HISTORICALLY, THE CONCEPT OF DISSOCIATION is usually distinguished from that of repression based upon earlier vs. later developmental themes and/or severity of anxiety. Dissociation has traditionally been associated with traumatic or profound anxiety occurring either in pre-verbal times or, if later, potentially of annihilating proportion. Anxiety-laden experience cannot be processed either verbally or emotionally, since the psyche is too undeveloped or fragile to even assimilate the experience, or the assault on the psyche is too profound. Repression, in contrast, is usually thought to occur either when anxiety-laden events can be put into words, the psyche is strong enough to handle them or the experience is anxiety-producing but not annihilation-producing. Dissociation then has traditionally been discussed as reflecting earlier and/or more severe psychological disruption, essentially inaccessible to subsequent awareness. Davies and Frawley (1992) have referred to the vertical split of dissociation in contrast with the horizontal split of repression.

Classical psychoanalysis, which was really the only psychoanalysis until the late 1940s, defined its purview as problems which revolved around repression of oedipal themes; the neuroses, if you will. This was distinguished from "character pathology" which was thought to be either pre-oedipal, pre-verbal or traumatic in origin; in other words, usually earlier and more serious. Such pathology was characterized by dissociation, not repression. There was no articulated psychoanalytic method for these problems because it was believed that earlier psychopathology, aside from being possibly pre-verbal, left character in a narcissistic state, unable to relate meaningfully to the other and therefore unable to form a
transference neurosis. The judged ability to form a transference neurosis was the diagnostic dividing line between analyzable and unanalyzable (Hirsch, 1984). It reflected an assessed level of personal relatedness on the part of the patient; the ability to meaningfully connect with another, to feel love, rivalry, loss and sadness in relation to another and to have the language to express these emotions in words. In the purportedly unanalyzable, those feelings either never registered in the first place or, due to uncanny anxiety, were dissociated beyond being retrievable in the transference. Psychological treatment for "character pathology" was crude; largely consisting of what in modern times is known as supportive therapy of various kinds.

Melanie Klein and her colleagues in Great Britain and then in South America, and Harry Stack Sullivan and his colleagues in the United States, both influenced by Sandor Ferenczi's pioneering but thwarted efforts, were the first psychoanalysts to focus their interest on the analysis of those who had been deemed unanalyzable. Klein (see Segal, 1964), initially working with children in play therapy, focused upon ascertaining the earliest and most primitive mental states of her patients. Such states emerged in play, non-verbally, and were believed accessible to the analyst's observation and interpretation to the patient. Her most important contribution to psychoanalysis, I believe, was her facilitation of the use of the analyst's emotional states in interaction with the patient, to put into words the likely experience of the patient. Heimann (1950), Little (1951), Racker (1968) and Bion (1970) elaborated this notion of projective identification and developed it into a new countertransference theory. The analyst's emotional experience reflected something meaningful about the patient's dissociated internal experience.¹ Countertransference was transformed from an impediment to analysis into a vehicle to understand the spectrum of the patient's unconscious experience. It widely broadened those who were potentially accessible to psychoanalysis and shifted the psychoanalytic method from the study of only one person, the patient, to the study of the psyches of two people. The analyst's

¹ I do not believe that the analyst experiences, like an empty container, the exact feelings of the patient. It is closer to empathy than to the magic of pure projection. The analyst must have similar feelings within his/her repertoire or else such transactions would be impossible.
way of best knowing the patient was an effort at empathic attunement to the
dissociated internal world of the patient, experienced as feelings within the
analyst. Racker referred to this type of countertransference as concordant and
this is in distinction to concurrent countertransference which developed more
out of Sullivan's interpersonal psychoanalytic tradition.

Sullivan's career was launched by his rather unique interest in working
analytically with schizophrenic patients. Most such individuals were not
equipped to rationally verbalize their feelings or life histories and indeed,
were quite absorbed within themselves. Sullivan's (e.g., 1953) interest was
thus not so much in the verbal reconstruction of life history as it was in what
the patients did, i.e., their actions. How people acted was observable inside
and outside the transference and external behavior was believed to reflect the
unknowable internal. Sullivan's focus on the patient's dissociated actions with
the analyst and with others led him to the conclusion that action does not
occur in a vacuum; it is part of interaction. That is, the analyst as observer
must also, albeit unwittingly, participate with the patient. The traditional role
of the analyst as observer thus became for him, participant-observation. The
analyst gets to know the essence of the patient by what is lived out between
them. Dissociated aspects of the patient's mental life are seen in the two-
person interaction. Following Sullivan, Freida Fromm-Reichmann (1950)
noted transference, rather than being absent in severe psychopathology, is
even more ever-present in the form of action. Racker's concurrent
countertransference is exemplified in what later interpersonalists (e.g., Edgar
Levenson, 1972) reworked into a kind of observing-participation; the analyst
participates in the patient's transference by living-out with the patient,
fascimiles of the patient's formative and basic relational configurations. His
radical interpersonalism is the logical extension of Sullivan's participant-
observation (Hirsch, 1992b).

