Potholes on the Royal Road

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Or Is It An Abyss?∗

Jay Greenberg (1995), in an editorial written soon after he assumed the editorship of Contemporary Psychoanalysis, wrote the following:

[A] century after Breuer and Freud announced that they had discovered a cure for some of the world’s most intractable incurable afflictions, little of the familiar foundation of psychoanalysis remains unchallenged. Few analysts today feel comfortable with Freud’s structural model of the mind, or with his technical prescriptions about detachment and abstinence, or with his positivistic philosophy of science. Virtually all the traditional conceptual, clinical, and epistemological premises that guided psychoanalysis through its first hundred years are being called into question. [p. 6]

If this is accurate, and I for one believe it is, where does that leave psychoanalysts who write, now that there is no routine theoretical “mainstream” for an analyst to support or oppose? We are gradually eliminating what used to be our greatest dread, the accusation of being called “unanalytic,” because it is becoming meaningless for an author to be called “unanalytic” when we can’t really agree on what it means to be “analytic.” But take heart—all is not lost. Although this makes writing analytic papers and books a much more humbling experience for the author because there aren’t any “experts” anymore, it also makes writing a much more interesting experience than ever before. Not being so sure of what we know allows us the pleasure of freer self-expression, which, as most of us have discovered the hard way, is interesting not only in the opportunity it offers for growth, but also “interesting” in the sense of the Chinese curse, “May you live in interesting times.”

If we less often write in order to present marvelous new “evidence,”

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clinical or theoretical, that supports or undermines the validity of one sacred theory or another, perhaps the real test of our courage these days is not, like the opening lines of Star Trek, “to boldly go where no one has gone before,” but to boldly go where everyone has gone before—to the office—and let our writing simply reveal, in our own clinical voices, the details of what happened in a particular treatment with a particular patient, in spite of what we did do and in spite of our having believed that we were doing it “right.” Why does this take courage? The main reason, I would suggest, is that some of the most clinically powerful material when read by others, is that which was unplanned by us when it took place, and as we all know, it can sometimes be a bit dicey to share what John Klauber (1980) called (a bit too benignly, I think) “those moments that present themselves to the analyst spontaneously, and occasionally even interpose themselves to his surprise just when he was about to say something else, adding the dimension of a human encounter over and above that of professional and client working together to solve problems of transference and countertransference” (p. 197, italics mine).

Spontaneity and surprise! Sometimes the gateway to our most pleasurable moments of intimacy with our patients, sometimes a Pandora’s Box we wished at that moment had remained shut, but each contributing a life-force to clinical psychoanalysis without which our work would be as productive and creative as painting by numbers. The centrality of surprise to the psychoanalytic enterprise was, in fact, recognized and openly stated more than sixty years ago.

In 1936, Theodor Reik made the startling suggestion—startling only because it was so far ahead of its time—that there is no “royal road” to the unconscious, and if there is indeed a road at all, it is to be discovered most vividly, not in dreams as Freud suggested, but rather in the experience of surprise, in that surprise allows an analyst to find something new that will then create its own technique. “An analyst ought to have learned in the course of his practice,” Reik stated, “that his own unconscious drags all kinds of things from the darkness. . . . It is not necessary for an analyst to be constantly occupied with his plan of campaign during the process. If he is a good psychologist, the blind urge within himself will teach him the right way” (p. 91). Reik, in other words, was proposing that what Freud (1900, p. 608) called the “royal road” is not something that is travelled by the analyst as an “observer of scenery”\footnote{1In an article on the journals of Princess Marie Bonaparte (Goleman, 1985, C2), a number of excerpts were quoted in which Bonaparte records comments allegedly made by Freud, among which is a passage about a European who comes to Japan and sends for a Japanese tree expert to have a garden planted. On the first day, the gardener sat on a bench all day long and did not do anything. On the second day, it was the same. And the same on the third, fourth, and fifth day, all week long. When the European asked when he was going to get started on the garden, the gardener replied, “When I have taken in the scenery.” “It is the same with analysis,” Freud commented. “One first has to take in the scenery of every new psyche.”}\footnote{1}

an objective interpreter of the patient’s associations as observed text. Nor is the patient’s unconscious a destination that is reached as a “goal,” like the pot of gold at the end of a rainbow. The road to the patient’s unconscious is created, and it is created nonlinearly by the analyst’s own unconscious participation in its construction while he thinks he is simply observing it. As Reik well knew, the experience of “surprise” in an analysis is an event that is not just intrapsychic, but is inherently dyadic.

In contemporary terms, some aspect of what is unconscious in the patient is always present in what we call “enactment,” an intrinsic dimension of the ongoing field of shared affect, thought, and interaction that comprise the analytic relationship. It is the enacted piece of each partner’s impact upon the other that makes the royal road a “bumpy road,” and makes it all too evident that the raw material from which the road is constructed is drawn not only from the unconscious of the patient, but also of the analyst. Paving the potholes in the royal road—that is, bringing the bumps from the level of enactment to the level of conscious perception and conscious thought—is at best a trying job, and with some patients it is an uncomfortably sweaty mess that stretches to its limit the analyst’s capacity to endure it. Why do we have to go through this? (Sometimes when I ask myself this question what I really mean is “who needs it?”) The answer I’ve arrived at after many years of climbing out of potholes is that, like it or not, an analysis without potholes is, in the “final analysis,” a pseudo-analysis.

