"Speak! That I May See You"
Some Reflections on Dissociation, Reality, and Psychoanalytic Listening

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The new emphasis on nonlinear dynamics in psychoanalytic thinking is rapidly changing our view of both psychological structure and psychological growth. The conceptualization of psychoanalytic listening and technique as therapeutically mediating the lifting of repression and the resolution of intrapsychic conflict is reexamined here in terms of new types of questions having to do with such concepts as "self-organization," "states of consciousness," and "dissociation." This paper presents the view that dissociation is as basic as repression to human mental functioning and as central to the stability and growth of personality. Even in the most resilient personality, an analyst will always encounter domains of dissociated experience that have weak or nonexistent linkage to the experience of "me" as a communicable entity. Before these "not-me" states of mind can be taken as objects of analytic self-reflection, they must first become "thinkable" while becoming linguistically communicable through enactment in the analytic relationship. This depends on the analyst's ability to acknowledge the divergent realities held by discontinuous self-states in the patient while simultaneously maintaining an authentic dialogue with each. By "unfreezing" the concrete, literal quality of a patient's discontinuous states of consciousness, the patient is able to embrace the full range of his perceptual reality within a single relational field, so that the process becomes a dialectic.

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An earlier draft of this paper, entitled "Speak! That I May See You: Some Reflections on Psychoanalytic Listening and the Concept of Technique," was presented as The Second Annual Bernard Kalinkowitz Memorial Lecture at New York University on February 25, 1994. It was jointly sponsored by Section V of Division 39 (Psychoanalysis) of the American Psychological Association, and the New York University Postdoctoral Program in Psychotherapy and Psychoanalysis.
between seeing and being seen, rather than simply being seen "into." It is through this that intrapsychic bridges are built between a patient's self-experiences that could not formerly be contained in a relationship with the same object, and a transition begins to take place from enacted dissociative experience to interpretable intrapsychic conflict.

To Thine Own Selves Be True

The following clinical vignette was not written by a therapist but by a physicist. It is from a book entitled Einstein's Dreams (Lightman, 1993), which has to do with the many possible natures of time and the many possible natures of reality that depend on how we experience past, present, and future.

Every Tuesday, a middle-aged man brings stones from the quarry east of Berne to the masonry on Hodlerstrasse. . . . He wears a gray wool coat in all seasons, works in the quarry until after dark, has dinner with his wife and goes to bed, tends his garden on Sundays. And on Tuesday mornings, he loads his truck with stones and comes to town. . . . And as he passes people on the street, his eyes are on the ground. Some people know him, try to catch his eye or say hello. He mumbles and walks on. Even when he delivers his stones to Hodlerstrasse, he cannot look the mason in the eye. Instead, he looks aside, he talks to the wall in answer to the mason's friendly chatter, he stands in a corner while his stones are weighed.

Forty years ago in school, one afternoon in March, he urinated in class. He could not hold it in. Afterwards, he tried to stay in his chair, but the other boys saw the puddle and made him walk around the room, round and round. They pointed at the wet spot on his pants and howled. . . . A clock with big red hands read 2:15. And the boys howled at him, howled at him as they chased him around the room, with the wet spot on his pants. . . .

That memory has become his life. When he wakes up in the morning, he is the boy who urinated in his pants. When he passes people on the street, he knows they see the wet spot on his pants. He glances at his pants and looks away. When his children visit, he stays in his room and talks to them through the door. He is the boy who could not hold it in (pp. 167-170).

What if this man were in analysis? How would we see the nature of his problem? What happened to him that day in school? Is he psychotic? After all, he does hide from his children. Is he "borderline"? Is the therapeutic issue one of shame and pathological narcissism? If so, what is the process through which we might hope to comprehend what he feels as an adult, much less know what he felt as a child? What kind of transference can we expect? I am starting here, because I want gradually to approach the topic of what we imagine we are doing when we do psychoanalysis; what our image is of the human being we are listening to; and what our conception is of the mental apparatus and the personality structure that we are applying our technical skills to engage. In what way was this man's emotional response adaptive to the event, how did it become pathological, and how does one listen to such a man so as to determine why his emotions overwhelmed him and to find a way to help him? Consider what Nesse (1991) has to say about emotions:

[Emotions are set to maximize Darwinian fitness, not happiness, and . . . natural selection has molded each kind of bad feeling to help protect against a specific threat. . . . Emotions adjust a person's response to the task at hand. In that sense they are similar to computer programs, which adjust the setup of the computer to carry out a certain kind of task. . . . The behavioral, physiological and cognitive responses that help a person elude a tiger are different from those that help woo a lover or attack a competitor. Thus, fear, love and anger are highly distinct psychological subroutines gradually shaped by natural selection to improve the person's ability to cope with each challenge. . . . When a tiger bounds towards you, what should your response be? Should you file your toenails? Do a cartwheel? Sing a song? Is this the moment to run an uncountable number of randomly generated response possibilities through the decision rule? . . . How could you compute which possibility would result in more grandchildren? The alternative: Darwinian algorithms specialized for predator avoidance . . . and upon detecting a poten-
tial predator, constrain your responses to flight, fight, or hiding [p. 33].

But human relationships, especially for the young, are sometimes not that simple. What of situations where there are competing algorithms at the same moment? What of a moment when your mother bounds toward you with fangs bared? Or a moment when your father approaches you with penis bared? Or, as in this man’s case, where your peer group suddenly becomes a pack of hyenas, stripping you bare while you are still alive? The algorithm of flight, fight, or hiding pertains only to escape from predators. What does someone (particularly a child) do when there is another strong algorithm already operating, such as “obedience to a parent or an adult,” or “love of one’s caretaker,” or “being accepted by one’s peers”? This is the situation, I suggest, that, at least from an evolutionary standpoint, defines the meaning of trauma, and may explain why natural selection seems to have endowed the human mind with a Darwinian algorithm that helps us cope with trauma by providing what Putnam (1992) has called “the escape when there is no escape” (p. 104)—the mechanism of dissociation. Where drastically incompatible emotions or perceptions are required to be cognitively processed within the same relationship and such processing is adaptationally beyond the capacity of the individual to contain this disjunction within a unitary self-experience, one of the competing algorithms is hypnotoidly denied access to consciousness to preserve sanity and survival. When ordinary adaptational adjustment to the task at hand is not possible, dissociation comes into play. The experience that is causing the incompatible perception and emotion is “unhooked” from the cognitive processing system and remains raw data that is cognitively unsymbolized within that particular self-other representation, except as a survival reaction. Thus, the person retains the capacity to survive by preserving the dissociated “predator” experience in its pure form of deadly assault (or in contemporary terms, “abuse”) and also retains the original self-other representations organized by obedience, love, and friendship, but without the capacity to modify them by appropriate courses of action that take self-interest into account.

