

Our Greatest Vulnerability in the Therapeutic Encounter: Being Human

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Abstract

The desire to heal, the fear of failing, and the question of whether to gratify our clients' needs or requests intermingle in the space where the personal and the professional seamlessly coalesce. Our inside humanness is an unavoidable part of our outside professionalism, but it is in the area of our very humanness that as professionals we are most vulnerable. The aware, reflective, responsible, humane, professional clinician will be able to navigate the inevitable tension between inside humanness and outside professionalism. In this article, the authors explore these ideas using clinical material to highlight this complexity. They also offer possible ways to navigate the psychotherapy journey in a professional, humane way in which both client and psychotherapist are protected, not from their humanity but from their capacity to injure in the attempt to protect their human vulnerability.

Keywords

vulnerability, failure, protection, injure, gratification, needs, omnipotence, malignant regression

He killed the noble Mudjokivis. / Of the skin he made him mittens, / Made them with the fur side inside, / Made them with the skin side outside. / He, to get the warm side inside, / Put the inside skin side outside. / He, to get the cold side outside, / Put the warm side fur side inside. / That's why he put the fur side inside, / Why he put the skin side outside, / Why he turned them inside outside.

—George A. Strong, 1918

[The subjective experience described in this article is that of Elana Leigh. The pronouns *I*, *me*, and *my* refer to her experiences and reflections.]

A client who has been in treatment for over 10 years enters the session angrily: "I am wondering if what we are doing is really working. Friends and family think I should have more techniques from you in order to help me through this challenging time. Perhaps what we did together has worked, but now something new is needed. What do you think?"

I am flooded with an immediate sense of shame and failure. As I momentarily sit with this feeling, I notice how quickly I move to an internal defensive position, wanting to pathologize him for asking this pertinent question. I feel the urge to show him that asking the question fits with his repetitive

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patterns of thinking, feeling, and behaving as if someone else is always to blame for his uncomfortable experiences.

I pause. I reflect that in the past months we have been talking about his need to develop a stronger sense of agency, which would increase his ability to take charge of his anxiety and thus lead him to feel and be more autonomous. This imagined autonomy, we have agreed, creates in him a terror of being separate and evokes an unconsciously motivated sabotage to his therapeutic process, thereby keeping him attached in a hostile way. Together we have acknowledged the complexity of this intrapsychic and interpersonal dynamic.

As I pause and examine my own reactivity to his request, I realize that my immediate defensiveness was a response to my own vulnerability, a feeling that I had failed him and that if I respond from this position I will re-create the repetitive response that he received from his mother when he attempted to separate and individuate.

After distilling this information, I say, "Whew! This is a big moment!" I pause. "This feels so important, and we need to stop and think together about what we are doing and what needs to happen in a different way, however uncomfortable or uneasy this may be for both of us."

I feel challenged by his question and notice my desire to defend the therapy and myself. When I stop and reflect, I realize that this is an attempt to protect my own vulnerability and that a defensive response to his question would overlook his need to be taken seriously and again replay how in the past, and possibly now, he felt missed. I therefore think that we should embrace his question.

He is relieved and moved to tears, and we begin thinking about new treatment options.

This article begins with a clinical example that represents a particular moment in the life of a psychotherapy journey when the outside failure that brought the client into treatment enters into the therapy. This is the moment when external stories become background, and, now, the real here-and-now story between the psychotherapist and the client is brought into the foreground. The fact that the issue being raised is, in many ways, a repetition of history does not make it any less real. In fact, ironically, it is often the realness of the content that triggers the psychotherapist's vulnerability. In this instance, I am afraid that I have failed the client, and irrespective of whether this failure is my personal vulnerability or not, the experience of registering a sense of failure leaves me feeling scared and wrong. My reactive impulse is to offer options and skills or, paradoxically, to coldly, aloofly stay out.

As the client's outside story infiltrates the therapy and the therapist, the potential failure is now inside the therapy.

