

**Re-Defining Practice:
The Power of the Transference
through an Intersubjective Lens**

by

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Abstract

This case study chronicles the five-year therapy of a woman struggling with post-stroke limitations. It illustrates not only the necessary grief work but also the development of the positive transference. The transference is interpreted less from a classical perspective and more from the intersubjective lens, allowing a mutual close connection to further fuel the transformation. The case study demonstrates how intimacies are managed in the treatment room, how the patient's mind is open to new possibilities, and how phenomenological listening and psychoanalytic training all help to prepare the therapist to use the transference to affect change. The re-definition of practice for a classically trained analyst is illustrative of the transformation for the therapist, maintaining a professional use of self while intensifying the complexities and intimacy of the work.

My relationship with Susan began with a phone call. The voicemail was barely intelligible. I played it over and over again trying to decipher what she was asking through her tears. The voice-activated machine kept cutting her off, not wanting to recognize her choked cries as an attempt to speak. The sounds coming from her throat seemed to frighten her. "I've had a stroke, I can't stop crying and my doctor sent me to you," is what I finally made out. She seemed determined to consummate her plea no matter how many times the machine fought her. "Determined" would be one of many words I would come to use to describe Susan as I learned more about her. Determined, persistent, perfectionistic, and ultimately inspirational.

After settling into our very first session together within days of that phone call, Susan defined her goals with me. "I want to come to terms", she said, sobbing, not able to finish her thought. What she meant was she wanted to come to terms with the destruction of the body she had known and counted on for six decades. Susan had suffered a right hemispheric stroke a year before. It was attributed to her underlying atrial fibrillation, a very rapid irregular muscle contraction in the heart. The neuropsychological consultant described a "sad wheelchair bound woman" and recommended speech and occupational therapies; strangely enough, given Susan's identification as "sad," psychotherapy was not recommended. It was her internist who later suggested that she speak with someone.

Susan wore "granny" glasses and walked with a limp when she came into my office five years ago. A short neatly dressed woman in her mid-sixties, she wore her long grey hair loose to her back. She carried a heavy knapsack over both shoulders and with the agility of a contortionist flipped it to the front of her body, unzipped it with her teeth, and removed a spiral notebook. Her left arm hung at a ninety-degree angle to her body, stiff with a closed fist. She pried open the fingers one by one but they didn't stay. She seemed to want her left hand to look more like the right and was annoyed at these fingers that couldn't and wouldn't cooperate. She handed me test reports and began to cry. Through tears she said, "I'm a perfectionist, and I can't use my left hand at all. Part of my brain that was killed by the stroke controls my arm." At this point Susan was sobbing. The depth of her sadness was palpable. Neither of us was breathing and the walls of the office seemed to engulf us both as we sat with her sorrow. She took a deep breath and continued. "My husband and I used to take long walks together at our farm, and now I'm not able

**Informed Consent: Informed consent was obtained from the individual participant included in the case study.*

to keep up with him.” Tears streaked Susan’s face as she continued, this time emphatically and with anger, “I’m so dependent on him, and I don’t like it. I don’t like myself anymore. Before the stroke I was fine. I haven’t been happy since. I have to come to terms with all the things I cannot do.”

Often patients, who, like Susan, have had a severely emotionally and physically challenging experience, enter treatment with a hope that the therapist will help them find a way through it. In some cases there are bodily assaults such as rape, birth disfigurements, or accidents. In others there are secrets that have been kept for years, even decades. Often these physical and psychic assaults have been hidden, from others and, frequently from the patients themselves. These are the patients who break our hearts, who make us think more deeply and engage more fully. We watch them struggle to accept what can feel so unacceptable. For Susan it was the stroke that altered her life. For Fran it was the unexpected death of her husband at age forty-six that left her with three small children to raise on her own. For Doug it was living since childhood with a congenital deformity that left his chest sunken in and his self-esteem hollowed-out. The list of assaults goes on and on.

My years doing this work have led me to believe that the intimate connection that develops in the treatment room and the ensuing transference is what helps patients to find a never-before-accessed source of vulnerability; that in turn leads to acceptance, to embracing the truth of their psychic or physical wounds and ultimately to freedom from torment. I came to see how my listening to their suffering without the limits of classical “neutrality” was essential to helping my patients make sense of random and traumatic events. Over time I realized that more actively accompanying patients back inside their fears allowed for a more fluid exchange. Allowing the energy that “co-created” (Ogden, *The Analytic Third*, 1994) by the two of us, the patient and me, helped move the work from a place of despair to a place of hope.

How we connect is an art form. We therapists are the artists in the room. Together with the patient we make alterations to the old normal to make way for the new. Stolorow, Brandchaft, and Atwood (1994) speak of “the foundation of treatment being the safety of the therapeutic relationship.” And Jody Davies (2002) says, “We must be able to fully occupy the space that is constructed between us and the patient” (Davies, 2012). As clinicians, we use ourselves to create

that space of safety through ambience, attunement, relatedness, tone, affect, and voice. Then we reside together with the patient in that space and begin to bring the patient’s experience to light.

Not all patients can go the distance. It is with the ones who can, the ones brave enough to slog through the pain, that the relationship and attachment in the intimate therapeutic dyad have the most impact. Patients who dare to journey back to the scene of their trauma and then back again through a reconstructed narrative allow us to accompany them as they travel through the years of distortions that have been built around coping with their wounds. These are the patients who allow us to come with them to their black holes, to their individual Bermuda triangles, to peer with them into what has been an abyss, these are the patients I have transference with, the ones who go the distance.

Brian Bird describes transference as a “universal mental function, which may well be the basis of all human relationships.” He agrees with those who believe that “analysts themselves regularly develop transference reactions to their patients, and that these reactions play an essential role in the analytic process.” (Bird, 1972, *Ibid*). The exposing of trauma and the move from anguish to acceptance is fueled primarily by the relationship in the treatment room. As therapists we have a privileged position with patients, and if we navigate this with compassion and care something powerful and intense comes out of the experience.

