Getting Personal: Thoughts on Therapeutic Action Through the Interplay of Intimacy, Affect, and Consciousness

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How do patients internalize new good object experience and how do these previously closed systems open up? What happens within and between analyst and patient that leads to the opening up of affective channels between them and allows consciousness to become transpersonal? The ways in which self-state experience becomes more fluid and cohesive, or less dissociated, is an affective process. This process occurs intersubjectively, as well as between self-states within each individual. When particular self-states come together between analyst and patient, especially those associated with pain and shame, disruption and instability may result within the mind-system (intrapsychic organization) of either or both partners. Managing the affective strain and psychic destabilization are vital tasks for the analyst and patient, in order for relationships between parts of the self (within one individual) to move from pain and hiddenness to compassionate recognition, thereby allowing and facilitating for parts of the self within the other individual to, in turn, move from pain and hiddenness to compassionate recognition. This is a core process of internal life, leading to the development of intimacy between self-states as well as between individuals.

What moves patients from operating within the closed systems of enactments, characterized by old object relational patterns/transferences, rigidity, dissociation, narrowing of consciousness and deadening hypnoidal states, to the open systems of new object relational patterns characterized by fluidity, expansion of consciousness and greater complexity, association, and healing? How do the interiors of our patients become fertile ground for the development of new identifications based on good object experiences with us?

In our understanding of enactment and how we find our way out with patients, we have come to appreciate the role of our own dissociative processes and how these processes align with unconscious aspects of the patient’s internal object world. These dissociated elements arise from the complex interplay of our own internal object world with that of our patient, all within the context of the intersubjective field. The resulting enactments continue on unabated, until one of the partners is able to manage the affective strain and destabilization of identity that ensues, in order for what is dissociated to become conscious. The affective strain and destabilization of identity will,
of course, range between very minor experiences of feeling unsettled to the extremely disruptive and disorienting.

There are two points I wish to make in this paper. I wish to put forward the notion that the development of intimacy and empathic identification between the self-states of an individual may facilitate intimacy, empathic identification, and ultimately compassionate acceptance between the self-states of another individual and that this process is bidirectional and mutually facilitating. I believe that these internal experiences within ourselves move back and forth between the analytic partners through the “interpenetrating mix-up” (Balint, 1968, p. 136) of the interpersonal relationship, potentiating and intensifying the opening up of previously closed off self-state experience. In a sense, when patient and analyst become intimately involved, they each dream the other’s self-states into existence, to borrow from Ogden (2004) and Bion (1962). These self-states contain core truths for the patient to discover about him-or herself, and in a likewise manner, for the analyst. This development of internal intimacy within analyst and patient becomes a central element or process of internal life.

This opening up of closed systems leads us into my second point, which concerns the complicated relationship between affect and consciousness, and how we understand the nature of consciousness as it relates to experiences of interpersonal intimacy as well as “internal intimacy.” As psychoanalysis has transformed into a field theory, we have become increasingly aware of the radical uncertainty (see Bion, 2005; Hoffman, 1998) within which the analyst must function. This uncertainty intensifies affects and may make us more vulnerable, and this vulnerability may be difficult to sustain. I would like to explore the inevitable experience of affective strain that patient and therapist will endure as well as the inherent risk of a (temporary) destabilization of identity, which inevitably occurs during this kind of work. I believe that part of what is destabilizing for us and patients, is the reorganization of self-states, including the opening up/dissolving of old dissociative barriers as well as changes in how self-states relate to one another. There has been much written about affect regulation and its importance in clinical work, and I discuss the interplay of affect with the development of intimacy, both internally and interpersonally, as well as the relationship between affective experience and the changes in consciousness described above.

VULNERABILITY, AFFECTIVE STRAIN, AND THE ANALYST

I wish to focus on one’s relationship to one’s self and to unpack this very complicated subject. A primary reason that we avoid feeling vulnerable, and hence avoid emotional intimacy, with our patients is grounded in our humanity, that is, our instinctive avoidance of experiences that are unsettling, frightening, and potentially disruptive; experiences which will likely lead us into an encounter with what is unconscious for ourselves. Here we enter the territory of affect and our ability to be present and conscious of our own and our patients’ affects. Analysts working from a relational approach will acknowledge more uncertainty, given their own clinical sensibility. Experimental findings suggest that the subjective feeling of uncertainty intensifies people’s affective reactions (Bar-Anan, Wilson, & Gilbert, 2009). This finding has important implications for the analyst’s regulation of her affect, namely, that as analysts enter into the kind of intimate encounters that I am focused on in this paper, they will necessarily grapple with their own intense affects. These affects may or may not register as conscious emotion in the moment.

The late Ruth Stein (1998) thought about affects as being double-edged, that is that affects are both knowledge carriers as well as pleasure–pain givers. She proposed that affective experience
moves along two vectors (in parallel fashion); one of these involves the unfolding and expression of experience, and opening up of that which was previously unknown or unformulated. The other vector involves affect regulation and the mind’s attempts to maintain dissociations. She described these two vectors as relating to each other in a dialectical manner, guided by two principles, the first being the principle of articulation (she referred to as Principle A) and the second being affect sparing (Principle B). Stein wrote, “Protecting consciousness from pain (Principle B) opens the door to develop and expand the self (Principle A), whereas expanding one’s self awareness, including knowledge of one’s feelings (Principle A), enables one to contain more pain (Principle B)” (p. 215). What Stein described is a very complex process, often operating outside of our awareness, and having tremendous influence on how we are relating to ourselves and our patients. These affective processes help to determine what we may allow into consciousness at any given moment, that is, our capacity for awareness from moment to moment.