In the end the patient uses the analyst's failures, often quite small ones, perhaps maneuvered by the patient. . . . The operative factor is that the patient now hates the analyst for the failure that originally came as an environmental factor, outside the infant's area of omnipotent control, that is *now* staged in the transference. (Winnicott as cited in Ehrenberg, 1992, p. xi)

Winnicott's "failure of the environment" for not providing what was needed for the child's healthy growth is true for my client, both in his history and now in his psychotherapy.

My client's pain and difficulty had, until that moment, resided in him and his anger with others, but now it was in the psychotherapy and with me. The original presenting problem that brought him into treatment was a deep depression, from which it was difficult for him to emerge in the world and because of which he had trouble maintaining contact. He felt internally collapsed and experienced himself as having little or no agency. His hostile, dependent attachment was enacted in most of his relationships; he would swing between feeling overly dependent, on the one side, and extremely angry and needing to flee, on the other. His internal and external conflict resulted in self-destructive patterns of behavior and severe anxiety and depression. Over the years, we have come to understand

the etiology of these feeling states and how his struggle to be a separate self evokes these strong emotional reactive states.

I believe my client's dynamic of feeling internally helpless and outwardly angry had entered the therapeutic space, in which I now became the disappointing other. This provoked and evoked my sense of failure and was now our challenge to work with. Alongside this moment of the outside failure having entered the therapy, with its concomitant impact on the therapist, sits another human desire: the desire to help. Emory University neuroscientists Rilling et al. (2002) have argued that compassion is an innate human response embedded in the folds of our brains and that helping others brings the same pleasure as does the gratification of personal desire. Our wish to gratify, cure, heal, and protect can be understood "at a biological level, that as a member of my species I have a fierce need to protect life in those who matter to me, as fierce as the need to safeguard my own" (Landaiche, 2014, p. 77).

Our human desire to help often transmutes into behavior that protects, gratifies, supports, and defends. The combination of my feeling uncomfortable and being asked to step into the treatment in a new way led me down a path of self-reflection and recollecting memories of similar professional moments in my career. I came to realize I was recalling moments in which I had felt free to work with my clients in a directive, spontaneous, and creative way. I felt both sentimental and nostalgic for those days when the metaphorical parents in my head were creative humanists who believed that psychotherapists had the capacity to provide for and fill the deficit needs of their clients. Notwithstanding the efficacy and brilliance of those revolutionary practices in that early humanistic era, unfortunately, that warm, fuzzy feeling did not arrive without its counterpart, which is my memory of falling from grace when realizing that love and provision could not always cure and that failure was an unavoidable human condition.

The other theme in this case example is one of failure, in both the client and myself. In terms of the client, this lay in him experiencing a failure of personal mastery and his sense of disappointment in both the therapeutic process and me. With regard to my experience, this manifested in my sense of failure in him, the therapeutic process, and myself. The struggle to stay authentically engaged with such experiences of failure in the face of human pain and despair was excruciating, particularly because I am, whether I like it or not, in the role of the paid professional who has been entrusted with making a difference and easing his pain. Authentic engagement now means that there is nowhere for me to hide to protect myself from the experience of failure. By this I mean not the intellectual understanding of the value of making mistakes (Casement, 2002) but the emotional, somatic, subjective experience of feeling the fear of being a failure. I could not hide behind theory or knowledge or interpretation. At such moments, knowing, highlighting, and interpreting are not curative. These interventions can, in fact, be destructive because they are based on the assumption that the responsibility for the mistake lies with the client. This idea runs counter to our current belief (which, in this case, is so alive) that most experiences are coconstructed and, therefore, so is the repair and healing.

