STANDING IN THE SPACES

Essays on Clinical Process, Trauma, and Dissociation

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and detachment. The second peer group, bringing me together with Lee Caligor and Jim Meltzer, began as an effort to explore the supervisory process and led to our edited book on psychoanalytic supervision in 1984. Our trio has continued to thrive as both an ever-deepening personal and professional relationship, and as a diverse, lively, and fertile exchange of ideas. The third peer group is the Editorial Board of *Psychoanalytic Dialogues* in which I have participated pleasurably since the journal's inception in 1991; my thanks to Neil Altman, Lewis Aron, Tony Bass, Jody Davies, Muriel Dimen, Emmanuel Ghent, Adrienne Harris, and Stephen Mitchell for all they have given me.

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1

INTRODUCTION

"What is the use of a book," thought Alice, "without pictures or conversations?"

—Lewis Carroll, *Alice's Adventures in Wonderland*

I've always been wary of words—a perhaps curious opening remark when one considers how many are to follow. As far back as grammar school my stubborn refusal to substitute the grownup language of "real reality" for the felt reality of my inner experience would get me into no end of trouble with the people whose job it was to educate me. My report cards, for example, invariably contained the anticipated note from my teacher: "Philip appears to be very bright but he seems to live in his own world. I never know where his mind is, and nothing I do or say seems to change that." My parents, who knew first hand what my teacher was talking about, would nod their heads with both recognition and resignation because they didn't know how to deal with it either. To the adults who were trying to help me "pay attention," my ability to disappear "inside," as if in another world, was clearly a bad habit I needed to change. I, of course, never thought about it that way and couldn't understand why it seemed so important to everyone else. So I continued to do it, and apparently to such an extent that my mother hit upon the strategy of making me repeat what she said, hoping thereby to defeat my efforts to tune her out. I can still recall the day she realized that her "technique" didn't work. Standing in front of me, hands on hips, she growled; "You never listen to me. You never hear a word I say! I'm going to tell you something right now, and I want you to repeat it to me exactly." She then told me whatever the "something" was, and I did indeed repeat it word for

word, exactly as she said it. She looked at me with a strange combination of bemusement and consternation. "I don't know how you did it," she said, "but I know that even though you were listening you still didn't hear it. I don't know how you did it, but you *did* it!" She was, needless to say, absolutely right about my not processing what I was taking in while I was being "educated," but more importantly, her sense of humor about it probably contributed a great deal toward my feeling more or less comfortable with my "insideness" as I got older. As Langan (1997, p. 820) wryly put it, "What is one to do with the fractionating discovery that, as the poet Allen Ginsberg remarked, 'My mind's got a mind of its own'?" And who knows? Perhaps it was because of this that I am now able to find humor in similar moments with patients—moments that might otherwise hold a potential to become grimly adversarial as our realities collide.

I begin with this vignette from my own childhood because it touches what may be my earliest awareness of what I hold to be the heart of personality growth—the paradox of being known but still remaining private, of being in the world but still separate from it. This paradox is often as confounding to psychoanalysts as it was to the adults in my early life. The acquisition of new self-experience is a process that is not mediated by language alone. There must be communication with an "other" at a felt level of personal validity in order for linguistic content to be integrated pleasurably and safely as self-experience. The analytic situation is designed as a negotiated therapeutic relationship to bring about this integration.

The following chapters are a selection of clinical essays written over the last twenty years. They can be read simply as a book of collected papers, or they can be read, simultaneously, as the unfolding of a clinical perspective—a series of reflections on the analytic relationship with its own implicit order, its own progression of ideas, and its own internal dialectic. My hope is that most readers will find this latter approach more congenial to their taste. How a reader reads will partially depend, of course, on the extent to which the growth of his own clinical experience and the historical development of his own ideas share some common ground with the evolution of mine over the past two decades. Writers need readers. In her 1996 novel, *Hallucinating Foucault*, Patricia Duncker argues that what writers have for centuries referred to as "the Muse" is none other than the reader for whom they write. Through the voice of her protagonist she puts it this way:

> I have never needed to search for a muse. The muse is usually a piece of narcissistic nonsense in female form. . . . I would rather a democratic version of the Muse, a comrade, a friend, a traveling companion, shoulder to shoulder, someone to share the cost of this long, painful journey. Thus the Muse functions as collaborator, sometimes as antagonist, the one who is like you, the other, over against you. . . . For me the Muse is the other voice. Through the clamoring voices every writer is forced to endure there is always a final resolution into two voices. . . . But the writer and the Muse should be able to change places, speak in both voices so that the text shifts, melts, changes hands. The voices are not owned. They are indifferent to who speaks. They are the source of writing. And yes, of course the reader is the muse [pp. 58–59].