Dissociation is not inherently pathological, but it can become so. The process of dissociation is basic to human mental functioning and is central to the stability and growth of personality. It is intrinsically an adaptational talent that represents the very nature of what we call “consciousness.” Dissociation is not fragmentation. In fact, it may be reasonably seen as a defense against fragmentation, and in this regard, Ferenczi’s (1930a, p. 230) struggle with whether fragmentation is merely a mechanical consequence of trauma or may actually be a form of adaptation to it was brilliantly ahead of its time. The answer to his question, however, took 60 years to appear. There is now abundant evidence that the psyche does not start as an integrated whole, but is nonunitary in origin—a mental structure that begins and continues as a multiplicity of self-states that maturationally attain a feeling of coherence which overrides the awareness of discontinuity (Bromberg, 1993, p. 162). This leads to the experience of a cohesive sense of personal identity and the necessary illusion of being “one self.” One of the major reasons that this understanding of the normal mind has taken so long to reach full scientific consciousness is that changes of state are, for the most part, difficult to perceive in normal adults. The developmental process that eases the transitions across states of consciousness typically results in a healthy person being able to smooth out awareness of the changes, an achievement that is greatly facilitated by caretakers who, through a process of mutual regulation, help the child attain nontraumatic state transitions by appropriate interactive responsiveness to the child’s subjectivity.

For psychoanalysts, this view of the mind has been supported by psychoanalytically oriented infant studies such as those by Emde, Gaensbaure, and Harmon (1976), Sander (1977), Stern (1985), Wolff (1987), and Beebe and Lachmann (1992), but the most direct support has come from nonanalytic empirical research into normal and pathological adult mental functioning—research representing a wide range of disciplines and research centers. The director of the Dissociative Disorders Research Unit of the NIMH, in a seminal paper discussing nonlinear state changes as a developmental paradigm (Putnam, 1988), speaks to the fact that the most central property of states is that they are discrete and discontinuous. Asserting that “states appear to be the fundamental unit of organization of consciousness and are detectable from the first moments following birth,” he describes them as
self-organizing and self-stabilizing structures of behavior. When a transition (switch) from one state of consciousness to another state of consciousness occurs, the new state acts to impose a quantitatively and qualitatively different structure on the variables that define the state of consciousness. The new structure acts to reorganize behavior and resist changes to other states. . . . [S]witches between states are manifest by non-linear changes in a number of variables (Wolff, 1987). These variables include: 1) affect; 2) access to memory, i.e., state-dependent memory; 3) attention and cognition; 4) regulatory physiology; and 5) sense of self. . . . changes in affect and mood are, however, probably the single best marker of state switches in normal adults [p. 25, italics added].

Nonlinear switches in discontinuous states of consciousness! The implications are profound. A case could be made, for example, that the reason a state such as depression is difficult to alleviate even with medication is that it is not simply an “affective disorder” but an internally coherent aspect of the self. For many people, it is a self-state with its own narrative, its own memory configuration, its own perceptual reality, and its own style of relatedness to others. It is not simply something one feels—it is who one is, at least at certain times. There is, therefore, as much of a need to preserve self-meaning in this state of being as in any other, despite its painful, guilt-ridden, and often suicidal nature—to not allow any domain of one’s personal reality to be destroyed as though it were meaningless simply because it is painful. The resistance to losing one’s depressive reality is greatest where personality is organized more by a dissociative mental structure than by conflict, because the importance of the feeling of selfhood attached to a given state of mind is greatest when there is least simultaneous access to alternative self-states with other potential perceptual realities and internal self-narratives. So the “curing” of depression must be a process that does not become an effort to cure the patient of “who he is.” Thus, the analytic exploration of the suffering in depression, before it can become accessible to a mutual cognitive perspective in the analytic relationship, must be in a dialectic with a multiplicity of different self-narratives, perceptual realities, and adaptational meanings to the

patient, each of which speaks with its own voice. To put it a bit more poetically, an analyst must be constantly negotiating with a range of self-states with different voices, even when the voice of pain is louder than the others.

“Speak! That I May See You”

“Speak, in order that I may see you,” Socrates is alleged to have said (Reik, 1936, p. 21). Speak, that I may see the speaker hidden in his words. Freud (1913) implied almost the same thing in formulating his basic rule of the free association method. Speak everything that comes to mind, and I will discover the person you wish to hide. But the process of being seen “into,” no matter how benign or well-meaning the motive, evokes what analysts traditionally have called “resistance.” Socrates, in fact, was invited by the Athenians to retire permanently, and though the descendents of Freud haven’t yet been offered the hemlock, most psychoanalysts are wearily familiar with the image of the “headshrinker”—the dangerous “truthsayer” holding a special power to discern hidden secrets inadvertently revealed by the other’s unguarded speech.

Here I present an argument that both supports and challenges this image. I hold that when psychoanalysis is successful as a method of psychotherapy, the reason is indeed to be found in Socrates’ words, but that in any successful analysis the process is a dialectic between seeing and being seen, rather than simply being seen “into.” That is, when optimally effective, analysis simultaneously frees our patients to do unto us, with equivalent perceptiveness, what we are doing unto them, to see us as part of the act of listening to us.

Words begin as carriers. In early childhood they are vocal carriers of personal feeling—an articulated form of a cry (Sullivan, 1953, p. 185). With the onset of communicative speech they are more than carriers; they are also building blocks in the relational construction of personal meaning. They shift from a sophisticated vehicle for relatively autistic expression of what one feels and what one needs, to the primary modality for the interpersonal creation of who one is. Relationally, words in themselves do not exist in time or space. Only the speaker’s meaning exists in time and space; and the speaker’s meaning is

1 I have used the male gender designation in this paper for convenience of exposition. Unless I am referring to a specific individual, it is intended to represent male or female interchangeably.
constructed from a perception of his words framed by the immediacy of the context in which they are spoken. Speaking is an action in an interpersonal context (real or implied). Schaefer’s (1976) concept of “action language” partly addresses this fact, but words—even “action words”—simply point in the direction of the speaker. Ultimately, the speaker must be seen if the words are to achieve meaning.