The developments just cursorily summarized not only have led

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2 Dissociative process, for Sullivan, was equivalent to what was thought of
as "unconscious." Uncanny anxiety led to "not me" experience while lesser
degrees of anxiety, to "bad me" integrations. I believe that for him,
dissociation was not an "all or none" concept; it existed in degrees along a
continuum. This was similar to his views about psychopathology. Normal to
schizophrenic was a continuum in contrast with the still prevalent view that
they are two distinct processes; almost people of two different species.
to shifts in who is deemed analyzable and in the conception of the psychoanalytic relationship but in the nature of the psychoanalytic data itself. In traditional, classical psychoanalysis the investigative method is the study of the internal world of one person, the patient. The analyst as objective natural scientist is sort of an archeologist (see Spence, 1982) plummeting into the depths of the patient, searching for reconstruction of memories related to conflictual sexual and aggressive drive states. Unconscious is "the unconscious"; it is an objective entity of repressed memories related to drives, which emerge as projections in the transference to the objective, non-participant, one-person psychology analyst. When the repressed is recovered in the transference, genetic insight is achieved and patients are in a better position to renounce immature drive states and control to their own destiny.

In the relational psychologies of the interpersonal and object relational traditions, for the most part (with the exception of some Kleinians) the concept of unconscious is a relative one. Unconscious, not "the unconscious," may certainly include specific repressed memories and conflictual drive states but more significantly consists of internalized self-other configurations and identifications (Hirsch & Roth, 1994). These interpersonal configurations rarely refer to specific memories or traumas (e.g., primal scene) but ongoing interactional patterns between the patient and his/her providers, which begin very early in life and usually run consistently through one's development. Very often, such experience has never been put into words or consciously registered. The range of feelings associated with these internalized templates of experience may include sex and aggression certainly but reflect the gamut of affective experience. Often more salient than sex and aggression are interpersonal configurations associated with feelings of loss, pain, dependence and vulnerability in relation to significant others as well as desires which conflict with those others (usually parental figures). Ergo, specific memories or drive states are not necessarily repressed so much as consistent vulnerability, pain and/or desire for self-expression may be unattended and then lost or dissociated. Anything which makes the significant caretakers sufficiently anxious leads to potential instability of self on the part of the patient and thus may be dissociated from the patient's self or being. Repression is a term best suited to describe specific moments in history in relation to affective states. Dissociation

- 780 -
best fits the notion of consistent patterns of interpersonal experience and associated affects which may be entirely out of awareness yet are relived in the patient's subsequent relations, including the two-person playground of psychoanalysis. The term need not apply only to anxiety associated with annihilation and can refer to any experience outside of conscious retrieval.

This unconscious is called the relative unconscious (see D. B. Stern, 1985) because the analytic observing-participant can never be certain what exactly happened in the patient's past. The analyst not only comes to the analytic dyad with his/her own biased theory but also with a personality. Both of these qualities inevitably and usually unwittingly interact with the patient's transference (Gill, 1983); (Hoffman, 1983); (Feiner, 1991). Further, as noted earlier, the analyst becomes caught-up in the interactional process and loses the capacity to be an outside, objective, scientific observer of "the unconscious" of the patient. Thus, dissociated experience is not so much discovered as repression is discovered (by archeological digging) but is usually lived out in a two-person interaction. The analyst becomes caught-up in the patient's fundamental interpersonal configurations and/or feels the patient's feelings and analyzes from the subjectivity of being somewhat lost within the system.

In this interaction, the patient brings or I should say lives-out through enactment, his or her dissociated self as well as what is dissociated. Winnicott (1965) has used the term true and false self to characterize his view of this distinction. "False" is what the patient learns in order to reduce the anxiety in the self and in the significant others and of the analyst in the transference. This is the dissociated self; it is a character persona or armor which protects both the patient and the patient's significant others. "True" self is what is dissociated, who the patient presumably might be under the most benign and facilitating conditions. Winnicott's analytic aim is to discover this self and/or to facilitate its development. My reservation about the terms true and false self is that they imply an objectivity or verifiability. What is called false, the dissociated self, is not really false but the fabric of the patient's personality or character. What is called true implies an almost inborn idiom (see Bollas, 1987). That is, the notion of pure or true self reflects a one-person psychology wherein a repressed true self will be facilitated by a non-intruding analyst; a mere container or
holding environment. I do not believe in the possibility of a pure facilitator, container or holding environment any more than I think it is possible to purely empathize or to be a blank screen. Nonetheless, I still believe it useful to attempt to distinguish the self that adapts by dissociation and what aspects of the self are hidden or dissociated. All of this can potentially be elaborated in analytic interaction more likely than through an archeological dig for lost memories or the pure gold of the hidden true self.