As I now contemplate the "otherness" of my own reader-muse, I wonder whether much has changed from the years when I would say to a supervisor, "I'll tell you about the last few sessions, but you really had to have been there." I find myself once again trying to oppose the constraints of language, felt here even more keenly in the written than in the spoken word, and unwilling to accept the inevitability that the "right" words to represent the "wholeness" of this book will be inadequate to express the individual personalities of its chapters and the range of my own clinical states of consciousness that went into birthing them. I yearn to impart a taste of the multiple experiential meanings that fueled my writing of the individual chapters at the time they were originally created, each a unique event that, like an analytic session, was most meaningfully "itself" when it happened. Perhaps my attempt to introduce this volume in such a fashion embodies my hope to overcome the limitation I do not want to accept, by evoking in the reader a heightened awareness of his own inner voices as we each struggle to grasp the phenomenon of two people, patient and analyst, purposefully confronting and engaging the multiplicity of nonlinear realities (their own and each other's) that organize the relationship we call psychoanalytic treatment.

"When I was young," Mark Twain wrote, "I could remember anything, whether it happened or not." Inasmuch as we have supposedly lost this capacity in growing up, the ability to relish Twain's humor is a remarkable human achievement. As adults, we like to call it "imagination." But as analysts, we know that this kind of logical impossibility, both in our patients and in ourselves, is the stuff of conundrum and, worse, impasse. Yet on the other hand, as analysts we also grasp that just "knowing" reality is not what growing up is all about. We are all well aware from our work that "knowing" reality can be a disastrously grim experience for many people. If a child is routinely allowed comfortably to retain his subjective experience while engaging with his parents in his own way as they tell him about what is "really"

happening, he stands a pretty good chance of growing into an adult who, like Mark Twain, always has a child along for the ride.

Central to the growth of psychoanalytic theory has been a continuing effort to formulate a working model of the analytic relationship that is clinically flexible and developmentally sound. All attempts, including those of Freud, have necessarily rested upon a set of explicit or implicit assumptions about the nature of reality and how human beings come to understand what is "real." These assumptions have to do with the way in which one's capacity to see things as others see them develops, stabilizes, and coexists with one's values, wishes, fantasy life, impulses, and spontaneity; in other words, these assumptions concern the conditions through which subjective experience of reality (including reality about one's self) is freed to move beyond the limits of egocentrically conceived personal "truth." In this regard, the psychoanalytic relationship is an interpersonal environment that frees patients' potential and appetite for a creative dialectic between their internal reality and the presentation of external reality as represented by the analyst as an independent center of subjectivity.

To the extent that analytic theory is not embedded in imagination, I tend to approach it mainly as an intellectual adventure, similar to my fascination with taking apart clocks during preadolescence—to see how they worked. In other words, I don't think it is necessary to have a *concrete* theory in order to work effectively, and in fact I suspect that too great a preoccupation with theory can interfere with the process of therapy in the same way that taking apart clocks can become a substitute for full involvement in the business of living. If full involvement in "living the psychoanalytic relationship" does indeed require imagination, then the soul of the process might in a certain way be seen as a return to the basics of childhood. To put it more lyrically, is there an analyst who, as a child, did not believe with Eugene Field (1883) that "Wynken, Blynken, and Nod one night sailed off in a wooden shoe," even though "some folks thought 'twas a dream they'd dreamed"?

I recall a particular session just after I had returned from summer vacation, when I was sitting, saying nothing, hoping to regain my "memory." My patient, from the couch, said: "You sound very silent today." My first internal response was "What does *that* mean?" If she had said, "You are very silent today," I could have connected to that at once. But how can I sound silent? As I started to think about what she was feeling, something happened; I "knew" what she meant. Not conceptually—I *already* knew conceptually. I knew in a different way because the words "sounding silent" no longer felt alien, just as *she* no longer felt alien to me. It's tempting to just give this a name—to

say I knew "experientially" or that I made contact with her "empathically" or something of the kind. Even though I do think in exactly this kind of way, I also believe that despite the understanding contributed by these terms we have barely begun to comprehend "what makes this clock tick." Something fascinating goes on in the process of human communication which continues to be the heart of what we rely upon clinically, as well as being the one genuine subject of all analytic theory no matter whether the vocabulary we use prefers to speak of transference-countertransference, enactment, projective identification, intersubjectivity, dissociated self-states, or even the phenomenon of "imagination."