“Speaking,” in psychoanalysis, is thus not simply a process of delivering content. It is also a relational act that shapes the content of what is spoken about. For patients dealing in a primary way with dissociative experience, this point comes into particular high relief because words themselves feel more or less meaningless. The person carries a sense of internal isolation as his natural state, and trying to convey this in words is experienced as an exercise in futility. But, in analysis, because he is expected to speak, a communicative route can potentially be constructed, sometimes painfully, through the relationship. In the interplay of silence and words, a patient can, at least potentially, force the analyst to give up his attempts to “understand” his patient and allow himself to “know” his patient—to know him in the only way possible—through the ongoing intersubjective field they are sharing at that moment. It is through this medium that an act of recognition can take place in which words and concepts can symbolize instead of substitute for experience. The analyst has an opportunity to recognize (personally know) the thing that cannot be said in words—the quality of subjective experience that makes verbal communication feel artificial and meaningless. But this can take place only if the analyst does not too quickly attempt to translate recognition into understanding, that is, if he does not substitute interpreted meaning for experientially symbolized meaning.

I recently listened to a case being presented to me in ongoing consultation. It may illustrate what I mean. The patient was a woman who had been in treatment for quite a few years and who had made major changes in her life and her self-experience, except with regard to the thing that had brought her into treatment in the first place, her obesity. She felt her weight as a burden that she would carry unto death, with no hope of relief. At the point I entered the case it was her analyst who was feeling no hope of relief, and that was a major reason for the consultation. The situation was quite an extraordinary one and impressed me once again with the fact that when it comes to certain kinds of enactments, it's really a lot more pleasurable to be the consultant than the analyst. As a consultant I'm spared the experience of being personally dismantled by the patient, a fact I feel is critical to comprehend in working as a therapist from this frame of reference. The analyst's willingness to participate in an enactment does not begin as "willingness" in the usual meaning of the term. It is not something the analyst does voluntarily, nor is it something over which he even has much control. It is, in fact, the opposite of what is usually meant by "technique" (something that one "applies" and has command over). The analyst's initial experience of his participation is much closer to the consternation that accompanies projective identification, and the two at times may actually be the same phenomenon with different names. The person "who you are" is perceived as seriously lacking in some way, with regard to the patient, and the more you try to incorporate what your patient is saying about you and use it within your current stance, the more evidence you seem to be supplying of your deficiencies. What the patient is saying in words does not carry the message; the message is carried by the relationship between the words and the experiential context in which they are heard—the way an analyst begins to feel about himself and about his patient as his position feels more and more uncontrollable within his natural stance and sometimes within his self-definition as an analyst.

This phase is not (and should not be) a pleasant experience for the analyst. If it is—if the analyst is feeling satisfaction from his willingness to be "used as an object" (Winnicott, 1969)—he is not really being used at all, at least not yet. The patient's need is to perceive and confront the analyst with what is perceived that has been known but unthought. This process involves a dismantling of aspects of the relationship that patient and analyst have used to define who they are to each other. In effect, it means that the patient is "destroying" aspects of the analyst's identity, who he is to himself, as defined through that relationship. Loewald (1979) calls it "emancipatory murder" (p. 758).

In the case of the patient I mentioned, whose treatment I had been following, the dismantling took place around the analyst's "failure" to mention the patient's weight when she herself wasn't mentioning it. "You ought to know," the patient insisted, "that when I'm talking about anything else as long as I'm still fat, it's only my good self that's talking and that I'm doing something self-destructive that you're not even
caring about." In fact, the analyst cared a great deal about it, as you might well imagine. It was the one painfully overt sign that something still needed to be "cured" and that talking hadn't helped. So the analyst had decided (on his own) to stop addressing it because he was tired of getting nowhere (kind of "fed up," you might say) and hoped that the patient would then bring it up herself. He allowed long silences to develop in which he hoped that she might ultimately put what she was feeling into words. Well, she did, but not in the way that he had hoped. As he was finding the silences increasingly hard to tolerate, she, without the least regard for logic, told him he had no right to stop trying to find out what she was feeling, and "what did he think he was doing?" This is not a situation in which a therapist can just sit back and comfortably do his work (at least, he shouldn't be able to). It was in the course of their dealing with the apparent "no-win" quality of his "failure" that he was able to begin to find a small island of shared experience on which he could plant at least one of his feet. It was at this point that the patient began to be able to "back off" from her concrete state of consciousness and to develop a cognitive perspective through which the "unthought known" (Bollas, 1987) became the thought known and through which the analyst could authentically experience himself as a willing participant.

"Only in my silence," the patient stated, "do I feel real. The only way I can get out of here is to be silent for a year." What she meant consciously by "here" was "here" meaning her inner world, and, unconsciously, meaning the analysis. But let's stay with what, at that moment, she was able to render conscious. How could it make any sense that the only way she recognized that she could release herself from the trap of her dissociated mental structure was without words, by remaining silent for a year? The point she was making was not that silence itself mattered, but silence in the presence of her analyst. Why? Because her silence in his presence could have a communicative impact—as long as he hadn't given up trying. This is the essence, I think, of the "projective identification" phase of enactment. The analyst has to get fed up; it is important that he get fed up; he should get fed up. But he shouldn't get so detached from his own "fed-upness" that he cannot perceive the retaliatory component of his behavior. If he is open to that, he will feel the communication from the patient as it is pressed into his soul through her silence as well as into his brain through her words. The patient was ultimately able to put into words this remarkable insight:

When I'm not talking to you and you don't realize that my silence is talking, I feel like I'm hurting myself and you don't care. I hurt myself by being fat in order to call attention to the inside "me." And if you don't notice or seem not to, it's like you're mad that I'm still fat and will let me hurt myself because I'm fat instead of putting why I'm fat into words. But if I do talk, it's not my fat self that's talking. So you have to find her by noticing the fat and not pretending you don't. If I get thin, no one will ever look for her because if I stop calling attention to her existence you will settle for my good self, which looks healthy because it is thin, and you will never know it isn't real to me. I'm like Dr. Jekyll and Mr. Hyde. [Shortly, the HYDE/H-I-D-E pun became clear.] Or, like with Clark Kent and Superman, the two parts never get into the same room at the same time because they're the same person.

In other words, by "noticing," through the impact of forced involvement with what the patient needs to call attention to without communicative speech, the dissociated self can start to exist, and a transition begins to take place to what this patient so evocatively described as a growing awareness of "Mr. Hyde." But the success of the transition depends on the ability of the patient to destroy successfully the analyst's conception of "what this is really all about" and thus destroy the analyst's image of the patient in which Mr. "Hide" is imprisoned. The analyst's own self-image, which is a part of all this, is also destroyed, and it is this destruction he must "survive" in Winnicott's (1969) conceptualization of object usage.

