in the hope that he would.

At first I was surprised and almost guilty about having such a reaction. When I began to consider that this might be important data about the situation, I found that I was able to make an internal shift myself and I was no longer "put off." After some thought I decided to tell him my reaction, emphasizing that I did not see his wanting to quit, or my wanting to let him quit, as a basis for disengaging but rather as important and necessary data for our work. I also wondered out loud whether my response was unique in his experience. John seemed visibly shaken and began to cry. He remarked that my reaction was exactly what he seemed to evoke in everyone. He then described
a date he had had the same week and other incidents when similar interactions had occurred. He described with much feeling the pain he felt about not being able to "connect" with anyone and not understanding why. He noted that he was very moved by my having the feelings, but, in contrast to others who simply would act on their feelings of not wanting to connect, I apparently was not going to act on them but instead was trying to help him figure out what might be going on. I was moved by his reaction, by his openness and the intensity of his feelings, and I told him so. He said how touched he was by my telling him this and expressed a new sense of hope that treatment might be helpful.

In the following session he described how he had found it difficult to allow any relationship to be important to him, especially ours, and he expressed a desire to be totally self-sufficient. He didn't want ever to have to rely on anyone who could possibly disappoint, hurt, or abandon him (as I was now about to do for one week). John, whose mother had died when he was a very young child, described now how he wanted to be able to “survive in a foxhole alone.” As we pursued these issues there were further associations to his terror of being "dumped" by me, or anyone, should he become involved. He noted that when he does get involved his feelings becomes so intense and out of control that it is terrifying. When one girlfriend broke up with him he lost 40 pounds and had a "breakdown." He stated that, “I have it so that even if a girlfriend were able to tell me to get lost, I would be totally unfazed." The issue of his cynicism and despair, his tendency to give up without trying—not only in treatment but also in life in general—could be addressed. When I emphasized my belief that it would be possible for him to work some of this out, he began to cry. Although there were many expressions of ambivalence, at this point he was willing to entertain the idea that my taking off for a vacation might have been more emotionally significant for him than he had allowed himself to consider. Moreover, he was able to reveal a deep sadness, a sense of fearfulness, of neediness, and of anxiety about revealing all this to me. We were now both engaged in what felt to be a very intense and moving way.
Laura

I think of a moment with my patient Laura (Ehrenberg, 1992) when she began to sob as she expressed relief and gratitude that I had stood up to her when she became abusive to me. She said that no one had ever related to her in this way before, and she told of fears that, like her parents, I would not be able to "handle" her. Associations followed to the ways in which, she now could see, she had terrorized her mother with her tantrums when she was a child, and how, instead of trying to stop her, her mother had let her become "loathsome" and then hated her for being that way. She continued to sob as she remarked, "If only she had stopped me!" She described how angry she now was that her mother had not stopped her. She then expressed a wish to have control imposed from outside because of her fears of her own destructive potential to herself and to others. Realizing this allowed her to consider that, even if her mother or I had had problems setting limits or had hurt her, adventently or inadvertently, she was not absolved of her responsibility for her own behavior. As a result of this very painful period of work, Laura reported that she finally understood how much she actually enjoyed tyrannizing others while presenting herself as the innocent, self-righteous victim. She described with embarrassment the "pleasure," the almost "sexual pleasure" this gave her. And, as she began to realize that she could take responsibility for helping me to understand her, she reported finding that she was actually able to take pleasure and pride in being able to do so.

In the months following, Laura went through a self-conscious and painful exploration of how "outrageous" she had been to me and to her parents over the years. She elaborated how she had “walked all over them.” Though she was still angry that they had permitted her to do that, she also began to express remorse for having exploited what she was beginning to see with growing compassion as their vulnerability and limitations. This realization evoked much sadness and pain, but also a sense of relief. As she began increasingly to see herself apart from her mother and to be aware of options she had not quite grasped before, the lines between us became clearer. She began to feel relatively safer and more curious, rather than threatened and
offensively defensive. Now, instead of becoming hopelessly tangled in battles over who was doing what to whom, we began to laugh together when things started to revert to the old patterns. The kinds of struggles that might have gone on over weeks or months in the past were resolved in one or two sessions, as we both felt safer and more trusting.