Out of everything I was taught while in training and what I learned in the years thereafter, I think what has most shaped my day-to-day work as a practicing clinician is the continuing echo of “Harry Stack Sullivan’s apocryphal though often quoted wish for God to spare him 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” (Bromberg, 1998, p. 13). It is the bumps in the royal road, what Reik called “surprises,” that provide the greatest leverage for therapeutic action, because they are the most powerful ongoing source of novelty, unpredictability, and spontaneity—the true wellspring of the unconscious— but they are also, as we know, the source of the greatest potential difficulty between analyst and patient,

because surprise sometimes crosses the threshold into shock, the hallmark of trauma. This, I suggest, is what leads to the stressful messiness of certain enactments, an inevitability at one point or another in most analyses, but an inevitability that for some patients can escalate into increasingly problematic enactments, long impasses, eternal therapeutic stalemates, and, often, terminations that both parties know are really “escapes.”

I have found that when an analyst tries to describe his experience of what it is like to be in such a treatment crisis—on a scale ranging from “hard work” to “Oh my God!”—a key factor among the host of variables shaping this experience with a given patient is almost always the degree to which early trauma was an issue for that patient. With some patients (those on the “easier” end of the continuum), as you lurch along the royal road together it feels more or less like encountering an array of bumps or even potholes, some worse than others and sometimes lasting for quite a while, but it doesn’t feel as if they will never end. The analyst is usually in touch with some feelings of vulnerability and his own limitations, but he doesn’t typically feel as if his very efforts to find a solution are somehow in themselves putting his patient, himself, and the treatment more and more in jeopardy and leading things inexorably toward a yet unknown disaster. But then there is a different group of patients—those who typically have a history of severe trauma. With this group, the unrelenting repetitiveness of certain enactments is more likely to eventuate in his feeling his patient getting closer and closer to the edge of an abyss, and he himself moving in the same direction—toward the “blackhole” of madness. These patients do not experience the escalating problem between them as simply bumps in the road—“just” potholes. It is quite a different story for them, and as it unfolds, the analyst’s view of their relationship—and worse yet, his very experience of reality—is destabilized in a manner that makes the term “stressful” feel grossly understated.

To the degree that such a patient hears the analyst trying to frame the event as if it were “just” a pothole, most gestures that would tend to be felt by other patients as an effort to be therapeutically supportive—such as, “I’m pretty sure that things between us will get better eventually”—will make this group of patients only feel worse. The reason, from my perspective, is that the analyst is unknowingly triggering increased feelings of emotional abandonment, because he is dissociating an aspect of the patient’s here-and-now experience in the room—the overwhelming

pain and shame held by that part of the patient’s self that is silently screaming for recognition and relief. At such moments we find ourselves groping for the “right” words; we try out our “best” interpretations; we mutter things about repetition of early trauma; we hint at parental neglect, maybe even parental abuse too early to remember; and of course, there’s always the likelihood of parental depression! Who hasn’t had at least one depressed parent? All to no avail: the patient’s silent scream goes on and, worse yet, gets louder.

“But it must be the parents’ fault; surely it isn’t mine; look how hard I’m trying!” Over and over we are refused the privilege of passing the buck to the parents—those shadowy figures from the past into whom we wish desperately to transfer some of the heat from the not-so-shadowy fix we are in right now. The patient’s anguish feels as if it is filling the room, and we are feeling more and more hopeless about ever finding a way to relieve it or, at least, help contain it.

A bulimic patient, whose dissociated acts of purging were starting to become a more fully conscious experience, began simultaneously to recall and refuse to talk about experiences of abuse at the hands of her parents. She first described it as

"having a pebble in my shoe that I can never get rid of." As she talked about what the experience of the pebble feels like, she began to recognize that the self that holds the secret keeps the secret only because of the pebble. Feeling the pain with me made it real "out there" and served to magnify the pain, because it threatened to betray the perpetrator and, of course, that part of herself that was identified with the perpetrator. It had been tolerable to hurt a person to whom she also felt attached, only if it came from an inadvertent "not-me" betrayal of the family secret through her "symptoms," but it was feeling unbearably shameful to betray and hurt, out of an ego-syntonic need to express her own reality with full awareness. "Why would I want to hurt the people I feel closest to?" she agonized. I, too, felt her agony, and was beset with my own concern as to whether my "help" was inflicting needless pain—hurting the person to whom I felt closest. Ridden with feelings of disloyalty at betraying not only her parents but also that part of herself for whom "goodness" was shaped by protecting the family secrets, she screamed angrily at me during a session following a particularly violent night of purging, "You'll never get me to stop vomiting, and I'll never 'spill the beans.'"

Along with many other contemporary theorists, I see the issue of affect containment as a critical one, but in my own view the most powerful

affect the person is unable to modulate is the experience of shame.

The patient is feeling overwhelmed, not simply by reliving such traumatic affects from the past as anger, fear, grief, sadness, and futility, but by a dissociated here-and-now shame experience that gets triggered by the analyst's unawareness and seeming indifference to the fact that his therapeutic "success" in bringing about the reliving of unprocessed traumatic affect leaves the patient needing relief, but being unable to communicate the need. As in the original trauma, the person from whom a soothing response is needed is the person least likely to offer it on his own, because he is also the person whose behavior is causing the pain. In other words, in the act of trying to help his patient find a voice for dissociated parts of self through reliving unrepresented affect in the here and now, the therapist becomes a person who is placing the patient in a situation whereby their own relationship, and the attachment bond on which it depends, has become more affectively complex and dangerous to the patient than can be safely contained as internal conflict within a single state of consciousness. To the degree that the patient's dissociated shame caused by this unaddressed and unprocessed aspect of their ongoing interaction remains unrecognized by the analyst, the threat of retraumatization is experienced as looming larger and larger to the patient. Because the patient will by and large tend to dissociate this "neglectful" aspect of the therapist, the therapist's own dissociative solution is reinforced, and he usually doesn't "get it" until things escalate to the point where he is forced to feel it through the enactment, whether or not he wants to. The patient, from this vantage point, has simply employed what has come to be his or her most reliable response to a situation in which the person whose behavior is causing the pain is the same person from whom the patient needs soothing. It is a defense against an experience of being flooded with a level of affective hyperarousal that threatens the stability and continuity of selfhood in those individuals for whom self-continuity remains imprisoned by the unprocessed residue of traumatic aspects of early object-attachment.

