

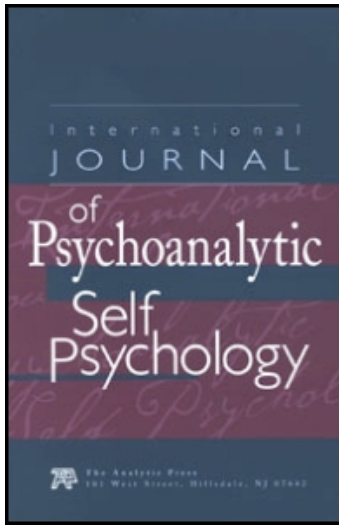
This article was downloaded by: [Canadian Research Knowledge Network]

On: 21 August 2008

Access details: Access Details: [subscription number 789956502]

Publisher Routledge

Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: Mortimer House, 37-41 Mortimer Street, London W1T 3JH, UK



International Journal of Psychoanalytic Self Psychology

Publication details, including instructions for authors and subscription information:

<http://www.informaworld.com/smpp/title~content=t783567628>

Connectedness, Permeable Boundaries, and the Development of the Self: Therapeutic Implications

Richard A. Geist ^a

^a Massachusetts Institute for Psychoanalysis,

Online Publication Date: 01 April 2008

To cite this Article Geist, Richard A.(2008)'Connectedness, Permeable Boundaries, and the Development of the Self: Therapeutic Implications',International Journal of Psychoanalytic Self Psychology,3:2,129 – 152

To link to this Article: DOI: 10.1080/15551020801922971

URL: <http://dx.doi.org/10.1080/15551020801922971>

PLEASE SCROLL DOWN FOR ARTICLE

Full terms and conditions of use: <http://www.informaworld.com/terms-and-conditions-of-access.pdf>

This article may be used for research, teaching and private study purposes. Any substantial or systematic reproduction, re-distribution, re-selling, loan or sub-licensing, systematic supply or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The accuracy of any instructions, formulae and drug doses should be independently verified with primary sources. The publisher shall not be liable for any loss, actions, claims, proceedings, demand or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.

CONNECTEDNESS, PERMEABLE BOUNDARIES, AND THE DEVELOPMENT OF THE SELF THERAPEUTIC IMPLICATIONS

RICHARD A. GEIST, ED.D.

The listening perspective from which the analyst works, however it evolves and is shaped by personal history, training, theory, and therapeutic experience, represents a sensibility that dramatically influences the course and nature of the analytic journey. Inherent in Kohut's listening perspective is an awareness that connectedness—the feeling of being a felt presence in another's life—is the unarticulated process upon which self-structure develops. Building on Kohut's implicit understanding of the importance of permeable boundaries inherent in connectedness, this article suggests a shift in the listening perspective to one that emphasizes the analyst's and the patient's experience as a felt presence in each other's lives. Employing verbatim interchanges highlighting the issues of selfobject transference, resistance, self-disclosure, and the disruption repair process, this article illustrates how a connectedness sensibility can expand, deepen, and fundamentally alter the listening perspective, organization of clinical material, and interpretative communications.

Keywords: connectedness, permeable boundaries, selfobject transference, listening perspective, self structure

If you never look just wrong to your contemporaries, you will never look just right to posterity [Randall Jarrell, 1983, p. 49].

Dr. Geist is a founding member, former member of the board of directors, and on the faculty of the Massachusetts Institute for Psychoanalysis.

The poet Kate Barnes (2003) once said that “in any art it is hard to find the moving edge” (p. 43). In the art of self-psychological treatment, despite its structural underpinnings, connectedness is the moving edge. Every analytic couple struggles to find that idiosyncratic bond that drives and holds together the therapeutic process and facilitates the reactivation of development and the resumption of healthy growth. As we tick and tock our way toward connectedness, we look over the edge, we back away from the edge, we move toward the edge, we walk along the edge, we find the trailing edge or the forward edge (Tolpin, 2002); but in every case we create the edge, together. Self-psychological analysis is always about this, about connectedness, about seeking, hiding from, and floundering about in the complexities of connectedness as much as it is about anything else. That fact does not limit psychoanalysis; on the contrary, it has in the past 30 years expanded and revolutionized psychoanalytic theory and practice and breathed new life into a withering and often destructive Cartesian paradigm.

Kohut understood the importance of connectedness both developmentally and therapeutically. Developmentally, Kohut remained ambivalently immersed in a one-person psychology and wedded to a structural theory in which growth is contingent on the development, maintenance, and restoration of the self. But, Kohut knew there could be no self without selfobject experiences. He knew there could be no selfobject experiences without connectedness.¹

Similarly in treatment, Kohut (1971, 1977, 1984) believed and wrote that the need to attain a sense of self-cohesion drove every analysis, but he knew that self-cohesion could be attained with a myriad of defensive structures. In other words, he knew that although a cohesive self is not a fragmented self, neither is it necessarily a healthy self or even an optimally functioning self. What allows the therapeutic evolution of a healthy self-organization—with its enduring sense of personal agency, continuity through time and space, stable self-esteem and sense of well being, unitary mind and body vitality, functional soothing and regulatory capacities, and the ability to seek out meaningful others with whom to share selfobject responsiveness and mutual intimacy—what allows this evolution is a connectedness between an empathically responsive analyst and patient that fosters a second

¹It is also true that selfobject experiences with the nonhuman environment (cf. Lichtenberg, 1990) exist for most people but, in my experience, developmentally these experiences are far less important to the child than human ones.

developmental opportunity. For it is only through such connectedness that the simultaneous building of new self-structure and the modification of defensive structures becomes possible (A. Ornstein, 2006).

Connectedness, as I am using the term, generally refers to a consciously or non-consciously felt sense of sharing and participating in another's subjective emotional life while simultaneously experiencing another as participating in one's own subjective life. More specifically, when two people feel connected, each person's responsiveness—including his or her selfobject functions, empathy, and subjectivity—becomes a felt presence² in the other's subjective world. What I am emphasizing in this definition of connectedness is how the interwoven qualities of connectedness—selfobject functions, empathy, and subjectivity—coalesce to form a wholistic tapestry that cannot be experientially separated.

Consider, for example, a 4-year-old who, while playing in her driveway, slips and bumps her knee and comes running frantically into the house. Mother, with open arms and a compassionate expression, empathically understands what Charlotte needs and then comments, "Oh, that must hurt, does it need a kiss?" With tears in her eyes, Charlotte says, "Yes, it hurts a lot, give it a kiss" and comfortably offers up her knee for what will be an instantly transformative kiss. Within seconds following mother's lips caressing her bruised knee, Charlotte, smiling and relieved of both physical and psychological hurt, returns to her exuberant play in the driveway.