In one such instance Laura reported realizing that she was choosing to defer to mother, or to me, to get “approval” and feel “connected.” Realizing that this was her choice made clear that, despite her subjective experience to the contrary, she was actually not at the mercy of the other, as she had assumed. Rather, she was slave to her own need for the (m)other’s approval. In effect, to sustain her own feeling of connection she had to deny any negative feelings toward her mother and was not even able to see that her mother was the one violating her. Thus, although she had assumed all along that it was the other who was trying to control her, and whom she felt “strangled” by, now she realized that it was she who was trying to control both herself and the other, to get each to think and feel what she wanted them to think and feel, no matter the cost to herself. As this scenario unraveled and she was increasingly able to realize the extent to which she was the one doing this to herself, there were associations to moments when she had actually attacked people physically, without quite being clear at the time what exactly had happened. Now she realized that perhaps one of the reasons she had angrily stormed out of our sessions in the past was for fear that, had she not done so at those moments of anger, she actually might have assaulted me. Although this revelation was a bit shocking and difficult to integrate, the reclaiming (or the claiming) of agency and of desire that it allowed was liberating and empowering and permitted her to feel whole and separate in a way she had never dared to feel before, as well as less threatened and “paranoid.”

Laura’s realizing that there were other ways to be connected created the opportunity for a process of mourning what might have been and how different her life could have been.
With a growing sense of closeness and trust, Laura reported feeling even more whole and separate, and less paranoid. She began to take more emotional risks. In this context she became aware of anxieties about our relationship, about how to know whether or not to trust her own judgment, and about her own vulnerability to influence. She noted with dread that she feared she would "lose herself" and not know whether she was feeling a certain way because of her own authentic wishes or because of her desire to please or to placate me. She expressed terror that she would not be able to survive disappointment and hurt if she truly opened herself and needed or depended on anyone. Details of early experiences of having been victimized by others as a child, which had not been in awareness before, now became accessible.

Although Laura continued to give me a hard time when she was frustrated, as we continued to work in this way, deep feelings of affection, tenderness, and respect developed between us. In contrast to the long and difficult periods that had been so painful for both of us, our sessions began to be a pleasure. For the first time, she began to explore her attachment to me. She also expressed surprise at the intensity of her feelings about sessions ending, about the time she had to wait between sessions, and about the pain of feeling so "vulnerable."

Comments

Though my emphasis is on “opening” the moment—which brings to mind William Blake’s (1800–1803) image of finding “the world in the grain of sand”—the process I am describing involves more than finding what already exists and is there to be found. Rather, it is a way of structuring a different trajectory of experience and of helping to generate something intersubjectively that could not have been achievable before. If we can find a way to deconstruct what might have been toxic, or constrictive, it becomes possible to engage more freely so that new experiences can begin to develop. Such experiences are not “there to be found.” They are intersubjective creations. When they are achieved, they can feel like wonders, and bits of magic. They are unique to the moment and to the particular relationship of the
moment, and they are never static. There is no way to “hold” them, for they are in constant flux. The key to their achievement is that we must be willing to be emotionally available and accessible and open to finding out where the experience might take us if we dare to let it, and patient and analyst must be willing to risk some degree of chaos, anxiety, and uncertainty. The unexpected and new experiences that then can be realized constitute the “insights” as we work and engage in this way.

I want to stress also that, even as attending to the interaction may be important when issues manifest interactively, there are other times with the same patients, or in general with other patients, when being very still and allowing the patient to engage his or her experience without interruption, intrusion or distraction, and without having to be limited by or reactive to the analyst’s thinking, can be key. At times it may even be a matter of simply being able to be together in an intimate kind of silence—where there may be no need for words—and where filling the space with words, by analyst or patient, may actually be a defense against “being” in the moment (Ehrenberg, 1992).

Moreover, despite arguments by many that good analytic work leads to the same outcome independent of theoretical position or technique, in my experience, not all roads lead to Rome. Each road and each process of travel along that road leads in another direction and generates different experiential possibilities.

A final note: As I have written elsewhere (Ehrenberg, 2005a), though the intersubjective exists only intersubjectively and changes from moment to moment across time, each time a new intersubjective possibility is realized, specific as it may be to the particular dyad and to the specific moment between them, something internal also changes, and consciousness is expanded in a way that leaves neither person the same. Something rearranges internally for each, so that each participant actually then does “own” something not “owned” before. The insight that one is capable of an experience of a kind that one did not even know was possible is something we do keep, even after the experience is over, and this becomes a kind of “private property.” One patient, in response to a dramatic kind of internal “opening” that occurred as we
engaged this way, described his experience very eloquently. He reported feeling as if “the ceiling was lifting on his imagination.”

**References**


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