In this context, analytic listening might be compared to approaching a patient's words in the same manner that Henry Adams (1904) advocated in appreciating medieval architecture—as if one were approaching medieval poetry in the troublesome "roughness" of the original language in which it was written. Adams wrote, in his delightful book Mont Saint-Michel and Chartres:

Translation is an evil chiefly because anyone who cares for mediaeval architecture ... ought to care still more for mediaeval
English... Anyone who attacks them boldly will find that the [verses] run along like a ballad, singing their own meaning, and troubling themselves very little whether the meaning is exact or not. One’s translation is sure to be full of gross blunders, but the supreme blunder is that of translating at all when one is trying to catch not a fact but a feeling. If translate one must, we had best begin by trying to be literal, under protest that it matters not a straw whether we succeed [pp. 18–19, italics added].

An interpretation is a translation, and what is reflected in an interpretation is the analyst’s personal view of the patient, which is one of many possible realities. At the moment the patient is looking at himself through the analyst’s eyes, he’s also looking at the analyst in a very personal way. The ability of the patient to accept the image of himself that the analyst is offering is directly influenced by his ability to trust his perception of the person presenting it. So his rejection of the interpretation is not only a rejection of a view of himself but also a rejection of an unpalatable view of the analyst—a view in which he experiences the analyst as asking him to substitute, without sufficient negotiation, the analyst’s subjectivity for his own. Within normal limits, this is simply part of the natural process of “trying to stay the same while changing” (Bromberg, 1991), but if the analyst’s interpretive posture attempts to conceal his own subjectivity while simultaneously attempting to deny that there is anything there to see, a collusive masquerade takes place. The patient seemingly accepts or resists as objective “reality” the language into which the analyst has chosen to translate the patient’s original verses (the analyst’s personal view of the patient), under the guise of its being a reflection of what is “really there” that the patient does or does not want to see.

Dissociation, Enactment, and Reality

I have essentially been arguing for an interpersonal and intersubjective listening stance, a viewpoint that many analytic writers, myself included, have passionately advanced for some time. In the remainder of this paper I would like to try to develop this position along somewhat different lines and present a few ideas that may help its progress toward what I feel is its most likely next step. To do that I want to return in greater detail to the phenomenon of the human mind as a complex system of discontinuous and shifting states of consciousness and examine the impact of this nonlinear model of the mind on the way we think about psychoanalysis as a theory and the way we think about psychoanalysis in “how we listen and what we do” while with our patients. As will be clear from the following anecdote, I personally find the normal nonlinearity of the human mind a mystery that continues to amaze me.

I recently took a cab ride that, among other things, cured me forever of complaining about taxi drivers who can’t speak English. The driver, who was listening to a radio station broadcasting a soap opera in Spanish, would at each red light pick up a newspaper from the seat next to him and start to read, while at the same time clearly following what was happening in the soap opera. I had just begun to feel irritated that he wasn’t even pretending to concentrate on what I was paying him for, his driving, when I looked at the newspaper and saw that it was in French. My irritation was replaced by a combination of envy and disbelief. “Is the human mind really capable of simultaneously processing different content, through different perceptual channels, in different languages? And even if it were, wouldn’t it be more natural (not to mention easier on the brain) to choose one or the other?” So I asked him about it, in English. He replied—in English easily as fluent as mine—that he never thought about it before. He’s lived in different places and speaks different languages; that’s all. He definitely didn’t want to get into a discussion about what language he thinks in, what language he dreams in, and whether he could do the same thing if the radio program or the newspaper were in English. He didn’t really want to “speak so that I might see him.” I think he had too many other things to do, but also he was afraid I was going to try to nail him for reading while he was driving. So I lost a potentially valuable informant, but I continue to wonder about it.

A recent paper in the American Psychologist (Barton, 1994) starts with the statement that “a new paradigm for understanding systems has been gaining the attention of psychologists from a wide variety of specialty areas” (p. 5). The paradigm, which describes the behavior of complex systems, is known as nonlinear dynamics, or Chaos Theory. It is a science without an implication of “prescribed” sequences, but
rather with a set of necessary and sufficient conditions to allow the construction of something different from the past pattern, but unpredictable as a future event. It postulates that complex systems (like the human mind) have an underlying order, but that simple systems (like a human interaction) can produce complex behavior. In theory, you could predict the course of an interaction far into the future, but in fact you can’t, because almost immediately very small effects start to make a difference and will eventually lead to unpredictable behavior. Gleick (1987) described the heart of the discovery as revealing that “chaos and instability... were not the same at all. A chaotic system could be stable if its particular brand of irregularity persisted in the face of small disturbances” (p. 48). He went on: “[C]haos brought an astonishing message: simple deterministic models could produce what looked like random behavior. The behavior actually had an exquisite fine structure, yet any piece of it seemed indistinguishable from noise” (p. 79).

The new emphasis on nonlinear dynamics in psychoanalytic thinking is particularly well captured by a changing view of mental structure, both normal and pathological. The conceptualization of personality growth as therapeutically mediated by the lifting of repression and the uncovering of unconscious conflict is being reexamined in terms of new types of questions—questions that have to do with such concepts as “self-organization,” states of consciousness, dissociation, and the readiness of the human personality to exhibit, in Barton’s (1994) words, “multiple self states that can change suddenly from one to another when a parameter value crosses a critical threshold” (p. 8).

Even in the most resilient personality psychic structure is organized by trauma as well as by repression, and an analyst will always encounter domains of dissociated experience that have weak or nonexistent links to the experience of “me” as a communicable entity. Before these “not-me” states of mind can be taken as objects of self-reflection, they must first become “thinkable” while becoming linguistically communicable through enactment in the analytic relationship. Until this happens, neither genuine repression nor the experience of intrapsychic conflict can take place, because each state of consciousness holds its own experientially encapsulated “truth” that is enacted over and over again without the availability of the necessary conditions for cognitive resolution. Chu (1991) has described the issue vividly and succinctly. He states that trauma that has been dissociated is repeated

with a compulsive quality that takes on an almost biological urgency, and that

patients are thrust back into the traumatic events both in their dreams and while awake. ... The reliving of the trauma is experienced as a real and contemporary event. That is, the patient does not talk about feeling as if he or she remembers the experience; rather, he or she feels the experience in the present. ... Therapists are all too familiar with the difficult task of attempting to help patients keep one foot in current reality at the same time as they experience the past [p. 328, italics added].

In analytic listening, regardless of whether we use the term “reliving” or “enactment,” each state of consciousness is signified by its own relational context. While one narrative is being “told,” another is being played out between patient and analyst while the telling goes on. Levenson (1982) has gone as far as to state that “analyzing the relationship between what is talked about and the behavior that goes along with what’s talked about constitutes the psychoanalytic process... and is what distinguishes it, essentially, from all other forms of psychotherapy” (p. 11, italics added). This, to me, is also what Winnicott’s (1967) concept of “potential space” is all about—the interpersonal construction of reality in which playing with meaning (deconcretizing it) becomes possible. It is why parapraxes are so wonderful! Not because they provide a window into what a patient “really” believes, but because they allow opposing realities held by different self-states to coexist, and mutuality can increase simultaneous access to a fuller range of self through the analytic relationship.