We must also take into account, as Mitchell (2000, p. 61) noted, that affective states, on the deepest level, are often transpersonal, meaning that intense affective states may be contagious or boundaryless. Our regulation of these affects, both our own and our patients’, along with whatever capacities we have for tolerating affect (see Krystal, 1975) are critical to the work. I like Stechler’s (2003) term “affective competence,” referring to the analyst’s relationship to his or her own intense interior processes and how he or she uses this in the analytic task. It is here that we struggle with our own dissociations, banished from consciousness by shame, anxiety, and fear. Billow (2000) wrote,

“We [therapists] fear the unknown, in ourselves as much as in our patients, and are averse to embracing unconscious as well as conscious emotional knowledge. Dreading the emergence of our primal emotions [i.e., the urge to love, to hate, and to seek knowledge, particularly emotional knowledge (Bion, 1963)], we resist and foreclose the evolution and the consequence of discovery. (p. 422)

For each of us, raising our consciousness of these dissociated self-states requires consistent effort, courage, and a valuing of emotional vulnerability on our parts. Ehrenberg (1996) stated,

I believe that our willingness to risk knowing and being known, touching and being touched by another human being, may be far more important than has been recognized. Perhaps our willingness to recognize the terror this holds for us, as well as for our patients, is critical if we are to dare work at this level. (p. 284)

When previously closed systems open, there is the potential for excitement as well as terror. Along with our patients, we may be more likely to dissociate in these kinds of encounters.

Another reason why analysts may avoid emotional vulnerability with patients has to do with anxiety associated with the potential for boundary violations. In graduate school, one of the constant refrains I heard were professors’, supervisors’, and peers’ dark warnings of “boundary issues” and tales of therapists who had gotten themselves into quite a bit of trouble. Freud observed his colleagues becoming romantically involved with patients when passions were unleashed within the intimate atmosphere of the psychoanalytic relationship. The result was the development of an almost phobic reaction to emotional intimacy between analyst and patient, a legacy of collective anxiety towards intimacy, if you will. This anxiety towards intimacy helped to institutionalize in the training a therapist self state, a mode, a work self, that was just not as vulnerable to being moved by patients as much as the analyst might be moved otherwise (Schafer, 1983, referred to this as the analytic “second self,” p. 291). The notion of a slippery slope tends to frighten us all, so why even venture close to the edge when it could result in complete disaster?
However, what we seldom seem to hear about is the other side: the casualties of analyses that never touch or reach or transform, or conclude with negligible results because the analyst played it too safe. These analyses, although much quieter affairs than the aforementioned boundary violations, may be disasters in themselves, particularly when problematic object relational patterns are merely reaffirmed and calcified through unanalyzed enactments. As an aside, I have wondered if one of the reasons that therapists commit boundary violations is because they have worked out of an overly rigid therapist self state and that that self state is not broad enough or flexible enough to be able to deal effectively with everything that can come up in the very intimate context of psychoanalysis. Just as we need to be aware of the potential for boundary violations with patients that results from too much risk taking, that is, a frame that is too loose, we also need to be aware of the potential for boundary violations resulting from a frame that is so rigid that it creates iatrogenic countertransference dissociation and boundary violating enactment on the part of the analyst.

INTIMACY AND THERAPEUTIC ACTION


Because learning to do analytic work is such a harrowing business, because there is so much intensity, responsibility, confusion, and dread, we work hard to cultivate a version of self that we can recognize as professional, psychoanalytic, and competent. But the most interesting and productive moments and periods of analytic work are often precisely those spent outside that familiar, reassuring professional self—times when confusion, dread, excitement, exasperation, longing, or passion is the dominant affect. (p. 193)

If we think about intimacy in a nonanalytic context, there is always mutual vulnerability and risk involved when people engage each other in this way. Mitchell (1993) wrote, “Intimacy, sexual and otherwise, involves a continual, mutual surrender” (p. 147). In their seminal paper entitled “Why the Analyst Needs to Change,” Slavin and Kriegman (1998) proposed,

A genuine renegotiation, reintegration (an increased experience of “realness”) is far more likely to occur when our patients see what happens when—tapping into the fault lines in our identity, our conflicts—they take us someplace that is obviously hard for us to go. (p. 281)

Ruth Stein (personal communication, 2007) believed that there are times that the therapist needs to experience vulnerability in the session in order to “help move the patient into a place of poignancy.”

Others have written about the analyst’s more-vulnerable-than-previouisly-acknowledged position vis-à-vis the patient. Hoffman (2006) pointed out our narcissistic vulnerability to the patient,
as opposed to “illusions of saint-like interpersonal transcendence and tolerance” (p. 59). Harris (2009) has written cogently about the analyst’s problems with omnipotence as a defense against potent, destabilizing affective states, usually in the form of sadness and shame. Davies (1999) pushed us to consider the importance of the patient’s evolving ability to facilitate a greater opening up in the analyst, including times when the patient provides a holding function for the analyst. She wrote,

> We do not seek to become dependent upon each other; at these points we simply are. The nature of the journey renders us inextricably intertwined for its duration. We create a place of such mutuality and interdependence, for only within such an interdependent place can we truly articulate and define the borders of our own agency and desire. (p. 205)

If we tend to maintain too safe a distance, both from the patient and ourselves, I believe we may deny the patient crucial experiences of deeper self knowledge and the subsequent self-organizational shifts that can occur through intimate relating. Relational analysts have attempted to correct for this overly bounded attitude towards intimacy between the analytic couple. One of the projects of the relational movement has been to examine the question: How do we allow more of our personal selves, which perhaps have not found their way into our professional self, into our work with patients? There will be times in the work where we need to call on those parts of us to be involved, because they facilitate the emergence of a greater range of self organizations within the patient. I want to add that these versions of ourselves, and their corresponding states of consciousness, may or may not have spent much time in supervision, depending on the level of intimacy in the supervision.