The ability of analysts to work with patients with so-called "character pathology," is supported by concepts of character discussed in the child observation literature of Daniel Stern (1985) and his colleagues. For the purposes of this essay, what is most important is that earlier, pre-verbal or "pre-oedipal" is usually not distinguishable from later. Parent-child interactions are found to be normally quite consistent, from the earliest moments after birth up through adolescence. Mitchell's (1988) introduction of the term "developmental tilt" further challenges the idea of earlier vs. later topography. He notes that earlier and later are often the same and that earlier does not imply "deeper" or more significant than does later. The child's interaction with providers is internalized throughout development. This notion supports the analyzability of those who suffer from pathological pre-verbal experience since that experience is likely to be developmentally continuous, as well as mutually lived-out in the transference-countertransference matrix through action and interaction. This point of view argues against the dichotomy of dissociation as necessarily a more pathological mechanism than repression, the latter supposedly occurring later in child development. From this perspective, dissociation of many aspects of self-experience is ongoing throughout the developmental cycle. All pathology can be referred to as "character pathology" since there is usually consistency of conflict and of self-other internalizations throughout development. I posit, therefore, that there need not be two different psychoanalytic procedures, one for the more severely disturbed and one for the more healthy. As with Klein, Sullivan, Fromm-Reichmann and Searles, I view psychopathology on a continuum without repression vs. dissociation, later vs. earlier pathology, or conflict vs. deprivation, to diagnostically dichotomize. The more contemporary interactional, two-person trend in psychoanalysis allows for a far wider range of patients who are deemed analyzable.
(see Merton Gill, 1984 for an extended discussion of this). Further, the presence of dissociation as opposed to repression is not in my eyes indicative of more vs. less serious pathology but to the contrary, is abundantly present in most of us. I am suggesting a broadening of the term dissociation just as the concept of transference has been recently redefined. I speak of dissociation not only in regard to annihilating anxiety but in relation to internalized self-other configurations and feelings which are associated with them, that are significantly out of awareness. Such experience is relatively contentless and ongoing and cannot be retrieved as specific memory or mental content. Internalization of interpersonal configurations occur over a period of time. The repressed memory search method of psychoanalytic inquiry does not fit here. Such interpersonal phenomena are far more likely to be apparent in the murky recesses of the analytic exchange.

Conflict is ongoing and does not refer to issues related to forbidden drives so much as themes of separation and individuation vs. security, safety and loyalty to loved ones (Fromm, 1964). What is dissociated is unacceptable to those significant others and subsequently, to one's self. Actualization of self is blunted to varying degrees, reflecting more or less serious psychopathology.

In the focus of this newer psychoanalysis, both the patient's manifest character or personality as well as what is less apparent is usually lived-out, in mutual enactment, in the transference-countertransference interchange. This is not discovered through clever detective work and brilliant interpretation but via the bumbling of unwitting participation and reflection about that participation. The stuff of psychoanalytic engagement is the examination of the intersubjectivity of mutual interaction and relating this to historical and current relational patterning (Levenson, 1972), (Ehrenberg, 1992). The analyst, influenced by the subjectivity of the analyst as person (Aron, 1992), is unwittingly pulled into the patient's psychic world, enacts recurrent affective patterns, feels a facsimile of the patient's feelings and does the understanding or observing part from within the system, or post-enactment. Dissociation refers to actions, self-other integrations and associated affects lived out in disconnection from their past and without self-awareness. These patterns of engagement are acted-out in the transference-countertransference matrix, highlighted in that playground and linked to past and to current. They may be profoundly out of the

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3 Personification is Sullivan's term for this.
patient's awareness or modestly so. Indeed, these patterns of being or
defensive armor or false self-configurations or character or personality style
were formed in interaction with historical others, based on identifications
with and negotiated wishes and needs of those others and the patient.
Character or false self or personality are seen as a compromise between the
striving of the patient for separation, self-development and optimal
enrichment and the requirements of the environment of the significant others
(Fromm, 1964), (Greenberg, 1991). In an ideal state, which never actually
exists, the providers are the pure facilitators of self-development. In real life,
the developing person always looks toward the wishes of the significant
others and adapts to them, providing safety and reducing anxiety for both self
and other (Schachtel, 1959), (Fromm, 1964). These interpersonal
configurations or personifications\textsuperscript{3} are internalized and a reflection not only
of stability, safety or anxiety reduction but of love and loyalty for and
preservation of those significant others (Fairbairn, 1952), (Searles, 1979).
Personality is developed out of these unconscious identifications and self-
other integrations and this persists because of the strength of these ties.
Personality is also persistent because it becomes familiar over time. The
compromised self becomes the comfortable and stable or rigid sense of self
and new experience ranges from normal fear to extreme dread. None of this is
usually available to be put into words (Fiscalini, 1991).

In contemporary psychoanalytic paradigms, the analyst unwittingly enters
this relational world (Hirsch, 1992). On one hand, the analyst wishes to
represent a new and therapeutic experience for the patient yet on the other, the
analyst always becomes caught up in the repetition of the old. Perhaps
paradoxically, the only way to the new is to live through the old. Patients also
enter analysis because they wish to expand but once there, the old internalized
interpersonal configurations dominate. Instead of viewing this as resistance,
something negative and bad, we can see it as persistence (Cobert).\textsuperscript{4} That is,
the repetitious living-out of dissociated interpersonal configurations in the
analytic interaction is a way of showing the analyst who the patient is. It
reflects both sides of the conflict: the wish to maintain rigid safety and the
wish to invite the analyst to provide new experience.