Susan’s disabling injuries demanded that I rethink the conventional posture in the office. Accompanying her on her journey forward from the stroke represents for me what Leslie Jamison in her newly published collection of essays on empathy describes as “a kind of travel where you enter another person’s pain as you’d enter another country, through immigration and customs, border crossing by way of query: What grows where you are? What are the laws? What animals graze there?” (Jamison, 2014).

Pain seeks us out in our profession and how we connect and respond to it can be a predictor for our patient’s progress. Susan is hardly the only one of my patients who chose to stare down their terrors, to understand how they have been defined by their histories, to explore their conflicts and ambiguities, and to join with me as witness to that understanding. They pursued, often heroically, that relationship with me despite the risks posed by changing the narratives they had grown used to. They all understood full well that

uprooting their comfortable discomfort would be destabilizing and that examination could juggle all the pieces that they had so carefully merged together to hide a loss.

This is where the relationship with the analyst becomes paramount. We are two people joined together to breed identity out of illness. This connection and the bond between us forms the alliance that becomes both the real and the transference relationship. Patients are able to achieve resolution through initially building meaning in the relationship with the therapist and then carrying that experience with them into their world. As one who has been on both sides of the analytic couch and dug deep into the well of feelings, I stand in awe of those who follow in similar tracks. Being able to do this work is “a product NOT just of the patient alone, but the patient-analyst system. It is the ‘fit’ between what the patient most needs to be understood and what the analyst is capable of understanding” (Bird, 1972).

Both Jessica Benjamin and Darlene Ehrenberg address issues of how best to use ourselves to help our patients. Ehrenberg (2010) explores the history of the original split between what she calls “intellectual freedom” and “orthodoxy” in psychoanalysis and discusses the implications of its persistence today. She quotes from Arnold Cooper’s 1982 presidential address to the American Psychoanalytic Association:

Where Freud’s concern with analytic identity helped advance the early cause of analysis, an excessive concern with protection of its boundaries may retard our future development...We will most benefit from our current scientific debate if we pursue boldly the implications of our differences. It would be astonishing, and disturbing, if the psychoanalytic situation and the psychoanalytic technique we devised more than a century ago were never to develop further. (Ehrenberg, 2010)

Freud was our pioneer but technique and our culture have changed over time. However, as our years in practice unfold it is our challenge, in fact, our duty as clinicians to identify the therapeutic actions that work best for each of us and each of our patients considering the culture and century of our time. If we don’t rise to this challenge our work grows stale and unexamined. It is understandable that as analytic students in training we feel safe under the mentorship and

tutelage of our teachers and supervisors, but like the child who grows and separates we must become critical thinkers for our patients and ourselves.

Benjamin (2010) identifies old views of neutrality and the “blank screen”. She goes on to describe her intersubjective view that “from the beginning of life we depend on creating patterns of mutual regulation and recognition with the other in order to develop.” She cites Beebe and Lachmann’s infant research from 2002 in recognizing that “the analyst’s participation goes hand in hand with recognizing the patient’s efforts at repair and contributes to growth and a sense of agency” (Benjamin, 2010). It is just this recognition that caused me to question the wisdom of adhering to the neutral, detached approach with traumatized patients like Susan. Her unique physical, cognitive, and emotional challenges made a classical analytic approach seem not only unwarranted but also disempowering and potentially rejecting.

In our early sessions Susan described the circumstances of her stroke in great detail. She had crashed to the kitchen floor while her husband was away on a business trip. It was Tuesday and she wasn’t found until Thursday. On the floor screaming for help Susan was breathless with exhaustion. She understood what had happened to her and knew that she was still alive; she hadn’t lost consciousness and needed to get help immediately. Susan knew that treatment within the first few hours after a stroke was crucial to recovery, but help was not to come: her voice was too weak to be heard and her body was too weak to crawl. Moreover, she was hungry and thirsty. There were apples from the family farm on the kitchen table, but she could not reach them. One side of her wasn’t moving. Susan eyed the phone on the kitchen wall but reaching that was also impossible. She had no strength to lift herself, and she collapsed in exhaustion, falling asleep. When she awoke, she had no concept of day or night or time. The kitchen was in the interior of the apartment, windowless. In my office, Susan reflected: “I think I lost a day. I can’t really remember. But I do remember feeling wet and realizing even my hair was soaked in my own urine probably from my slithering like a snake on the kitchen floor looking for light, for some opening where someone might be able to hear me.”

Susan spent nearly a year in hospitals and rehab facilities. Her “job,” as she described it, was to get back on her feet and return home. She accomplished both but still had to live with the

reality that she had a stroke and with its ravages on her body: her left arm was useless, her left leg often locked at the knee and swung out and around making her gait slow and walking difficult. At home she was alone with her losses, no longer distracted by the clanging of the medication carts in the hallways and the bustling of the rehab workers collecting their charges for another day of working their muscles. She spent many of our early sessions describing her hours alone at home, thinking, thinking about how she might have prevented this stroke, waiting for her husband to come to stretch her crooked leg, thinking even more about what she had done wrong and then eventually fully inhabiting the neighborhood of self-blame.

"I blame myself you know. I knew my pulse was rapid and that I was in A-Fib. I should've stayed on the Coumadin (a blood thinner). I set myself up for this. I should've known better. I remember feeling dizzy and tired and nauseous while cross country skiing one day up at the farm before the stroke. The cardiologist had found my A-Fib and Mitral Valve Prolapse did an ECG then and concluded I was not at high risk for a stroke."

"What made him think that?" I asked.

"Well," Susan said, "I didn't have diabetes or high blood pressure."

"So he was mistaken?" I asked.

"Yes, but I wanted to believe him because I wanted to keep skiing. If I fell and I was on Coumadin I could bleed internally so I didn't really want to take it. I had been off of the Coumadin for at least a year since I had been told that I didn't fit the profile for being at risk for a stroke. I wasn't in any rush to go back on. But the doctor should have insisted. He wasn't paying attention. But in the end I know I'm in charge of my own health and I knew how I was feeling. I should've insisted on the Coumadin."