The current request from my client to do something new or different gave rise to these memories as I was being invited to meet a need that historically was never met and was not being met now. I was being invited into both familiar territory in which the question may have been "What does he need?" and unfamiliar territory in which the question is "Can I surrender into this therapeutic regression neither repeating the past nor knowing what the map is?" Locating myself as a relational transactional analyst, I reflect on how the relational turn in the 1980s (Aron, 1996; Mitchell, 1988) was reflected in transactional analysis some years later (Cornell & Bonds-White, 2001/2005; Hargaden & Sills, 2002; Landaiche, 2014), and like so many revolutionary points of change, brought many gifts. However, they evoked in me a "beware sign," cautioning me against being seduced by a contemporary promise of cure and that this time we, the profession, could get it right and avoid our human capacity to fail and injure. In this relational paradigm there is a belief that if we share the therapeutic space, allow ourselves to be impacted, disclose more of ourselves, and use our

countertransference in a transparent and self-owning way, we will be effective and curative. Even though research supports this way of working, it still cannot save us from the inevitability of failure and wounding another. We have to live and work with this reality and perhaps give up the omnipotent belief that it can be avoided.

And yet, my client is asking me to provide and to do something more; he requests that I provide and actively introduce skills that will help regulate his high levels of anxiety and depression. "I think all analysts have at least a twinge of uneasiness from our 'classical superego' when doing anything, even when interpreting, that may be gratifying to an analysand" (Mitchell, 1993, p. 177). Whether or not I agree with my client's request does not change his perception that not enough of what is needed is being done or offered. Our clients—not we practitioners—define the success of our intentions, and although we may believe we are providing and being empathic, supportive, or whatever our intention, if the client does not experience these qualities, then this, in the end, is what defines the truth. Berne's third rule of communication reminds us that "the outcome of any transaction is determined at the psychological level" (Cornell, de Graaf, Newton, & Thunissen, 2016, p. 67). At the psychological level, my client needs more. That is what requires attention and causes me to feel like a failure. It is here that I experience my human frailty and vulnerability. Any attempt to protect myself from this could possibly lead to harming my client. A parallel process was now in play as I too faced a form of collapse and fear for his and my own well-being.

The dance between the needs of the client and the psychotherapist, the question of whether to gratify or not, and the tension between human responses and professional responsibility are central dilemmas for practitioners: Do we create a binary between therapist and client? Between being human and being professional? Do we have to choose between two competing sets of needs? The ultimate difference to those we serve will be made by how we engage with this challenge.

Winnicott (cited in Mitchell, 1993, pp. 132-133) invited us to engage with this dilemma by differentiating between instinctual wishes and ego needs, the former being more aligned with Freud's original description of basic drive needs and the latter being what Winnicott referred to as those needs that are connected to the development of the self. "The desires of the more disturbed patients represent 'ego needs' not instinctual wishes. Unlike the latter, they must be met, to one extent or another gratified, before anything else can happen" (Mitchell, 1993, p. 178). At a similar time, Balint (1968) made the distinction between "malignant and benign regression" (p. 127), the former being when an instinctual wish is met leading to a regression that does not carry the therapeutic work forward and the latter being benign as ego needs are met and the work moves forward as the attempt is made to heal the original "basic fault."

This clinical distinction and treatment decision, although not simple, is crucial to explore and work with. In the context of the contemporary relational frame, Mitchell picked up on this central theme of wish and need and strongly proposed that psychotherapists use their countertransference reaction to navigate their way through the decision to gratify or not. His research suggested that when it felt right to gratify and no malignant regression occurred, this requirement to gratify reflected an ego need; when it felt wrong to the practitioner, this countertransference reaction pointed to the request being a wish and, as such, perhaps not one that should be gratified. Although on the surface this interpretation may appear overly simplistic, its reasoning crude and deductive and thus perhaps likely to evoke a reactive disregard, when steeped in clinical wisdom and knowledge, it invites our thoughtful and considered engagement.