The experienced pull toward an "abyss," in those patients for whom an "abyss," is a dissociated reality, is due to the fact that the patient's and the analyst's dissociative processes continue to accelerate, unless the analyst

# Wakes up and begins to experience the entirety of the situation consciously. For the analyst, the feeling of its "never ending, no matter what we do" is what makes it feel subjectively as an invasion of our mental stability. For the patient, trying to talk about it has the horrifying effect of making it worse. She can't talk "about" her traumatic experience with a sense of safety, because its lack of symbolic representation means that she will be even more intensely reliving it in a dissociated part of her, no matter how much "holding" the therapist does. In the act of talking about it she will feel it as increasingly taking her over, and will feel shamed by her own desperate need for a recognition of this fact from the person with her, whose "help" is, in a sense, what is causing the pain to increase. To the degree that this need for relief through recognition is unmet—and it is invariably unmet because of its paradoxical nature—it further triggers her shame that the person to whom she is talking experiences her as affirming her need upon him, and enacts the fact that her need for soothing is shameful to her. She will take any and every sign—especially the analyst's "analytic" stance—as evidence that he is repelled by her unreasonable need to be soothed from the pain caused by the very thing they are doing together, and is distancing himself from her at a personal level. Her experience is of being left alone in her distress, and that it is her own fault.

The analyst is, of course, in an impossible bind because he cannot "do" anything about it, and no matter what he tries, he is more and more taken over by the intensity of an invisible assault on his own sense of cohesive selfhood. Experiencing the pain and causing the pain begin to merge, and his escalating failure to "do" something about the patient's pain gradually leads him to become in fact who the patient already experiences him to be. The analyst becomes immersed, dissociatively, in an effort to ward off his own disgust, as if he were being covered with something ugly of which he is feeling uncannily a part. As he begins to lose his boundaries, he becomes a part of the patient's shame dynamic.

The experience is not unfamiliar to most analysts. You feel the patient getting worse and worse right in front of your eyes. You can't do anything about it, but you can't not try to do something about it. So, the more you try the more you feel as if you yourself are toxic and that it is the patient's pain that is making you that way. Your increased efforts to

rescue yourself from the shame caused by this violation of your self-hood, through finding some “correct” therapeutic posture, makes your patient ever more certain that she is overloading you with her awful stuff, and that once again she is too much for anybody to take.

As a rule, the therapist's desperation to find a solution unwittingly perpetuates and often increases the patient's shame, because the patient can feel the analyst getting ever more alienated from her in his efforts to get rid of his own negative affect by getting rid of hers, and she knows experientially that he is unable to just be with her. And indeed, this is so; he is unable to be with her without feeling contaminated by his own dissociated shame in causing the pain—his warded-off experience of himself as hurtful, sadistic, or indifferent. It is only when the analyst "awakens" from the dissociation that he is sufficiently freed from the enactment to address and process with his patient their respective contributions to it, and also process what I believe to be the core affective issue it masks—the shadow of the "abyss" and its threat to selfhood and sanity—sometimes referred to as "annihilation anxiety."

This being said, let us take a closer look at the question raised by the title of this article. As I've written elsewhere (Bromberg, 1993, pp. 185-187), the course of any successful analytic process involves transition from a patient's use of dissociation and enactment in the transference-countertransference field to increased capability in sustaining an experience of internal conflict in those areas where it had been foreclosed or suspended. The analytic process during the transition involves a rebuilding of the links between self and other through the analytic relationship, which brings about a decrease in the patient's use of externalization, projective identification, and what Bollas (1987) calls "extractive introjection" as her primary means of securing dissociative boundaries between self-states. As the use of these modes of protection diminish, there is, happily, a corresponding decrease in behavior that we have come to call "acting-out” and the repetitive treatment crises that evoke the shadow of the "abyss."

In response to something festering in the treatment relationship for too long a time, however, the specter of psychosis can arise in a form that penetrates our very beings. This will happen despite our awareness that, in general, most traumatized patients (including patients diagnosed as borderline) will, as a rule, give the therapist a lot of latitude to "screw things up interactively" without their travelling too far south of the border. The reason that an actual fall into the abyss rarely takes place is that

the dissociative system is designed to prevent trauma from occurring by always anticipating it (see also Bromberg, 1995, pp. 194-195). The felt danger to sanity is if the trauma fails to be anticipated and hits unexpectedly—by "surprise." So the scenario of escape from potential trauma is played out over and over with the therapist, as if the patient were back in the original trauma (which one part of the self indeed is); but this time there are other parts of the self "on call," watching to make sure they know what is going on so that no surprises occur, and waiting to deal with the betrayal they "know" will happen.

Through this enacted scenario of escape from potential trauma, the patient relives "miniversions" of the original trauma with a hidden vigilance that protects her from having it hit without warning. Its effectiveness as an "early-warning system" is dependent on the preservation of her dissociative mental structure, which is designed to preempt any potential for lasting trust, hope, or spontaneity. Thus, these patients rarely, if ever, actually fall into an abyss (nor does the therapist), but with a seriously traumatized patient the experience is frequently one of being "on the edge," with a feeling of real danger.