"So, you blame yourself?" I asked.

"I'll never forgive myself. I could've prevented this."

I commented on how sure she seemed that the Coumadin was a foolproof guarantee to prevent the stroke. "You sound so convinced that Coumadin would've left no room for error, a guarantee against a stroke."

"I have to get over it and just accept it", she said, with a sigh of resignation.

"No", I said, "You don't have to get over it, but we do have to get through it and understand why you pass such harsh judgments on yourself. You speak about this as if you can control things that actually can't always be controlled, like having a

stroke. You didn't fit the profile, but yet you had a stroke anyway."

For six decades Susan had lulled herself into believing that she had control over her life. She had decided whom she wanted to marry against her parents' wishes, where she would go to school, live, how to raise her children and how to control her work environment. The thought that she might not have had control over the stroke and that there might be times going forward when she would have to let go of the idea of having control was anathema to her. I was left with the question of how to help Susan embrace what felt so unembraceable.

I knew that somewhere in the answer was the prospect of our joining forces to stare down her fears. The "blank screen" stance I had learned as a student and practiced religiously for years would be injurious to someone like Susan who had experienced such a traumatic physical and emotional assault. Susan needed to experience me as fully present and hitting all the right notes if she was to address her fears of not fully recovering, of having another stroke, of dying. The safety and reassurance of our connection would be crucial for her to absorb and make sense of her fears. Together we could tease out distortion from reality, fiction from fact; as a unit we could be witness to her integrating this new information and moving forward with it toward what Groopman calls "true hope" (Groopman, 2004, p. 210). I had visited these psychic places before with traumatized patients who relied on the attachment in the relationship and the safety in the treatment room to be able to go on. The trepidation and delicateness of facing the disordered psychic state can be not only terrifying but also lonely. Having the therapist there breathing with you through the overwhelming sense of apprehension can make the difference between turning back and proceeding with caution.

Susan suffered by refusing to accept the reality and the pain for what they were and for insisting that she could have and would have control in the future. A spiritual person might label this struggle as needing to "let go," a cognitive therapist would call it finding radical acceptance, and an analytic therapist would work through the grief and necessary defenses put in place to cope with an assault. Regardless of the approach, the goals are similar: to grieve what was and accept a new normal. Best-seller lists are flooded with memoirs written by survivors of traumatic injuries, both physical and psychic. These books describe the

mountainous climb to the new normal. In *On Grief and Grieving* (2005), Kubler-Ross describes finding the meaning of grief through the stages of loss. Though it is written with the loss of a loved one in mind it is easily translatable into a loss of any kind—loss of function, of health, of abilities. Kubler-Ross makes clear that acceptance should not be “confused with being all right with what has happened. This is not the case. Most people don’t ever feel okay about the loss. The stage of acceptance is about accepting the reality and recognizing that this new reality is the permanent reality. We might never like it but eventually we accept it. It is the new norm” (Kubler-Ross and Kessler, 2005). So, as clinicians, how do we do this work? Painstakingly, through hours of sitting with, listening to, and caring about the person sitting or lying in front of us. The passage can be a long hard road until the tectonic plates shift.

Though Susan claimed to want to “come to terms” with the stroke having been out of her control, the psychic pull toward what “used to be” kept her in tears for months. She would steel herself in our early sessions, feign a state of emotional stability and try to imagine a different life, life before the stroke. I watched her trying so hard to appear cooperative in our sessions as she spoke about her work life, the admiration she enjoyed from coworkers for her personal integrity even as she was producing at a much slower pace. Yet, her truth was in those moments was elsewhere. Her truth was in the hope that all would return to how it was before the stroke. Though she never said this explicitly, she conveyed it when describing her husband’s resistance to making any changes in the country house (the farm) they shared: there were no steps or railings at the entrance to the farmhouse, just a big rock, often snow-covered in the wintertime, with nothing to hold onto; the stairs to the second floor of the house were steep, and also without railings. Susan insisted none of it was really a problem. “I hold onto the wall when I go upstairs to bed,” she would say. Her defense against showing her own fear was her cooperation with her husband’s hope for her. Her dread was that in fact nothing would ever be the same. Steve Mitchell addressed aspects of this dilemma in his book *Hope and Dread in Psychoanalysis* (1993). Mitchell highlights the intrapersonal negotiations patients make with themselves in order to hold onto the hope and fend off the dread. Susan’s defense of pseudo-cooperation always ended in collapse, and her dread of not having control, of having another stroke, would reduce her to tears. Fairly early on

her reactions guided me toward realizing that our beginning work was in exploring and grieving life before the stroke.

When Susan started therapy with me she was in her mid-sixties, a former biochemist, now working full-time as a medical writer for a large pharmaceutical company. She and her husband Jay, a successful architect and city planner, had met in college, raised two sons, and were now enjoying their three grandchildren, two of whom were born during the course of our therapy. They had been married for over forty years and had found a sense of harmony in their lives and mutual careers. Both were fiercely independent, but shared long-standing friendships together. They retreated on weekends to their one hundred acre farm where, before the stroke, they enjoyed taking long walks and cross-country skiing together.

Susan, unable to engage in these pleasures now, threw herself full force into her work. But it quickly became clear that she could not maintain a full-time schedule, even given the option of working from home, and also keep up her outpatient rehab. The strain of trying to manage everything eventually took its toll, and within months of our starting to work together her company offered her a retirement package. “There’s nothing human about human resources,” Susan said. “They’re like the stroke, they just come in and take stuff away from you.”