As you might anticipate, my writing is more process driven than theory driven, and you will find that the aesthetic progression of the chapters, particularly during the last decade, is configured more and more by clinical vignettes as the context for my evolving point of view as an interpersonal/relational analyst. Although I touch on existing arguments in the literature and attempt to provide, here and there, challenges and what I believe to be corrections, I am basically trying to communicate a point of view with regard to the clinical phenomena and an approach to working with them. In other words, the theoretical formulations that arise out of my contemplation of the clinical material are for the most part responsive to the phenomena rather than an inside-out attempt to theorize them ahead of time.

How is it *possible* for psychoanalysis to work? Like the bumblebee, it shouldn't be able to fly; but it does. It is the issue that always percolates slightly beneath the surface of my clinical work, sometimes conscious, sometimes not, but always informing the sense of wonder with which I participate in the process of analytic growth with a given patient. How can a therapeutic link be constructed between seemingly irreconcilable needs of the human self; stability and growth; safety and spontaneity; privacy and commonality; continuity and change; self-interest and love? Asking oneself how it is *possible* for psychoanalysis to work is not the same as asking how psychoanalysis works. The former question comes from a clinician's more querulous and unsettled state of mind—the living part of an analyst's self that swims with his patient in more or less raw clinical process and has not been *subsumed* by his self-reflective consideration of how to conceptualize it. Trying to come to grips, clinically, with how it is possible to relate to a human being in a way that will enable him to accept dismantling the protection of his hard-won character structure in order to achieve gains that may or may not be realized, is perhaps the underlying motif throughout this book.

Safety and Growth

The drastic means an individual finds to protect his sense of stability, self-continuity, and psychological integrity, compromises his later ability to grow and to be fully related to others. Thus, a person enters treatment dissatisfied with his life and wanting to change it, but as he inevitably discovers, he *is* his life, and to "change" feels, paradoxically, like being "cured" of who he is—the only self he knows. "Can I risk becoming attached to this stranger and losing myself?" "Is my analyst friend or foe, and can I be certain?" Ernest Becker (1964, p. 179) considered this paradox "the basic problem of personality change" and asked trenchantly: "How is one to relinquish his world unless he first gains a new one?" Becker's question leads inevitably to a close examination of the kind of human relationship that allows a psychoanalytic process to take place. How does a relationship between patient and analyst come to exist that gets beyond the patient's having to make the impossible choice between being himself and being attached to and thus influenced by the analyst? (See also Mitchell, 1997b.) How does the relationship ever come to transcend the patient's determination to protect his own feeling of selfhood, and what does the analyst contribute that enables this transcendence to take place?

In my view the answer lies in the therapeutic creation of a new domain of reality in which coexists a hope of the "yet to be" and a dread of the "not me." No matter how great the pain of being trapped within one's internal object world, and no matter how desperate the wish to break free, it is humanly impossible to become fully alive in the present without facing and owning all of the hated, disavowed parts of the self that have shaped and been shaped by one's earliest object attachments. "Cure me of my blindness, but do not leave me in a void while I am learning to see. If I may come to know, finally, that seeing is not illness, will I exist at all?"

No matter what we say—and we say plenty—about diagnosis, nosology, severity of pathology, and psychoanalytic technique, it could be reasonably suggested that our clinical approach to any given patient is most broadly outlined by whether that person possesses the developmental maturity to *conceive* of asking the question: "Why am I living this way?" I'm not speaking about whether he has ever thought about what "this way" means or whether he has ever seriously attempted to answer the question. Some individuals come into treatment tortured by the question, having asked it for years without feeling any closer to an answer, while others have never asked it because, for them, the concept of "why am I living my life this way?" has no personal meaning. It is as if they have been able, somehow, to disprove

Socrates' time-honored opinion (Plato/Jowett, 1986, p. 22) that "the unexamined life is not worth living," and seem to live it anyway, but invariably in great pain.