In the moments I will be describing, the analyst has unexpectedly shifted out of his or her professional self state and the patient is now seeing a glimpse of a more private, personal, and intimate self. They are seeing a person in the analyst that those who know the analyst in other contexts may or may not be familiar with but that the patient has not previously seen—more vulnerable, spontaneous, more accessible selves. It is the departure from the more routine, known, comfortable modes of relating to each other and the emergence of the analyst’s emotional vulnerability to the patient and the impact on the treatment that interest me here. I want to bring into sharper focus the aspects of consciousness involved in this process of the development of intimacy and empathic identification between self-states, the subsequent development in interpersonal intimacy between the analytic couple and the resulting and parallel development of intimacy and empathic identification between self-states in the other. Although I will be discussing a patient prone to extreme tendencies for dissociation with a history of severe abuse, I believe that the concepts discussed may apply to many kinds of patients and therapeutic dyads.

**MY EXPERIENCES WITH TRUDY**

Let us consider all of these issues as I present some moments from an analysis. These moments I describe are ones that my patient highlighted as particularly meaningful and therapeutic. For me, they were saturated with affect and my own personal vulnerability in a way that contrasted with our more typical interactions.

I want to add that I am assuming that it is understood that I am advocating these clinical approaches against a backdrop of an overall therapeutic context that is bounded and focused on
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the patient. In this sense I am asking us to think about intimacy within the context of Hoffman’s (1998) notion of the dialectical interplay of “ritual and spontaneity.”

Consider the following experiences I had with Trudy, a patient I had been seeing for about four and a half years at a frequency of three times a week. In her early 40s, Trudy is a divorced mother of two and juggles graduate work with her full-time position managing a large pharmaceutical sales force. She first came to me with a worsening chronic depression, along with a habit of abusing painkillers to manage her mood. Through the course of our work, Trudy has come to understand how traumatically cold and distant her relationships with her family members have always been.

There are two experiences from Trudy’s history that had, in a sense, defined her for me. She told me of a time when, as a girl, she was sitting in her room doing homework when suddenly a fireman walked into her room. As he led her down through the smoke-filled first floor and out the front door, she noticed that several antiques were sitting on the front lawn. It dawned on her that her mother had not thought to come get her but instead had sought to preserve these things. There have been times when Trudy has dissociated in the sessions and told me of sexual abuse that occurred when she was 12 at the hands of a neighborhood man. She experiences this abuse as actually happening while talking to me. Trudy never told anyone of the abuse. These are all experiences that we continue to deal with in her treatment.

Early in our work, Trudy had spoken of experiences in which she seemed to know or perceive things that were difficult to explain. She had had these kinds of experiences for as long as she could remember and they had frightened her. In order to deal with her anxiety and fear, she had usually avoided thinking about these times, or explained them away as coincidence. For example, as a child, her family had planned a weekend trip out of town. Trudy remembered how she had complied with her parents’ directive to get her things together for the trip, while simultaneously thinking it to be pointless because of her felt conviction that the trip would not occur. Shortly before they were to leave, her parents informed her that the trip was cancelled. Trudy remembers feeling unsurprised but frightened. Another example occurred when she reported a dream in which she was mingling with members of my family. She mentioned that my father was, to her, conspicuously absent. As we explored her associations, she wondered aloud as to whether my father was still alive. She was thoughtful for a moment and then said, “No, I don’t think he is.” He had in fact been deceased for many years. It seemed important to Trudy to try to understand the meaning of these experiences and her sense that she could perceive in this way. I came to understand these experiences, at least in part, as a hypervigilance and heightened perception born of trauma, and her need to protect herself.

Trudy has always been very careful with me; careful not to intrude or to make too many demands. She is polished, responsible, and very independent. But we are also aware of how dependent some dissociated selves of her can be and her extreme aversion to this dependency. Sometimes I have pushed her to ask more from me, for example, telling her to call me when these selves are panicking about my absence, so that these vulnerable parts of her could be present and participate in our relationship. Slowly, over time, Trudy has taken more risks.

“I’d like to tell you about a dream I had last night,” Trudy said, starting off in her session. “There’s this baby boy in a car seat and he keeps getting out of his seat. He is your baby. There are efforts to strap him in but he keeps getting out. I have a strong sense of sadness about him getting out.”
As I ask Trudy for her associations, she looks down and shifts uncomfortably in her chair and says, “I’m not sure—I don’t really have any.”

“Do you have any thoughts as to what the dream means?” I ask.

There is a long pause. Finally she says, “Well, I don’t think this dream is about me,” she says slowly, “it feels like it has to do with you.”

I am beginning to feel anxious. My anxiety is not so much about Trudy directing the focus onto me but more about the sharp sensation of grief that has now arisen in the back of my throat. You see, I just found out this morning that my second in-vitro fertilization cycle has failed and the carefully drawn veil that has separated my devastation from my working self seems in danger of being pulled back. As soon as Trudy links her dream to me, I immediately associate the baby getting out of the car seat to my embryos not remaining in my uterus. It is a moment that shocks me and I feel unprepared for it.