Historically, my client's request in the therapy for gratification came from an unformulated desire wherein his sense of self was both undeveloped and fragmented, and I had held the frame more firmly. This contrasts with the present, in which his request feels like it emerges from a more solid sense of self and ego functioning. I believe this current request points to a developmental or instinctual need that has never been met inside a relationship in which two minds are operating together. However, although the psychotherapist's subjectivity is always valid, to extrapolate a rule

from countertransference experience is questionable. An interesting parallel process and question emerges as to whose malignant regression is at play. This may be where the practitioner's vulnerability lies, and in the need to protect and defend this vulnerability, we may naturally fail our clients, our profession, or ourselves. Our failure is not intentionally malignant but rather arises out of an unconscious natural desire—a desire that is part of the human condition and, as such, one that we psychotherapists experience. Rather than denying or avoiding or defending against our human underpinnings, it is our very humanness that compels us to actively work to shine the light on our broken wings in order to heal parts of others and ourselves. In reflecting on this, I note that my unresolved personal material has, at times, informed me in having an unconscious omnipotent belief that I could provide that which was missing in the client. This led me to either reactively gratify or withhold, both of which lead to a malignant regression. Such intervention, and the clinical judgment on which it was based—that is, it felt right and the diagnosis of ego need was correct—ran contrary to what Mitchell proposed.

Pausing and distilling (Leigh, 2011) this complexity led both my client and me to reclaim our sense of agency. What I now know is that each time I am called on to provide or do something, I experience anxiety, which I have come to value as a warning that I am being invited into a reactive, frightened, unregulated state that historically created the impulse to act in order to soothe. It is my cue to slow down, breathe, think, and find my own mind and feel my own skin. My client and I now were ready to think together about strategies to support the next phase of the treatment. With such thoughts, feelings, and reflections, I ponder the complexity of this case and what lies ahead for us both. I have been entrusted and have entered a professional relationship to use my knowledge, skills, and expertise to do no harm and hopefully ease psychic discomfort. I am governed by a code of ethics and professional practice that requires me to adhere to that which I contracted to do.

With our now two functioning minds and a task jointly shared, my client's request for something more to happen reflected, I believe, a crucial developmental stage of learning that was historically bypassed because he and his mother had not managed well the separation/individuation phase of development. They moved from need/wish through to satisfaction without ever addressing or meeting the frustration that is met when learning to do and achieve something new. For my client, this meant moving from his desired needs/wishes to a collapsed position (which usually occurred while having a tantrum) and was followed by his mother's collapse, through which the need was then met. This regulated them both. Nothing constructive and functional was achieved except for a long-lasting, hard-wired pattern, which now reemerged in the psychotherapy with me.

The challenge ahead in our work together became grappling with how to gratify a need in a manner that would hopefully not lead to the malignant regression Balint (1968, p. 127) described, a question that has kept us practitioners busy since Freud. We are constantly appraising, altering, adding, and correcting our practice methods in order to do no harm and to be as curative as we professionally and humanly can. My challenge required me to now step outside my familiar way of working. In so doing, it became incumbent on me to question my assumptions and fears about stepping deeper into the symbiosis (Schiff & Schiff, 1971) and perhaps to become more directive in working with skills and strategies. My previous trainers', supervisors', and mentors' words were internally alive, warning me against my newly adopted position, which felt historically familiar and currently unfamiliar.

Together, my client and I decided what was required: We have increased contact; we speak through his feelings of worthlessness and helplessness and his inability to shift his emotional and physical state; I think with him about ways to be and techniques to employ in moments when he experiences being down a "rabbit hole with no idea what a ladder looked like to help [him] climb out"; and we negotiate what he needs in order to shift from utter despair to locating his capacity to take the next small step in his life. Mitchell (1993) contended that

most crucial is neither gratification nor frustration but the process of negotiation itself, in which the analyst finds his own particular way to confirm and participate in the patient's subjective experience, yet over time, establishes his own presence and perspective in a way that the patient can find enriching rather than demolishing. (p. 196)

Thinking and negotiating with my client is proving to be the most effective way of being with him, and, in the process I am learning to differentiate between offering suggestions from within the old paradigm, the reactive anxious place driven by the impulse to soothe. I am learning to be with my thoughts, feelings, and responses and to make suggestions from a more informed and secure place in myself. In this new phase of the therapy, I have a sense that the skin between us is thin. I feel disrobed and suspect the way I wear my role as a psychotherapist has changed (or so it seems), leaving me exposed in an unfamiliar, unknowing way. I believe we are in a merger transference/relationship (Hargaden & Sills, 2002) that feels essential and nonnegotiable because I believe it is here that the healing and integrating needs to occur.