So, I repeat—what makes it all such a bloody mess is that, if the therapist doesn't allow himself to experience the danger as a real danger and protects himself indefinitely with thoughts like "Oh, it's not going to happen because I know that traumatized patients don't usually go crazy in therapy," then the patient will feel affectively abandoned, because experientially the abyss is really there and looming larger and larger. It is the difference between what we have come to call "the real" and the "really real." For the patient, the abyss is "really real." For the analyst, to the extent that his theory gives him a place to anchor his sense of professional competency (and of course, we all need such a place to stand), he won't allow the abyss to feel too "really real," unless he absolutely has to. Thus, until the analyst is forced deal with a patient's experience as something that gradually permeates its way into his soul in spite of his theories and his logic, the iatrogenic threat of potential retraumatization escalates. This is why the "royal road" at that point is an abyss experientially for certain patients, and "a pothole is not just a pothole." It is an abyss, even though the closeness to the edge is a retrospective falsification—a collapse of past, present, and future that is the hallmark of trauma. As Davies (1996) has cogently put it, "It is not our task to impose meaning ... but rather to stand ready to engage actively with the patient's internal self and object world and to recognize and confirm meaning when

that meaning is offered to us within a shared context" (p. 216). Because the abyss is subjectively an abyss to an aspect of the patient's self that feels it as "really real," if we are to personally live with and know that part of who our patient is, the abyss must become a "really real" experience for the analyst too.

Michael Greene (1954), discussing the work of the philosopher Georges Bataille,\(^4\) puts it in imagery that any analyst might well consider:

> To assume what is not known is like the known, just not known yet, is to shirk an encounter with the radically unknown.... Knowledge is always from the outside, requiring a subject-object relationship.... Inner experience attends to existence from within; it entails not knowledge of the abyss, but being in the abyss. [p. 56, italics mine]

And quoting Bataille himself (1932, p. 45), "Communication takes place only between two beings at risk—torn, suspended, and one and the other leaning onto their nothingness" (Greene, p. 64).

Like it or not, we are often forced to experience the treatment as being in crisis, and we don't know what to do about it. Paul Russell (1998), in fact, argued that treatment crises must occur in most analyses if the treatment is given a chance to develop, because a patient will choose the treatment crisis—the potential rupture of the therapy relationship—to try to convey that which is most important to him. A paradoxical situation arises, Russell asserts, in which the need for some kind of understanding and containment is at its greatest, and is least likely to occur. My own take on this seeming paradox is that it enacts, in essence, an attempt to force the analyst to repair the irreparable. It isn't simply a compulsion to repeat the past; it is a need to repair what is indeed irreparable—a frozen past. Of course, the past cannot literally be repaired, but it is only through the patient's determination that it be recognized and known by the other that the present can be repaired—as long as the "past-as-present" is known by an other who "hangs in," while being forced to go through the no-win situation of failing the patient most at those moments when one is trying hardest to be helpful.

In other words, the analyst's own repetitive efforts to relieve his patient's distress must fail in order for the analyst to know the patient's experience for what it is. But knowing isn't enough; the irreparable must somehow be repaired, and the only way the "past-as-present" can be repaired is within a relationship that repeats the failure of the past, but somehow does more than repeat it. Something new must occur—something that has to emerge out of what patient and analyst do in an unanticipated way. Raising the spirit of Reik once more, we might call these unanticipated relational events "safe surprises,"\(^5\) because it is only through surprise that a new reality—a space between spontaneity and safety—is coconstructed and infused with an energy of its own. The patient's potential for full aliveness slowly increases as the dread of retraumatization decreases, and trust gradually finds its place as part of his or her ever-shifting configuration of multiple self-states that embody the experience of "me-ness." In my own metaphor, the patient can more resiliently "stand in the spaces" between realities by building "bridges" (Pizer, 1998) between dissociated self states that formerly had been islands of incompatible "truth."

This is why, for an analysis to be more than a "pseudo-analysis," the relationship must feel safe, but not "perfectly" safe. If it were even possible for the relationship to feel perfectly safe (which it is not), there would be no potential for safe surprises, because it would never be surprising that the analyst was not behaving, as expected, like a bad early object. In fact, it is not unreasonable to offer this as a plausible explanation of why, historically, all attempts by analysts to cure patients through the technical stance of trying to be a good object have failed in their effort, including that of Ferenczi's "mutual analysis" (see Bromberg, 1994, pp. 262-263). A patient needs a human being as a partner—a human being who can accept his own limitations and failings, and most importantly, can tolerate it if they are pointed out when he doesn't see them. Only from this can "something new" develop as a relational event. In other words, whether or not the "abyss" becomes an issue, the work with any patient must leave space for "messes" and repair to occur, and

\(^4\) I would like to thank Dr. Karl Marshall, who first pointed me in the direction of Bataille's writing.

\(^5\) Edmund Burke considered the phenomenon of "safe shock" (see Edmundson, 1997, p. 30) to be a form of aesthetic experience associated with the "sublime." Burke (1757) wrote the following: "When danger or pain press too nearly, they are incapable of giving any delight, and are simply terrible; but at certain distances, and with certain modifications, they may be...delightful" (p. 86). "Whatever therefore is terrible...is sublime too...for it is impossible to look on anything as trilling or contemptible that may be dangerous" (p. 101). "If the pain and terror are so modified as not to be actually noxious; if the pain is not carried to violence, and the terror is not convulsive about the present destruction of the person...they are capable of producing delight; not pleasure, but a sort of delightful horror, a sort of tranquility tinged with terror...Its highest degree I call astonishment; the subordinate degrees are awe, reverence, and respect...distinguished from positive pleasure" (p. 165).