Work had always been central to Susan’s identity, and because there was no formal acknowledgment of her retirement, she felt discarded at a time when she most needed recognition. She spent many sessions talking about her personal integrity and her fear that her coworkers would feel abandoned by her. “I can’t leave work with projects unfinished,” she would say. “I am what I do.” During these sessions, I suggested to her that she too was feeling abandoned, given up on, deserted by employers toward whom she had been so loyal for more than thirty years. Susan worried about going on away from a vital source of her healthy sense of self—yet another loss, and one she could ill afford.

I grabbed every opportunity to explore feelings with her, especially when I encountered no resistance, I would introduce her to the world of dialogue about them, knowing she would need that repertoire when she was ready to take on the looming issue of the stroke and how her body had betrayed her. But first she shared having stuttered as a child, bitten her nails, and compulsively picked at her scalp, all due to her enormous anxiety about performance. We were able to

connect that anxiety to her fears about having no one now to perform for at work and about all the gratification that would be lost to her. We came up with a plan for Susan to request both an exit interview and a retirement party for herself. She composed a group email to her colleagues announcing her retirement and collected their responses to secure her reputation in her own mind and provide her with tangible evidence she could revisit on those days when her sense of value would plummet. Exploring all the feelings around retirement was her first foray into the language of feelings and the multitude of ideas that could co-exist. She began to see an advantage to our talking through difficult feelings even though doing so reduced her to tears. The world of was unknown to her and furthermore, frightened her.

Around this time Susan shared a gift with me, a book that one of her colleagues had sent to her while she was recovering in the nursing home. *My Stroke of Insight, A Brain Scientist's Personal Journey* (2006), Dr. Jill Bolte Taylor's moving and intimate documentation of her own severe brain hemorrhage, her recovery, and her celebration of the resiliency of the human brain. Dr. Taylor, a neuroscientist at Harvard, repeatedly lets us know that her book is "not really about a stroke;" the stroke was the traumatic event that brought about the insight. It is ultimately about her brain's journey into her right hemisphere's consciousness where she became enveloped in a deep inner peace. Taylor writes, "One of the greatest blessings I received as a result of this hemorrhage is that I had the chance to rejuvenate and strengthen my neurocircuits of inner joy. Thanks to the stroke I have become free to explore the world again with childlike curiosity" (Taylor, 2006).

This book became the bible for Susan and me early in our work together. Susan was inspired by Dr. Taylor's journey on the long road to recovery, as was I, and at moments when the waning of her own progress had her demoralized, the book gave both of us the courage to not travel to a place of despair. Susan identified with Dr. Taylor's newfound delight in the world around her and in relationships. Relationships other than those with her husband, sons and mother had always been secondary for Susan. Work was primary. But now this was changing. She was moved by the devotion of her family and friends through the hard first year after the stroke, and even more important she was realizing she needed others to survive, both physically and emotionally. In sessions she

would describe a lovely evening out with another couple or a lunch with an old friend and how their conversations had shifted to both a more personal and deeper place. "I can thank my stroke for this!" Susan would add. I was secretly joyful. I knew she would need solid substitutes for what had been lost with the stroke and deeper connections were a serious contender. Susan was thrilled by the closer friendships she built on the frankness of discussions with her friends, her family and me, much as they exposed her sensitivities and often made her feel vulnerable and tearful.

"But Pat, that's not the only time I cry," Susan said. "I cried the other day when I sent a fruit basket for the holidays to my daughters-in-laws' parents. I wrote notes to both sets of parents saying how sorry I was that we couldn't all be together for the holidays because we all live so far from one another. I did this all online and I could hardly see the message I was typing through my tears. Now what's that about?"

"It's about connection, Susan," I said. "It's about how moved you are when you connect to people. It's about your feelings being more accessible to you now."

During our next session, two days later, Susan declared, "so you were right. It IS connectedness. Today coming here on the subway someone smiled at me while we were both watching someone nodding off onto the shoulder of a complete stranger. I smiled back at him and then felt like crying. It was funny of course but I loved laughing with another person and connecting! I also cry when people try to help me on the subway, not just because I don't like being helpless, but because I'm moved that they care. I remember when I first came home from the nursing home and I had an aide who was helping me walk in the neighborhood. A friend came up when she saw me and put her arms around me to welcome me back. I cried then, too."

"Yes, because you felt so connected and cared for."

"Pat, remember when I first came to you, I was so troubled by not understanding why I was crying so much since the stroke—I know strokes make people labile, but this didn't feel like just that," Susan said. "I understand it all now. I cry for other reasons, too, but certainly one of them is feeling all the connection from people since the stroke. Sometimes it makes me smile, it's just such a fine line."

In her book *Narrative Medicine* (2006), Rita Charon writes of the analyst as being in a unique position to listen in a way that many have never

been listened to before. We must honor that position as it allows us to know patients in a fuller way as we help and encourage them to develop their own narrative: "Reorienting our clinical practice toward the possibility of bearing witness to our patients' suffering requires training and skill in listening to patients' self-narratives. Not only receiving an account of trauma but also allowing the teller to see beyond it may be required for healing" (p.181). Charon quotes from Dominick La Capra and Claude Lanzmann who interviewed victims of the Holocaust and reminds us that,

The tendency for a given subject-position to overwhelm the self and become a total identity becomes pronounced in trauma, and a victim's recovery may itself depend on the attempt to reconstruct the self as more than a victim. Our practice must incorporate a shared effort to envision with the patient a future beyond trauma, realizing how critical are our narrative skills for our witnessing practice. We may be on the threshold of a more muscular clinical practice having made this turn toward witnessing, sharpening our understanding of empathy or compassion to include within it the respectful, disorienting, and emotional experience of the otherness of the other person. (p. 181)