For them, the question of "why" is inherently unaskable, and no matter what we may say diagnostically about such an individual when they choose to enter treatment with us (usually in search of some relief from their pain), the initial phase of therapy either succeeds or fails depending upon whether it enables the person to reach a point where that question becomes in fact askable. Unless this point is reached, analyst and patient will have very different images of the "reality" in which they coexist and the purpose of what they are doing, and in my experience, some of the "inevitable" treatment stalemates and failures in working analytically with such patients are created by each partner trying, futilely, to force his own "treatment reality" into the mind of the other.

Dissociation and Conflict

Increasing a person's capacity to question the way in which he is living his life requires a clinical process that expands the development of self-reflectiveness. Self-reflectiveness, traditionally referred to as the presence of "an observing ego," has been the most often cited criterion of analyzability. It allows a patient fully to exist in the moment and simultaneously perceive the self that is existing. The ability of the human mind to adaptationally limit its self-reflective capacity is the hallmark of dissociation, a phenomenon that, in both its normal and pathological forms, is being taken increasingly seriously by most contemporary schools of analytic thinking. As a defense, dissociation becomes pathological to the degree that it proactively limits and often forecloses one's ability to hold and reflect upon different states of mind within a single experience of "me-ness." It is my view that this burgeoning of psychoanalytic interest in dissociation as basic to human mental functioning, and equally powerfully, in the phenomenology of mental-states, reflects an even more central shift that has been taking place with regard to our understanding of the human mind and the nature of unconscious mental processes—toward a view of the self as decentered, and the mind as a configuration of shifting, nonlinear states of consciousness[1] in an ongoing dialectic with the necessary illusion of unitary selfhood.

1. Mitchell (1997a), for example, notes the increasingly strong "currents within contemporary psychoanalytic thought that portray the self as . . .

In my writing over the last two decades I have been developing a clinically-based perspective increasingly focussed on the central role of dissociative processes in both normal and pathological mental functioning, and its implications for the psychoanalytic relationship. Data from many sources, both research and clinical, underline the fact that the human psyche is shaped not only by repression and intrapsychic conflict, but equally, and often more powerfully, by trauma and dissociation. My thinking evolved initially from my treatment of patients suffering from personality disorders, but I believe it to be applicable to any therapy patient regardless of diagnosis. The traditional analytic view of the therapy relationship is that of a process technically designed to facilitate the lifting of repression and the expansion of memory through the resolution of intrapsychic conflict. It is my argument that this view at best underestimates and at worst ignores the dissociative structure of the human mind and has forced us to omit from our clinical theory a central element in how personality growth occurs—an element that is present in every psychoanalytic treatment that is mutative and far reaching—the process through which the *experience* of intrapsychic conflict becomes possible. I am referring to the interpersonal process of broadening a patient's perceptual range of reality within a relational field so that the transformation from dissociation to analyzable intrapsychic conflict is able to take place.

When I first began to publish analytic papers, I wrote quite a bit about the "schizoid personality" and almost nothing about "dissociation," but I've never really surrendered my interest in the concept of "schizoid," either conceptually or clinically. I think, however, that you get a richer picture of people who are schizoid if you take into account that they also have a personality structure that is extremely dissociative yet so rigidly stable that the dissociative structure tends to be noted only when it collapses (see chapter 13). I first began to touch upon this (Bromberg, 1979) in a paper which addressed the fact that the term "schizoid" started as a concept that defined a tendency towards disintegration and was nearly synonomous with "pre-schizophrenic," but was actually much more interesting as an idea designating a stable character structure—at least it was to *me*. What intrigued me was that, apart from its dynamic origins as a mode of escape from

inaccessible, fluid, or discontinuous: Winnicott's incommunicado, private self; Lacan's register of the 'real,' beneath the evanescent shiftings of the 'imaginary'; Ogden's decentered subject, oscillating within dialectics between conscious and unconscious, paranoid-schizoid and depressive positions; and Hoffman's perpetually constructed and coconstructed experience" [pp. 31–32].

certain experiences including, for many individuals, annihilation anxiety, the *stability* of the personality structure is both its most cherished asset and its most painful handicap. I wrote that the mind from this vantage point is an environment—a stable, relatively secure world in which the schizoid individual lives. He is oriented towards keeping it from being rearranged by the outside, but also towards making it as personally interesting and cozy to live in as possible. Insularity, self-containment, and an avoidance of spontaneity or surprise are therefore quite important. A boundary is built between the inner world and the outer world to *prevent* a free and spontaneous interchange beyond the already known and the relatively predictable or controllable.