as most of us are aware, in analytic work there are plenty of such opportunities. Why? Because no matter what school of thought organizes one's basic stance, the intrinsic structure of the analytic situation—the inevitable collisions between the treatment frame and the human relationship—pulls for relational collisions. Enactments are what we count on to make the analysis of transference possible; it is only when seemingly unresolvable treatment crises emerge from enactments that we even question this.
I offer the view that what we experience as a treatment crisis takes place when an enactment begins to become personally problematic for the analyst by arousing feelings that are not comfortably containable within his basic “professional” stance. This leads to the analyst’s hypnoidal disconnection of consciousness from whatever aspect of the relationship is creating the problem by dissociating that part of himself that is engaged in it. Once this happens, he is unable to be fully himself with his patient, and in order to secure the dissociation, he increasingly tries to “manage” the relationship as a substitute for participating in it. His “management” efforts become directed, dissociatively, toward trying to restore himself by finding a “solution” to the disruption in the relationship, and this, of course, escalates the enactment. The patient is trying, equally dissociatively, to force recognition into the analyst through an enactment, which leaves the analyst no place to stand, except in the same mess in which the patient feels caught up. The felt “crisis,” one might say, is when the analyst is browbeared by his patient out of whatever professional context of meaning he is using to keep at bay the affect held by his own dissociated self-states when with his patient, and cannot, despite his best efforts, comfortably maintain the professional frame he relies on to “understand” what is going on.

So, from my perspective, a patient’s need for repetition (the historical “repetition compulsion”) includes as a central element the need to get the “other” (in this case, the analyst) to experience his own part in the failure: that is, fruitlessly trying to help until he is forced to recognize himself as failing his patient in the same way she was failed by her primary objects. In other words, the repetition of the crisis is fundamentally the enactment and re-enactment of a failed communication that has the potential to become a successful communication only if the oppressiveness of the repetition eventually impacts upon the analyst’s communication with his own internal objects, drawing the analyst’s inner world into the enactment. If this takes place, the crisis will make room for “something new” that will bridge past and present, thereby allowing words the opportunity to symbolize what is taking place between and within each partner in a way that is safe enough and immediate enough for the unsymbolized dynamics of the patient’s early developmental trauma not simply to be repeated, but to undergo repair in the process of repetition.

Highly relevant to this last point is Tronick and Weinberg’s (1997) powerful research finding that it is not affective synchrony between infant and caretaker that is the salient factor leading to sturdy personality development, but that “reparation of interactive errors is the critical process of normal interactions that is related to developmental outcome rather than synchrony or positive affect per se” (p. 65, italics mine). They write:

With the experiential accumulation of successful reparations and the attendant transformation of negative affect into positive affect, the infant establishes a positive affective core. ... Specifically, the infant develops a representation of him- or herself as effective, of his or her interactions as positive and repairable, and of the caretaker as reliable and trustworthy. These representations are crucial for the development of a sense of self that has coherence, continuity, and agency and for the development of stable and secure relationships. [pp. 65-66, italics mine]

The significance of this cannot be overemphasized, because it bears directly upon what we contribute that enables our patients to grow, heal, mature, change, or whatever words we prefer. An example of this occurred in a session recently reported to me in supervision. The patient had reached the point in treatment where words were no longer feeling hollow and she could reflect on her experience of what had until then been possible only to enact. “I’m going through all this pain and you’re sitting there looking so peaceful,” she accused. “I feel like you have it to give and you’re withholding it. You could make it better but you won’t. I feel victimized.” Then her state abruptly shifted. “Now I feel like I ought to apologize for feeling that way about you. I don’t blame you; who would want to go through what I’m dumping on you? Maybe I shouldn’t come for a couple of weeks until I stop being like this.”

The analyst at that point offered his opinion that a part of her still needed to preserve her safety in believing that only by finding some way to soothe herself, all alone, could she keep the connection between them from being unexpectedly destroyed. He said he thought that today she was feeling it as a real possibility that he might finally give up on her, and would protect himself from knowing this by sealing-off (maybe behind an artificially “peaceful” facade); then it would be all over, and she wouldn’t be able to change it, and would feel it happened because of her. The patient then responded in a way that was for her “something new”—genuinely linking a real present with a real past. “I get like this,” she said. I got like this a lot as a kid, and would go to my room and hope someone would find me. But no one ever came.”

The paradox, of course, is that until the enactment begins to undergo at least some degree of repair, all of the analyst’s efforts to deal with the patient’s communications at the level of words, conflict, verbal meaning, and genetic reconstruction are experienced by the patient as signs that the analyst really doesn’t want to “know.” The patient’s experience is that the analyst is offering empty words and concepts as a facsimile of “recognition,” while leaving her even more alone and hopeless than before. The internal experience is that of being once more failed, and there being no way to communicate this without escalating the pressure on the relationship and increasing the kind of intense shame that, for many individuals, threatens the very existence of selfhood by threatening to destroy the self-other attachment bond on which selfhood depends. Sometimes repair, in fact, fails to happen and the treatment does indeed fail; but I have found that if the analyst hangs-in, and learns

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while he is hanging-in, even if he isn’t sure he wants to learn or can learn, most treatment crises can undergo repair.

Nevertheless, until repair begins, the analyst’s professional stance—his most reliable asset—is no longer a flexible means of relating to his patient; it has become his own dissociated “truth” to which he then clings (at least for a time), compromising his ability to experience other realities about their relationship, and keeping himself and his patient frozen in their separate islands of truth, treating one another as objects to be managed. To the degree that the patient’s shame is not recognized and addressed by the analyst, the already impaired capacity of the patient to regulate shame is increasingly compromised. There is no way the patient can, on her own, point out the analyst’s inattentiveness to the pain being caused by his efforts to help her “talk about” what needs to be talked about, because the analyst is attending to the “material.” In our vernacular, he is preserving the “treatment frame.” The patient responds by needing more and more to destroy the treatment frame, so as to make it impossible for the analyst to use words, ideas, and concepts as substitutes for “being with” her. The analyst is then gradually forced to feel at a personal level what it is like to be talking to someone and causing her this much pain through pursuing what he holds is right and necessary.