Working intersubjectively incorporates the understanding of the "other" in the room. We need to understand the process of therapeutic change through not simply the role of cognitive insight but also the role of "affective attachment" (Stolorow, 1994). Within affective attachment arises the transference. Both Gill (1982, 1984) and Schwaber (1986) affirm that attention must be paid "to the analyst's contribution to the transference... because this is what can bring about a deepening of the analytic process in both its here-and-now and genetic reconstructive dimensions." Stolorow, in *The Intersubjective Perspective* (1994), speaks of the power of new relational experiences with the analyst, what long ago social workers called the "corrective emotional experience." The hope is that patients will use this "reciprocal mutual interaction," this intersubjective transference experience, to reorganize their historical convictions and correct the distortions and ideas they have lived under for years, often decades. Removing distortions and faulty convictions is removing obstacles to change. Atwood, Stolorow and Orange (1997) echo the

developmental context that the child organizes his principles and experiences of affect around the original child-caregiver system and then "acquires the unconscious conviction that unmet developmental yearnings and reactive feeling states are manifestations of... badness" (p. 80)

Susan was raised by a highly critical and perfectionistic mother, and a father who, though busy tending to a large dental practice, always made time for his family. Susan developed convictions accordingly about what would be considered ideal and tolerable affect. Her affective states after the stroke did not fall into any ideal category—quite the contrary, in fact: her affect felt intolerable to her and she imagined it to be as intolerable to others. But in the presence of a therapist who not only encouraged her to express these feelings but also applauded their emergence in the sessions, Susan felt this all to be incongruent to her idea that basically feelings should be hidden.

From the beginning, my relationship with Susan had unique aspects. My office is in a duplex suite, down a full flight of steps to a waiting room and then another short flight to the office itself, not ideal for someone paralyzed on one side. "Oh, no worries," Susan said, when I wondered out loud how this was going to work for her. "It's great PT for me." Getting up and down stairs was one thing, but doing so while carrying a knapsack and heavy winter coat was surely another. I offered to carry her things while she navigated and that led to helping her with coat zippers and winter hats, which drew us physically close at the end of many sessions. In my mind, these were appropriate adaptations to Susan's disabilities; they no doubt had an impact on our connection, however. The transference was a strong one even without the physical proximity, but the contact was another playing field for the relationship to deepen.

Often when I bent down to secure the coat zipper I reminisced that I hadn't done this since my sons were little. Rather than focus on her helplessness, Susan took my remarks as opportunities to remember caring for her own two boys, zipping up their winter jackets. We bonded as mothers. We would chuckle when her long hair would get caught near the zipper or her arms had trouble finding the sleeves of the coat. She seemed to enjoy my tending to her, and I quite liked it as well. It became an end-of-the-session bonding time for us, and it was through this experience that I began to sense how deprived Susan had been of closeness and nurturing. It was the feeling that came with my help, the warmth,

the shared reminiscences, and the laughter, that enlivened her and touched me.

Susan coped with her inner critic and judge by making sure she left little room for criticism. We saw this in her diligence at work, the meticulous way she researched almost anything and her relentless investigation of treatment alternatives for her rehabilitation. It was her conviction that she was really on her own with no one to help her with her internal or external life. Susan had turned inward to her own mind to find a sense of safety away from the expected criticism. She sought out ideas she could control as a substitute for personal relationships, which she could not control. It was this that shifted through the treatment and more specifically through our relationship.

Many similarities between us became evident over the years that I was witness to Susan's narrative, as we were reconstructing her post stroke self. Both of us were fiercely independent, absorbed with and committed to work, and caring for elderly and ailing parents. Both of us had raised two sons—and both of us loved to ski. My mother died, and, unbeknownst to me, Susan had read the obituary and made a donation to the suggested charity. She sent a sympathy card and seemed particularly gentle with me in sessions. She asked about my feelings of loss and I shared them. She worried that she would be devastated and unable to handle her own mother's death; going through my mourning period was a prelude to going through her own, a dress rehearsal. Four months later, during my summer vacation, her ninety-five year old mother died. I was gratified when she felt entitled enough to seek me out and reach for the connection she needed then.

Over time I could see that Susan was using the mini-laboratory that was our relationship in the treatment room as a way to model for herself friendship and intimacy. She began to have fun, not just with me but also by emailing friends personal notes, which she often brought into sessions for me to review with her before she sent them out, fearful that she was being inappropriate or might be crossing a personal boundary. On the Mother's Day after her own mother's death, she sent me an email from the farm wishing me a Happy Mother's Day:

You are more like a mother to me than my own mother was and I have learned so much that I hadn't known before. I knew I wanted a woman therapist and I chose you by instinct. You were away on vacation when I originally called but your message was kind and I liked

that you left someone in charge while you were away. You're a mother with boundaries and sometimes those boundaries don't feel good but without them I'd worry that I was taking advantage of you.

The following winter I had an accident that altered the course of my work with Susan and others. I fell, the day of one of my twice -weekly sessions with her, fracturing every bone and tearing every ligament in my left ankle. On the cusp of being wheeled into the operating room to have five hours of reconstructive surgery, I realized that it was the exact time of my session with Susan and that she would be worried and waiting. I felt compelled to ask for a phone and call her personally rather than have her hear the news from a colleague. A flurry of emails and cards followed from her during the next several days wishing me a speedy recovery. What I didn't realize then was that I was now going to struggle with walking just as she did and would have to find compensatory ways to manage.

I hired a young, former football player to drive me to and from the office—to many patients he became known as my “hunk.” His role included transporting my briefcase, crutches, and walker. I often imagined him effortlessly whisking Susan in and out of the office and up and down the stairs so I didn't have to watch her struggle each session. My ankle fracture was an obvious intrusion into everyone's treatment and required a week away from the office. On my return Susan greeted me with, “You're walking like me now! My husband said you did this to see what it felt like to have a bum leg. I'd hug you but then we'd both topple over!”

“Actually,” I replied, “I do think I understand much better now what you struggle with every day. It's not easy.”

“No, it's not. But you're like me Pat, you're determined.”

I recognized her “twinning” with me and saw it as part of our positive connection.

“I am, I admitted, and real tired of going down my office steps on my backside.”

