



## ON THE THERAPIST'S YEARNING FOR INTIMACY

BY HANOCH YERUSHALMI

*From the beginning of clinical psychoanalysis, analysts have been at risk of succumbing to yearnings for intimacy and contact that are stirred up by the heat of the analytic encounter. Recently, as theoretical developments have encouraged us to create moments of meeting (Stern et al. 1998) and have urged us to tolerate the feelings stimulated by enactments, these risks have increased. The author points out that foregoing the realization of this yearning within the analytic relationship and the resultant mourning for the loss of a fantasy or illusion carries a heavy personal price tag for the therapist.*

**Keywords:** Yearning, intimacy, analytic encounter, mourning, moments of meeting, enactment, analytic framework, therapist's authenticity.

The more developed our understanding of intersubjective processes and the greater our ability to describe them in a meaningful way, the more we can broaden our understanding of the various complex challenges that face us as psychoanalytic psychotherapists. However, the risks to therapists of one meaningful challenge have recently increased. This challenge derives from a recognition of the importance of authenticity and spontaneity in contact with patients. It is accentuated by the stance held by relational theory, which encourages a close, emotionally touching, and mutually therapeutic relationship in order to provide an outlet for the internalized dramas of both patient and therapist.

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This clinical-theoretical stance finds expression in the study of *moments of meeting*, which are encouraged phenomena in the analytic process, and of *mutual enactments*, which are tolerated. These two concepts—as well as others, such as self-disclosure, affect attunement, and expressive involvement—deal with authentic and spontaneous self-expression, considered an inseparable part of the psychoanalytic psychotherapeutic process. These theoretical developments invite the therapist to take an active part in the analytic therapy process and to become closely involved and engaged with them.

I suggest that this increasingly relational tendency among therapists can induce a deep yearning in them, within the analytic context, for a close, intimate relationship and a merging with significant others. This yearning can obviously attain only a very limited outlet in the therapeutic relationship, which always includes reasonable boundaries in order to contain an intersubjective therapeutic space. Because of these boundaries, this yearning, often a never-ending one, cannot be satisfied.

Therapists, therefore, often find themselves having to relinquish this yearning, which leads to a subsequent process of mourning. The psychoanalytic literature addresses the mourning that therapists must experience as part of their involvement in therapy, such as mourning for their grandiose, unsatisfied wishes for the therapy and its outcome. By and large, however, analytic writers have not addressed mourning and the experience of loneliness in relation to the yearning I am describing—a yearning that arises in the aftermath of intense personal involvement, and gathers strength from current relational clinical-therapeutic approaches.

Lack of a mourning process for the impossibility of realizing this yearning is likely to spark an avoidance reaction and a fear of repeating the traumatic experience. Conversely, ongoing observation of this process and appropriate working through of mourning might help therapists find an appropriate emotional balance when such yearning for intimacy arises. Awareness of these processes will enable their relatively fast identification and the search for renewed balance among wishes, fantasies, and perceptions of relational realities.

Many writers believe that the emotional intensity and centrality of the therapeutic relationship increases its effectiveness (e.g., Epstein

1994; Fosshage 2007; Frank 1997; Greenberg 2002; Mitchell 1993). This belief in the importance of the therapist's authenticity encourages integration of parts of the therapist's self-experience into the analytic therapeutic relationship, and attributes a crucial therapeutic impact to these parts, even when they are not in line with preplanned therapeutic goals (Bollas 2006; Fosshage 2007).

Since authenticity may be best expressed through spontaneous actions and reactions, increasing numbers of analytic thinkers are recommending that therapists maintain an intentionality toward voluntary and disciplined, spontaneous therapeutic engagements, which at the same time are less restrained. These engagements may be manifested through remarks, gestures, facial expressions, and actions that appear as a result of an outbreak of emotion in the absence of deep thinking or premeditation on the therapist's part (Bacal and Herzog 2003; Kindler 2010; Lichtenberg 1999; Teicholz 2000; Wolfe 1985). Authors explain that such spontaneity must be expressed with caution and in the context of maintaining the therapeutic process and the patient's central position within it; they warn against its unethical use.