We need not be analysts or therapists to know that someone else providing the identical function would lack the magic of a parental kiss and would deprive Charlotte of experiencing her mother's empathy, comfort, or soothing as part of Charlotte's own self-experience. I would argue that in the soothing, comforting safety of the moment Charlotte experiences her parent's empathy, subjectivity (the unique way this particular mother responds and kisses her), and the mother's soothing, comforting selfobject function as a vital quality of Charlotte's own organization of experience.³

In other words, Charlotte cheerfully bounces back to her play because the mother-daughter connectedness has catalyzed in her aspects of self-em-

²The apt description of a "felt presence" is borrowed from Mary Oliver's (1995) description of Edna St. Vincent Millay as "a felt presence at Steepletop, a spirit, the heart of the house and our lives" (p. 85). Frank Lachmann also used a similar phrase—presence in the other's subjective world—subsequently in his article on the co-creation of empathy.

³It is also true that mother's response would contribute to an expectation (that eventually becomes an enduring emotional conviction) that others would be optimally responsive in times of need.

pathy, self-soothing, and a subjective capacity for evoking soothing, comforting responses from others (implicit procedural knowledge). It is, at the moment of the kiss, difficult to distinguish which is more important for the child, the subjectivity of the particular parent, mother's empathy, or the selfobject experience. As Winnicott might say, we never should even ask the question. For however much we may assume a capacity for distinguishing theoretically between otherness, an empathic affective bond, and selfobject experience, for Charlotte all are experienced as an integral whole. This is a paradox, like the transitional object, that we clinicians must tolerate.

The clinical value of understanding the analyst's total responsiveness as part of the patient's experiential world has become increasingly neglected as self psychology has followed a pluralistic, post-Kohutian trajectory. Perhaps this is because we are continually seduced into observing the analytic couple from the outside and perceiving two separate people in the room rather than focusing empathically on how the two people often experience each other as part of their respective selves (P. Ornstein, personal communication, January, 2006). Indeed, if we focus on the way things look from the outside, we become adept at conceptualizing selfobject functions, empathy, and subjectivity as qualities belonging to, experienced by, or provided by separate people, although they may be contextualized intersubjectively. But in so doing, we perpetuate false dichotomies and dissemble the clinical value of Kohut's metaphorical connectedness at its deepest and most meaningful level. In what follows, then, I attempt to free the concept of connectedness (and its selfobject, empathy, and subjectivity components) from its metapsychological ghetto and infuse it with a clinical sensibility. In this way I hope to demonstrate how we can use connectedness as a pitch pipe to key our clinical interventions. I believe that our deeper understanding of the clinical possibilities captured in the concept of connectedness can fundamentally alter our approach to treatment in unique ways that have not been openly discussed in the literature. To particularize our understanding of connectedness in this entangled context profoundly affects the analyst's listening perspective, organization of clinical material, and how we speak in the interpretative mode.

CONNECTEDNESS SENSIBILITIES: PERMEABLE BOUNDARIES

If we can agree that connectedness denotes a deeply felt presence of another in one's experiential world, then we can posit that connectedness al-

ways implies permeable boundaries. Kohut's self is an open system not delimited by physical boundaries (P. Ornstein and A. Ornstein, 1994). Therefore, there is an inherent metaphorical fluidity to interacting selves, which is heuristically suggestive of a shared and overlapping emotional life regardless of how much asymmetry we attribute to the analytic dyad.

May Swenson, a poet who understood before Kohut that our subjective realities are inevitably altered by our imaginative modes of perception, once captured the essence of permeable boundaries inherent in connectedness in her poem "While Seated on a Plane (1963)". There the poet glances out the window at the billowing clouds of furniture and imagines herself into the inviting comfort of a celestial parlor, but she is taken aback by its floating changeableness. She enters this fickle world by "refusing the fixture of a solid soul," imaginatively relinquishing, on one level, her own shape and form. "One must be a cloud," Swenson says, "to occupy a house of cloud ... I traded shape for versatility of air." Nowhere is there a better experience near description of the transformative nature and permeable boundaries of connectedness.⁴

A patient with an unusual capacity for describing her feeling states once wrote to me a few months previous to my August vacation:

As a baby I was born with all my pieces, and then my mother tore and ripped a good portion of them out. At first you cry and get upset each time, knowing they are gone—but as you sit down at the puzzle, by this time you're used to working with "(fewer) pieces" to try to figure the bigger picture out. There comes a time when you give up hope and no longer want to work on your puzzle. ... Then you meet someone exceptionally special in your life—someone who gives you pieces back, someone you love, except this person goes away for a whole month and with him part of your puzzle pieces as well.

Within the analytic dyad we are continually part of the other's metaphorical space, deeply experienced in the patient's (and the patient in the analyst's) organization of experience. Without the idea of permeable boundaries, patient and analyst become like James Michener's⁵ pebble that is thrown into the water, where it becomes wet on the surface, but never becomes part of the water.

⁴See Richard Wilbur (1997) for a similar discussion of May Swenson's poem.

⁵This statement has been attributed to James Michener, but no confirmation is available.

What I am suggesting is that true healing requires connectedness; we must as analysts and therapists allow ourselves to become part of the water, to connect in a way that facilitates and permits our patients to experience us as a felt presence in their lives. I am further suggesting that inherent in connectedness is a metaphorical permeable membrane that embraces aspects of selfobject experience, interpenetrating subjectivities, and mutual empathy.

Kohut's original conceptualization of selfobject experience included the idea of permeable boundaries. In fact, 20 years ago when Stolorow, Brandchaft, and Atwood (1987) discussed selfobject functions, they stated that, "Once an analyst has grasped the idea that his responsiveness can be experienced subjectively as a vital, functional component of a patient's self organization, he will never listen to analytic material in quite the same way" (p. 17). Although de-emphasized in post-modern self psychology, the idea of overlapping boundaries remains endemic to selfobject experience. Most of us have little trouble understanding that mirroring, idealizing, or twinship transferences strengthen the self as a result of the analyst being included in the patient's self-organization.

For example, as a patient and I were discussing how he was sensing a deeper connection between us, Frank said, "It is true we're more connected. One way especially I've been feeling *that* is that we're kind of like each other, not in every way of course"—and here he laughs and says, "you don't have self esteem problems like me—but (alike) more in the way we see the world." I responded by wondering if the similarity between us was sort of another way for us to connect and increase his sense of well being. Frank replied, "True, but you know, there's something more important about it. When I feel like we're the same, like the last few days, it opened a new door for me that had been closed. I feel freer, stronger, like I can do things like speak up at work, things I've never been able to do before." Frank then remembered a dream of losing a tooth, which he associates to the idea that when kids lose their first tooth, they feel like they are growing and becoming stronger and bigger despite the fact there is anxiety present. He thought that the anxiety in the dream represented the risk of losing me, having the rug pulled out from under him if he believed that I was part of his world. I return shortly to how the concept of connectedness offers a different vantage point for understanding and responding to selfobject transferences, resistances, the disruption and repair process, and the demands for self-disclosure. Presently, I merely want to re-emphasize the forgotten importance of recognizing permeable boundaries in selfobject experience.