The mind as a stable, relatively secure world, designed to be as cozy to live in as possible, and structured so that insularity and self-containment prevent rearrangement by the outside, particularly by "surprise"! I had no idea at the time that I was writing about what I would later come to see as a dissociative defense against the "shock" of trauma and potential retraumatization. I was then describing the pathological form of what in every human being allows continuity and change to occur simultaneously and thus makes normal personality growth possible—a mental space that allows selfhood and otherness to interpenetrate, and provides the context for continuity of human relatedness *while* self-change is taking place. More recently (chapter 17) I have come to speak of it as a co-constructed mental space, uniquely relational and still uniquely individual; a space belonging to neither person alone, and yet, belonging to both and to each; a twilight space in which "the impossible" becomes possible; a space in which incompatible selves, each awake to its own "truth," can "dream" the reality of the other without risk to its own integrity. I've suggested it to be an intersubjective space which, like the "trance" state of consciousness just prior to entering sleep, allows both wakefulness and dreaming to coexist. From a more spiritual frame of reference, Roger Kamenetz (1994, p. 28) offers a similar thought in his fascinating cultural excursion to the interface of Judaism and Buddhism. He observes that "dawn and dusk are basic times to pray, because then you have daytime and nightime consciousness at the same time." I am suggesting that psychoanalysis, at its clinical best, facilitates the same interplay between seemingly incompatible states of mind.

Interestingly, there is increasing evidence that this seemingly impossible mental space that is at once uniquely relational but still uniquely individual is not only possible, but has a known neurophysiological substrate. Henry Krystal, for example (Krystal et al., 1995, p. 245), suggests that it may in fact be mediated by alterations in the activity of the thalamus that links "a spectrum of altered states of consciousness such

as hypnosis, dreaming, and other conditions in which there is a combination of the features of sleep and waking states." At the level of personality growth, what Krystal is addressing here is what I call the therapeutic process of enhancing a patient's capacity to feel like one self while being many—the clinical relationship through which bridges are built between defensively unlinked islands of self-experience so that the distinction between what is "me" and what is "not-me" becomes more and more permeable (cf. Dennett, 1991; Kennedy, 1996).

Trauma and Clinical Process

Sullivan (1953) made clear that a child knows what is "me" and what is "not-me" through relational patterns of meaning established early in life. The child's experience of "me-ness," as developmental research has been convincingly demonstrating, is most sturdy when his states of mind are experienced and reflected upon by the mind of an other, particularly during moments of intense affective arousal (cf. Fonagy, 1991; Fonagy and Moran, 1991). If the other's behavior, even if it is not fully welcoming, shows that his state of mind is emotionally and cognitively responsive to what is most affectively immediate in the child's mind rather than tangential to it (Laing, 1962a), the engagement of minds constitutes an act of recognition that allows the child to accomplish the developmental achievement of taking his own state of mind as an object of reflection. He thereby becomes able to cognitively process in the here-and-now, affectively intense and affectively complex moments as states of intrapsychic conflict. Fonagy and Target (1996, p. 221) indeed put it that by the age of five or six a child should normally establish what they refer to as a reflective, or mentalizing mode of psychic reality, and that in order to do so "the child needs an adult or older child who will 'play along', so that the child sees his fantasy or idea represented in the adult's mind, reintrojects this and uses it as a representation of his own thinking."

What Fonagy and Target mean here by "play along" is of paramount importance in considering therapeutic development as well. They put it as follows:

> Our acceptance of a dialectical perspective on self-development shifts the traditional psychoanalytical emphasis from internalization of the containing object to the internalization of the thinking self from within the containing object. . . . The reflective aspect of the analytic process is understanding and not simply empathy (the accurate mirroring of mental state). It cannot simply "copy" the internal state of the patient, but has to move beyond it and go a step further, offering a different, yet experientially appropriate re-representation [p. 231].

In other words, whether parent or analyst, the one who is "playing along" must be himself while being a usable object; that is, he must be engaged as a person in his or her own right and must be relating to the child or patient as such. It is through this that a child or patient becomes capable of retaining a more cohesive self-experience without the felt risk of traumatization leading to pathological dissociation, the failure of symbolization, and impairment of the ability to cognitively represent affectively intense or complex experience within a self-narrative of "me-ness."