As my body erupts with grief and sadness, I feel myself trying to hold onto my analytic function and calm myself down. I am afraid my body will betray the raw intensity of what I feel and I work to steady myself. I feel bewildered by what seems to be her accurate perception. Stunned and filled with uncertainty about how to proceed, I also remind myself that my role is to analyze her fantasies. This calms me somewhat. I ask Trudy, “What makes you think this dream is about me?”

“It’s a strong feeling I have that I can’t explain but I just feel certain that this dream is about you.” Trudy pauses and says, “I feel uncertain about talking about this—I’m concerned that it could feel intrusive to you.” She is looking down now. It is a break in the intensity of the encounter and a moment for me to reflect.

There is something about this moment that feels full of possibility. I really feel that Trudy is trying to connect with me in a different and deeper way—she is letting me know that she is aware of something going on inside of me, something that makes me very vulnerable, and that she wants to approach me if I will allow her. I find myself wanting to let her in some way. I am fairly sure that she has perceived my grief in this moment.

Yet there is something else going on here. I am aware of a feeling of danger. As I am struggling with this grief-stricken, vulnerable self now emergent for me, it is not just the intense sadness that I am worrying about containing. I am also aware of a desperate need for reassurance from Trudy. It is as if a part of me is looking to her to tell me that everything will be all right, as if Trudy could somehow know my future and that she can tell me that I will be able to have a baby some day. I feel like a desperate child looking to a parent for soothing reassurance. Disoriented and horrified by these feelings, and not clearly conscious of all that is going on inside me, I pull myself away from these impulses and this vulnerable self. I am able to reorient myself and we spend the remainder of the session exploring her concerns about being intrusive with me.

In contrast to this session the next couple of sessions feel dead. The deadness in the sessions only further convinces me that some opportunity was lost. Something vital has closed down. In the meantime, I have felt more certain about my original reaction to Trudy and I feel ready to be more open with her. I also no longer feel overwhelmed by my own grief. I do not feel so horrified now, but I also do not fully understand how this reaction may connect to Trudy. At this point I have assumed that it is simply a piece of my own personal countertransference needing further reflection. In the next session I bring up her dream of the baby and the car seat. I tell Trudy that I did have an experience the week before that connects with her dream but that I did not feel ready to acknowledge it to her last week. I tell her that I had just found out that very morning that
I had failed to get pregnant and that this news had been intensely disappointing to me. As I say this, I feel my voice breaking and my eyes tearing up and I am trying to control myself. But I am also aware of a willingness within me to show this side of me to her. Trudy has been steadily looking down into her lap, listening intently.

I am concerned about how Trudy is reacting and I ask her what is going on. She looks up at me and says, “This is the first time it’s felt real in here.”

Over the next several sessions we return to talking about what happened between us. Trudy told me that, at the time, she was afraid that she had hurt me and had withheld some further interpretations relating to me of her dream about the baby getting out of the car seat, all of these involving aspects of infertility, pregnancy loss, and me. When I asked what made her think that she had hurt me, she responded that she could see the pain in my face and she assumed that she had, at least partially, caused it. We explored her fantasies and she associated to the characteristic avoidance of emotional engagement between herself and her mother. Trudy explained how her mother would become angry with her whenever her mother began to feel anything beyond her usual blandness. Trudy always had to be careful to stay within the confines of her mother’s very narrow affective range (we can readily understand how impossible it would have been for Trudy to have told her mother about her experiences of sexual abuse). Trudy had hurt me in the sense that she had caused me to become conscious of the pain and to experience a different self in that moment with her, a self that I had left outside of my office before beginning my work day. The inevitability of causing each other pain is, of course, part of the terrain of intimacy and it is our mutual survival which facilitates and deepens intimacy.

When we explored the meaning of “it feeling real” with me, Trudy said she was surprised and pleased that she could remain connected to me while feeling sad without “switching out,” a phrase she has used to refer to how when she becomes emotionally overwhelmed she transitions to another self-state. She remarked, “That’s the first time that’s happened and I’m okay! I know it’s going to be all right.” She described the experience of being able to share in my pain around my pregnancy loss as completely new. She felt that she really needed to experience this loss with me and yet it worried and scared her because she did not want to hurt me and did not want me to recoil from her for making me feel the pain. I said, “There’s an aspect of this experience that I don’t think you’re considering.” She looked up expectantly and I continued, “It doesn’t seem to occur to you that I could have felt deeply recognized by you and that the atmosphere in here became much more intimate in a way that felt good to me.” Trudy smiled and laughed as she said, “No, no, that definitely wouldn’t have occurred to me. I understand what you’re saying but I don’t feel like I have had those experiences and so this is all very new and unexpected.”

There are several possible interpretations of Trudy’s dream, such as a wish that I would be concerned about her as a child, a wish that I would take care of her, her concerns/fears that her infantile wishes could get out of control and her desire for me to help contain her, and probably more. I am also aware that my intense reaction to Trudy could be conceptualized as a projective identification, where I was receptive to identifying with Trudy’s projected dissociated, desperate (likely grief-stricken) child self and that I needed to focus on this aspect of her in these sessions. Why did I believe that it would be best to pursue the dream in the way that I did? I was aware that my reaction, in those microseconds before I could attempt to veil it and contain it, was not lost on her. The emotional cat was out of the bag, even if only at an unconscious level for Trudy. I knew I had to deal with this part of our process, with what had transpired in the field, so as not to simply reenact Trudy’s experiences of her mother’s impenetrability, her avoidance and
repression of any kind of emotional reaction, leaving Trudy to fend for herself in the wake of the relationship’s sterility. At this point in our relationship, I felt Trudy was attempting to push beyond limits imposed by her own transferences, that she wanted to get inside me, to penetrate and to know me.