It is clear that the therapist's attempt to achieve authenticity and spontaneity leaves him more exposed and vulnerable than is the case when rules and texts are strictly adhered to. I suggest that when the therapist strives for spontaneous expression of authentic self-experience, with the greater risk of vulnerability this entails, an emotional hunger may frequently be evoked within him—or, in other words, an archaic yearning may arise. This yearning is for a relationship, for contact, and for merging with significant others—a wish buried deep inside the individual self-experience of all of us (Ehrenberg 2003; Stolorow 1994, 2002), and one that is stimulated under certain conditions.

Deeply rooted from an early age, such a yearning shapes all our relationships with significant others (Davies 1998). This archaic yearning is composed of the need for:

. . . nourishment and warmth; the need for emotional resonance and physical contact; the need for recognition and affirmation; the need for reliable and knowable limits and boundaries; the need to survive and watch others survive our own aggressive and

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rageful assaults; the need to trust, rely on, and ultimately surrender to the other. [p. 805]

This yearning for a deep, touching relationship and for merging with significant others is not necessarily a longing for something we have had and lost, such as actual experiences or memories. It can be a yearning for relationships and intimacy that exist only in our imaginations, in our hopes and desires for the future (Person 2006). It often appears as the desire to merge with a significant other, while denying separation from him or her and clinging to the belief that he or she understands one's needs without having to be told (Ehrenberg 2003). This yearning for intimacy contains a hidden meaning that conveys the idea of "I want it, I must attain it, and I will attain it," together with a magical denial of the difficulty of its achievement (Phillips 2002).

Archaic yearning is frequently aroused in the therapist following the establishment of dialogue and a close relationship with the patient—a relationship in which the therapist sheds barriers and inhibitions on the way to authentic self-expression, which will appear spontaneously in the therapy. This yearning, which might be deeply concealed underneath mature, controlled self-organization and the shroud of professionalism, might wait a very long time for the opportune moment to burst forth in an individual's emotional life, including a psychoanalytic therapist's.

The significant connection with patients, mutual therapist–patient contact, and the uniqueness of the moment may arouse within the therapist a hunger for something that the therapeutic reality cannot provide: greater intimacy, a deep relationship experience, and genuine or imagined merging. Such hunger will have been buried within the therapist from a very early age and is stimulated in the present.

We may learn of the existence of such yearning when it appears implicitly in the therapist's fantasy of a relationship with a patient outside the office. The therapist often finds himself imagining how he could develop a relationship with his patient, painted in ideal colors, as a perfect solution to the social distress and existential isolation that the therapist sometimes feels. At other times, the therapist may imagine a role reversal with the patient, in which the therapist is the one being treated, or the

therapist may fantasize about being treated by a different therapist in a relationship in which he feels genuinely seen and understood.

Fantasies such as these express the desire and archaic yearning for a relationship that is not limited to a rigid analytic framework, a relationship that is far more total, enveloping, and fulfilling than is possible within the structure of the therapist's current role. This yearning has a primitive source and is removed from the limitations and conventions of reality.

Attempts or aspirations to realize part of this yearning through intimacy are permissible in any relationship that is not of an analytic therapeutic nature. However, analytic therapy leaves no room for long-term development of this yearning because of its structure and its mission. It is intended to advance therapeutic goals; it is not intended to satisfy the therapist's deep personal goals or to exist in and of itself.

In my view, this situation creates an inherent difficulty and an occasional need among therapists to mourn the fact that the therapeutic context cannot meet the needs of the yearning evoked within them. A mourning process is required because the therapist must separate from the idea, hope, and fantasy that this initial, basic yearning can be realized in the present context. This process may arouse frustration and anger in the therapist, and sometimes even despair, but these can be alleviated through their acknowledgment by significant others.

The therapist experiences mourning when she must relinquish her yearning, despite having derived satisfaction from the achievement of therapeutic goals, and despite the patient's genuine expression of gratitude. This relinquishment and subsequent mourning may assist the therapist in understanding the patient's pain at the loss of subjective omnipotence—that is, of the exciting illusion that the patient can own and control the therapist (Winnicott 1960). This painful loss is part of the patient's journey toward acquiring knowledge of his internal world and his organization of self-experience, and toward an understanding of how these intersubjective systems are created with significant others. In a parallel way, it may emerge that it is actually the therapist's deep emotional involvement in the therapeutic process that is so painful for the therapist.