The lightness of our exchange seemed to give Susan permission to begin talking about her recent road trip to Florida with her husband. All along the route they had stopped to visit old friends who had moved away. Susan used these opportunities to practice some of her new-found openness. She consciously and deliberately shared feelings about her stroke with those friends and was rewarded by them saying, “Oh Susan, you're

just so much more than your stroke.” She also shared feelings about her grandchildren living so far away, and the extra effort one needs to make to keep in touch and make the relationships central.

“Pat, this intimacy stuff deepens relationships so much more, it’s great!” Susan said. “You know my husband thinks my attachment to you is silly, but then he doesn’t understand how it helps me... he thinks I’m paying you to be my friend.”

“You’re not paying me to be your friend,” I said. “We’re working together so you can recognize how you feel and consequently how others might feel, so you can learn to be a friend, to yourself and to others. You integrate what we talk about and then you own it, and it’s yours to keep. You carry it with you.”

“I know,” she said, “He’s just jealous!”

Lacan, in his paper, *The Presence of the Analyst*, tells of a gift given to him on which is written, “The art of listening is almost as important as that of saying the right thing” (Lacan, 1973). How we listen is a non-verbal form of communication to the patient. It includes what feels at the same time to be the intangible, interpersonal, intersubjective experiences, and the quite tangible energy that flows between two people—the therapist and the patient. We are in fact “the therapy”: in sessions we can “feel” the connection in the room, or not; it is through the feel of this connection that the work flows, that the dialogue begins. For Susan and me, the therapy embodied listening intently, both of us, but for very different reasons. I was listening to try to imagine what it must have been like for Susan to have had this stroke and what it must be like now to walk in its aftermath. Susan was listening for any signs of my disapproval and criticism. Darlene Ehrenberg’s book *The Intimate Edge* (1992) includes a chapter on “Analytic Interaction Beyond Words,” where Ehrenberg states that analysts “have not always fully appreciated the power of what goes on affectively between patient and analyst, the power of unconscious communication, and the degree of enactment and unconscious collusion that inevitably occurs in the analytic situation” (p. 14). This is what Ogden referred to as the “analytic third”, the third subject, co-created in the room between therapist and patient, which takes on a life of its own (Ogden, 1994).

More than one hundred years ago, in his paper, *The Unconscious*, Freud wrote, “It is a very remarkable thing that the unconscious of one human being can react upon that of another, without passing through the conscious” (Freud, 1915). Modern-day infant research data supports

the corresponding idea of a primitive but powerful preverbal, affective, and unconscious form of communication. This is the energetic silence between two people that speaks volumes. Awareness of such interpersonal energy and intersubjective experience adds another dimension to the intrapsychic focus of traditional analysis. They need not be mutually exclusive. Ehrenberg moves from recognizing what is unspoken to recognizing the power of words, and writes:

Words can serve as barriers or bridges...they can be used to conceal or reveal, they can be weapons, camouflage, cries for help, gifts...used to seduce, amuse, amaze, charm, insult, penetrate, invade, betray, manipulate, hurt, shock, deceive, or distract. Being able to truly express oneself in words is a rare and special gift, and yet there are times when even with such a gift words are inadequate. (Ehrenberg, 1992, p. 14)

There was one of those times in Susan’s therapy. Several years into it, she became stuck in, and struck by, the person she had become. She railed against how altered she was from the stroke. In order to walk she had to think consciously of where she placed each foot and how she bent her knee to shift her gait. Food didn’t taste the same and she could no longer run after her grandchildren and scoop them up into her arms. She was feeling angry and powerless. Her post-stroke vision of herself that was incongruent with the self she had always inhabited. She had come face to face with the limits of her control and did not like what she saw. I couldn’t blame her. I became increasingly aware that my own feelings had become entangled with hers. I had been in a cast for three months and I understood her frustration in a different way now. But my disability was not permanent. I would ski again, Susan would not.

I felt her wish to be whole again. I had the same wish, for her sake. I would often find myself cheering on her efforts to do whatever it would take for her to regain control over her life. But the therapist in me knew it might not happen. I had to remind myself I was the one she had asked to help her “come to terms” with her situation. Part of my job as Susan’s therapist was to help her let go of the illusion of control and begin to learn and embrace its limits. Yet, I was as invested in beating this stroke as she was. I wondered silently if this dilemma was universal among clinicians working

with injury, illness, disability, trauma, or terminal disease.

Susan hated being helpless. During one very moving session she recalled her days on the kitchen floor immediately after the stroke. She remembered being desperately thirsty and trying everything to get her paralyzed muscles to move so she could get to some water, but nothing worked; moments when she was lucid and others when she either lost consciousness or fell asleep from exhaustion—the frustration and defenselessness nearly drove her mad. She interrupted her monologue about those days to assure me that she would never be caught this helpless again.

“I know how to get up now,” Susan said. “My brother-in-law showed me when he visited. We got down on the floor and figured it out just in case it happens again. Look, here’s what you do!” With pride and glee she shimmied to the floor of my office to show me what she had learned. She did this with great abandon and without any visible signs of self-consciousness. I, on the other hand, was a bit nervous, but not because I worried that she wouldn’t be able to lift herself up. For that I had complete faith. Her belief in herself had convinced me. It was more the idea that I had a patient on my floor. I sat in amazement as this sixty-eight year old mother of two, grandmother of three, crawled on her knees in my office and then hoisted herself back into the chair. She grinned with satisfaction; I did too. No words passed between us. Any attempt to describe our profound connection at that moment would never have captured the feeling.

The determination Susan showed in the office that day permeated every aspect of her life, to a fault however. Her family began to complain that she was obsessing about treatments and spending all her time researching clinical trials for stroke patients. In an email she shared with me, her younger son writes,

Mom, Congratulations! You made it to retirement! You had a wonderful, meaningful, rewarding career, something that you should be and are proud of. A debilitating stroke was not how you planned to cross the threshold into your golden years. And the question of how you are going to spend your retirement has been answered, by striving to recover from your stroke. You’ve done an impressive job of finding therapy options for yourself when most people would’ve given up long ago. Your drive and persistence is inspiring, but

how much do you want this to define your life after career. I wonder if you realize how many of your tools to recovery currently rest unused in your own hands.