Not a pretty picture of an analyst, I suppose, and at those moments when we are most in touch with other parts of ourselves that are “nicer” people, it will tend to feel like an unfair caricature. The “unfairness” that we feel, in fact, speaks to why the capacity to dissociate is simply part of being human, and why patients and analysts in this regard are no different from one another. In a relationship we value and are trying to enhance, preserve, and protect, when we are simultaneously being forced to experience ourselves damaging it or being damaged by it in a way that is too disjunctive with our self-experience at the moment, the mind’s capacity to defensively dissociate goes into action. Trapped within a shared dissociative cocoon, the analyst is now being forced, little by little, to relinquish his confidence that what he is doing as an analyst has validity. The enactment will continue or escalate until the analyst runs out of ways to “understand” it and out of techniques to deal with it. A classical interpretive stance in such a situation is doomed to fail, because it is simply frustrating without being validating, and this is why such patients have been considered by some classical analysts to be unanalyzable. But what stance does work? Does any? And if not, why not?

Let me offer a clinical vignette that I hope makes it more interesting to think about these questions, even if it doesn’t provide answers. Imagine this scene. A patient (I’ll call him Alec)6 has been in analytic treatment with me for about one year, on the couch, coming regularly to sessions four times a week, and has for several months been more and more openly dissatisfied that the treatment isn’t moving “fast enough.” He can’t describe the details of what “fast enough” means or what the sessions feel like to him, other than to say it feels pointless to just lie on the couch and discuss how pointless the sessions feel. He also asserts that despite his wishing not to come to sessions, he has every intention of staying in treatment, even though he doesn’t quite know why. All he does know is that he wishes he could get something out of it. I’m not feeling consciously uncomfortable with this development (yet), and maintain my curiosity in trying to address this new “material” with Alec,

6 The interested reader is referred to Bromberg (1986), an essay on a somewhat related theme in which an earlier version of this vignette appeared.

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using my own feelings as a source of data, as well as my patient’s difficulty in articulating his. I anticipate that as the transference-countertransference context becomes clearer, the “work” will move along.

No such luck! Alec arrives for a session and tells me that he has joined a group run by a student of Albert Ellis. He informs me (with more enthusiasm than he has shown in months) that he wants to see if he can help the analysis move along faster, and expresses some concern (which he attributes to his own insecurity) that I might disapprove. I’m taken completely off guard by this development and experience some anxiety and mild irritation; but I realize that if whatever is going on between us can be explored, this might start to provide the clarity I’d been hoping for. Determined to maintain empathic contact with my patient’s own viewpoint while inquiring into the interaction between us, I shift my perspective on the situation to one that sees Alec’s behavior as an act of self-expression that requires respect and acknowledgment, though not necessarily agreement. I’m now feeling able to encompass, at least consciously, what I experience as going on in myself at that moment (including my negative feelings toward Alec) as simply “more grist for the analytic mill,” and I’m more curious about my irritation than threatened by it. I say to myself something like, “O.K., Alec will either stay in this rational-emotive therapy group or he won’t, but whatever he does, we will have a chance to explore the meaning of it to him, along with his experience of the fact that I didn’t distance the importance of it to him. Perhaps it is even ‘good’ that he goes.” My anxiety and irritation are, at least for the moment, held in a professionally containable framework of meaning through this empathic identification. I then ask Alec to tell me more details about the feeling of disapproval he is anticipating from me, expecting that this may start to make some sense of both my own and my patient's feelings in the same context.

Alec, however, responds by saying that the additional cost of the group makes him now unable to continue paying for four sessions per week, at least for the next year, and he is going to have to cut back to three. I can now feel myself getting hot under the collar. My anger is now feeling somehow “personal.” I am even able to recognize that my patient's infuriatingly

“impersonal” manner must be a corresponding part of the same context as my own feelings, but the awareness isn't feeling like “material.” The concept of “setting limits,” usually an idea I employ only with great reluctance, suddenly feels like a weapon. I realize that it would be useful to have my own feelings under better control before saying anything further, and decide to wait and remain silent as I think about what is happening. Alec breaks the silence by saying that he feels I'm very mad at him right now and that using the couch feels “wrong.” As I'm considering how to respond to this, Alec sits up and tells me that it feels much better sitting up and being able to look at one another, and in fact he wants to try sitting up for a while. “Perhaps,” he says, “between the group and sitting up, the analysis may move faster.”

I'm now on the ropes. I can feel my own hatred in my body and in every sentence I formulate in my mind but reject saying. I also know that it shows in my face and that Alec, now sitting up, can probably see it. I then decide that if I were able to communicate what I was feeling to Alec, it might be useful, because he might then be freer to deal more openly with what he already sees but can't fully use. I want to place it in a therapeutic context rather than just “unleash” it, and I say to Alec, “I don't know what to make of what is happening between us right now, but I'd like to see if we can make some sense of it from both of our perspectives. How are you experiencing what is going on?” Alec, ignoring my gesture of what seemed to me a more intersubjective stance, replies that he doesn't know what there is to look at, and that now he is totally confused and upset because it feels like nothing he said was understood. “But,” he goes on, “I know that I have so many problems it makes me wonder if I'm seeing this all wrong. After all, I did come to you because you're the expert. Maybe I should have a consultation with another analyst to get clear on that. Would that be alright with you, and would you give me someone's name, since I don't know any other analysts?”