Let me underline this point with an observation from another of their papers (Target and Fonagy, 1996, p. 460): "A transactional relationship exists between the child's own mental experience of himself and that of his object. His perception of the other is conditioned by his experience of his own mental state, which has in turn been conditioned developmentally by his perception of how his object conceived of his mental world." Thus, if the other systematically "*dis*confirms" (Laing, 1962a) a child's state of mind at moments of intense affective arousal by behaving as though the meaning of the event to the child is either irrelevant or is "something else," the child grows to mistrust the reality of his own experience. He is traumatically impaired in his ability to cognitively process his own emotionally charged mental states in an interpersonal context—to reflect on them, hold them as states of intrapsychic conflict, and thus own them as "me." Dissociation, the disconnection of the mind from the psyche-soma, then becomes the most adaptive solution to preserving self-continuity.

In this light, psychological trauma can broadly be defined as the precipitous disruption of self-continuity (cf. Pizer, 1996a, 1996b) through invalidation of the internalized self-other patterns of meaning that constitute the experience of "me-ness." Coates and Moore (1997, p. 287) speak of it as "an overwhelming threat to the integrity of the self that is accompanied by annihilation anxiety,"[2] a portrayal I find

2. With regard to annihilation anxiety in treating patients for whom dissociation and dissociative states are central issues, Fonagy and Target (1995b, pp. 163–164) hold that the aim of psychoanalytic treatment is to reduce "the intense annihilatory anxieties that have been evoked by contact in the traumatic past." The authors then go on to draw an interesting comparison between their model of therapeutic change and mine as similarly embracing the view that "the therapist must resist his inclination to correct

vividly accurate for the large number of patients one can justifiably call "trauma survivors."

Psychological trauma occurs in situations, explicitly or implicitly interpersonal, in which self-invalidation (sometimes self-*annihilation*) cannot be escaped from or prevented and from which there is no hope of protection, relief, or soothing. If the experience is either prolonged, assaultively violent, or if self-development is weak or immature, then the level of affective arousal is too great for the event to be experienced self-reflectively and given meaning through cognitive processing. Physiologically, what takes place is an autonomic hyperarousal of affect that cannot be cognitively schematized and managed by thought. At its extreme, the subjective experience is that of a chaotic and terrifying flooding of affect that threatens to overwhelm sanity and psychological survival, but to one degree or another its shadow is an inherent aspect of what to some degree shapes mental functioning in every human being.

In other words, dissociation as a defense, even in a relatively normal personality structure, limits self-reflection to what is secure or needed for survival of selfhood, while in individuals for whom trauma has been severe, self-reflection is extremely curtailed in order that the capacity to reflect does not break down completely and result in a collapse of selfhood. What we call annihilation anxiety represents the latter possibility. Thus, paradoxically, the defensive division of the self into unlinked parts preserves identity by establishing more secure boundaries between self and "not-self" through dissociative unlinking of self-states, each with its own boundaries and its own firm experience of not-self. Consequently, dissociative patterns of relating come to define personal boundaries of selfhood in a very powerful way.

What was formerly normal dissociation, the loose configuration of multiple self-states that enables a person to "feel like one self while being many," becomes rigidified into a dissociative mental structure (the most extreme form of which we know as "multiple personality" or "dissociative identity disorder"), each self now uncompromisingly boundaried within its specific pattern of interpersonal engagement that gives its self-meaning the cast of truth. Because the individual states are defensively and rigidly isolated from one another, the dissociative structure has not only been restored but now is able to protect indefinitely the subjective sense of self-consistency and continuity by locating personal identity tightly within whichever self-state has access to consciousness and cognition at a given moment. The security

the patient's faulty perception of reality and instead create a relationship in which previously unsymbolized experiences can find expression."

of the personality is now linked to a trauma-based view of reality whereby the person is always ready for the disaster that he is sure is around the next corner, and some dissociated aspect of self is "on-call" to deal with it. The price that is paid is that the individual can no longer afford to feel safe even when he is.