Permeable boundaries also affects the second component of connectedness—subjectivity. The importance of subjectivity is inherent in Kohut's (1976/1978) profound and deceptively simple belief that it matters more who you are than what you do. Kohut's (1984) definition of selfobject—"that dimension of our experience of another person that relates to this person's functions in shoring up our self" (p. 49)—emphasized isolated functions that Kohut inferred could be performed by interchangeable people with disparate personalities and varying degrees of connectedness to the patient or child and still remain effective in strengthening and completing the other person's self-organization. Bacal and Newman (1990) and Orange (1995), however, pointed out the erroneous omission inherent in this definition. Instead, they emphasized that the particular person who performs selfobject functions matters greatly and is not interchangeable with others who may provide those same selfobject functions. Put simply, the analyst's subjectivity matters. We cannot deny our subjectivity, and we cannot deny that the patient will know our subjectivity and experience it. But what I am emphasizing in delineating this second aspect of connectedness is that the analyst's subjectivity is more than alterity; there is no Cartesian real other who is only and "truly perceived as outside, distinct from our mental field of operations" (Benjamin, 1995, p. 29). The analyst's subjectivity is felt also as a presence within the patient's self (and vice versa).

As the analyst consciously and unconsciously expresses aspects of his self-experience—his feelings and perceptions, his personality, his history—the patient comes to know the subjectivity of the therapist. This means that "what consciously feels like getting to know one's partner is actually arriving at a more integrated sense of oneself" (Fonagy, 2006, p. 15). Why should his be so? As one patient who had been in three previous therapies and who knew a great deal about me said, "Isn't it obvious that the more open you are and the more I know about you, the more intimate we become, and the more intimate we are the more the boundaries get blurred?" She then added, "There is also something about you being open that reveals your vulnerabilities. I know that your being vulnerable with me requires that you have a strong sense of self, and *that* somehow lets you be vulnerable, which blurs the boundaries so that you feel part of me and I can let myself feel vulnerable." What I am emphasizing here is that too often we assume that interacting subjectivities means recognition of otherness; in fact, the analyst's willingness to express his perceptions and feelings, even when they differ from the patient's experience, can and often is felt as a self-enhancing quality of the patient's self-organization.

The third component of connectedness is empathy, a process equally affected by permeable boundaries. Empathy was conceptualized initially as a mode of observation in which we immerse ourselves in another's subjective world to collect data about her experiential states. Later, Kohut (1984) expanded his definition of empathy to include the analyst's ability to respond with "greater freedom ... deeply reverberating understanding, and resonant emotionality" (p. 82). Eventually, Kohut's slightly one-person notion of empathy metamorphosed into a powerful, mutually affective bond between two people. The difference between these definitions of empathy was expressed best by an analytic patient who in the beginning months of treatment told me, "I feel that you really understand me, you get me more than anyone else has, but I don't feel connected yet." In other words, during this early phase of treatment, Sara felt deeply understood, but she knew intuitively that connectedness required a more mutually pervasive and passionate sense of affective presence in each other's lives. Only many months later could she feel, in her words, "that we are connected now because I know you're with me when I'm not here, and I'm becoming more sure that I'm with you between sessions." Indeed, Sara was correct in that she had become a strongly felt presence in my life.

In *The Restoration of the Self*, Kohut (1977) suggested that empathy was a psychological nutrient as important to psychological life as oxygen was to biological life (p. 253). What has not been emphasized sufficiently when we allude to this now well-known analogy is that just as oxygen both surrounds us and is experienced as part of us, that form of empathy which sustains connectedness requires an interpenetrating mutuality. In this sense, empathy is not only intersubjective and co-created, it is a form of bidirectional merger (Geist, 2007). Here, Kohut's term empathic *immersion* (as differentiated from empathic inquiry) remains meaningful because it captures a mutuality in which each member of the analytic dyad imaginatively uses heart, mind, eyes, and ears not only to sense how each is experiencing and organizing his or her subjective world and one's place in it, but also to imaginatively allow the patient's and analyst's understanding to become a felt presence in each other's lives.

CLINICAL IMPLICATIONS OF CONNECTEDNESS

Although connectedness is not the only significant experience between patient and analyst, I believe that it underlies all therapies and analyses that are healing, for connectedness contributes directly to the development of

selfobject transference, the structuralization of the self, and the capacity for mutual intimacy. Without connectedness, an analysis may be possible, but its depth and curative potential is significantly limited. Let me turn, then, to the meaning of connectedness in the clinical situation—to how an awareness of the meanings of connectedness alters the analyst's understanding and responsiveness in the microprocess of the clinical moment.

CONNECTEDNESS AND SELFOBJECT TRANSFERENCE

There has been increasing debate among self psychologists regarding the optimal response to the patient's expression of selfobject needs. Some self psychologists (Kohut, 1977; Wolf, 1988) have suggested that what facilitates the treatment is our understanding, explaining, and validating the patient's needs as they emerge in the transference; others (Bacal, 1985; Lindon, 1994) have suggested that the analyst's remaining open to responding in a non-interpretive manner should the moment call for it may be more therapeutically optimal for some patients than understanding and explaining (N. VanDerHeide, personal communication, September, 2006). If, however, we discern the patient's expression of selfobject need from the vantage point of connectedness, and thus experience ourselves as part of the patient's self, our theory may offer a more specific empathic guideline for what is optimally responsive.

Deborah, an intelligent, articulate, emotionally deep woman who had experienced a long, frustrating, and unsuccessful analytic treatment, began her analysis with me in a state of sorrowful amusement. Ruefully disappointed in her previous therapist and simultaneously puzzled that she sensed in me some "weird" confidence that this treatment could be different, she proceeded to spend her initial hour trying to convince me, on the basis of her previous treatment, that she was, in her words, "too complex for shrinks to understand, unable to use interpretations, and unfixable." Tuning in to both the hope inherent in her trying again and the belief that interpretations did not help, I wondered if her first treatment had been "too much analysis and not enough relationship." A single tear and a slight change in expression let me know she felt understood.