My clinical choices were also very much contextualized by Trudy’s history of having pre-scient, extremely perceptive experiences and that these experiences could never be talked about with her parents. These choices were also made with the knowledge of Trudy’s sexual abuse and severe maternal neglect as well as her severe dissociation. I felt that Trudy was approaching her dream as a way of knowing something about me. I sensed that there was a conviction on her part that it was about me. Her tentativeness appeared related to her sensitivity about disturbing me as opposed to any uncertainty about her perception. I felt that a meaningful coincidence had occurred and that one possible meaning of the dream was her perception that I was struggling with infertility (she later claimed that she had interpreted the dream to herself in this way but held back from saying so at the time). She wanted me to associate to the dream as if it were my own. I am reminded here of Bass’s (2001) fascinating exploration in “It Takes One To Know One; Or Whose Unconscious Is It Anyway?” when he wrote, “If it is yours, and I can recognize it, mustn’t it be mine as well? And if it is mine, you will know that soon enough as you come to know your own” (p. 685).

I do believe that there were disadvantages to handling her dream in the manner that I did. Introducing my desire and attempts to get pregnant, especially in the midst of her attempts to draw closer to me (by saying the dream is about me), could be alienating to her, in particular, to younger parts of her who have developed or are developing intense maternal transferences to me. Letting her know that I am trying to have a baby of my own could very well send these parts of her further underground, just as they are emerging in our relationship. It is easy to imagine Trudy experiencing competitive envy with my baby to be or experiences of despair that she will be displaced by this baby—will there be room for her baby selves?

In a second example, rather than being flooded with affect and destabilized, my subjective experience was quite different. Trudy and I seamlessly slid into the hypnoidal state of a particularly traumatic object relationship for my patient (and to some extent for myself) that was arid and deadening, yet not altogether unpleasant. It was several months later and a kind of impasse took place during the time period after I became pregnant and had told her about this pregnancy and upcoming planned maternity leave. About six months before my due date, over the course of several sessions, I told her I was pregnant and would be taking three months off from my practice. I also let her know that I could arrange to have another analyst available to see her if she liked, during this time. Trudy was happy for me and appeared to take the news in a matter-of-fact manner. Given my experience with her up to this point, I realized that there were more dependent, dissociated parts of her that would have the most difficulty with my absence (and perceived abandonment) and I remember thinking to myself that I would need to address these parts of her over the next several months.

But we never seemed to be getting to those other parts. Trudy, who had abused painkillers in the past, was now using them again. She also told me that she was “missing time” at work, something that had not happened very often before. Her dissociative symptoms were becoming

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1 Over the course of our work she had seen another analyst during two previous long vacations.
more prominent once again. I became very focused on these symptoms, and I attempted to reach the vulnerable selves whom I believed needed my help in dealing with the emotional upheaval caused by my pregnancy and impending leave, but neither of us was able to access these parts of her. There was a growing distance between us in the sessions, but intriguingly there was a kind of “belle indifference” about this distant deadness for both of us. Looking back now, it seems that we were going through the motions of preparing for my leave, that is, we talked about it frequently but neither of us was really connecting to each other or to selves within each of us that could viscerally experience the separating.

This distance between us continued over the course of many sessions. Over time I was feeling nudged by a dim but growing awareness that I did not feel much about separating from her. I also found it very difficult, if not impossible, to imagine how she felt about my time off or my pregnancy in an empathically connected way. In other words, I knew this was very difficult for her on a cognitive level but I did not really connect affectively. At that point I became very concerned about my lack of feeling. As I began to reflect, I realized that the reasons for my dissociation of this particular identification were overdetermined. I was, in fact, enacting the cold, unfeeling mother who was indifferent to her hurting, vulnerable child. Also, given my own approaching motherhood, it seems obvious why I would not want to see myself as cold or indifferent to another’s vulnerability (D. Mark, personal communication, 2005). In addition, I saw that I was, in a sense, abandoning “children” I had come to care for deeply in order to care for my own child. Upon further reflection, I became aware of an intense guilt about leaving her as well as feelings of vulnerability and extreme sadness. I was able to make some important connections to my own history and psychology, particularly around the guilty feelings. Subsequently I was able to feel many things with regard to leaving her.

In the session following these insights, I told Trudy that we would plan for her to meet with a therapist who was covering for me, that I had already called him, and that we needed to talk about her concerns regarding my absence before I actually left. I know I had said most of these things in previous sessions, as far as talking about her concerns and getting coverage, but I know I was in a very different place emotionally this time. I am reminded here of Davies’s (1999) question, “Who in the analyst will speak in this particular moment?” When I think back now, I know that I had looked forward to talking with her about these arrangements and that I felt a quiet confidence in my ability to manage the situation and soothe her, and help her prepare to deal with my pregnancy and absence. I believe that I now felt a maternal desire towards her that I had not felt since before becoming pregnant.

After this session, she left me with a voice mail, which was unusual for her, and she told me that there was something very different about this session. She said that I was different, that she felt very reassured, and that she knew she would not be taking any pain pills during my maternity leave. In the following session, Trudy said that she had sensed a shift in me and now she wanted to know why I was different. I told her that I had become aware of not feeling things that I thought I either should be or normally would be feeling. I then said that I realized that I had dissociated my experience of being in contact with her more vulnerable, scared selves and that after some figuring out, I felt a shift within me and was finally able to feel.