For example: A 40-year-old male patient, a widower early in life, was furious and self-righteous because his current girlfriend had refused to accept his claim that he could not marry again because of his religious conviction that his original marriage was a holy covenant. “She won’t believe,” he shouted, “that I really care about preserving the sanctimony (sic) of marriage.” Did this delightful slip lead him to replace his religious conviction with a new image of it being nothing but self-serving and hypocritical? No! But it was funny enough to each of us that we could work with both words in a way that produced another “slip,” which led to the emergence of a dissociated self-state
that held the memory of why the religious conviction was so important. The second parapraxis was: “When I think of forgetting my wife, I feel so selfish that I’m afraid God is going to punish me. The world feels like it will come to an end, so I can’t cut the “un-biblical cord (sic).” As we “played” with this one together, he became in my presence the traumatized five-year-old boy whose world had felt as if it were ending when he was sadistically punished by his mother for wishing to leave her in order to live with his beloved aunt. To “teach him to be good,” he had been placed in a children’s home overnight, having been told he would have to stay there “for as long as it took to learn his lesson.” He relived, in interaction with me, the terror of this dissociated experience and the pact he had made with God never to be bad again if God would only let him come home. For the first time in his treatment, this 40-year-old man was able to meet the frightened five-year-old who accompanied him to every session and for whom the therapy itself was nothing more than a different version of the children’s asylum from which he was waiting to be released.

If an analyst thinks of a person as speaking from different self-states rather than from a single center of self, then the analyst will inevitably listen that way. It demands an overarching attunement to the speaker, an attunement that addresses the same issue described by Schafer’s (1983) mode of listening and interpreting in which “the analyst focuses on the action of telling itself . . . [and] telling is treated as an object of description rather than . . . an indifferent or transparent medium for imparting information or thematic content” (p. 228). From a nonlinear perspective, however, this means a special attunement to both the impact the speaker is having on you at any given moment and the shifts in that impact as close to the time they occur as possible. Obviously I am looking at the shifts as representing shifts in states of self that are to be held by the analyst as an ongoing focus of attention. It is a way of listening different from that of hearing the person feel differently at different moments. The latter takes the switches in states of consciousness as more or less normal background music, unless they are particularly dramatic. The former takes them as the primary data that organize everything else you are hearing and doing, including how you approach the issue of unconscious fantasy and the reconstruction of personal narrative. We speak of a person as being in different “moods,” or as being emotionally “labile,” or as not being “himself.” These metaphors are useful, particularly with certain patients at specific moments. But because they are based on a conception of affective shifts as emanating from a unitary, centered self that is temporarily decentered, an analyst’s traditional posture and listening stance has tended to focus on the content of mental states without particular regard for the basic discontinuity in structural context—the states themselves. What an analyst hears has thus tended to be organized by a search for continuity between conscious and unconscious meaning rather than by a dialogue between discontinuous domains of self-meaning held by a multiplicity of states of consciousness, some of which can be told and some only enacted. I am offering the view that for any human being, feeling differently at different moments about the same thing, or “getting into a mood,” represents a shift to a state of consciousness with its own internal integrity, its own reality, and sometimes its own “truth.”

The challenge for an analyst is in being aware that with every patient some state shifts have minimal or no link to other states of consciousness, even to those that may have just preceded the change. The change points are moments that sometimes may indeed signify the presence of an interpretable state of conflict and at other times may herald the emergence of a dissociated domain of experience. In a personality that is significantly organized by dissociative protection against trauma, there is, of course, a greater likelihood that an affective shift signals the presence of a self-state that not only is disjunctive with the one preceding it, but also is relatively inaccessible to it. But even in a patient without a diagnosed dissociative disorder, a shift in self-state may signify the absence rather than the presence of a state of conflict even though the patient may appear conflicted because the content has remained the same. In such instances, what the analyst may be conceptualizing as “externalization of conflict” is often precisely the opposite—the presence of a dissociated self-state that cannot yet experience intrapsychic conflict, much less externalize it. From a nonlinear listening stance, shifts in states of consciousness are firstly viewed by the analyst as moments of recognition, exploration, and potential negotiation within the transference-countertransference field and only through this process as genuine windows for conflict interpretation and resolution.

Once again, language does not merely carry meaning, but constructs it as a relational process. The analyst’s goal is not to bring the patient
to a point where he can eventually accept a “delivered” interpretation and to assume that, if such a point is in fact reached, it means that the interpretation has already been made. It was “made,” in the sense that it was “constructed,” in interactive exploration of the multiple realities of opposing self-states held by patient and analyst, rather than “made” (as in “delivered”) by the analyst. The result is not literally a “new” reality and most definitely not the correction of a faulty or distorted “old” reality. It represents a linking of opposing subnarratives held by different states of consciousness that have been dissociatively inaccessible to an experience of internal conflict. Psychological integration, as I have suggested elsewhere (Bromberg, 1993), does not lead to a single “real you” or “true self.” Rather, it “is the ability to stand in the spaces between realities without losing any of them . . . the capacity to feel like one self while being many” (p. 166).

The patient’s ability to move from dissociation to conflict depends on the analyst’s ability to relate to several selves simultaneously while maintaining an authentic dialogue with each. It is through this process that relational bridges are built between self-experiences that could not formerly be contained in a relationship with the same object. Because, however, the conception of the human mind has been anchored in linear, rather than nonlinear, dynamics, each major school of thought has had its own emphasis in accounting for the therapeutic action of psychoanalysis. One could say that, despite the effort of every experienced analyst to maintain a clinical balancing act, the stance of any given analyst has tended to slant toward one of three postures partly organized by individual differences in metapsychology—interpretation of conflict, detailed inquiry, or empathic attunement. It is interesting to observe, however, that built into each posture, regardless of differences in theory, is an acceptance, based on its own clinical logic, of the fact that the transference—countertransference field is where the action takes place. In other words, any analysis from any theoretical context that has as its goal enduring and far-reaching characterological growth is grounded in this understanding. Why?