\textsuperscript{4} Willa Cobert, personal communication.

- 784 -

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This new experience may reflect original experience which was dissociated or indeed, it may be brand new. One can never know for certain. The central stuff of psychoanalytic work with all patients can be viewed as the addressing of dissociated repetitious patterns of internalized relational configurations, as they emerge in the transference. This to me is the most likely route to an acceptance of self and the potential enrichment of self.

Subsequent clinical discussion refers to other than the supremely hysterical individual about whom the term dissociation has been traditionally linked. Take for example, a man who is deeply in love with and dependent upon his mother and yet can only survive by dissociating his loving engagement and thus, freezes up. Such an individual may not be able to love anyone or be dependent directly, though may display love or dependence very indirectly.

Following this example, until dissociated love and dependence is lived out with the analyst and perhaps also recognized historically, the patient and analyst may repeat a life together of emotional isolation and emptiness. In such instances, it sometimes may be that the patient never begins to connect with dissociated love until the analyst, through concordant countertransference, first discovers it in the analytic relationship. The development of the patient's capacity to love or to be directly dependent may or may not be reconnected to historical affect. It may surface only as a new experience vis à vis the analyst. One could just as well say that the love and dependence are repressed. However, to the extent that these qualities are subtly but ongoing present somewhere within the transference-countertransference matrix yet totally irretrievable in language, also qualifies the term dissociation.

In my thinking, more can be done in therapy by examining dissociated interaction than by searching for moments in history which were repressed, though repression and dissociation are by no means mutually exclusive. Repression usually seems more related to specific moments or specific contents. The contemporary analytic aim may no longer be to recover the original interpersonal integrations and accompanying affects because they may just not be recoverable. The aim can shift to one of new experience, to wade through the coldness or distance or paranoia (the patient's character) in the transference-countertransference exchange to the point where the patient may risk experiencing the dangers of dissociated affective engagement in the analytic here and now. We may only assume or guess that the newly experienced
love or trust or vulnerability is related to historical interaction prior to the need to disown such affective involvement. The most important factor for mutative action is that the split-off internalized interpersonal configurations and the affects associated with them, be examined in the immediacy of the analyst as observing-participant. This is central along the broad spectrum of diagnostic category and its origins and as Searles (1979) and Gill (1984) have noted, it makes for the widest scope of analyzability.

Introduction to Clinical Examples

I have argued that the new psychoanalytic paradigms which have grown out of interpersonal and object relational thinking have more potential to accommodate the widest range of patients than does the traditional classical paradigm. Contrary to the commonly held view that patients who dissociate (as opposed to repress) are suffering from both earlier and more severe psychopathology, I suggest that dissociation may be a more meaningful term for what happens with people across the continuum of problems. In so doing, I have significantly broadened the meaning of the concept. I suggest that the relational-conflict model or the observing-participant model lends itself to dissociated experience being examined, in vivo, in the two-person analytic interchange, thus providing a meaningful opportunity for change. Since much of psychoanalytic writing has focused upon dissociation in relation to severely disturbed patients (e.g., schizophrenia, multiple personality, extreme narcissism) or those who have suffered significant trauma (e.g., incest), I will present examples of individuals who indeed function very well in many respects (of course, many incest survivors do as well). As a male analyst of middle age, many of my patients are men who are successful in their work and in some aspects of love, perhaps. Often, however, they are quite blocked in their capacity to love and come to analysis, in some way or another, to address this limitation. Depending on one's point of perspective, these individuals could be called schizoid, narcissistic, obsessional, detached, cold or all of the above. They have dissociated aspects of self-experience which were dominated by love and

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5 Dissociation has been most widely associated with the extremes of hysteria, particularly, so-called multiple personality. My illustrations emphasize very different sorts of character constellations.
dependency. The first example I give is of a fictional character or caricature; in this instance, of the stereotype of the emotionally frozen upper-class English gentleman. I believe the author who depicts him is offering a satiric view of a class of person in England but as in most good caricature or satire, there is much relevance. My second and third examples are composites of men in my own practice. They are my own fiction because for the sake of confidentiality, each character represents features of a variety of individuals. The men described function very well in the world. As with the example from fiction, they are either friendly, warm, engaging, generous or simply likable in most of their work-related relationships and in their respective communities. In closest contact, however, they are often cold or sadistic and very difficult to reach emotionally. I believe their manifest warmth may reflect dissociated dependency and love but cannot be experienced as such. In these examples I wish to illustrate how dissociation plays out in the everyday life of our work with normal individuals and not simply with those at the extreme or dramatic ends of psychological difficulty.

Clinical Illustrations

My first illustration will come from the world of fiction: Josephine Hart's (1991) novel "Damage," later made into a movie with Jeremy Irons. In the novel, the main character is not referred to by name, a point of some significance. I will refer to him as Dr. F., the name given to him in the film. He is not named, I believe, because he is a man with minimal conscious feeling; at least before the novel's dramatic turn. On the surface he is near perfect; the handsome, elegant, brilliant, articulate and engaging married father of a daughter in the "Public Schools" and a son at Oxford. He is from the upper-classes and impeccably educated as a physician and ultimately as a member of the House of Lords; actually a future prospect for Prime Minister. His beautiful, gentle, stately wife is the daughter of a leading member of the House of Lords. In his early narration, Dr. F. refers to himself as an "adman's dream," as close to a perfect person as one could find.