A theoretical-clinical approach neither examines the arousal of archaic emotional hunger for relationships and intimacy—which therapists with a relational emphasis are especially likely to experience—nor suggests what should be done with it. Neither does such an approach suggest how therapists can return to a more observational and less involved standpoint following such personal and emotionally arousing participation.

## THE THERAPIST'S MOURNING PROCESS

The therapist's mourning of the inability to satisfy his yearning for relationships—for emotionally touching and merging with significant others, and for recognition of his loneliness—is by and large not addressed in the psychoanalytic literature. However, some writers have addressed other mourning processes that therapists experience as part of their analytic therapy work.

Steiner (2011), for example, writes that the therapist's own vulnerabilities, which are enhanced by the patient's projective identification, sometimes cause the therapist to dissociate from the patient's emotional reality and unconscious communications and to try to compensate for these vulnerabilities. In such cases, the therapist is likely to project her own internal objects onto the patient, and to attempt to retrieve them through grandiose fantasies of rescuing the patient. To escape from this vicious circle, the therapist must recognize that her grandiose fantasies have dominated the therapeutic process and must mourn her loss of omnipotence. She must understand that her perception of reality is numbed and is full of a desire to heal the patient, instead of to understand the patient's internal world and needs.

In Steiner's opinion, mourning the lack of omnipotent healing powers might be the lot of all therapists at one point in time or another. Smith (2004) and Werbart and Levander (2006) also believe that many therapists, on many occasions, are forced to forgo fantasies of omnipotence regarding their patients and positive therapeutic outcomes through a painful process of mourning.

Rather than the therapist's mourning as a consequence of disappointment arising from his yearning for closeness, as I am discussing

here, the psychoanalytic literature tends to deal with the opposite phenomenon: the yearning that arises in the therapist as a result of loneliness, which, as described by Adler (1980), can be overwhelming in certain circumstances. Adler explains that analytic therapists encounter intense loneliness that can cause stress in the analytic work, or therapeutic impasse, or a yearning for significant others. In his opinion, this loneliness arises through the patient's transference or as part of the patient's defensive devaluation, which causes the therapist to feel inhuman and isolated, leading to an intense need for company and for sharing with others in order to escape from this feeling.

Schafer (1995) explains that analytic therapists are often flooded by the experience of being "alone" in their therapies. The therapist begins to understand this after starting to experience sudden listlessness, impatience, distraction, or irritability. Reflecting on his feelings often leads the therapist to identify his feeling as *aloneness*. These experiences can appear at different stages of the analytic therapy—for example, when the patient becomes very defensive and entrenched in her stance, or with a patient who becomes especially anxious, guilty, and defensive, or one who has feelings of omnipotence. In such cases, the therapist might draw the erroneous conclusion that there is no way for him to reach the patient, as his words will always fall on deaf ears, and that starting therapy with this patient was a mistake.

Schafer explains that, generally, the situations described above cause the therapist to experience a certain amount of mild loneliness. Schafer believes that, for many therapists, this loneliness produces great longing for a special kind of company that is achieved only in deep analytic therapy. Schafer also believes that this longing will usually advance the work but, on the other hand, it might expose the therapist to destructive manipulation by the patient. This can happen under certain conditions, when the usually tolerable existential loneliness turns into an intense experience and hence into the sense of aloneness. This upheaval occurs when the therapist begins to rely entirely on his patients to satisfy all his needs for company, and is then trapped in a stance from which he is unable to provide the patient with analytic help.

Buechler (1998) believes that this type of extreme, problematic loneliness might be created by three factors: by the therapist's own pro-

found loneliness, by the patient's primarily distancing and negating attitude toward the therapist, or by the patient's intolerance of the therapist's countertransference. Skolnikoff (1996) describes profound loneliness that can be created in the therapist who spends lengthy hours in clinical practice, charged by her patients with an emotional burden, but still needing to maintain their confidentiality. The therapist may escape from her loneliness through memories and images of her supervisors, colleagues, therapists, or family members, as if they are silent, concealed observers of the analytic situation.