At this point I am feeling totally “possessed” by the out-of-control quality of my own feelings. Alec is no longer feeling to me like a “patient.” He has joined a group representing a rival approach to treatment, is sitting up, has rejected the “transference context as a valid medium for the work, and now wants me to agree that a consultation might be useful and to recommend the consultant. I ask you to keep in mind that at the time, I was already a relatively experienced clinician; I was accustomed to dealing in a flexible way with unanticipated “breaks in the frame” and with severe character pathology. The variable use of the couch, adjunctive types of therapy, medication, changes in frequency of sessions, outside consultations, and so on, were all familiar to me, and in most situations were used successfully, when needed, as part of an adaptation of analytic context. The affect I was feeling here that was so disturbingly overpersonal resulted from the fact that Alec left me no way to respond to what was happening between us as part of any analytic frame that had meaning to me. I was without a place to organize and address my subjective experience within a conceptual frame of reference that could hold my identity as an analyst. My affect felt completely irrational—a “not-me” experience in which every form of response I could think of felt either deceitful, hopeless, punitive, or submissive. I experienced my patient's behavior toward me as somehow hatefully motivated and a successful personal attack on my very being. I was forced out of my professional identity, was now hating my patient in a totally personal way, and could not for the moment regain access to my “therapist self.” What started as a therapeutic enactment had become a potential “abys.” My state of consciousness now held the power of a “personal truth”; “I'm simply doing my best as a good therapist, and Alec is behaving as though everything I offer is either poisonous to him or irrelevant. Clearly, Alec has lost his ‘observing ego.’” I was feeling totally “misunderstood,” and the unfairness was getting to me in a big way. I was held captive within our shared dissociative cocoon, and in this kind of situation we either escape together or neither will escape alone. Some slight temporary relief is, of course, always at hand if the analyst tell himself that his patient is in the midst of a “psychotic transference,” but this is a dangerous path to take, because he might never get off it.

I could go on to describe the further options I considered, how I discovered each to be “wrong,” and how, when I finally ran out of techniques (yes, I did run out) and gave up trying to do the “right thing,” Alec and I ultimately made “personal” contact and openly worked with our respective experiences, including the extent of our undisclosed anger toward one another and the warded-off shame it masked. But this would take me too far from the central point of this illustration, which is that within the analytic relationship, enactments are not worked through by the unilateral application of proper analytic technique, no matter what school of thought it represents, but emerge from each unique relationship as a solution that is not repeatable, even by the same analyst. So, even though I know it's not a very “relational” thing to do, I'm going to let the story of Alec and me end here, with the treatment crisis unresolved, rather than enact the vignette by attempting to “tidy” things up with a “relational miracle” tacked-on at the end so you won't be frustrated by my leaving you with the mess.

But now that I've said that, I just can't resist adding one little piece more—a seemingly minor event that occurred shortly after Alec and I began to relate more fully as human beings. I was feeling deeply moved and personally “changed” by Alec's willingness to hang-in while forcing me to see what I couldn't before acknowledge—that my out-of-control anger protected me from experiencing the dissociated shame held by another part of myself that I could now own. I spontaneously thanked Alec, and he, undramatically and straightforwardly, simply said “You're welcome,” a nurturing moment for me (I felt wonderful), and a

powerful statement of Alec's growth. At that moment, Alec revealed that he felt deserving of being acknowledged for having just given me something valuable, his help, and pleased that I was not "above" being personally enriched by it in the same way that he felt enriched by mine.

The point I am trying to emphasize is not about the technical issue of saying "thank you." It is that shifts in state of mind, whether the patient's or the analyst's, provide the core context for a genuine analytic experience to take shape, and that a shift in the analyst's own affective experience within the ongoing field is not his private property, but belongs to the intersubjective space they share equally. "Gratitude" toward one's patient may or may not be something an analyst routinely will attend to in himself, but it is only one feeling among many about which this is true. Feeling "sorry" that your patient is in acute distress during a session, even though you may also feel that the pain is inevitable, is another.

If an analyst can't recognize that he has been protecting himself against feeling the unprocessed pain being evoked in his patient by what they are doing together, then he can't feel personally sorry—as opposed to "professionally" sorry—about that aspect of it, and his patient is forced to hold onto his unrecognized feelings as though they don't exist. And indeed, they do not exist as part of the self, because dissociated aspects of self will not be "real" unless they come to exist affectively in the mind of the "other." If they are not personally real for the analyst, then they are not personally real for the patient either. Thus, these feelings continue to remain beyond the self defined by human relatedness, and the patient continues his desperate need to press into the analyst's mind the dissociated aspect of self that the analyst is ignoring. This process is what makes the "repetition" of the past not a literal repetition, but an effort to rework the past by forcing the therapist to succumb to that domain of the patient's reality for which words do not exist.

A word about "self-disclosure." Can it be misused? Can it sometimes be intrusive? Sure it can. But I do not at all believe that the analyst's self-disclosure has a defensive meaning inherently packaged with it. I believe that, used judiciously, telling one's patient in words what one is feeling has to do inherently with something quite different. Simply put, if an analyst tells his patient what he is feeling so that his patient can respond to it in his own way, it enhances the coconstruction of new meaning by bringing what is being dissociated in the here and now into the mix, adding to the experiential material needed to symbolize the unspoken. In many, if not most cases of an escalating treatment crisis, if the therapist does not do this, then the patient will more and more feel closed out of what he must possess of himself in order to feel whole and real (as in Alec's case).

I've found in my own work that what I am advocating here addresses the analytic necessity of heedng Nathanson's (1992) position that helping a patient manage his or her affect cannot be done without addressing the moment-to-moment impact of your efforts themselves, and that disregarding the here-and-now effects of your behavior, as though it were just a "technique" being applied, can have the effect of pushing the patient into a far greater degree of negative effect. No "soothing techniques," as such, are in fact required. What becomes soothing is the analyst's invitation to the patient to enter his mind in a personal way, and it is the analyst's genuineness in revealing his experience of their relationship and simultaneously attending to the impact of this that both extends this invitation and provides the safety that leads to soothing the dread of runaway affect (cf. Fonagy, 1991; Fonagy & Target, 1996; Target & Fonagy, 1996).