In the beginning months of treatment, Deborah amplified her efforts to persuade me that she was untreatable and that, just as she had no "motivation to try" at work, neither did she feel she should have to work in the analysis—"a feeling," she said, "that my previous shrink did not approve

of.” In one typical session during the third month of analysis, Deborah spent the first 15 minutes telling me how incompetent she was; how she could not think clearly; how she had no motivation, no ambitions, or interests; how she wanted a new job; but it was fruitless to seek new opportunities because she knew that she would bring the same motivational difficulties with her. She knew her boyfriend was not the right person for her, but he was the only person in her life, so why leave? She concluded her monologue saying, “It’s the same here. I could commit to coming here for the rest of my life and be telling you the same thing every hour. Eventually you’ll get bored and fed up with me. That’s what happened with Dr. T.” I said to her that “to experience such deep pessimism, you must have been stuck with these feelings for an awfully long time.” “You’re right, since as far back as I can remember, although I can’t remember much before five. So, if I’m so stuck, fix me, it’s *your* job to fix me, not mine,” she said. I replied, “You’re absolutely right; it is my job to fix you.” Deborah looked up and said softly, “Dr. T. could never have said that.” I agreed, saying, “I know, that was part of the problem with the treatment.” Deborah then asked, “So how long will it take you to fix me?” I struggled for a few seconds and then said, “I just don’t know, how long do I have?” Deborah responded, “I stayed with him seven years, which I shouldn’t have and we never discussed it, but,” and here, smiling, she teased me for the first time, “I’ll give you seven years just to be fair.” There was a brief silence, and then Deborah mused, “I think we’ll know this therapy is working when I can let myself like you and let you like me.”

This brief interchange could lead us in many directions, but I intend to focus only on how the concept of connectedness informs the micro-process. From an experience near perspective, Deborah’s self-organization remained glued together only so long as her “I’m unfixable” emotional conviction (a self-blaming defensive structure, the development of which I do not have time to chronicle here) remained a meaningful constituent of her self-organization—something crushingly present, to use Stolorow’s words. This emotional conviction filled in the deficits that occurred in her organization of experience as a result of a collapsing selfobject milieu when she was very young.

Listening to Deborah’s 15-minute monologue, empathic immersion guides my collection of data as I experience simultaneously her stuckness and my own frustrated feelings as she tries to convince me that I can be of no use to her. At that moment, seeing the world from her perspective, she experiences me (and I feel included) as part of her depressive, helpless self, thus as an analyst who will not be able to fix her. But this recognition of connectedness allows me to articulate my understanding of the breadth and depth of her

stuckness rather than, from an external perspective, experience her complaints as motivated by self-defeating behavior or some sadistic intent to defeat me. As Deborah feels understood, her self-experience momentarily strengthens and her curative fantasy (P. Ornstein and A. Ornstein, 1977) emerges into awareness. Hope replaces pessimistic defeat and she imaginatively experiences a deep conviction that I can and should fix her. It is my job. Rather than retreating from being used as a responsive presence in her self over which she has omnipotent control, and thus insisting on a morality-tinted recognition of the need for two separate people to work together in the treatment, I allow myself to be shaped and molded in her creative metaphorical space. For in this space, it is Deborah's rightful expectation that I should fix her, an expectation that I validate.⁶ The confirmation leads her to an understanding of the lack of connectedness in her previous therapy and then a return to her metaphorical space in asking how long it will take to fix her. Here I search for a way to remain a presence in her self-organization (How long do I have?), thus continuing to allow her omnipotent control. As her sense of self is buoyed by my willingness to remain part of her self, Deborah playfully teases me while temporarily relinquishing her defensive structure. Then, feeling comfortably connected, she expresses hope for a blending of our subjectivities through her desire for mutual liking.

The sequence illustrates several important phenomenon: first, how mutual empathic understanding facilitates the unfolding of connectedness; second, the importance of allowing oneself to be made into the selfobject the patient requires; third, how this freedom to be molded and shaped by the patient can be played out in the therapeutic space without the analyst's or therapist's sense of self feeling threatened; and finally, how when the patient experiences such connective responsiveness, it facilitates the inclusion of interpenetrating subjectivities. Thus there is no need to confront the patient with my otherness.

RESISTANCE

Self psychology conceptualizes resistance as an attempt to protect one's self-organization from (a) anticipated or actually experienced retraumatization similar to what the patient experienced growing up (A. Ornstein, 1974, 1991) and (b) a sense of anticipated or actual fragmentation resulting

⁶The interpretation that I keep in my head—that every infant has the right to expect that her mother would know how to fix her and gladly assume that responsibility—is conveyed in my response “it is my job to fix you.”

from disrupted selfobject transferences that threaten the patient's structurally vulnerable self during the treatment process. Thus, resistance is always in the service of psychological health and survival (Kohut, 1984, p. 115). Stolorow, Atwood and Orange (2002) amended this conceptualization when they, accurately I believe, pointed out that resistance "fluctuate(s) in concert with perceptions of the analyst's varying receptivity and attunement to the patient's experience" (p. 48). If we view resistance from the perspective of a connectedness sensibility, we add an important dimension to Stolorow et al.'s (2002) emendation. Resistance tends to occur when the analyst, although attuned to the patient's experience, does not allow himself to be included in the patient's self-structure, molded and shaped according to what the patient metaphorically needs him to be.

Let me illustrate how resistance appears in the microprocess if we gaze through a lens tinted with a connectedness perspective. Carol, a depressed 7-year-old who began treatment wearing her sadness like a blanket, barely related to her therapist for the first 5 months of treatment. By the 8th month, however, she had formed a strong attachment to her female therapist; but concurrently, Carol repeatedly refused to leave the office at the end of each treatment hour. Instead, about 10 minutes before the end of every hour, Carol sat stubbornly on the floor ripping paper into tiny pieces, tossing them in the air, and angrily watching as they wafted around the room. An emphatic "I'm not leaving" was her only verbal response.

As the supervisor in this case, I listened for several sessions to her therapist's diligently frustrated efforts to tune into, interpret, cajole, confront, and limit set. With stubborn sureness, Dr. M. acknowledged Carol's anger and sadness; interpreted her need for control; commented on her pleasure in Dr. M.'s helplessness; and, with an unintended harshness, repudiated Carol's plaintive demands to remain in the office. As Dr. M.'s frustration increasingly washed over the therapeutic dyad, she began to point out the regressive nature of Carol's demands, the reality that Dr. M. had another patient to see, and that mother was impatiently waiting for her daughter. At times she would even gather Carol in her arms and carry her kicking and screaming to the waiting room, where mother sat helplessly embarrassed. Once Carol settled in her mother's lap, sobbing and screaming, she assumed a vacant, depleted expression, as if her self had collapsed into a state devoid of thoughts and reflection.

As Dr. M. and I discussed Carol's refusal to leave the office, my supervisee's distress, anguish, and frustration became increasingly palpable. Emphasizing the separateness inherent in the therapeutic relationship, Dr.

M. told me, "Carol has to learn that other people have needs too, but I feel like such a bad therapist at the same time." Clinging to her theoretical training, however, Dr. M. insisted that by forcing Carol to leave, by combining limit setting with recognizing Carol's anger and sadness (fragments of Carol's whole self), her resistance could be overcome. In other words, via her identification with Dr. M.'s ego strength, Carol would gain some capacity for delay, autonomy, and recognition that others have legitimate and sometimes conflicting needs.