Clinically, the transference—countertransference field is characterized by its vividness and its immediacy. But why is this fact so important that it is able to transcend metapsychology in the best utilization of this field? My own answer is that, regardless of individual metapsychologies of therapeutic action, every school of thought clinically attempts either explicitly or implicitly to enhance perception, to facilitate a patient’s access to the broadest possible range of consciousness by reducing the use of dissociation. The patient, through one technical approach or another, must be freed to see the analyst while the analyst is seeing the patient. “Speak, that your patient might see you,” in order that his dissociated states of mind may find access to the analytic relationship and be lived within it. Dissociated domains of self can achieve symbolization only through enactment in a relational context because experience becomes symbolized not by words themselves but by the new relational context that the words come to represent. Judith Peterson (1993) has addressed this in her cogent observation that many steps are necessary in order to move someone from a dissociative state to an integrated one. . . . However, the therapy [does] not consist of Freud and Breuer’s definition of abreaction, nor of discharging emotional energy to release repressed ideas. . . . The focus is not on abreaction but on the change points or moments in therapy where cognitive insights, reconstruction or blending and integration occur [pp. 74–75].

Particularly illustrative of this focus in my own work (Bromberg, 1984, 1991) has been the direct appearance in sessions of the Isakower phenomenon (Isakower, 1938), a dissociated autosymbolic hallucination that typically occurs in the twilight state of falling asleep. When it appears, it is most often reported as a soft, white, amorphous bubble descending slowly upon the person’s face and threatening to engulf him. My first experience with it was in treating a man whose schizoid personality encompassed all the elements of an extreme dissociative disorder. Other patients like this man have also sometimes had in sessions with me dissociated experiences similar to the Isakower phenomenon itself. I believe that all these perceptual events, including the Isakower phenomenon, may represent an effort to restore a developmentally normal process that was traumatically impaired early in life—the process of perceptual transition to linguistic symbolization of experience. The hallucinatory experience, when it has appeared in my own patients, was at times “blank,” at other times "gridlike," and at still other times, imagistic.
It is my hypothesis that in the process of moving from dissociation to conflict, the use of language in the act of constructing cognitive meaning from experience is first represented schematically through perception, and this is sometimes manifested by the degree of articulation that occurs in transitional perceptual experience when the individual is neither fully awake nor fully asleep. It is a state of consciousness that bridges both and is notably similar to the trance and fuguelike states preceding major dissociative episodes. The early literature on the Isakower phenomenon is suggestive in this regard. Depending on an author’s perspective as to whether the person was believed to be more asleep or more awake when the phenomenon occurred, the event is written about as either a form of dream or an autosymbolic hallucination. Thus, it has been interpreted by Lewin (1946, 1948, 1953) as what he calls “the dream screen” and by Stern (1961) as what he has labeled “blank hallucinations.” I think it is not unreasonable to suggest that the hallucinations may be a kind of “waystation” on the road to the use of language, the individual’s attempt actively to restore the linkage of his creative and his adaptational capacities. One of my patients (Bromberg, 1991) actually reported that his earliest childhood memory of the Isakower phenomenon was of trying to cope with it by attempting to write into it, but the bubble was so soft and mushy that his hand went into it and left no impression—a description remarkably similar to that of his early experience with his mother (pp. 406–407). Treating this kind of patient, one can often see a structural resonance between the autosymbolic visual imagery and the simultaneously occurring enactment in the transference-countertransference field, particularly during phases when dissociative structures are being surrendered.

**Trauma and Technique**

What about the issue of “technique”? It is in my view too linear a concept; if you do “this” correctly now, then “that” will follow later. It feels too overly based on an “if this, then that” model that looks for linear causes for events, with individuality seen as random “noise” in the system. From the vantage point of nonlinear dynamics, it is the unpredictability that is the very nature of the event, and proper analytic technique lies in the analyst’s ability to beware of its presence, to be as attuned as possible to those moments when application of “technique” has replaced a stance centrally organized by ongoing involvement with the patient’s experience. A pattern of pointless retraumatization in analysis can take as many forms as there are analytic techniques, and any systematized analytic posture holds the potential for repeating the trauma of nonrecognition, no matter how useful the theory from which the posture is derived. Nonrecognition is equivalent to relational abandonment, and it is that which evokes the familiar and often bewildering accusation “you don’t want to know me.” In other words, it is in the process of “knowing” one’s patient through direct relatedness, as distinguished from frustrating, gratifying, containing, empathizing, or even understanding him, that those aspects of self which cannot “speak” will ever find a voice and exist as a felt presence owned by the patient rather than as a “not-me” state that possesses him.

Areas of personality that are organized by conflict are always interwoven with areas organized by trauma. Trauma produces dissociation, and dissociation creates retrospective falsification of the past and retrospective falsification of one’s ability to predict the future. The linear sequence of time experience is altered as a protective device. Amnesia is produced, at least for the perceptual memory of the events, but experiential memory remains relatively intact. It is as if the person “feels” something happened to him because “he just feels it,” but he can’t remember it as a perceptual event—an image that can be processed cognitively—and thus, temporally, as a piece of the past.

What takes the place of the memory is a “time condensation,” a reliving of the past as a frozen replica that structures the person’s image of the future and of the present. Instead of being able to deal with “what happened to me,” the person enters therapy in order to deal with what he is sure will happen to him and what is happening to him now. Terr (1984) has discussed this issue in the context of her research into the aftermath of various traumatic events, including the kidnapping and burying alive of a busload of schoolchildren in Chowchilla, California.

Following psychic trauma, disorders of time sequencing may assume various guises: (1) condensations of contiguous events into simultaneity; (2) time-skew; (3) retrospective significances (including omens); and (4) the sense of prediction. These post-traumatic
distortions of ordering require sizeable suspensions of reality sense, and they may lead the psychiatrist or psychoanalyst erroneously to conclude that the psychically traumatized patient suffers from a "borderline" or worse condition [p. 644].

The difficulty for psychoanalysts is that they do not have a strong theoretical model to deal with the implications of this phenomenon because Freud, abandoning trauma theory, replaced it with a conceptual system leading to the belief that, except for the most seriously disturbed patients, interpretation of intrapsychic conflict (with or without "parameters") should be sufficient. In fact, trauma and dissociation breed discontinuous realities in every human being that are not amenable to interpretation. Even though a patient's bleak view of the future is a psychodynamic issue based largely on something that really happened in the past, because of the nature of dissociation, he often has minimal perspective on his pain or his dread. It is an experiential truth that he lives with. Thus, the more an analyst pursues his interpretations, the more a patient frequently feels that the analyst really doesn't want to know him. The "him" that he feels the analyst doesn't want to know is the dissociated self-state holding the experience of trauma that can't be processed as a memory. So the analyst is right but wrong, and in being wrong he is presented with a context to discover the speaker hidden in the words. It is an opportunity for an analyst to live with his patient through an inevitable enactment of the original trauma, thus providing the best chance to have the unprocessed experience become a real memory. How does this occur? There is no answer to that because it takes place differently for every unique patient-analyst dyad. But the approach as I have stated can at least be stated.