In my experience, most instances of an analyst's tampering with his patient's reality through the use of self-disclosure come from the fact that the analyst is feeling unsettled with regard to his own ability to sort out what is "real" and what is "not real," and he is trying to ground himself by attempting to define reality for his patient in his own (the analyst's) terms. It is at such times that an analyst is most inclined to bolster his protective system by selecting his favorite version of the different ways that a therapist can convey to a patient "it's your problem," which adds to the patient's shame without the analyst even knowing that he is doing so. He has, in effect, abandoned his patient by abandoning his involvement with the patient's subjective experience, and replacing it with a total involvement in his own—while, I might add, seeing himself as being "helpful." It is this kind of "helpfulness" that invariably accelerates the enactment. The patient reacts to his dissociated sense that his therapist has left him, and feels more and more as if his own need state is toxic, because the therapist is having to defend himself against it, a perception that is in fact accurate.

All in all, I think that the issue of self-disclosure ultimately hinges on whether it is an act of authentic disclosure—showing where one stands—rather than a means of exerting control over the relationship and over what the patient is feeling or thinking. In any treatment, whether a given act of disclosure by the analyst is experienced by the patient as helpful or as controlling is an issue that is engaged again and again as part of the ongoing collision of multiple subjectivities contained within and between patient and analyst. It is important to remember, however, that when the analyst does choose to be open about his subjective experience, there is a responsibility that comes with it. It is not simply enough to hope that the patient will then be equally open about his or her own. The analyst must actively inquire into his patient's reactions, including how it feels to her for her therapist to be so open. In other words, self-disclosure, used relationally, is not a "technique"—an act designed to produce a certain outcome. The therapist is not attempting to put something into the patient as a substitute for the patient's own reality, but is offering an invitation to engage the therapist's experience with her own reality as part of the evolving development of intersubjective space.

Why do I believe this so strongly? Because experience doesn't get symbolized simply through words; it gets symbolized through words that become consensually meaningful in a here-and-now perceptual context. It is when that perceptual context is relationally open on both sides that the construction of a transitional reality will take place most richly, most safely, and lead to the most enduring personality growth; but that is only going to take place by going through "the mess" in which realitites collide, and sometimes collide and collide and collide. As Davies (1998) observed, “associative and dissociative processes exist along a psychic continuum, a nonlinear, nonhierarchical mode of organizing consciousness and unconsciousness that oftentimes determines the direction of our clinical interventions” (pp. 205-206).

There are times, for instance, particularly at the ends of sessions, when the therapist thinks he has had a good hour and the patient leaves and comes back feeling awful, and the therapist doesn't know what happened. From my perspective, one part of the patient's self felt acknowledged. The part that is committed to preservation and the protection of the dissociative structure is feeling unappreciated, alienated,

...and endangered by all this new “wonderful” change that's going on. It feels to that part of the patient's self as if the therapist doesn't want it around, so you hear a voice from this dissociated self-state reminding the therapist not to get too carried away by his own therapeutic skill. It is in effect saying, “You think that everything is OK because you had a good session, but I am not OK; I am very scared.” I believe that this perspective facilitates the work of every analysis, even those we look at as more or less "routine."

For example, a patient came into a session complaining about her step-father, how bad he is, and how her mother was brutalized by him. The theme of that session opened up the idea that the patient's hate may not only be an expression of her own feeling, but also that of her mother. The next session she came back in tears, overflowing with gratitude. "I walked away from the last session" she said, "feeling like I finally understood something that reached right down to my soul. It's something that years and years of previous therapy had never reached. I can't tell you how freed I feel by the insight I had last session."

Right! The next session she came in again complaining about her step-father in the same way. She had only a vague memory of the previous session, and denied feeling liberated by what she had said last time, claiming that anything she had felt was just an avoidance of the "real truth."

I was somewhat stunned to find myself being accused of not being interested in her problems, not wanting to hear how depressed she really felt, and that she felt she was getting nowhere in therapy. Oddly, I felt startled and unprepared for the switch, despite the fact that this sequence of events had happened before. If I'm not willing simply to attribute this "shock" to an intractable denseness on my part (which I can't rule out), I find it plausible to see it as an example of the fact that whenever dissociation is operating in the patient, it is frequently operating also in the analyst.

Paul Russell (1998), whom I cited earlier, proposed that the ambiguous and urgent tension between the present, the past, and the transference creates at times "a critical grey area of ambiguity that includes the therapist's own grey area," during which times "the patient impacts upon the therapist in a way that necessitates that they struggle it out together again and again. The uncertainty," Russell writes, "is a mutual and shared uncertainty."

Any technically organized posture, no matter how empathic or reasonable it is, will thus be obliterated at such points because these situations

...are organized by something that overrides reason—the increased tenuousness of a person's (any person's) psychic stability when dissociated aspects of reality collide. It is these times, Russell asserts, "when the therapist's sanity is most shaky." I would agree, and I also find it a fascinating idea to think about—a treatment experience that, because it shakes up an analyst's sanity, carries the potential for the deepest and most far-reaching analytic outcome, if the therapist allows himself ultimately to enter it rather than control it.

When I myself am in the throes of such an experience and can find enough space to breathe a little, I sometimes find myself wondering if it's crazy to believe that this process actually has some rational piece to it, and that maybe I'm making it up so I can write papers. But then, if I haven't lost my sense of humor, I hear another part of me murmuring in a voice that sounds reassuringly like Polonius talking aloud to himself about Hamlet: "Though this be madness, yet there is method in't. And, don't worry, Philip; on some days you might actually be able to tell which is which."

References

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