6 The novel, "Remains of the Day" (Ishiguro, 1990) also made into a movie, can also be used to illustrate the same situation though the tragedy of the protagonist is of a different dimension.
In a brief early chapter he describes how smooth and easy everything had been in his life. He did everything correctly, much at the behest of his powerful father. Nothing is mentioned of his mother. In commenting about this ideal life, he states, "It was a good life; but whose life?" On closer scrutiny, Dr. F. lacked intense conscious feeling of any kind; almost a stereotype of the upper-class English man. He clearly appeared attached to his current family and eagerly spent time with them but there was little overt affection or display of emotion. He built an edifice of a strong and devoted family life but was detached and correct at the same time. Similarly, he had been an excellent, humanitarian physician and was a leading and very capable and rather liberal member of parliament. He achieved all of this with ease. Everything seemed on automatic pilot.

The foil for this character study was in the form of his son's new girlfriend and then fiancée. Anna Barton (she had a name) was all sexual passion, living-out a repetition of a childhood event where her brother committed suicide after she was sexually unfaithful to him. She is not the character of focus for me; enough said that she was compelled toward destruction of those who responded to her passion. As soon as their eyes met, Dr. F. lost all of his reserve and succumbed fully to this strange sensation, for him, of uncontrollable sexual desire. His life rapidly was consumed by his sexual connection to Anna, despite the fact that the son of whom he was so proud, continued to also have a sexual relationship with Anna and had announced plans to marry her. The plot builds to the inevitable tragedy. The son accidentally comes upon their passionate sexual coupling and in backing away in shock and horror, falls over a bannister and crashes to his death.

So, what is dissociated in this tragic tale of a man with no feeling and then with one uncontrollable feeling? From the minimal information provided by the author, Dr. F. had the talent to live just the way his father desired, the embodiment of the accomplished English gentleman; a renaissance man. He lived in the most decent and proper way. He identified with the wishes of his family and culture, never either rebelling or discovering his own unique idiom. In his loyalty to his internalized family, he was the perfect son and the perfect citizen. His own inner direction was never facilitated, "It was a good life but whose life?" He never
recognized his dutiful compliance and was thus never able to do anything about it. Intense personal connectedness, whether sexual, affectional, rageful, rivalrous or sad, was evidently not part of the family configuration. It was most notable that his own mother is never mentioned. I have the impression that she was simply not emotionally present. Whatever stirrings he had along the lines of familial passion (anger, deprivation, loving attachment) were "not me" feelings, banished from conscious experience within the family and dissociated from his experiential world. His core problems could certainly be meaningfully conceptualized as related to repressed sexual and aggressive drives, including oedipal rivalry most particularly. Suppression of passion was indeed the house rule. A richer conceptualization for me speaks to feelings which were barely if at all allowed to register in the first place, a dissociation of whatever was against the external and then the internalized grain of the important others in his development. He seemed thoroughly identified with and undifferentiated from his own father and identified as well with his mother's schizoid privacy. One could say that specific feelings were repressed though more information is provided, I believe, by saying that such feelings were "not him".

Dr. F. lived a seamless life and was dissociated from the origins of his personality. For a man so extraordinarily socially aware and brilliant, he did not at all reflect upon how he became who he was. He thereby could never discover his dissociated hurts, passions and desires, nor the dissociated self-other configurations which were the building blocks of his personality. There are two types of personal tragedy that are possible here. For much of his life he lived the first, though his level of personal and professional achievement were such that the tragedy of his undiscovered self and his idiosyncratic desires were not manifest and caused no serious trouble.

His level of dissociation, however, was like a time bomb; at some point his dissociated passion was likely to erupt and when it did, he became like another person. He was discontinuous from so much of the self that had been him. From total modulation of passion he became thoroughly possessed by it and from absence of conscious hatred or rivalry, he essentially killed his own son. Needless to say, had he been more acquainted with those dissociated
aspects of himself his life would have been more chaotic and certainly far less perfect but the worst of all possible human tragedies may have been averted.

Were Dr. F. a patient of mine what would I have hoped for? In the first place, his life ran too successfully and smoothly for him to wind up in my office. He would have had to have been coerced there by his wife, most likely. She may not have felt sufficiently loved by her husband or perhaps, sufficiently made love to. Perhaps she would notice that although he seemed involved and prideful with regard to his children, he did not convey this to them with any ardor. On the other hand, he did not at all appear out of the ordinary in this regard from others of his social class and background. Yet, her own father was much more overt in his display of love for her than was her husband to her or to their two children, so she may have noticed.