The struggle continued unabated, so I suggested that we try to feel our way into how both of them experienced their connection with each other. According to Dr. M., Carol had mobilized an idealizing transference. She admired Dr. M., emulated her mannerisms and personal style, craved her knowledge and experience, and felt calmed by her during the treatment hours. When out of the office, however, Carol was frustrated with the time between sessions and complained of feeling lost, although she thought about her therapist frequently. Dr. M., on the other hand, was fond of Carol, enjoyed their therapy sessions (until the final 10 minutes of the hour), but rarely thought about her patient between sessions. Dr. M. agreed with my comment that only when the two of them were together did they both experience a close connection, a felt presence in each other's life. I suggested that in the office Carol, via her idealized connection with Dr. M.'s particular way of being (her subjectivity), experienced her therapist as a sustaining part of her self, which evoked in Carol a cohesive sense that all her parts were glued together. To leave at the end of the hour was tantamount to losing a part of her self and thus a threat to her cohesiveness—a threat concretized through the act of tearing paper into fragments.

In their next session, as Carol began her weekly refusal to leave the office, Dr. M. empathically acknowledged how good Carol felt about herself when she was connected to her (the therapist). Encouraged by Carol's nodding agreement, Dr. M. added that to leave probably meant she would feel all in pieces, so it was understandable she would want to stay—How else could she feel together? Carol agreed, saying, "My teacher showed us that if you drop a piece of mercury, it goes into pieces; that's me when I leave." Dr. M. responded, "That's what makes it so hard, you're not connected with me when you leave, so you don't feel strong and together." "Yup, that's right," Carol said, as she cheerfully left without a fuss.

Such a vignette illustrates how Dr. M.'s conceptualization of two separate people in the consulting room informed her belief that Carol's resistance to independence must be overcome—that health would be embodied

in the capacity not only to leave the office, but also to recognize the subjective needs of others. For Dr. M., pathology, in the form of regression and dependency, was inherent in Carol's wish to remain connected to her therapist. Once Dr. M. recognized emotionally the importance of Carol's experiencing her therapist as part of Carol's self, however, the patient's wish to remain in the office no longer represented resistance at all. Rather, Dr. M. understood the controlling, omnipotent demand as a healthy attempt to maintain a sense of connectedness to a particular person who felt embedded in her self-organization. The need for connectedness then became far more important than autonomy, or even simple attunement, in the child's psychic economy. Once Dr. M. permitted herself to be sculpted into a specific metaphorical presence in Carol's life, Dr. M. relinquished her need to change Carol from the outside, instead allowing her presence in Carol's life to catalyze the tension modulating capacities endemic to the patient's sense of self.⁷

SELF-DISCLOSURE

Analysts are not known for being confessional, although some post-modern therapists have nudged more in that direction. Generally, however, we have more willingness to portray the inner states of our patients and to avoid the private danger of self-revelation. Although some relational analysts believe that expressing their subjectivity is in and of itself therapeutic, their belief is more often couched in general terms: the beneficial effects of authenticity, the recognition of otherness, and insight into relational patterns and expectations. Approaching the therapeutic relationship from a connectedness sensibility, however, offers a disparate motivation and theoretical rationale for self-disclosure. In a world of permeable boundaries, self-disclosure is guided by our empathic understanding of interpenetrating selves. Experiencing the analyst's authenticity in the context of connectedness allows the patient to realize that our personality (our subjectivity) contributes significantly to our understanding of them (and thus to the patient's self-understanding). However, more important, when our otherness is experienced as part of the patient's self-organization, it facilitates a fundamental change in the patient's capacity to be authentic.

⁷Although beyond the scope of this discussion, the capacity to be a felt presence in Carol's life also allowed Dr. M. the clinical flexibility to allow Carol to become an increasingly felt presence in her own life.

Linda is an engaging, insightful patient with a dramatic flair and a self-described borderline personality that sometimes breaches our intimate connectedness. Despite a traumatic, severely physically and emotionally abusive past that left her in a continuous fragmentation prone state, Linda achieved a remarkable sense of self-cohesiveness during her first year of analysis. She frequently attributed her progress to my self-revealing openness—a characteristic, she told me, that allowed her to express herself fully and completely. In addition to her own childhood traumas, Linda underwent an unbearable tragedy when her first-born son contracted an acute bacterial infection and incurred severe brain damage that required permanent institutionalization. During one session toward the end of the first year of treatment, Linda told me that despite her progress, she had been unable to talk with me about her son, Tom:

You've never been able to understand ... , you don't want to get it, you just want to block it out. Each time I've tried you can't respond. You act as if you actually care ... because it feels like you think I need to talk about it. You probably think you should be able to (listen) because you're a child shrink, but you don't know what it's like to go through what he went through or what I went through.

This was not the first time that Linda had conveyed to me her belief that the depth of her pain about Tom was just out of reach for me. I told her that I had been searching for the truth in what she observed—that perhaps I *was* closed off to her nightmare. Indeed, I told her, at first I thought it was just too painful for any parent to hear; but there was something more, I thought, that reverberated with my own history. She was curious about this personal analog. So I told her that each time I pictured Tom's trauma, it evoked an image of a stillborn child so defective that one could not decipher if it was male or female. "You mean your sister who died?," she inquired, reminding me that I had shared this piece of history with her on another occasion. Without waiting for an answer, Linda continued, "You mean you associated that (memory) to Tom and were overwhelmed so much you couldn't put it into words?"

"Yes," I responded, "a 2½ year old probably would have had a hard time putting it into words, so yeah, I think that part of it got in the way." My self-reflection stimulates Linda to ask, "Do you think it would have felt to Jamie (Tom's sibling) like he lost a brother?" When I responded that I definitely thought so, she confirmed my belief, saying, "I know it felt to him like

his brother died." I said I thought "It couldn't have felt any other way." Linda questioned me again. "Did anyone talk to you about what happened, I mean explain it to you?" I continued to share my subjective history. "That's a good question, not that I know of till I was older, although it's hard to know what a 2½ year old remembers." Continuing a frieze of associations, Linda remembered that Jamie was born when Tom was 2½. Chiding me gently she said, "I wish you had told me what you realized earlier, whenever you came to it. It makes a big difference knowing that. It makes me able to tell you about him." She then muses about her reluctance to share Tom's detailed history with me, saying, "You know part of me thinks I also didn't want to talk about Tom with you. ... I have some block, some void of emotion about Tom too." Linda then spends the remainder of the hour describing in intimate detail the horrific sequence of events that culminated in Tom's tragic deterioration from healthy to brain damaged child within a matter of days as she and Tom's doctors helplessly watched. "It's real and unreal at the same time," Linda reflected. "I have no one I can talk to about it; it was so horrific. I'm glad I can finally tell you." Agreeing, I said, "Yes, and I can let you."