Trudy was surprised and said that this did in fact fit with a dim awareness she had but that she would have never brought it up to me. I asked her, “Why not?” She responded that she was afraid that she was just imagining it or that I would be angry at her for intruding on me. I told her that just as I had seen in her moments or experiences where she seemed to be dissociating,
that perhaps she could notice and ask about the same in me. “I want you to know,” I said, “that it’s okay for you to ask about these things; in fact I really want you to. I trust you.” There was an intensity of emotion that I felt as I said this and a sensation like an electrical current that ran through my body. I think in part this was because it was a powerful truth that fully registered for me in the moment that I was stating it.

While I was talking, I noticed that Trudy was looking down into her lap. I asked her what she was feeling and she said, “It feels real in here again. I felt this intense feeling in my whole body, like you were filling me up.” “Can you say more about it?” I asked. “I felt like you were giving me something, I don’t know what to call it. I think compassion, maybe love; these words come close but aren’t quite it. I felt like you were really open, like there was nothing in the way to stop me from connecting with you. I’m not expecting that—it becomes confusing—like we have this relationship but I’m not supposed to expect anything more personal from you. But then I think, ‘but if it’s only one-way that would be so dead for me!’ That if we only focused on me, we could learn some things but it would get very boring at some point. I feel like the reason I’m here is that I need these kinds of experiences we’ve had that I’ve called ‘real’—I need this!!”

I let Trudy know that I agreed with her and that I was intensely moved as well. I was becoming aware of how often I had been going back and forth in my own mind about what to disclose, or perhaps I should say who in me to disclose, while maintaining good boundaries. In the first example, when I experienced a desperate need towards Trudy after finding out my IVF cycle had failed, it seems that my shame and horror towards my own wishes for help and reassurance from Trudy, contained within a younger, vulnerable self of mine, helped to potentiate my own dissociation of this vulnerable self, a process parallel with Trudy’s own dissociation. My dissociation of this self was manifested in the sessions that felt dead. I would also add that these enacted experiences of taboo surrounding vulnerability easily meshed with the institutionalized therapist self-state that I discussed earlier. Subsequently, we were able to discuss Trudy’s own internal process and we further facilitated her access to her own vulnerability.

When one considers that a large part of my work with her was to invite in and encourage the more vulnerable of her selves to become conscious in the sessions, it’s fascinating that in these instances, she seemed to be seeking to do the same with me. When Trudy and I talked later about these experiences, she said that part of why these times were so helpful to her was that she could witness me experiencing intense, distressing, disruptive emotional states and that I could survive feeling these things. She associated to her sense of how chronically unhappy her mother seemed but that these feelings never surfaced in a way that was accessible to either her mother or to her.

I want to be clear that I am not simply advocating for the analyst to be more expressive or self-disclosing, but rather that the analyst may need to go to places within herself, places that may expose her to affective states that have been unconscious for her within this particular relationship, or perhaps always. Davies (1999) has elaborated on this point.

DESTABILIZATION, AFFECT, AND EXPANSION OF CONSCIOUSNESS

Going to these places may feel risky, I believe in part, because they are a departure from the current repertoire of self-states the analyst has embodied within this relationship, and perhaps within the consulting room. These self-states for the analyst, as well as corresponding states for the patient, fall outside of the established analytic third (Ogden, 1994) or intersubjective space.
that has characterized and bounded the relationship up until this point. These are the places or points that feel disruptive, frightening, and/or unsettling. Simultaneously there is the risk, for the analyst, associated with moving into states that may feel in opposition to or outside the range of states that fit into one’s identity as “analyst.” In my first example, I move into a grieving, vulnerable state, initially unintentionally, and then later, with intention. In the second example, I become aware of my own dissociation and invite Trudy to notice and help me with future dissociations, letting her know that I have developed a trust in her. In both of these instances, I have experienced major shifts in consciousness. Trudy has also experienced major shifts in consciousness. These experiences subsequently expanded my range of self-states within my relationship with Trudy (not to mention the expansion of my own analytic identity). There was also an expansion of the analytic third, the intersubjective space that has defined each of us, including what is possible for each of us within this relationship. And in turn, Trudy’s sense of identity is changed. She is able to claim as her own, previously dissociated selves. The limits or boundaries of affective, subjective, and intersubjective experience have been expanded and transformed and new kinds of experience, previously unknown, are now possible.

At this point I feel it is important to say something about the risks involved in working this way. To return to the first part of my clinical example, when I became highly anxious and overwhelmed by my grief, my anxiety (which generated the horror reaction) was not about experiencing vulnerability within a bad-object context but actually resulted from my anticipation of experiencing my vulnerability in a good object context. That is, I was viewing my patient as kind, loving, and maternal, and I had become a vulnerable, needy child (internally). I was frightened by the possibility that I could use my patient in this way and, as her analyst, wanted to protect her from this needy, dependent, and vulnerable me. Trudy’s perception of my desire to surrender in this way to her, that is, within a good object context, I believe contributed to a destabilization of her own affective/self-state organization. And here is where the potential dangers lie for the analytic couple. What if I had completely lost control of myself affectively and had attempted to actually engage her as a maternal other in this state? If I had not worked so hard to contain my affect and had instead expressed more fully the raw intensity of what I was feeling, even if it was nonverbal? I believe this would likely have been transgressive and destructively burdensome for the patient. I think that for us as analysts, there is terror or horror at the prospect of completely losing our bearings and collapsing into states that could potentially lead to boundary violations with patients. In addition to the risk of boundary violations is the fear of our patients discovering something shameful in us before or at the same time that we are discovering it (see Maroda, 1999). And yet, if we think about it, relationships with analytic patients are some of the most intimate relationships, and so we should expect these kinds of discoveries.