The essential nature of trauma is that because the person is not prepared to cope with it, the integrity of the ego is passively overwhelmed, and the experience of "being oneself" begins to fragment and depersonalize. It is in this sense that dissociation protects against self-fragmentation and restores personhood and sanity by hypnoidally unlinking the incompatible states of consciousness and allowing access to them only as discontinuous and cognitively unrelated mental experiences. It works, but the basic problem for the traumatized individual then becomes his own self-care. The living present and the image of the future serve largely as warnings designed to protect the person against trauma that has already occurred. The capacity for imagination is perverted into a way of making sure that the unanticipated quality of the unremembered original event cannot be repeated. By consistently mobilizing for disaster, the person is unwittingly contributing to its likelihood, and no matter how bad it turns out to be, the person is already prepared for it and his ego is set to master it. To deal with the original trauma, a dissociated state of consciousness is created that holds the experience as a terrifying, but retrospectively falsified temporal event. The nature of the fear is real enough, but the mind retains it as a dread of what can happen or is happening rather than as a memory of what has happened. The result is that the person, through continual enactment of the experiential memory, creates a world of miniature versions of the original situation and lives in that world as a reality that continues to be substantiated through his ongoing relationships. It is as though he is not to be allowed any peace. Around each corner is potential trauma; peace is simply the calm before the storm, and if he goes too long without verification of the reality of his dread, he needs to find some event that provides evidence that justifies his need for vigilance in a world of traumatic reality.

The "truth" that is held by a dissociated state exists as an experiential memory without an accurate perceptual memory of its traumatic origin. It will remain untouched unless a new perceptual reality is created between patient and analyst that has some impact on altering the narrative structure that maintains dissociation as though the past were still a present danger. The quality of the relationship between patient and analyst at any given moment will thus determine the degree to which the content of an interpretation will be heard as an interpretation rather than as a verbal disguise for what is experienced as the analyst's repetition of the original abuse or neglect. In other words, for traumatic experience to be cognitively symbolized it has to be reenacted in a relationship that replays the interpersonal context without blindly reproducing the original outcome. If the analyst includes this fact in his working stance, then he is more likely to be attuned to the shifts in states of consciousness—his own as well as his patient's—that signal when an enactment is taking place and that a modification in approach is required which may or may not include verbally addressing the enactment at that moment.
All in all, I think the patient’s dilemma has been particularly well described in a four-line poem by Emerson (1851) that is in its own way a kind of tribute to the patient. Unfortunately, you can’t read it to your patient because he will not only deny its validity but will take it as further evidence that you don’t want to know his pain. The poem, called “Borrowing,” reads

Some of the hurts you have cured,
And the sharpest you still have survived,
But what torments of grief you endured
From evils which never arrived!

The Uses and Abuses of Self-Disclosure

With regard to how one approaches analytic intervention with this frame of reference in mind, probably the prime clinical issue that addresses the difference between linear and nonlinear thinking in technique is that of self-disclosure by the analyst. Like any other choice an analyst makes with a given patient, self-disclosure derives its meaning from the ongoing context of the relationship in which it takes place, not from its utility as a “technique.” Its usefulness to the analytic process is organized by the quality of its genuineness as a human act, particularly the degree to which the analyst is free of internal pressure (conscious or unconscious) to prove his honesty or trustworthiness as a technical maneuver designed to counter the patient’s mistrust. The analyst’s self-disclosure must be what Symington (1983) calls an “act of freedom” in which the analyst comfortably retains his right to not disclose or, if he does choose to disclose, to claim his own privacy and set his own boundaries. If it is not an “act of freedom” then it also loses its potential as an “act of meaning” in Bruner’s (1990) terms, a relational act through which personal narrative is reconstructed as a perceptual event in a context of interpersonal authenticity.

The subjective experience of freedom to say “no,” or the absence of such freedom, inevitably forms the way in which the patient’s self-disclosure is shaped, and it is equally true for the analyst. His motivation and affective state become as much a part of what is disclosed as the intended content. In other words, if the analyst’s choice is moti-

vated by his need to be seen in a certain way by his patient (such as honest, accommodating, unsadistic, or innovatively “free” as an analyst) then self-disclosure becomes a technique and as a technique is as instrumentally linear as any other intervention based on an “if I do this, then the patient will do that” model. Like any human quality that is “packaged,” self-disclosure too can lose its primary relational ingredient (mutuality) and become what Greenberg (1981) has called “prescriptive.” When it fails in its purpose, it is usually for that reason. It lacks the authenticity, spontaneity, and unpredictable impact on the future, that makes analytic growth possible.

A colleague of mine (Therese Ragen, personal communication) has commented that my viewpoint implies a distinction between genuineness and honesty, and I agree. Genuineness is a human attribute only in a relational context. If you try to turn it into a technique, it loses mutuality and becomes a personal instrumentality called “honesty.” Any attempt to turn a therapeutic discovery that emerges from a relational context into a technique that can be “applied” to other patients is an illustration of what I believe to be the single most ubiquitous failing in all analytic schools of thought as methods of therapy, and the shared blind-spot in each of their creators (including Freud, Ferenczi, Sullivan, and Kohut).

For example, Ferenczi’s failure with “mutual analysis” as a technique (Dupont, 1988) occurred not because what he did was wrong, but because it failed to be right. What I mean by this is that an analyst who systematically attempts to gratify needs fails the patient, not because gratification is “wrong” or intrinsically harmful, but because it is a form of nonrecognition and for that reason fails, just as does systematic frustration of needs. Both are evidence to the patient that the analyst is unable or unwilling to authentically “live with” the patient’s state of mind in whatever form it presents itself and attempt to know it without surrendering his right to “be himself” as part of the process. I believe this to be a more accurate assessment than Ferenczi’s own statement of his disillusionment, in which he concludes (Dupont, 1988) that “mutual analysis is merely a ‘last resort’ made necessary by insufficiently deep analysis of the analysts themselves [and] ‘proper analysis by a stranger, without any obligation, would be better’” (p. xxii). Ferenczi’s concept of “mutual analysis” was based on something he originally perceived as demanded of him by certain patients, particu-
larly by his famous patient Elizabeth Severn, known as RN. At that
time, his approach to his patient was genuinely mutual—it was not
Ferenczi’s technical creation but a cocreation of that particular patient
and analyst dyad. Following that, Ferenczi turned it into a technique
he called “mutual analysis,” at which point, like any other technique, it
was no longer a cocreation and, I submit, was in fact no longer mutual.
It was something, for better or for worse, applied prescriptively, and it
failed because of that.