If in treatment, Dr. F. and I would enter into his world of dignity and formality. He would do all of the correct things as a patient: dream, associate, analyze meaning, attend with great frequency and show me the utmost respect and courtesy. Perhaps his dreams would reveal his dissociated passionate side; though I doubt that, for a long time, he would personally connect with those dreams other than intellectually. It would be clear after some time that the experience, although pleasant and quite interesting, was passionless for each of us. I would have to be the first to address this by describing to him the tenor of our relationship and how it lined-up with that of his current and historical families. The absence of passion of any kind, including an intense bonding with me and even modest anger toward me would have to be placed in full relief. In my concurrent countertransference to his transference, I would be facilitating his being the model patient in the context of a relationship which would eventually seem sterile and cold to me. Since I suspect I would be quite interested in him and he so charming and ideal as a patient, it might take considerable time for me to viscerally recognize the vacuum between us.

My concordant countertransference would likely penetrate my awareness more rapidly and affect the concurrent countertransference in ways which are unpredictable to me. There are three primary affective configurations which I imagine would dominate my own consciousness: one, an intellectualized coolness; two, admiration,
affection, love and passion for him; and three, rivalry and jealousy. The first, as already mentioned, would likely begin to dominate the conscious interchange after some time. The second and third would be not at all experienced by him and only by me and I would be left to decide how to use those feelings. I would try to be aware of my own personal or private affection and jealousy while suspecting that some of those feelings also reflect dissociated aspects of Dr. F. Knowing my own inclination to address such issues as they emerge in my consciousness, I suspect I would bring them into our verbal relationship sooner rather than later. Other analysts might hold or contain such feelings for a longer period of time. Through my affection and/or admiration (perhaps intense at moments) and my jealousy or rivalry with Dr. F., I would try to explore those dissociated feelings within him, for me and toward others. Between the articulation of our cool, proper and formal relationship and my raising what else might be there (the passions), I would hope to eventually establish with him a more deeply personal, interpersonal configuration. If I could, this would indeed be new for him, a recognition of the contrast between old familial configurations and his core sense of self on one hand and the eventual disruptive and disorganizing personal encounter with me. Were he acquainted with the degree of his passionate love or of his hatred and rivalry such feelings might not have to be acted-out in such tragic and destructive display. Dr. F. learned about dissociated aspects of himself the hard way, through actions which were irrevocable and tragic.

Mr. A., married with a family, is a successful lawyer. He started therapy because he was chronically unhappy, depressed and ruminative, always comparing himself with others. In addition, despite being very well liked in his professional and social communities, he had no close friends, argued brutally with his wife and was remote toward his children. Finally, he had a long-term smoking habit which he could not break despite trying every conceivable cure. His father died at a young age and smoking was a factor. In his family of origin, he resembled his father in many ways, particularly in his affability outside of the home and his remoteness toward his children. Father was passive and gentle but obliviously in his own world. He recognized very little about Mr. A. and his older sister. Father, like son, was exceptionally intelligent.
but father was never able to earn a good living and the family lived just close to the poverty line. Mother was the aggressive one and was always angry at father for his passivity and for their financial woes. She was the more responsible parent but it was a dutiful presence, not a soft, tender or nurturing one. The atmosphere in the family was one of remoteness, unrelatedness and tension. Mr. A. and his sister did not seem to bond together either; everyone was manifestly detached from everyone else. Mr. A. was lonely and depressed as a child, quite conscious that other kids had more literal and figurative richness at home. He was always comparing and he still does.

Mr. A.’s current home resembles his family home despite valiant efforts to live quite differently. He tried to make his actual home opposite to the one of his origins but despite the luxury and size, it has been similarly empty. Mr. A. bickers with his wife as often as his mother did with his father. When he started treatment, he was so absorbed in work and in efforts to earn significant money through investments, that he rarely saw his children and could not deeply connect with them when he was present. Ironically but predictably, investment setbacks have left him comfortable in annual income but deeply in debt. Despite his success and his vow to never be forlorn and poor again, he is overwhelmed with financial woes and a cold and empty home. He is always comparing himself with colleagues who have made better investments and have congenial marriages and close friends. Since beginning analysis he sees how similar he is to his father: remote, miserable, thoroughly self-absorbed and headed to an early grave. In his relationship with me, Mr. A. initially was dysphoric, ruminative and otherwise affectively unrelated. He was chronically late to sessions and this has never consistently changed. After a period, he became warm, generous, friendly and affable, displaying an excellent sense of humor and a good feel for who I was as a person. Though angry at his chronic lateness and the similar intransigence of his self-destructive and passive-aggressive smoking and self-absorption, I became very fond of him. I experienced him as a strong, solid person and felt a distinct dependence on him. For example, I had fantasies of his taking care of me around some legal issues I was dealing with. Our senses of humor were in great harmony; we shared very many common interests and "wave lengths" and I felt toward him the deep affection I do to
my closest friends. As I do with my best friends, we sarcastically "kibitzed" a good deal. I believed that the intimacy and warmth we shared in the fabric of our interchange reflected a new capacity for him, an interpersonal richness and intimacy as antidote to his remote and impoverished history. My sense of things was underscored by his reports of notable changes in his relationship to his children. He clearly was more involved, related and affectionate toward them. I assumed that he and I had traversed the depths of mutual isolation and self-absorbed dysphoria and had evolved to a playfully affectionate connection. Though he was still miserable to his wife, self-destructive and lacking in close friends (aside from me), I was optimistic that all of this would soon follow.