However, in contrast to other authors, I suggest that a specific experience of loneliness arises after the therapist experiences an unfulfilled yearning caused by his attempts to be authentic and intimate with his patients—to influence and be influenced by them and to realize the ideals presented by a two-person psychology. When the therapist recognizes that he has developed a yearning for a patient, he knows that he must forgo its fulfillment within the analytic therapeutic relationship. With separation from the yearning and the longing that it creates, the therapist experiences a process of mourning and loneliness, the recognition of which should provide him with considerable relief.

This mourning is not a relinquishment of grandiose desires and is not related to patients' emotional situations and communications, but to a loss of the hope that the closeness and warmth of the therapeutic relationship evoke, of the illusion that it is possible to reclaim the lost paradise of symbiotic life. This movement between hope and disappointment does not usually cause stress or create traumatic situations; it is likely to be natural in anyone who does not retreat into the self or into the immediate environment and who is interested in opening up to the world and engaging in a dialogue. This pain appears to be a necessary accompaniment to authentic contact and relationality, to connection and subsequent dissociation from significant others, and to the readiness to influence and be influenced by them.

In the following section, I will describe two well-known therapeutic phenomena that may be more prominent than others, and that involve therapists' personal, nonspecific, authentic, and spontaneous components: *moments of meeting* and *mutual enactments*. These two phenomena have been studied in the analytic literature and are receiving recogni-

tion as important clinical developments that can enhance therapeutic understanding and contribute to the patient's individual development. Subsequently, I will explain that these theoretical developments greatly contribute to recognition of the therapist's need for authentic and spontaneous self-expression and of the value ascribed to it.

## MOMENTS OF MEETING

Stern et al. (1998) claimed that interpretation has traditionally been regarded as the most important intervention within the transference relationship, associated with the most significant change in the patient's intrapsychic worlds. However, this group of researchers gives a name—*moments of meeting*—to actual occurrences that promote change in patients' and therapists' *implicit relational* (or *procedural*) *knowledge*. Stern et al. explain that implicit relational knowledge has to do with affective communication processes with primary objects. This knowledge is not repressed (as opposed to knowledge concerning the significance of impulse derivatives). It refers to processes, not structures, and can be deduced by observation (of parent-child relations, for example). In this sense, it is simultaneously intrapersonal and interpersonal.

Stern et al. (1998) explain:

Procedural knowledge of relationships . . . is implicit, operating outside both focal attention and conscious verbal experience. This knowledge is represented non-symbolically in the form of what we will call *implicit relational knowing*. Most of the literature on procedural knowledge concerns knowing about interactions between our own body and the inanimate world (e.g., riding a bicycle). There is another kind that concerns knowing about interpersonal and intersubjective relations, i.e., how "to be with" someone. [p. 918]

According to Stern et al., a change in the analytic dyad participants' mode of *being with* each other will elicit a change in their implicit relational knowledge (or in what Cohen and Squire [1980] termed *procedural* knowledge). This change takes place following a process of mutual regulation and acknowledgment, after which the intersubjective dynamics are no longer the same.

When this process takes place within therapy, it does not correct past empathic failures or compensate for past deficiencies. Rather, it changes the quality of the relationship and the intersubjective environment. Such a change entails the assignment of new meanings to past and present relational experiences, to their being recontextualized. In other words, this change in individuals' relational knowledge also changes the mental framework through which they explore the world.

Stern et al. (1998) wrote about such a *moment of meeting*:

When a "moment of meeting" occurs in a sequence of mutual regulation, an equilibrium occurs that allows for a "disjoin" between the interactants . . . . The constraint of the usual implicit relational knowledge is loosened and creativity becomes possible, . . . [allowing the patient to] re-contextualize his new experience. [p. 909]

These moments of meeting frequently take place in dyadic relations in joint, complex, and mutually regulated movement toward certain goals (Tronick 2001). Such movement entails struggle, ongoing negotiation, failure, and corrections, which maintain the balance between the two participants. To withstand this turmoil, each must patiently tolerate the other's failures. The mutual aim will be optimally reached when both partners recognize each other's motives, desires, and aims.

## MUTUAL ENACTMENTS

Enactments usually incorporate nonverbal messages, including those subdued within verbal communication in the form of tone and intonation of speech. These activities seem to conform to the assumed needs, desires, and fantasies of the other. The patient's and the therapist's recognition that each of them fulfills a certain role in the therapeutic partner's internal drama will elicit a change in their understanding of how they position themselves in their relationships—the influence they exert and their sensitivities.