In this vignette I am guided by my assumption of connectedness, which interestingly was not disrupted as a result of the interaction between Linda and me. I accept Linda's subjective reality that some unconscious phenomenon prevented my hearing the depth of her trauma. When she experienced curiosity about the nature of this barrier, I shared with her my relevant imagery, my subjectivity. Linda remembers my history and relies on an increasing, mutual empathic connectedness to suggest that I was so overwhelmed that I could not put her trauma into words. I experienced her response not only as a sign of progress in the treatment (A. Ornstein, 2006), but as her capacity to recognize (because I am a felt presence in her life) how her own trauma might inhibit her elucidation of Tom's tragedy. Further reflecting on my state, Linda assumes that her younger son would have experienced Tom as having died. She inquires if anyone had helped me deal with the loss of my sister and then quickly returns to her own experiential state—her reluctance to share the trauma with me. If I, as an other who is part of her self, however, can acknowledge a void of feelings, then she can also experience this void in *her* self. In other words, once she comprehends what could have blocked me from understanding, she realizes she may not have wanted me to understand her either. The fact that I had become part of her, empathically, subjectively, and as a selfobject, is now connected to her ability to recognize what is happening inside her self.

Because Linda experiences me as part of her self, learning something about me when that learning is guided by empathic immersion increases Linda's self-cohesion, affirms her self, and catalyzes her ability to transcend the normal dialectical tension that every trauma patient experiences between the wish to reveal and the fear that no one can possibly understand. In other words, Linda's self is enhanced by my metaphorical presence in her psyche when I am known to her.⁸

DISRUPTION AND REPAIR

Historically, whenever a stormy relationship between patient and therapist threatened an analytic journey, the resulting turbulence was attributed to the patient's pathology—a negative therapeutic reaction, unresolved aggression, the emergence of a negative transference. Kohut and Stolorow, each employing slightly different language from their diverging but frequently compatible theories, challenged these traditional assumptions. They highlighted the fact that all such analytic storms occurred in an intersubjective context, and that it was our therapeutic responsibility to search for how the patient's felt hurt, his perception of the analyst's contribution to a stalemate or disruption, and his perceived understanding of the analyst's conscious or unconscious intent contained at least a grain of subjective truth. For Kohut, empathic failures spawned these analytic storms, although currently many of us believe it is more felicitous to think in terms of disruptions in the analytic bond, disjunctions that are evoked by mutual misunderstandings and misattunements.

The therapeutic impact of analyzing disruptions includes the patient's experience of a corrective emotional experience, the alleviation of self-blame, the acceptance of being imperfectly human (Wolf, 1995); the restoration of the analytic bond, the understanding of the developmental trauma it replicated, the highlighting of emotional convictions that orga-

⁸Although beyond the scope of this article, an important implication of this argument is that rather than assuming that the patient benefits from not knowing the analyst (which self-psychological, intersubjective, and relational theorists agree is impossible), I am suggesting that in many instances we underestimate the profoundly important, self-enhancing experience for the patient when, at her request, she is *allowed* to know the analyst. This does not mean, of course, we are in any way encouraging the patient to recognize the "other," but merely acknowledging that as the patient comes to know us, "the ... [patient's] relational experience [with the therapist] becomes encoded as self experience" (Lessem and Orange, 2000, p. 23).

nized the meaning of the disruption for the patient, and the analyst's comprehension of his contribution to the disruption (Stolorow et al., 1987). When working through the disruption repair process, we often "wear the attributions" (Lichtenberg, Lachmann, and Fosshage, 1992) where the patient's subjective qualities attributed to the analyst are accepted but not validated or questioned. Through a connectedness lens, however, I believe we enhance a frequently overlooked quality of healing that occurs in the repair process—the development of the capacity for self-empathy. Consider the following disruption repair process with Deborah, which occurred about 8 months following the initial vignette in which she told me it was my job to fix her.

As Deborah and I felt drawn to each other, sometimes painfully and sometimes playfully, nearly always tenderly, she gradually revealed brief moments of emotional vulnerability that seemed to appear on the wings of an emerging attachment disorder. Despite knowing how much she needed to be an equal partner in our journey (an incipient twinship relationship shared by both of us), I mistakenly used the word asymmetry at the end of one treatment hour as the two of us were floundering about trying to understand our relationship. She left the hour feeling, in her words, "heartbroken and devastated." I knew instantly I had inadvertently crushed the budding tendrils of a deeper connectedness.

The following day Deborah told me angrily:

You'll never understand me. It's *asymmetrical*, remember! I hate myself for beginning to let myself feel vulnerable. You're just like Tim [her boyfriend] and Dr. T. and all the others, and I had thought this was maybe going to be different, but it isn't worth talking about because you won't understand it anyway, and there's no relationship here. I just deluded myself into thinking there was, or you deluded me into thinking there was.

I acknowledged that my heartbreaking comments must make her feel like not even trying. "That is correct," Deborah informed me, "but it's up to you to fix things. I," she said, "have checked out." I told her that I could understand why, that checking out is the best way she had of protecting herself when I caused her to lose me. It was like losing part of her self, and that is a devastating feeling. Deborah responded with a frisson of hopefulness. "I just want you to react and let me know what I make you feel. That's the only way you can fix it. You want to fix it, tell me what you're actually feel-

ing about all this, and don't tell me you didn't mean to hurt me. I know your intention wasn't to hurt me." There was a brief silence as we both gazed at each other. Recognizing how much she felt part of my self, I said, "Deborah, I had a dream last night. You were in a forest and I was trying to reach you. Every time I got close you disappeared and then you'd show up some place else, and I'd come to find you and you'd disappear again."

With obvious relief that she remained an important presence in my life, she asked, "Were you feeling anxious in the dream?" "A little," I acknowledged, "I was feeling you were so frightened and I couldn't find a way to reach you and bring you to safety."

"That's my checking out whenever I'm injured. I do that you know," she said. Then, with a self-empathic, whimsical awareness, she wondered whether her long history of checking out contributed to her inability to connect with anyone. Deborah then articulated her longing to reconnect with me again, but not unless I knew the depth of her devastating hurt and assumed responsibility for it. "You know," she admonished plaintively, "you can empathize with me and still be real like you just were. I can't do this unless you let me know you, and the only way I know is if you let me know. ... Why couldn't you have done what you did today earlier in the week? This was a really terrible week." Following a brief silence, Deborah asked, "Do you feel better—I mean reconnected—now?" I told her I did feel reconnected and wondered about her—"Yes, I do, I didn't think it would happen today. Will you try to let me know you, like you did today?"

When the analyst willingly acknowledges his contribution to a disruption, when he discovers and validates the kernel of truth that corresponds with the patient's subjective reality, he is simultaneously empathizing with his mistake. Confirming that my comments were indeed heartbreaking initiated a prolonged discussion of my role in the disjunction. More important, however, from the perspective of permeable boundaries, as the analyst's self shades into the patient's organization of experience, the analyst's empathy with his own mistakes is experienced by the patient as part of her self, and they facilitate the patient's increasing empathy with herself. It is this self-empathy that becomes so important in the therapeutic journey because it is extremely difficult to process emotional experience without the capacity to be empathic with oneself (A. Ornstein, personal communication, November, 2005).