Several authors have discussed the necessity of disruptive experiences within the analyst in order for real change to occur in the patient. Seligman (2005) used the term “calibrated disequilibrium” to describe what happens at transformative moments in treatments and how working at these unstable points can be a strain on analyst and patient. Seligman stated that skilled therapists know this implicitly and calibrate accordingly. Stechler (2003) referred to “destabilization of the patient’s affective being” (p. 718) and how this can bring about a parallel destabilization in the analyst. He went on to explain how this process is necessary in order for new states to form in the individuals as well as changes in the relationship. Stechler emphasized the pain and anxiety in these moments and how difficult it is for us as analysts to remain open to the experience and the potential for benefit.
THE DEVELOPMENT OF INTIMACY BETWEEN SELF-STATES AND THE TRANSPERSONAL NATURE OF CONSCIOUSNESS

As the relationship between analyst and patient becomes more intimate, the potential for shifts in consciousness in the analyst and patient increase. As others have noted (Bromberg, 1998; Davies, 1998), it is important for the analyst to be willing to tolerate disruptions in her consciousness and allow herself to shift and then to be able to think about the shift. Davies (1998) referred to this internal process as the movement from dissociation to multiplicity. However, I would emphasize that this process, when it occurs in the analyst, allows for various self organizations of the analyst to make contact with each other and to relate to one another in a new way. I think of this critical development as an increase in the intimacy between self-states. This shift involves an increased conscious access to dissociated selves or fluidity (Davies, 1998), as well as the development of an empathic identification between self-states, and often times, a loving connection between these selves within the person (Davies, 2005; Davies & Frawley, 1994). For Trudy, there were self-states that were intensely at odds with each other, even to the point of one state wishing that another would go away or die. There were feelings of fear, repulsion, and other affects that served to maintain dissociation between these self-states. In some ways, I saw my task as seeking a relationship with each of these self-states, recognizing who they were and their importance for the patient, and eventually “introducing” them to others within the patient in a way that facilitated respectful, if not loving, feelings for these parts of her (Davies, 2005; Davies & Frawley, 1994).

In the examples I have given, a self-state characterized by vulnerability has taken the foreground in the work between us. Historically, Trudy has had to dissociate or avoid experiences of vulnerability, both internally and interpersonally, from an early age due to traumatic early object relations. For Trudy, as for many individuals who have experienced early trauma, vulnerability and desire are contained within a child self-state, a self-state who exists in a context of trauma and submission (Davies & Frawley, 1994). There is no or very little linkage between adult self-states and experiences of vulnerability. In the first example, when I felt acute grief over my pregnancy loss, I initially recoiled from this self-state in the session with Trudy. This state was not fluid with my therapist self. Over time, my therapist self was able to claim not only my grief but also the dependency feelings towards my patient associated with this state. I was able to empathically connect with this vulnerable self. This fluidity between self-states is at this point only a potential experience for Trudy. I could now compassionately identify with the part of me that perceived Trudy as a kind, loving, maternal other, and I could recognize this capacity in my patient without becoming overwhelmed by anxiety. The development of internal intimacy within the analyst may lead to a greater intimacy within the relationship between the analyst and the patient. This greater intimacy in the relationship will then very likely lead to a further shift in the patient, parallel to the one which occurred in the analyst, and a similar increase in intimacy, or decreased dissociation, between the patient’s self-states. When the patient experiences the analyst’s movement towards owning what was previously dissociated, there is a facilitation of integration within the patient.

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2There has been much written on the relationship between trauma, dissociation, and affect regulation, and this literature is outside the scope of this paper. The reader is referred to the work of Krystal (1975), Davies and Frawley (1994), and Bromberg (1998), as well as many others. In previous work, I have written on the relationships between dissociation and trauma, affect, and substance abuse (Burton, 2005).
Just as Mitchell (1997, p. 61) noted that affective states are often transpersonal, I am suggesting that consciousness may also be transpersonal. Perhaps it is more accurate to say that, when therapy is going well, consciousness increasingly becomes transpersonal. What I mean here is the development of a greater propensity towards therapeutic regression within the dyad, where states of consciousness flow across boundaries of patient and therapist, resulting in powerful affective experiences, including merger with the other, boundarylessness, and ambiguity with regard to identity. Tronick (1998) noted that “the complexity of the infant’s state of consciousness is not solely dependent on processes endogenous to the infant. As an open system, the complexity of the infant’s state is expandable, with input from an external source—the caregiver” (p. 295). I would add that within this densely affective and intimate relationship, the mother is opened up as well, by her baby, and that the mother’s consciousness becomes expandable via the child’s input. The mother’s degree of openness to her baby would be mitigated by her level of comfort within the regressive pull of the relationship. We can imagine that Trudy, given the severity of her dissociation, is very much a “closed system” and that the operation of her mind is dominated by what Tronick (1989) and the Boston Process Change Study Group have characterized as “self-directed regulatory behaviors” as opposed to “other-directed behaviors.” These other-directed behaviors of infancy form a basis for what may evolve into adult intimacy. We are able to be deeply at home with others as we become deeply at home within ourselves. This development of recognition, acceptance, and compassion for who we are is very much an affective process. And, of course, the development of this recognition, acceptance, and compassion fundamentally changes who we are.