I was thoroughly jarred when in articulating his generosity and our warm and mutually attuned connection, he confessed that he knew not what I was speaking of. He said that he felt absolutely nothing for me or toward me and had no idea to what I was alluding. He also noted that I seemed to him like a cold and aloof person. I didn't believe him; I accused him of denying feelings that seemed so obviously expressed toward me. I even accused him of lying and trying to cover-up his love for me. He thought I had gone crazy; that I was living in a delusionary world. He indeed genuinely felt nothing toward me; we were back in the family home where emptiness reigned. Ironically, this revelation reflected that like his parents, I had not really known him. I felt that I should have known better, for he had clearly conveyed to me that in his social world he was quite generous, affable and warm on the outside and that many people depended upon him and liked him quite a lot. A surface warmth and friendliness was easy for him; he did not feel close to any adult and as repeatedly noted, had no intimate friends. He devoted much time to his community but was generally unable to take help from anyone.

What is dissociated here? For one, Mr. A.'s profound closeness and identification with his depressed, self-absorbed and suicidal father is palpably obvious to me, intellectually to him but not manifestly experienced as such. Mr. A. can see the similarities but he does not feel them. He also does not fully own the wish to die like his father, nor does he feel a deep connection with the compulsion to live the same impoverished life of failure as the latter. The emotional connection is dissociated; lived-out but not affectively experienced. As long as this is so he seems doomed to repetition. In
the transference, his love for me and his rage toward me for failing him like both his parents and sister is similarly dissociated. He feels aloof, nothing; I am the irrational one with all of the crazy feelings. From his perspective, it's "not me" but "him". His identifications, his hatreds, his dependency and his loves are all dissociated in the transference and historically (though he has always often hated his scapegoated wife and now more manifestly loves his children).

My own efforts at personal recovery vis à vis Mr. A. begin with a renewed effort to draw links between his sense of our coldness and isolation and mutual destructiveness and that of his original family. I hope to facilitate an awareness of desire for repetition; to connect and not dissociate his loyalty and attachment to what was and to the self-skin in which he is most comfortable living. In addition, I hope to use my own injury in relation to him and the hate which stems from it, to help him feel his own destructive hatefulness. His father did not care what happened to his children when he died so young and Mr. A. as well is still willing to do likewise. I know what it feels to be murdered by him. Finally, I still feel much affection for Mr. A. Despite everything, I feel deeply connected with him and I do believe that some of what I feel is dissociated from Mr. A.'s own being. It is like I am the patient and dependent upon and in love with my analyst. He, of course, is dissociated from his transference dependency and love and if he stays alive long enough he may wear down and feel this. My strongest ally is the part of my feelings which belong to him as well. Mr. A. will not emotionally connect with his compulsion for repetition and his loyalty toward his loved ones until he connects with his dependency, love and hate toward me. We are living together in his estranged original family home (and to some extent his current one as well) and the therapeutic action lies there. It is my task both to not continue to enact the past remoteness with him and to feed back to him his dissociated feelings which he subtly conveys to me and which I feel toward him in my countertransference.

Mr. B. began analysis at the behest of his wife-to-be, the focus being his reluctance to commit to marriage. He presented himself as a gentle, inhibited, shy and very socially awkward man, with a long history of "social blocking". After a period of time he acknowledged a preoccupation with sadomasochistic, heterosexual
fantasies, magazines and videos. One would not guess this from his "nice guy" manner. After he married, his wife began to feel his sadism in the form of a cold remoteness; a trait which Mr. B. preferred to see as shyness. He became profoundly dependent upon his wife yet this was not at all apparent to him. She, for instance, made virtually every financial and family decision, including the decision to marry and have children. They very quickly did have children and he has been a loving, warm and very attentive father, while growing even more remote from and dependent upon his wife. His career, which lends itself to his schizoid intelligence, is developing well. Were he more a personal presence he could do better. His wife essentially makes all major business decisions for him. He has a basement bunker in his home where he watches his sado-masochistic videos and has computer sex. He is very pleased that he has become both a much more involved father than his own father as well as more financially secure, yet is still upset by his extreme social discomfort with prospective women lovers or potential male friends. He is also disturbed by his wife's wanting more love than he claims to feel for her, though he doesn't want to disrupt his family life.

Mr. B. is very similar to his father, a profoundly remote man who was thoroughly unngiving to his wife. Like his son, he spent considerable time (before the video and computer era) with pornographic magazines and unlike his son, minimal time with his only child. Mr. B. recalls longing to be with his unavailable father as a youngster. My patient's overt emotional life belonged to his mother and their relationship was so tight that it bordered on physical incest. Mr. B. had serious separation problems from everything that one could conceivably have them from, yet, by the time he reached young adulthood, he had dissociated any loving or dependent connection upon his mother and as much as he resembled his father, felt no overt emotional tie there either. He froze in relation to them as a way of surviving and turned these profoundly close connections and identifications into sado-masochistic control. For a very long time, he failed to even slightly mourn his parents' death. Mr. B. became his father; soft and gentle on the outside, remote and sadistic on the inside, yet he could not experience the closeness which such similarity suggested. His dependence, love and rage toward his mother were all dissociated and his ability to feel deep love for his children disguised his inability
to feel anything for adults. He viewed his private sado-masochistic world as a sexual peccadillo and it did not interfere with his basic view of himself as a gentle and caring person. For example, he had very liberal political beliefs and strong feminist commitments, enabling him to mask his defensive hatred of women.