Deborah's attempts to regain absolute control over me—the lost part of her self—surfaces as she insists that she has "checked out" and it is up to me to fix things. As I allow her expected regulation of me (her selfobject) and empathically understand the need for her protectiveness in the face of

my failure, Deborah rekindles the hopeful possibility that I could once again become a meaningfully felt presence in her life. She checks back in and dares to inform me how to fix things—"tell me exactly what you're feeling about this"—in other words, share your subjectivity. Unfettered by any sense of separateness, I conveyed my dream from the previous night, which enabled our interpenetrating "selves" to flutter about in a mutually re-established connectedness. Deborah understood immediately that my dream anxiety and her checking out were overlapping subjective states—that I had included her injured self in my world and that she was now ready to re-allow my self a place in her world. She then reminds me that while empathy is a necessary ingredient in our connectedness, incorporating my subjectivity into her world facilitates at that clinical moment her experiencing me as a felt presence in her life.

From a connectedness sensibility I am arguing that the repair of disruptions requires not only the analyst's empathic understanding of himself and the patient, but equally important, the patient's empathic understanding of the analyst. A deep sense of self-empathy and self-understanding can only emerge when our boundaries become permeable enough to allow a shared feeling of vulnerability. The restoration of selfobject connectedness requires a complex admixture of empathic understanding and intertwined subjectivities. The patient cannot feel understood by the analyst if the patient lacks a subjective understanding of that particular analyst. As Deborah suggested, "the only way I know is if you let me know." Contrary to many theories, such mutual subjective understanding evolves on a foundation of permeable boundaries, not on a footing of otherness.

CONCLUSION

The listening perspective from which the analyst works, however it evolves and is shaped by personal history, training, theory, and therapeutic experience, represents a sensibility that dramatically influences the course and nature of the analytic journey. We can never hide our sensibility. It is, to use Elizabeth Bishop's (1983) words, "like a first coat of whitewash when it's wet, the thin grey mist lets everything show through" (p. 110). Inherent in Kohut's listening perspective is an unarticulated awareness that connectedness is the sensibility that winds and weaves its way through the evolution of self psychology. Despite being a structural psychology, self psychology includes a sense of permeable boundaries that Kohut concretized when he removed the hyphen from his original delineation of "self-object"

and merged the two words into an overlapping concept that anchored his theory and therapy.

Building on Kohut's implicit understanding of permeable boundaries, I have suggested a shift in our listening perspective to one which emphasizes the analyst's and patient's experience as a felt presence in each other's lives. Employing vignettes of selfobject transference, resistance, self-disclosure, and the disruption repair process, I have attempted to illuminate how, through the lens of permeable boundaries, connectedness may expand and deepen our modes of understanding and explaining clinical interactions. Once we realize that we exist as a felt presence in the patient's life, and he or she in ours, a number of profoundly simple changes occur. I have described how interpenetrating subjectivities enrich the therapeutic soil in which intimate relationships can flourish; how allowing the patient to experience the analyst as part of his self facilitates his capacity to shape and mold our responsiveness in the service of an internal rekindling of normal growth; and how the mutually empathic immersion of interpenetrating selves promotes deeply affective bonds that obviate the compliance and stark asymmetries which characterize so many analytic treatments. Finally, I hope to have demonstrated that the components of connectedness—self-object transferences, subjectivity, and empathy—while isolated and highlighted for the purpose of clinical discussion—cannot be separated in the everyday work of psychoanalysis. When the patient experiences us as a felt presence in his life, he generally senses our total responsiveness. Although occasionally one component (empathic understanding, personal sharing, or experience of selfobject function) may be in the foreground, and thus temporarily feel more important to the patient, it is the wholistic feeling of intertwined connectedness that provides the necessary conditions for revitalizing thwarted development.

Edgar Allan Poe, in his story of Eleonora, said, "Those who dream by day are cognizant of many things which escape those who dream only by night" (Wilbur, 1997, p. 14). Permeable boundaries are a given in our nighttime dream states, but when we appreciate them in our daytime relationships, connectedness becomes the unarticulated process upon which Kohut's self-structure is built.

REFERENCES

- Bacal, H. (1985). Optimal responsiveness and the therapeutic process. In *Progress in Self Psychology, Vol. 1*, ed. A. Goldberg. New York: Guilford, pp. 202–227.

- ____ & Newman, K. (1990), *Theories of Object Relations: Bridges to Self Psychology*. New York: Columbia University Press.
- Barnes, K. (2003), *Kneeling Orion*. Boston: Godine.
- Benjamin, J. (1995), *Like Subjects, Love Objects: Recognition and Sexual Difference*. New Haven, CT: Yale University Press.
- Bishop, E. (1983), *The Complete Poems: 1927–1979*. New York: Farrar, Straus & Giroux.
- Fonagy, P. (2006), *A genuinely developmental theory of sexual enjoyment and its implications for psychoanalytic technique*. Plenary paper at the winter meeting of the American Psychoanalytic Association, January, New York City.
- Geist, R. (2007), Who are you, who am I, and where are we going: Sustained empathic immersion in the beginning phase of psychoanalytic treatment. *Internat. J. Psychoanal. Self Psych.* 2(1):1–26.
- Jarrell, R. (1983), A view of three poets. In: *Richard Wilbur's Creation*, ed. W. Salinger. Ann Arbor, MI: University of Michigan Press, p. 49.
- Kohut, H. (1971), *The Analysis of the Self*. New York: International Universities Press.
- ____ (1977), *The Restoration of the Self*. New York: International Universities Press.
- ____ (1976/1978), Creativeness, charisma, group psychology: Reflections on the self analysis of Freud. In: *The Search for the Self: Selected Writings of Heinz Kohut: 1950–1978. Vol. 1–2*, ed. P. H. Ornstein. New York: International Universities Press, pp. 793–844.
- ____ (1984), *How Does Analysis Cure*. Chicago: University of Chicago Press.
- Lessem, P. & Orange, D. (2000), Emotional bonds: The therapeutic action of psychoanalysis revisited. Unpublished manuscript.
- Lichtenberg, J. D. (1990), What is a selfobject. *Psychoanal. Dial.* 1:455–479.
- Lichtenberg, J. D., Lachmann, F. & Fosshage, J. (1992), *Self and Motivational Systems: Toward a Theory of Psychoanalytic Technique*. Hillsdale, NJ: The Analytic Press.
- Lindon, J. (1994), Gratification and provision in psychoanalysis. Should we get rid of “the rule of abstinence”? *Psychoanal. Dial.* 4:549–582.
- Oliver, M. (1995), *Blue Pastures*. New York: Harcourt Brace.
- Orange, D. (1995), *Emotional Understanding: Studies in Psychoanalytic Epistemology*. New York: Guilford.
- Ornstein, A. (1974), *The dread to repeat and the new beginning. Annual of psychoanalysis*. New York: International Universities Press.
- ____ (1991), The dread to repeat: Comments on the working through process in psychoanalysis. *J. Amer. Psychoanal. Assn.* 39:337–398.
- ____ (2006), Psychoanalytic psychotherapy of self disorders: Tracking changes in the course of psychotherapy. Paper presented at The Therapeutic Action of Psychoanalytic Psychotherapy: Current Concepts of Cure, March, Boston.
- Ornstein, P. & Ornstein, A. (1977), *On the continuing evolution of psychoanalytic psychotherapy: Reflections and predictions. The annual of psychoanalysis*. New York: International Universities Press.
- ____ & Ornstein, A. (1994), On the conceptualization of clinical facts in psychoanalysis. *Internat. J. Psycho-Anal.* 75:977–994.
- Stolorow, R., Atwood, G. & Orange, D. (2002), *Worlds of Experience*. New York: Basic Books.
- Stolorow, R., Brandchaft, B. & Atwood, G. (1987), *Psychoanalytic Treatment: An Intersubjective Approach*. Hillsdale, NJ: The Analytic Press.