I choose the word intimacy for the purpose of drawing a parallel between the processes of dissociation that occur within individuals and the processes that take place between two people. Intimacy implies a cohesion, whether within the self or between individuals. This word also captures the risk involved in making contact, whether that contact is between two people, or between self-states. The relationships between internal objects are critical to optimal affective regulation and the subsequent capacity for reflective functioning. The closed internal object world of the patient needs to be opened up so that changes can occur, resulting in new relationships between various self-states in the patient. I believe that in the clinical process, and later self-reflective process by the analyst, I am describing, the analyst herself becomes the missing link, emotionally speaking, between the dissociated self-states in the patient; in effect, the analyst’s self-state’s ways of relating to one another may be internalized by the patient. In the moments that Trudy describes as “real,” I have empathically connected to parts of myself that resemble dissociated parts of Trudy. I believe that in these moments, Trudy’s dissociated, younger, vulnerable self has connected with, or become permeable to, her adult self. Conversely, the patient may also become a missing emotional link between dissociated self-states in the analyst. This process takes place through the medium of affect, affect associated with self-states that the analyst may (or may not) more readily access within herself. As the missing emotional link, the therapist is able to help break open the closed system as Benjamin (2004) described it. It is the growing intimacy between patient and analyst that provides the necessary environment for an affective dialogue to take place, resulting in alterations of consciousness.

For Trudy, her sad, grief-stricken, vulnerable selves were dissociated to a severe degree, that is, she had never before been fully conscious of these feelings. When Trudy pulled for and I occupied a sad, grief-stricken, vulnerable self in response to Trudy’s perception that the dream about the baby in the car seat was about me, I introduced into our dyad a self that was closely
related, affectively speaking, to selves in Trudy. I was in fact speaking from this self, with all of
its affective coloring, behavioral appearance, and intersubjective ambience. When I was willing
to bring this self into my relationship with Trudy so that we could talk about it, I had already
done the internal work of linking up within myself. In this sense, I went first (Symington, 1983;
see Davies, 1994) and by allowing this self into our relationship, I was able to link up for Trudy a
concordant self, or identification, within her (Racker, 1968). When this recognition and linking of
her vulnerable selves with mine occurred, there was a subsequent decrease in dissociation within
her and an increase in the intimacy between us. These unbearable affective states, which were
previously dissociated, are not simply transformed into bearable conscious experience but rather
into a new relational intimacy that deepens connections within the self as well as between self
and other.

In the heightened affective climate of the kind of clinical exchange I am describing, the
patient is breathing in this experience. Now the patient witnesses the analyst being vulnerable
not only without traumatic results but experiences the presence of the analyst’s vulnerability as
helping to intensify the experience of intimacy and create a powerful, emotional connectedness
(both interpersonally and intrapsychically). Trudy’s visceral knowledge of her own vulnerability
and desire is then transformed. Vulnerability, previously dissociated within a context of sub-
mission and shame, is now felt as potent, and perhaps even vitalizing. This transformation of
vulnerability into something so completely different and new is powerful and exciting, and desta-
bilizing. Developmental processes of identification may begin anew as these experiences are
internalized.

These kinds of clinical exchanges arrive unbidden. As analysts we are not seeking to be vul-
nerable, but rather I am advocating a degree of readiness to embody one’s vulnerability at times
that cannot be known in advance. If vulnerability and intimacy were prescribed, it would prob-
ably not feel intimate to either party. As I have already said, I believe that Trudy’s experiencing
of my subjectivity, in this case, my fairly intense affective experience which included both feel-
ings of vulnerability and my desire to connect with her in a deeply emotional, personal way,
contributed to a state of disequilibrium of the closed system of her internalized object relations
(Benjamin, 2004; Seligman, 2005). Just as important, Trudy’s seeking out a more vulnerable self
in me and my eventual responsiveness to her, disrupted the closed system of our relationship.
When she saw my eyes tear up and heard the emotion in my voice, it was in this moment between
us that a “dialogue of anxieties” took place, as Seligman (2005) termed it, that is, the how or
when to reveal one’s desire to the other. Paradoxically, my “choice” to reveal myself in this way
felt somewhat out of my control, as Seligman (2005) described when discussing nonlinear sys-
tems, and yet very much my choice at the same time, as Hoffman (2005) emphasized. I believe
that this paradox represents the force of Trudy’s unconscious desire influencing me while I am
simultaneously exerting my own choice to draw closer to her. “I want you to want it to be your
dream” might articulate Trudy’s desire to which I found myself responding (S. Cooper, personal
communication, 2010). So, as Trudy experiences my own potency and choice in these intimate
interactions as well as her own ability to move me (even though this experience may begin on
an implicit level), she is developing her own basis for a sense of potency in her negotiation of
intimacy.

In these kinds of analytic encounters, safety and trust become bidirectional. And so, as the
analyst feels safer, the patient develops an appreciation of the analyst’s vulnerability and needs
for safety, and in the process the patient becomes aware of her impact on the potential for intimate
relating (Cooper, 2000; Davies, 1999; Hoffman, 2006), that is, how she may deepen it as well as how she may shut it down. The patient’s development of the capacity to regulate the other develops alongside her growing ability to regulate herself.

There is something so indescribably powerful, and sometimes exhilarating, about the inter-penetrating atmosphere that is created when two people enter into an intimate engagement. The resulting alchemy yields unexpected shifts in consciousness, penetrates dissociative barriers, and ultimately creates a healing love.

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