Susan was proud of her son for writing this and for being so personal with her, yet in her mind rehab was her new full time job. She began to secretly feel that perhaps retirement had its advantages. She felt her stress level reduce as she volunteered for every appropriate clinical trial to advance the rehab of her arm and leg. She had shots of Botox into her arm to relax her fingers and give them more flexibility. She experimented with different devices—robotic, orthotic, and bionic—and with braces to aid her weakened muscles and to strengthen her leg so she could someday enjoy walks again with her husband. She had a yoga therapist come to her home twice a week to stretch her and work on balance, an acupuncturist to loosen her rigid arm, and a sex therapist to teach her techniques to restore her sexual pleasure following nerve damage from the stroke. She read articles on the consequences of stroke in nursing journals, brain and language journals, and every stroke journal she could find. She copied many of them for me, urging me to join with her and her wish to get back to “normal.” I read most of what she gave me, realizing that it was giving her some sense of power in the face of her feeling she could control so little.

An examination of many of the articles she brought in around the effects of stroke led me to see that Susan often focused on the hope-producing parts and disregarded the rest. This is where treating grief toward acceptance requires sensitive navigation. As therapists, we walk a balancing act between hope and realism, trying to determine what actually needs to be grieved, and when and where to abandon hope for recovery.

“I’m going to the University for another evaluation,” Susan said. “I don’t want to stay like this for the rest of my life. I need gait. I’m spastic in my muscles.”

“So you’re hoping that someone will know how to help with this, to know whether these muscles have been damaged to the point where they can no longer cooperate.”

“This wouldn’t be the case if I hadn’t stayed at that first hospital,” Susan said. “When I finally transferred to the Rehab hospital they called me Wonder Woman. Did I ever tell you that? They didn’t believe that I’d be able to walk with the orthotic. If rehab had been started earlier I’d be walking better now. Where was my family? Why

didn't they advocate for me? Why didn't they have me transferred sooner to a real Rehab hospital? Why do I have to figure this all out for myself? Why five years later am I travelling to Philadelphia for treatments I should've gotten years ago that probably won't work now? It's all too late."

Here was the grief for time gone by, for treatments not started promptly, for her aloneness with her injuries. She was right to be angry, but ultimately the anger would have to transform into acceptance, not resignation. Here is where the transference, the new experience of the attachment with the therapist, can fuel resilience, can act as an insurance policy against depression.

"You don't have to like any of this Susan," I said. "But you have to try to accept that this has happened and that people may have made errors in your treatment."

"I know, I know, Pat," Susan said. "When I get really frustrated there is part of me that knows I'm lucky I survived at all, but still, I'm mad at myself. Others can accept because their injuries are permanent. I can accept things that are permanent but not things I still have hope for. Did I tell you about a new device called a bionic leg? It's a robot I can attach to my leg, to my tibia, it's in a trial, and I'm being fitted for it next week."

Here it was, side by side, the frustration and the compensatory hope that followed it. The anger was more than she normally allowed herself. Usually it translated into self-blame. She ventured into the grief waters and often quickly pulled herself back, no doubt fearful of drowning in an the abyss she couldn't escape from. But each time we met she ventured a bit farther before pulling back.

In the following session, two days later, Susan returned with our discussion clearly still on her mind.

"Pat, you asked me at one point why I think my leg can be helped. I'm not giving up yet. I still have avenues to explore. I think I just haven't found the effective therapy. I know people whose gait has been helped."

"I know this is a full time job for you," I said.

"You're probably wondering why I can accept my arm but not my leg. I've thought a lot about this since our discussion. My mom didn't drive so I walked everywhere or rode my bike. Walking has always been a big part of my life, of our lives with the children. We hiked and walked everywhere. My arm will never get better so I want to concentrate on my walking. Besides I hate how I look when I walk. I look weird. I look like I'm drunk."

So much was attached to Susan's desire to walk properly. It was not only the obvious wish to appear normal and to walk more quickly, she pursued the therapies, clinical trials, and various devices as a way to assert some control and be an active participant in her own care, and also to repair what she felt had been her and her family's earlier passivity.

How easy it was for either of us to get swept up in the excitement of a new treatment or new gadget. I was keenly aware of the animation of my own "hope" each time Susan presented another path to explore, another device to try, another Rehab facility to investigate, and I struggled to balance my own excitement with the understanding that Susan's damage may well be permanent.

Balancing hope with acceptance was our task. I knew Susan would want to cooperate and get on board with a shared goal, but I was well aware that, at times, she was in dogged pursuit of a "cure" and not interested in balance. In this context, Susan's ability to continue to exert control actually influenced the amount of hope she continued to have. Jerome Groopman, in *The Anatomy of Hope* (2004), connects the capacity for hope with control. Groopman writes, "For many who cannot see hope (their) vision is blurred because they believe they are so completely at the mercy of forces around the" (p.209). He writes about an equilibrium that needs to be established that integrates "the genuine threats and dangers—and doesn't erase emotions like fear and anxiety" (p. 210). This Groopman labels "true hope" and he sees as its companions courage and resilience. He compares it to "false hope" that could easily collapse when the reality intrudes and destroys the illusions it subsists on.

Susan vacillated in sessions. At times she could stay with exploring the limitations the stroke presented. When her awareness of them became too clear or too frightening she retreat to a more left-dominant mode where her rational analytic mind took over and put that awareness in a safer place. This was adaptive for her; it helped to keep at bay the onslaught of thoughts she dreaded. Dread was the dragon in the closet.

Even as Susan poured her efforts into her physical recovery she was becoming more intrigued by our work together. We had been at it for nearly four years at this point. She tentatively became more personal and intimate, often looking away from me with a mixed anxious grin of embarrassment and delight.

“One of these days I’ll come in here without this silly grin on my face,” she said. “You’re not retiring anytime soon, are you Pat?”