McLaughlin (1991) explains that enactments are responses to others' behaviors and communications, intended to influence, convince, or force them to behave in a particular manner. These responses may

assume the form of intonation, gestures, different behaviors, or affective responses (Ginot 2001). Considered forms of communication, enactments within a therapeutic framework are thought of as an opportunity to identify the patient's unconscious motives (McLaughlin 1991).

Some argue that the concept of enactment derives from Bion's (1959) interpretation of the concept of projective identification not as an unconscious fantasy, but as an interpersonal phenomenon of influencing an object by means of projection onto it, so as to avoid mental anguish (Joseph 1989). These unconscious behaviors and gestures harness one's objects through the transfer onto them of one's fears, fantasies, hopes, and real or imagined traumatic events (Cassorla 2001), as a way of organizing one's internal experience (Chused 1991; Roughton 1993).

Following this line of thought, Renik (1993) argued that enactments are an important channel through which therapists can identify and explore their countertransference and better understand occurrences in the analytic relationship. He explained that the therapist's awareness of her countertransference can ideally help her avoid enactments originating in herself, yet it is often only after the occurrence of such enactments that she may recognize the role and effects of her countertransference.

## FURTHER DISCUSSION

Both the concept of moments of meeting and that of mutual enactment describe a system of mutual messages and interactions between the participants in the therapeutic dyad, expressed through behaviors and gestures on a level different than the structured verbal and declarative one. They describe those contributions to the interaction that entail an authentic and spontaneous deviation from the participants' formal roles of patient and therapist and manners of conduct. The penetration of spontaneous reactions is made possible in the two clinical phenomena described because some of the therapist's reactions evade ongoing self-reflection about his actions and omissions, and because of a special space made available to analytic therapists for the expression of such personal and authentic material (Friedman 1997; Jacobs 1999; Renik 1993).

Despite similarities between these two situations—mutual enactments and moments of meeting, both of which call for therapists' authenticity and spontaneity—it is important to note a fundamental difference between the two. Whereas moments of meeting are essential phenomena that advance the analytic therapy, and therapists are encouraged to nurture them, mutual enactments do not constitute a therapeutic ideal or a phenomenon invited by therapists. By contrast, the therapist is likely to be merely tolerant of mutual enactments in therapy, and although she may gain valuable insights about her own and her patient's self-other schemata through such enactments, she certainly neither invites them nor hopes that they will occur.

Through further discussion of these two spontaneous clinical phenomena, which have been described at length and recognized in the literature as significant, I will explain in what follows how archaic yearning may be evoked and may carry a heavy emotional price tag for therapists.

In the case of moments of meeting, two people establish spontaneous, active, and nonverbal contact, thereby broadening and deepening their relationship and their understanding of it. This is a special opportunity in which an authentic, tangential encounter occurs between them, unintentionally and unexpectedly. In general, both therapists and patients internalize the meaning of the special intimacy between them and learn new ways of *being with* each other, but do not need to discuss and analyze these events. The deep connection and delicate mutual response that occurs in moments of meeting may evoke in the therapist—in precisely the same way as in the patient—desires that are usually well concealed: to be seen, emotionally touched, and understood by others to a greater extent, as well as to have much deeper contact and connection with others.

These are, of course, unique experiences related to the individual and to relationships, and they are important for developing the therapeutic relationship and for recognizing how the patient creates and participates in the intersubjective space. Nevertheless, with all the difficulties involved, the therapist must have a deep understanding and conviction that he is merely a vessel serving the analytic therapy goal, and is not the goal itself.

In the case of enactments, each of the participants feels as if she is swept into a drama imposed upon her by the other, in a way that far from corresponds to the preplanned method of achieving the goals of analytic therapy and the actions required for this, and that frequently even contradicts them. In this therapeutic interaction, a connection between the two members of the analytic dyad is built up around a shared drama that occurs between them and of which they are completely unaware.

In general, it is only in hindsight that the therapist succeeds in reflecting on this drama and understanding its significance. Such reflection compels the therapist to connect to the deep and dissociated emotions that caused him to be swept along and to deviate significantly from analytic rules and principles. The moment at which the therapist encounters his authenticity and self-experience, from which he is usually disconnected, is unique and painful.