I now ponder what constitutes a healthy or unhealthy merger. How does one establish and know the difference? Am I merging with him as a way of avoiding my own failure to cure his anxiety and depression?

The infant's experience of the mutual interaction with a self-regulating other (Kant 1971) becomes, in our view, an integral part of the child's sense of cohesive OK self, which we visualize as being contained in a type of amniotic sac, which [is created by the environment established by the mother and baby]. (Hargaden & Sills, 2002, p. 18)

I do feel like I am in an amniotic sac with my client, an experience I have avoided, believing and feeling that merging at this primitive level is destructive because it creates regression and dependency.

I have since come to understand that, paradoxically, the iatrogenic regression that often emerges in psychotherapy is caused when needs are not met, thus evoking further frustration. The practice of withholding supports the belief that frustration is an essential state that needs to be mastered in order for an authentic integration of the self to occur. I have come to know and understand the difference between consciously withholding from a client because the theory and practice advocate this and the genuine decision not to supply a need because it is not possible or realistic. The former can be experienced as persecutory. The latter may, perhaps, be frustrating but can also be experienced as considered and negotiated through a respectful relationship in which both parties' needs are taken into account. In the latter circumstance, the most vital curative factor is processing together the therapist's inability to satisfy the need. I have come to understand that a healthy merger is distinguished from an unhealthy one by the mother's/psychotherapist's capacity to self-regulate and hold his or her sense of self and mind. This clarifies that it is not the merging that is destructive but the losing of one's mind and the assumption that the baby/client cannot think for himself or herself.

My challenge now became holding on to my client and his capacity to think, even in those moments when it felt clear that there was a fragmented baby in the therapeutic dyad, one that appeared not to be able to think for himself. "The analyst's expertise resides in developing and drawing the patient into a collaborative inquiry that allows both the patient's desire and the analyst's authentic participation to find a home" (Mitchell, 1993, p. 201). Through the meeting of ego needs (Winnicott, 1960), as opposed to instinctual wishes, the therapist can facilitate a client's healthy development.

In the work with my client, the change of treatment direction evoked many additional clinical questions around the issue of dependence and enactment: Was I engaged in an enactment that mirrors his relationship with his mother? Are my decisions, like his mother's were, an avoidance of feeling helpless and a failure? When he decompensates, do I step in and rescue him by thinking

for him, thus soothing my anxious feelings of fear and helplessness? When reflecting on these questions, I again cast my mind back to consulting in the 1980s and early 1990s, when a reparative transactional analysis model informed my practice and my intention was to provide and fill the deficit in the client. I believed “it was never too late to have a happy childhood” (James, 2002), and my method of treatment was highly interactive and directive. I could not know then what I did not know but now understand: that I was a psychotherapist who believed in her modality and frame of reference and that, consequently, I was in role. My confidence in what I thought I knew, coupled with my protection against my own fear of failure, did not allow for doubt and failure to exist easily. On reflection, I naturally failed many times, mainly because I did not have the capacity to truly step into the relationship at those moments of failure. Equally, I now consider whether, in fact, this lack of capacity mirrored a limitation of the modality of that time, which did not have a belief that the therapeutic relationship is coconstructed. Transactional analysis was in its own evolutionary process, and although it had taken so many courageous steps in its development, it still could not know what it had yet to discover.