- Tolpin, M. (2002), Doing psychoanalysis of normal development: Forward edge transferences. In: *Postmodern Self Psychology: Progress in Self Psychology. Vol 18*, ed. A. Goldberg. Hillsdale, NJ: The Analytic Press, pp. 167–190.
- Wilbur, R. (1997), *The Catbird's Song*. New York: Harcourt Brace.
- Wolf, E. (1988), *Treating the Self*. New York: Guilford.
- _____ (1995), Optimal responsiveness and the disruption-restorations. In: *Optimal Responsiveness: How Therapists Heal Their Patients*, ed. H. Bacal. Northvale, NJ: Jason Aronson.

Richard A. Geist, Ed.D.
 1905 Beacon St.
 Newton, MA 02468
 617-964-6943
 richard.geist@comcast.net

TRANSLATIONS OF ABSTRACT

La perspectiva de la escucha desde la que el analista trabaja, aunque proviene y está formada a partir de la historia, formación, teoría y experiencia terapéutica de cada uno, representa una sensibilidad que influye en gran manera el curso y la naturaleza del trayecto analítico. La conciencia de que la conexión, es decir sentir que se es una presencia sentida en la vida de otro, es el proceso no verbal sobre el que se desarrolla la estructura del self, es inherente a la perspectiva de la escucha de Kohut. A partir de la comprensión implícita de Kohut de la importancia de los límites flexibles que son inherentes a la conexión, sugiero un cambio en nuestra perspectiva de la escucha en el sentido de enfatizar la experiencia del analista y del paciente como una presencia que es sentida en la vida del otro. Empleando intercambios transcritos literalmente que subrayan cuestiones como la transferencia de selfobject, la resistencia, la auto-revelación, y el proceso de interrupción y reparación, este artículo ilustra como una sensibilidad centrada en la conexión puede expandir, profundizar, y alterar de manera fundamental nuestra perspectiva de la escucha, la organización del material clínico, y las comunicaciones interpretativas.

La perspective d'écoute au centre du travail de l'analyste, quelle que soit la façon dont elle s'est développée et a été façonnée par l'histoire personnelle, la formation, la théorie et l'expérience thérapeutique, représente une sensibilité qui influence dramatiquement le cours et la nature du trajet analytique. Inhérente à la perspective d'écoute de Kohut se trouve la conscience que la connectivité – le sentiment d'être une présence ressentie dans la vie d'un autre- représente le processus non articulé par lequel la structure du soi se développe. En me fondant sur une compréhension implicite chez Kohut de l'importance des frontières perméables inhérentes à la connectivité, je suggère une modification dans notre perspective d'écoute en mettant l'accent sur l'expérience chez l'analyste et chez le patient d'une présence ressentie dans la vie de l'un et de l'autre. En utilisant des échanges textuels qui mettent l'accent sur des enjeux de transfert objetsoi, de résistance, de révélation de soi et de processus de réparations des perturbations, cet article illustre comment une sensibilité de connectivité peut élargir, approfondir, et fondamentalement altérer notre perspective d'écoute, l'organisation de notre matériel clinique, et nos communications interprétatives.

La prospettiva di ascolto da cui l'analista lavora, comunque si sviluppi e prenda forma dalla storia personale, dalla formazione, dalla teoria, e dall'esperienza terapeutica, rappresenta una sensibilità che influenza in modo cruciale il corso e la natura del viaggio analitico. Intrinseca alla prospettiva di ascolto di Kohut è la consapevolezza che il contatto – la sensazione di essere una presenza sentita nella vita di un altro – è il processo non formulato su cui si sviluppa la struttura del sé. Sulla base della comprensione implicita di Kohut dell'importanza che ci siano confini permeabili inerente al contatto, propongo di spostarci verso una prospettiva di ascolto che sottolinei l'esperienza dell'analista e del paziente come presenza sentita nella vita l'uno dell'altro. Grazie all'impiego di scambi letterali che chiariscono i temi del transfert d'oggetto-sé, della resistenza, dell'auto-svelamento, e il processo di rottura e riparazione, questo articolo illustra come la sensibilità al contatto possa ampliare, approfondire e fundamentalmente alterare la nostra prospettiva di ascolto, l'organizzazione del materiale clinico e le comunicazioni interpretative.

Die aufmerksam zuhörende Perspektive, aus der heraus der Analytiker arbeitet – gleichwohl sie aus seiner persönlichen Geschichte, seiner Ausbildung, seiner Theorie und seiner therapeutischen Erfahrung entstanden ist und ihr ihre Form gibt - stellt eine Sensibilität dar, die den Verlauf und das Wesen der analytischen Reise beeinflusst. Kohuts zuhörender Perspektive liegt ein Bewusstsein inne, dass Verbundenheit – das Gefühl im Leben des Anderen eine gefühlte Gegenwart zu sein – ein unausgesprochener Prozess ist, innerhalb dessen sich die Selbststruktur entwickelt. Aufbauend auf Kohuts implizitem Verstehen der Wichtigkeit durchlässiger Grenzen, die in Verbundenheit eingebettet sind, verweise ich auf einen Wechsel in unserer zuhörenden Perspektive - hin zu einer, die das Erleben des Analytikers und des Patienten als eine erspürte Gegenwart im Leben des jeweils Anderen betont. Auszüge aus Verbatimprotokollen, die die Frage der Selbstobjektübertragung, des Widerstandes, der Selbstenthüllung und des Prozesses von Unterbrechung und Wiederherstellung herausheben, verdeutlichen, wie eine Sensibilität der Verbundenheit die Organisation des klinischen Materials und die deutende Kommunikation unsere zuhörende Perspektive erweitert, vertieft und fundamental verändert.