Only such direct connection to dissociated emotions will enable the therapist to pursue a path along which he can hold an exploratory and productive conversation with the patient about the unconscious meaning of the mutual enactment system between them. This authentic, emotional connection, the vulnerability caused by its exploration, and the preoccupation with these emotions might evoke in the therapist an emotional hunger and yearning to be completely understood, contained, and enveloped far beyond what can be expressed and actually realized in the analytic therapeutic relationship.

These two phenomena of mutual enactments and moments of meeting promote the therapist's need or inclination for an authentic presence and mutual closeness with her patients. Moments of meeting are an intersubjective phenomenon that is presented as a therapeutic achievement and as advancing the therapeutic relationship. Conversely, mutual enactments are an intersubjective phenomenon that is presented as a surprising—and not always comfortable—possibility, but one that is very meaningful for learning about patient–therapist relationship patterns. Even though mutual enactments are not invited by therapists and might hinder therapeutic processes, they can also serve as a profound and important tool with which to understand intersubjective processes that would otherwise be inaccessible.

These two concepts have entered the relational therapists' *therapeutic storylines* (Schafer 1992), which are guidelines used by therapists when describing clinical cases or problems. It is important to mention that enactments, at least, have also entered the storylines of nonrelational therapists as well. In addition, while *moments of meeting* is a term specific to Stern and his group (1998), the idea of a warmer, more engaged analytic stance is filtering its way into the thinking of clinicians of all theoretical persuasions. Thus, these two concepts encourage therapists to recognize the importance of achieving authenticity, mutuality, and closeness with patients.

These two concepts highlight the fact that archaic yearning may be aroused in therapists due to their deep emotional participation, which can cause increasing emotional and relational hunger. Such a yearning is covert and nearly always finds indirect and usually hidden expression in therapists' lives outside the therapeutic encounter. We might view such yearning, however, as aroused both as part of and in the service of the therapeutic experience.

## CONCLUSION

There can be great analytic value in relinquishment of and mourning for the yearning aroused in analytic therapists—who naturally bring personal and authentic material to the analytic discourse—that cannot be fulfilled in the therapeutic context. These processes may enhance therapists' ability to understand a different type of ongoing pain that patients experience: the pain that occurs in reaction to the necessity of foregoing subjective omnipotence in favor of acknowledging reality (Winnicott 1960).

In fact, in a way, this painful experience on the patient's part mirrors the therapist's experience of relinquishing the yearning for a relationship and intimate contact with the patient. These two processes, which occur simultaneously in therapists and patients, bring them closer to each other and may increase their mutual sense of identification. Therefore, the more the therapist acknowledges the importance of personal and authentic material, of spontaneous personal involvement, the more

he creates a situation in which the therapeutic space is mutually beneficial.

Supervision and peer supervision play a significant role in acknowledging the pain that may arise following the relinquishment of this yearning to create a close connection with the patient. This is part of a basic yearning to be seen by others and to receive their approval, mirroring, and validation of essential self-experiences. This yearning on the therapist's part cannot find an outlet in psychoanalytic psychotherapy, and therapists must seek other forums in which to express it and receive a response. Supervision cannot and need not comfort analytic therapists, but should make room for them to mourn this yearning and the fact that it will not receive a response within the analytic therapeutic relationship. In this sense, the supervisor does not play the role of a savior who rescues the supervisee from the distress of yearning, but rather that of a witness who observes and remembers that these painful mental processes typically occur.

Mourning for the yearning that arises following a mutual, close, involved analytic process is an emotional reaction that therapists allow themselves to experience as they develop in their profession. When first starting out as an analytic clinician, the therapist experiences this mourning as an emotional burden and pain, and it may be expressed in an ongoing need for figures such as supervisors or colleagues to witness this suffering. Over the years, however, such yearning develops into an inseparable and tolerable part of the therapist's role.

Therapists learn to live with this, just as parents learn to live with the ongoing mourning deriving from their children's efforts at separation and individuation, or with mourning deriving from other narcissistic losses that accompany the aging process. In all these examples, mourning becomes integrated into life's tasks and becomes tolerable and possible if accepted as natural and universal.

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