Although I believe I did touch my vulnerability at times, I did not have the knowledge or ability to stay engaged in the discomfort of the failure or to make sense of it. Instead, I moved to the position of unconsciously or consciously pathologizing clients for their regression, a practice common at the time and that I unquestioningly engaged in. As a way of protecting my vulnerable self, I withheld information and advice and the option of thinking with clients because I believed that I should not further merge with them for fear of reentering the unhealthy symbiosis (Schiff & Schiff, 1971). In so doing, I sometimes inadvertently injured clients and the psychotherapy process.

So many of us psychotherapists, in our own unique ways, unconsciously use our roles, theories, and techniques to avoid feelings of vulnerability. In that avoidance, damage can be done. As I recall those days, I realize that what was missing was “me—the ‘I’ of the beholder” (Leigh, 2016). I had not arrived at the point where I now am, which is to know that failure is part of what and who we are. The challenge is not to avoid mistakes and failure (because we cannot) but to work together with clients to face that which can often feel unbearable to touch.

As I sit with these questions in my present self, I note how they have been met and answered through time. Do not both my historical and present fears reflect the same trepidations as those of all the great teachers on whose shoulders I stand? Do these fears not mirror the practitioner’s conundrum, which is to navigate either the desire to gratify or the fear of doing so, with the feared consequences of injuring and the actual consequence of failing? Freud, Winnicott, Ferenczi, Balint, Mitchell, Berne, and many others all talked about the same issue in different languages. They were evolving and crafting theories and methodologies to ease human psychic pain, and in the crafting they were navigating the central themes of our profession: dependency, regression, gratification, loss, autonomy. They, like us, were all doing this through their subjective lenses, which are influenced by personal history and humanness and thus make each unique and yet vulnerable to the same frailty.

So what of my work with my client? Discovering and learning what is and will be effective will be an ongoing, coconstructed, mutually defined experience rather than one that is unilaterally determined by me or, indeed, him. We are truly dependent on each other, which creates in us both vulnerability and strength. The emotional encounter and the meeting of our minds will see us through this journey (Aron, 1996).

Whether we speak of Winnicott’s instinctual wishes and ego needs, Balint’s benign or malignant regression, or Schiff and Schiff’s functional or dysfunctional symbiosis, we are talking about how to be in a therapeutic relationship that requires deep attachment, regression, and the fulfillment of deficit needs—all this, inside a professional relationship that simultaneously requires boundaries, limits, and the valuing of autonomy. When psychotherapists are steeped inside a relationship with a client, they experience love, attachment, desire, and many other human feelings. The capacity to

differentiate between being human and professional is a challenge central to our vulnerability. Over many decades, if not from its inception, the training and practice of psychotherapy has explored, examined, critiqued, played with, and perhaps damaged the human desire to help. The story of the wounded healer is almost synonymous with the helping profession, and through our self and our obligatory collective exploration we have found ways (depending on our chosen modalities) to accommodate and shape this desire.

Being human is our greatest vulnerability, and in our human need to help, inside a profession that has so many caveats in this area, we may protect ourselves from failing in the eyes of our profession. In so doing, we may, perhaps, fail the people we are serving. This leaves us standing vulnerable and naked in the face of the human frailty of failure. It is incumbent on us to disentangle the complicated “knot” (Pizer, 2008) of whom it is we are failing and who has failed us.

Unless patients can feel that they have reached their analysts, moved them, changed them, discomfited them, angered them, hurt them, healed them, known them in some profound way, they themselves may not be able to benefit from their analyses. From this perspective, psychoanalysis is a profound emotional encounter, an interpersonal engagement, an intersubjective dialogue, a relational integration, a meeting of minds. (Aron 1996, p. 136).

Epilogue

How do I reflect on the contradictions inherent in writing about this case study in the context of the theme of the vulnerability of human failure? If the medium is the message (McLuhan, 1964), I wonder how even in writing I am unconsciously seeking to sooth that which is impossible to ease.

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