In fact, the way Ferenczi discovered this “technique” reminds me a
bit of the old joke based on Charles Lamb’s (1822) essay about the
farmer in ancient China whose house burned down with his pig in it.
While removing the dead animal, the farmer scorched himself, and
when he put his finger into his mouth to cool it, he became so thrilled
with the exciting new taste that he called all his neighbors to try it.
And so, the joke goes, roast pork was discovered, and on the same day
each year until the farmer’s death he would gather his neighbors
together for a feast and burn down his new house with a pig in it. My
own addendum would be that perhaps that joke isn’t really about the
discovery of roast pork but the discovery of “technique.”

I am suggesting, in other words, that the reason Ferenczi was suc-
cessful with Elizabeth Severn (and perhaps a few other patients later
on) when he attempted “mutual analysis” was not because patients in
general need soul-searching emotional openness from their analysts,
but because that patient at that moment in Ferenczi’s work was able to
confront his inauthenticity with regard to her. She settled for “mutual
analysis” because she could not hope to change his personality. In an
ironic way, she asked for what she knew he might be able give, not for
what she really needed. She asked for a demonstration of honesty
rather than an effort at mutuality because there was no way to get the
real thing. In his own way, of course, Ferenczi did ultimately respond
with genuine mutuality even though, ironically, he missed her real
message—“I need you to be yourself while recognizing what I am feel-
ing, but since you haven’t yet been able to do both, let’s see what you
can do if I push you to the edge.” His courage to try self-disclosure at
that point came mostly from his need to control what was going on
between himself and his patient, and because it “worked” it prevented
him from potentially experiencing and recognizing the complex inter-
play between what his patient was saying to him and what she was
doing with him while saying it. Ferenczi could not register, as part of a
single configuration, the controlling and intrusive way she was behav-
ing toward him while she was talking about “mutual” analysis as the
only way she could “protect herself” from him. But he could experience
in himself at that immediate moment the presence of the very kinds of
feelings toward her that she was accusing him of harboring. He could
feel what she was saying about him as accurate—his reaction to what
he called in his clinical diary her “terrorism of suffering” (Dupont,
1988, p. 211)—and he turned toward what she insisted was the only
possible path that could validate her feelings and enable her to trust
him: that of self-disclosure equivalent to hers. It “worked.” And because
it “worked,” he came to believe it was the technique that accounted for
the improvement in the treatment relationship. In my terms, he con-
 fused authenticity with self-disclosure and kept burning down the
house to get the roast pork. But unlike the farmer in the joke, he didn’t
even end up getting the pork again. His subsequent patients, for the
most part, kept reacting as though they were doing something bad to
them, and I would have to agree; he was inadvertently retraumatizing
them to no immediate therapeutic purpose. All this could have turned
out much better if he had adhered to what he had already written
about the importance of trauma in personality development. Don’t just
attend to the words; try to see the dissociated speaker who is relating to
you at that moment, the part of the self that “lives on, hidden, cease-
lessly endeavoring to make itself felt” (Ferenczi, 1930b, p. 122).

All this having been said, I must admit that Dupont’s (1993) state-
ment that “gratifications should only be granted to demands aiming at
recognition” (p. 154) doesn’t provide much of a place to anchor one-
self when a patient is rocking the couch and insisting with absolute
conviction that you are depriving him of the one thing he needs to get
better. At such a moment an analyst is often floundering and not at all
sure of what he thinks. There are very few external guidelines, and it’s
very lonely with only your doubts to keep you company. All I can say is
that, while I do believe that gratification is most often experienced by
patients as an empathic abandonment because it is typically a substi-
tute for the more painful effort at recognition, there are in my experi-
ence certain patients for whom some directly gratifying response by the
analyst is the only way they can trust the analyst’s concern for them, at
least for a period of time.
With such an individual at such a moment, I sometimes find myself making some compromise that is invariably not satisfying to either of us but almost always seems to move the work ahead. Over the years I've come to believe that it may be the limitation in my flexibility—the fact that I do implicitly draw a line in the sand—that has the most impact because it emanates from relational authenticity. If I do ultimately move the line, the process through which that happens is at least as important as the accommodation itself. It carries the fact that what I'm doing is not a technique but a personal effort I am willing to make as long as it does not exceed the limits of what I establish as my personal boundaries and is thus part of a genuine relational negotiation. So, all in all, I could probably say that my position on technique feels compatible with Kaiser's (1965) observation that "whenever you feel the need to do something, or to refrain from doing something for the purpose of showing [a patient] your concern, you can be certain that your concern is lacking" (p. 170).

Many different analytic concepts have, each in its own metaphor, addressed the fact that the aesthetics of analytic communication is an ineffable coming together of two minds in an unpredictable way, from which something "new but not new" is constructed. Michael Balint's (1968) "new beginning," Winnicott's (1967) "potential space," and Sullivan's (1953) "parataxic mode of experience" are just a few of the more influential examples. I believe that the logic of conceptualizing the intersubjective field in these ways is strongest in the context of a nonlinear view of mental structure and the discontinuity of self-states. The ability of a patient to take in and seriously consider the analyst's perception of him is possible only if another reality (or truth) being held in a dissociated state is not being invalidated as a tradeoff. The patient doesn't need to be "agreed with" or need a heroic attempt at self-disclosure by the analyst. What is required is that the multiple realities being held by different self-states find opportunity for linkage. The most powerful medium through which this takes place is the analyst's ability to recognize that his feelings about his patient are not his personal property, and that his own feelings and his patient's are part of a unitary configuration that must be linked in the immediacy of the analytic relationship in order for the multiple realities within the patient to become linked through cognitive symbolization by language.

Peterson (1993), whom I quoted earlier, referred to the "change points" or moments in therapy where cognitive insights occur. My view is that these change points occur when an enactment is serving its proper function and the patient's dissociated experience that the analyst has been holding as part of himself is sufficiently processed between them for the patient to begin to take it back into his own self-experience little by little. It is a change point because the patient's processing of the experience continues internally as a state of conflict rather than intersubjectively. In other words, the use of language, instead of being a substitute for experience, allows a new self-narrative to be created. It moves a new experience of reality that begins as perceptual and interpersonal to its most mature level of mental processing by the use of thought and intrapsychic conflict resolution. Put most simply, "unfreezing" the concrete, literal quality of a patient's states of consciousness allows him to embrace the full range of his self-narratives by first embracing the full range of his perceptual apparatus within a single relational field. All in all, perhaps Socrates would not mind if the title of this paper were changed to "Speak! that I may see both of us."

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Dissociation, Reality, and Psychoanalytic Listening


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