Standing in the Spaces

Part of our work as analysts facilitates the restoration of links between dissociated aspects of self so that the conditions for intrapsychic conflict and its resolution can develop. By being attuned to shifts in his own self-states as well as those of the patient, and using this awareness relationally, an analyst furthers the capacity of a patient to hear in a single interpersonal context the echo of his other selves voicing alternative realities that have been previously incompatible. I might add that it is easier for an analyst to speak to several parts of a patient's self in the same moment if he keeps in mind Harry Stack Sullivan's apocryphal though often quoted wish to be spared from a therapy that goes well—his way of dramatizing the fact that a successful treatment does not just perambulate smoothly along while you enjoy watching your patient grow. As most clinicians know, a thriving analytic therapy is frequently the opposite, seeming to move from impasse to impasse while the two participants gain increasing ability to successfully negotiate and make therapeutic use of relational collisions between different aspects of each of their selves. The form of this phenomenon with which analysts tend to be most comfortably or uncomfortably familiar is the inevitable enactment around the "treatment frame," or as I prefer to express it, the dialectic between the "personal" and the "professional" as a central configuration of the transference/countertransference field.

The opposition that patients feel toward entering a professional relationship of such intense intimacy is known to us all, but it is only because the line between "personal" and "professional" is permeable rather than hard-edged that it is possible for the therapeutic relationship we call psychoanalysis to exist in the first place. Enactment, as a phenomenon, occurs in every human relationship regardless of its nature, but it is only the psychoanalytic relationship, because of its inherent ambiguity, that allows enactment to both occur and be analyzed within the same context. When the context becomes overly personal (or insufficiently personal) it loses the paradoxical quality that makes it usable. A relationship cannot analyze itself if it has unlimited freedom to remain perpetually enacted. Enactment will of course still

occur, but it will lack the analyzable collision between the personal and professional elements that creates the ongoing "analysis of the analysis"—the core process that distinguishes it from other forms of psychotherapy. A patient is given room to express himself as freely as he is able, but always within a "professional" frame of conditions established by the analyst. Which aspects of the "professional" frame are openly revealed by the analyst, which are gradually "discovered" by the patient, and which are covertly "managed" by the analyst, are themselves issues that distinguish the nature of the approach adopted by any given analyst. How the professional frame is communicated by the analyst to the patient may vary widely from clinician to clinician, but its existence is always felt as a palpable force by the patient even when genuine elements of it are denied by the analyst.

The collision between professional and personal is often the raw material of enactment. It is experienced as problematic by the analyst only when he is forced out of whatever professional context of meaning he uses to process this experience, and cannot comfortably maintain the professional frame he relies upon to understand what is going on between himself and his patient. As long as his own meaning-context feels like it is still in existence and is accepted as valid (either explicitly or implicitly) by the patient as well, personal feelings are experienced as relatively routine. They do not endanger the analyst's sense of professional identity because, no matter how "personal" they feel, they can remain framed in some manner as "material" to be looked at. It is only when the patient seriously threatens or actually manages to render the analytic situation an invalid means of examining his feelings about what is going on within it that the permeable line between personal and professional has been (at least temporarily) obliterated, and the analyst is feeling helpless in being able either to shift or regain the analytic frame he uses to give these feelings meaning.

Spruiell (1983) described what he called the "rules and frames of the analytic situation" as the analyst's way of protecting himself from the "truth" about his own deficiencies. Spruiell puts it that: "Patients who persistently broach the analytic frame are regarded as 'difficult' patients," and that "sometimes the analyst has to temporarily abandon the analytic frame in order to preserve the possibilities of work" (p. 18). In treating certain individuals, however, the point at which the analyst has to temporarily abandon the analytic frame is often not a matter of choice. Sometimes the analyst is reduced to a state of genuine helplessness and is in the grip of feelings which are experienced as out of control. If, however, he is gradually able to open himself to his full range of self-states in a context where he is no longer "possessed" by

these feelings, his personal reactions to his patient—the previously dissociated quality of what he has been feeling—can then be communicated judiciously and *jointly* processed as not only material but also as "real." Analysts have always considered it a seeming paradox that certain patients start to improve characterologically only when they believe that what is going on is not part of the "treatment." I look at these examples as simply the more dramatic instances of what takes place more subtly in every analysis—an ongoing movement between impasse and repair that allows the gradual creation of a shared "potential space" by providing a patient with increased access to the reality of the "other" without surrendering his own. From my perspective, as later chapters will elaborate in more detail, it is this process through which formerly dissociated self-states begin to become integrated into a patient's configuration of "me-ness" as a cohesive human experience by becoming *relationally* consistent with his own "truth" about who he is.