After the glow of Mr. B’s development into a wonderful father and a reasonably successful businessman, our relationship became as remote as one might expect. He felt that I was not the warm paternal father replacement he had envisioned when he had thought about being in therapy. Indeed, I often did not feel warmly toward him. I did feel so in the first year or two when the frightened, gentle and reserved side of him dominated our interchange and then when he developed into a loving father to his children. Actually I had experienced myself as very giving and forthcoming to him during our early relationship and then saw him freeze-up and withdraw from me. As he withdrew, I chased him and as he withdrew further, I became alternately sadistic and withdrawn. This passive-aggressive, sado-masochistic interchange played out until I clearly recognized it but by this time he was quite blocked and withdrawn from me. Like with his parents, his dependency, attachment and identification were dissociated and he felt either nothing or fear of my potential crushing power. He spent much of the time for two or so years talking about his wife’s demands which he could not meet and of his desires to overcome his lifelong social inhibition and meet sexy young women. The latter became his overriding goal in analysis and he felt that I, in a judgmental fashion, refused to help him with this aim. During this period, my concurrent countertransference engaged him in a repetition of his remote relationship with his father and the sado-masochistically controlling one between his mother and himself. My concordant countertransference was primarily emotional isolation or rage, yet when I raised with him the rage he must be feeling toward me, it was far too strong a feeling for him to connect with. His identification of me as the father toward whom he was so disappointed was as far as he went. His dependency on me was lived out in the form of indirect requests for business, family and social direction. These requests were subtle but powerful. They were, however, also dissociated and reversed by a lack of acknowledgment of my importance. It became clear to me that he
was enraged toward me in relation to his dissociated attachment to me and dependency upon me. This, however, was lived out by displacing it on to fantasied women who he handcuffed and abused. This was a direct repetition of his relationship with his mother; he was the object of her sexualized domination and control. The longing he felt for a stronger more present father was evident only in his disappointment in me; the longing per se was dissociated. The profound physical love and neediness he had felt for his mother was thoroughly dissociated and he reported nothing close to such feeling in the transference. In summary, for a long period of time he lived out attachment and dependency toward his wife and me both but did not feel it. Similarly, he also lived out rage but felt it only toward sexually fantasied women. He also dissociated all of the intense love he felt toward his mother and the longing he felt toward his father and felt this toward no adult; only in relation to his children and the idealized beautiful young women he hoped to one day meet.

The primary analytic focus in our final three years together was the largely frozen nature of his feelings toward me. Other than disappointment and periodic fear, I was like a stranger to him. In this context, he had a series of dreams which were pointed and poignant. In one dream I was the injured object of homosexual, sado-masochistic sex with a colleague of Mr. B.’s. In another dream I was dying of cancer and he woke up crying. In a third dream, I was trying to escape a hurricane and was banging on his door and he would not allow me entry. These dreams occurred over a period of time and were the first dreams he had with me present in them. In response to the first dream I conveyed to him that I often felt tortured by his coldness and that I had on many occasions wished to physically assault and injure him as a way of penetrating him. After the second dream I noted with some pleasure that he finally seemed to really love me like the father he once so longed for and that despite the freeze between us, I believed we would really miss one another when we were no longer together. In response to the third dream, I conveyed that his coldness and his cruelty often alternates with my emotional withdrawal or retaliation but so far, I have always returned.

It was not the dreams which led Mr. B. to directly connect with his dependency, love, longing and hatred for me; the repeated focus on these themes in the transference-countertransference
matrix facilitated his telling me of these dreams in the first place. Mr. B. had been in a perennially stand-off position. His loyalty to his father did not allow him to be different from father and his embeddedness with his mother prohibited his truly loving any other adult. His dissociation from such connections left him an an empty schizoid world vis à vis adults. Our focus in the here and now of the analytic interaction helped Mr. B. connect with his past loved and hated ones through the long and arduous interpersonal negotiations with me. We had to live through his and my own dissociated and schizoid self-states for quite some time before different self-other configurations emerged and began to broaden.

**Conclusion**

I have tried to illustrate that the concept of dissociation can be broadened to describe the analytic experience with other than profoundly hysterical or severely disturbed individuals. This concept can be used to refer to internalized interpersonal, relational configurations and self-experience which may never have been articulated or formulated. Such experience is inevitably lived-out in the context of the transference-countertransference matrix. Though exact replicas of ongoing historical experience can never be precisely known, approximations of such internalized self-other patterning can be gleaned from the subjectivity of the analytic interaction, with the analyst in the position of observing-participant. Such an analytic forum may be of particular value for patients who have long been isolated from a range of emotional experience and are able to display affect only quite subtly in the context of analytic engagement.

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