Laughing with me, she continued: “You know I think my friends in Florida were shocked that I spoke about my stroke. They said they find me much more verbally expressive now than they ever remember. I attributed that to the work we do in here. Now I think I’ve learned how to be a friend, a real friend, even though sometimes it feels uncomfortable to feel that close.”

I held a steady position of encouragement, all the while reassuring her that her discomfort was understandable, navigating the foreign territory of feelings. She often commented on how unfamiliar it was to be this open with someone. She trusted the doctor who had referred her and transferred that trust onto me.

The assault of the stroke was her primary concern, but no longer her one and only. We began to look at her relationship with her husband, her connections to her sons and grandchildren, and to the people she had referred to as friends. Nothing seemed to make sense to her anymore. Her previously dominant analytic mode suddenly took a back seat to the flooding by her right hemisphere emotions. She was inundated with desires she didn’t understand or recognize. She wanted a closeness, an attachment and words of love from her husband that had not been part of their marital landscape. The words she wanted from him changed the contract they had operated under for decades. The contract was one of devotion to their family and to one another, though with mutually independent somewhat parallel lives. Their marital harmony was disrupted by a demand from her that frustrated and bewildered him and even more importantly, made him feel inadequate.

Jay was a devoted and loyal husband. He had visited Susan every day the year she spent in the nursing home being rehabilitated from the stroke. He helped her now with her daily exercises, stretches, cooking, and shopping; he did all the driving. But he found himself married to a woman who demanded his attention in ways that baffled him. Meanwhile, she found herself struggling with a dependence on him that upset the very core of her self-concept. I suggested to Susan that we invite him in to discuss these concerns. With a nervous giggle she agreed, eager to plunge even further into the intimacy of our work together.

I thought the opportunity for both of them to voice their concerns about the changes in their marriage would be useful, even necessary, given

the circumstances of her stroke and its consequences. We had only one session together, but it was enough to give me a sense of their interaction. He was clearly uncomfortable and, like Susan had been early on, anxious about being personal with a stranger. Whereas her early discomfort had a backdrop of some real interest and excitement, however, a self-conscious curiosity about being personal, he had none. He was formal and straight-backed, wore a perfect bow tie, and looked like he’d rather be almost anywhere other than my office. He was there to cooperate with his wife’s request. He did speak openly about how his wife’s demands for loving exchanges seemed peculiar to him after forty years of marriage; Susan would intermittently interrupt to correct some minute detail, no doubt channeling her mother.

Having the joint session with her husband engaged Susan’s curiosity into becoming even more conscious of feelings she had ignored or discovered had been unavailable to her for decades. She began flooding me with emails between sessions, opening the path for me to suggest meeting more often. Her attachment to me grew and her feelings intensified. She wanted me as her research assistant, her best friend, even her lover.

One day after we had worked together for years, she came in and announced: “I have transference to you!”

Diligent researcher that she was, Susan had been reading about the therapy process. When I reached for her definition of transference she continued, “I’m attached to you. I’m worried about failure but not with you. With you I can practice intimacy. But I don’t want to confuse the closeness with sex.”

Susan had been leaving sessions eyeing me as if there were something more she was wanting from me. “I want to hug you. Often,” she said, and then launched without any hesitation into memories about other women long ago with whom she had felt connected and toward whom she had had similar feelings. It had frightened her then that she had thought of them as sexual and she quickly moved away from the friendships. She realized now that those feelings were signs of her having enjoyed those relationships. In our relationship she could discuss the closeness, the gratitude, and the excitement of being able to unearth any and everything she was feeling. Again came a deluge of emails between sessions, all connected to the same theme.

I am sending this as an email because I still find it easier to communicate in writing than face-to-face even with you. Why is that? As with my previous emails, no response is expected. I need to learn to deal with people face-to-face. We can discuss this when I see you. But here is the anxiety part. If understanding and analyzing transference is the "cure" then why didn't we discuss the role I have transferred to you? Or did we? I think that role is changing over time and I'm not sure what it is right now. Is it too early in my therapy to be discussing this? Human behavior is so complicated! I think I am making progress in some of my behavior and in how I view myself, but maybe you already know this. I think I have now told you everything I was afraid to tell you in the past and nothing awful has happened. I am even smiling as I write this note to you so what we are doing seems to be working. Is part of my cure that I need to believe and accept my emotions rather than relying solely on my rational and rationalizing brain?

Susan was in the throes of a transference that would be the vehicle that would lead us to explore her emotional experiences with others and set the stage for us to move on to the more difficult task of embracing the fact of the stroke. She took advantage of every session, often referring to notes as her agenda. No doubt the notes acted as a shield, a layer between her and the scary places of feelings she continued to need to navigate. Although she still has not fully accepted the limitations the stroke imposed, Susan has been introduced to an emotional expansiveness that is now hers to keep. Her feelings have been elevated to priority status, occasionally even trumping the prospect of a new treatment procedure or clinical trial; her relationships are vital to her well-being. Our relationship, and the intensity of our work together, has been the catalysts for change, for us both.

I realized that the classical model of transference as being intrapsychically generated was not the only experience happening in my office. Susan's subjective world was transforming because together we formed an environment where that world could unfold. My subjective professional world had transformed back when I recognized what had been most helpful to me in my own analyses: transformation was only possible because of the relationship and trust we had built over years. This, together with my own

intrapsychic piece allowed for a transference rich in both objective material and subjective context. Each of my therapists came from a different theoretical background but what they all had in common was a real presence in the room with their patients, and they all projected a sense of caring about getting it right.

I remember years ago railing at my analyst for his silence at the time of my father's unexpected death. I had moved from the couch to sit up because my sobbing was making it difficult to breathe. I lashed out at him: "Why can't you say something comforting! I'm in pain!" I stared at him for what felt like an eternity. He took a deep breath and said, "There just are no words that can capture your grief." He was right. And I never forgot that. Sometimes there are no words, but there is so much more.

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