For this to take place, the patient's experience must somehow or other also be consistent, at least momentarily, with the analyst's own "truth" about who *he* is. And this is not always easy or fun. The reader might guess where I am going, or rather where the last two decades have brought me. As a child I drove my mother slightly crazy by preserving my innerness. But as an analyst I find I have to let my patients drive *me* crazy, to borrow Searles's (1959) felicitious phrasing, by using my innerness as though it were their own despite the fact that at these moments my innerness does not stop being inner to me. Simply put, the patient's effort to "use" the analyst's mind as an object will be inevitably resisted by the analyst, thus allowing the patient to find himself in it by increasingly forcing his dissociated selves into the analyst's mind. The analyst will sometimes feel these as the patient's, but more often will first be in touch with them as his own feelings.

And here let me close this introduction by remarking again on the dialectic between the personal and the professional. At these critical points in treatment, the analyst must contribute to "an act of recognition," but "recognition" is not passive observation. The analyst is always a *participant* observer, and with some patients the analyst's needed participation comes about only—to use again Harold Searles's idiom—through his being made a little "crazy" by his patient. This forces him to experience dissociated aspects of his own selfhood that lead to the recognition of dissociated aspects of the patient's self, and as this oscillating cycle of projection and introjection is processed and sorted out between them, the patient reclaims what is his. Until then, neither patient nor analyst gets much rest. There's a wonderful little

poem by Langston Hughes (1941) that captures it better than anything in the analytic literature:

> Seems like what drives me crazy
> Ain't got no effect on you—
> But I'm gonna keep on at it
> Till it drives you crazy too.

There is a class of personal reactions to certain patients at such times that is unlike any other countertransferential response I have. At those moments I have no doubt about the phenomenon of projective identification as an interpersonal channel of communication. "Why are you shouting at me?" a patient will shout. It matters not that I am "sure" my voice level did not rise. The accusation as I feel it might more accurately have been, "Why are you existing at me?" My experience at such moments, once I am able to process it, is typically a powerful channel through which I know my patient, but unlike empathy (see also Ghent, 1994), the experience does not feel voluntary; it is as if the knowledge is being "forced" into me. The struggle to find words that address the gap that separates us is the most potentially powerful bridge between the patient's dissociated self-states. My ability to use this experience therapeutically depends on my capacity to tolerate it long enough to reflect upon it. Once the words are found and negotiated between us, they then become part of the patient's growing ability to symbolize and express in language what he has had no voice to say.

What a patient is able to hold and symbolize cognitively versus what he must hold without symbolic processing and must thereby enact is the key issue. What is *there* is going to be registered in some form or other, and some unprocessed aspect of it will be enacted. The challenge for an analyst is to make what is there useful analytic material. How an analyst does this is what distinguishes the differences in "technique" between analytic schools of thought, but it is also what distinguishes individual analysts within a given school and, one may hope, the individual analyses conducted by any given analyst.

PART I

VIEWS FROM THE BRIDGE

trying to escape, her head was at immediate risk of being trapped under the car. Nevertheless she didn't feel panic. "My head isn't caught yet," she said to herself, "and maybe it won't be." In fact it didn't get caught, she was able to swim out, and the dream ended.

Her associations led her to say to me both with pleasure and some fear, "I guess not everyone who is scared is scarred. They're not the same." Christina was now able to experience anxiety for the first time and distinguish it from the traumatic dread that had been her constant companion, telling her she was always on the edge of the "black hole." She could now recognize anxiety as something unpleasant but bearable—something she *felt* rather than a way of addressing the world. The dream spoke to the fact she no longer felt herself living "on hold" in a world that required perpetual readiness for trauma, and she allowed herself to be aware that she had begun to surrender the armor of her dissociative defense against the potential return of unexpected trauma the moment she feels she is safe. That is to say, she came to understand that hurt is not equivalent to traumatic destruction of selfhood. She recognized that she was now taking the risk of pursuing a life that included self-interest, and that in choosing to live life rather than wait for it, she had accepted the inevitability of loss, hurt, and ultimately death as part of the deal.

My story of Christina ends here, and so does the book, but Christina's analysis did not. It continued for several more years and, as you might expect, involved intense mourning, not only for the loss of early objects, but also for the self whose life had for too long been unexamined and, in a true sense, unlived. Her dread of "going out of my mind" was replaced by a conviction that she had a secure place *within* it, as I did within hers. As the work evolved she became increasingly stronger, less dissociated, more spontaneous, more playful, and more loving. At the point we ended, as far as I could tell she had most of her selves pretty well in hand and she was using them robustly and creatively in a full life, even, as she put it, "at my age."

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