Getting Cold Feet, Defining “Safe-Enough” Borders: Dissociation, Multiplicity, and Integration in the Analyst’s Experience

Jody Messler Davies, Ph.D.

This paper attempts to explore the fate of the analyst’s multiple self/other organizations during times of heightened countertransferential enactment. It is suggested that such countertransference activity involves the “de-homogenization” of otherwise indecipherably integrated self/other constellations, evoked independently or in response to, but always in interaction with, the patient’s own unique organization of multiple centers of psychic awareness and unconscious receptivity. An extended clinical example is used to illustrate the theoretical conceptualization.

Back in the “olden days” of psychoanalysis when analysts really believed that they knew what they knew, and meaning was something that one looked up in a dictionary rather than negotiated interpersonally, the one thing that analysts of all persuasions spoke about with even greater certainty than anything else was their ability to analyze and resolve transferences and to understand their own occasional, conflictually based countertransferences. Our current psychoanalytic milieu recognizes the simple naïveté of this statement and, one hopes, appreciates the nuances and complexities of real working through and psychic change with a steadily growing sophistication and subtlety.

We now recognize the transference-countertransference process as intrinsically and irreducibly intractive. “An interactive matrix,” as Greenberg (1995) has termed it; “irreducibly subjective” as Renik (1993) has described it. Transferences are not distortions but competing, oftentimes conflicting, organizing schemas or interpersonal fantasies lying at the foundation of each participant's unique striving toward self-integration. They are sets of expectations which nourish the essential illusion that we live in a predictable world populated by knowable people. Transferences are not necessarily displacements from the past. Although they begin in our earliest formative relationships, such meaning schemas reorganize and reconfigure themselves throughout the life span in accord with ongoing interpersonal experience. As organizing schemas, transferences are not resolvable. Perhaps expandable, perhaps malleable to a certain extent, renegotiable in new contexts, but at the same time, entrenched in their devotion to old object ties and familiar outcomes. We therefore no longer emerge from our treatments “cured.” We seek, rather, to familiarize ourselves with our conscious and unconscious preconceptions, thereby opening the door to new experience; to expand and enhance our familiarity with aspects of self previously unknown or unformed; and to seek and find others who will depart from the expected, those who will know us and touch us in a myriad of previously unimaginable ways.

Implicit within this conceptualization of the transference-countertransference process is a model of mind which I have articulated at greater length elsewhere (Davies, 1996, 1998; see also Bromberg, 1996; Mitchell, 1993; Pizer, 1996) but will repeat here briefly in order to put the present discussion into context. It is a model of mind which replaces the more linear, topographically organized, repression-based structures of classical analysis with a dissociative-integrative continuum along which mind, indeed the individual's experience of self at any given instance, reconfigures itself in accord with the present interpersonal moment. This model of mind involves viewing psychical processes as a kind of confederation of multiple, dynamically
interacting, but otherwise autonomous sub-organizations of internalized self and object representations which move in and out of conscious prominence depending upon the evocative potential of the current interpersonal moment. Within such a model, analysis of the transference involves allowing the interpersonal present, as it exists between patient and analyst to fill the moment, to invite a suspension of integrative processes and a temporary, iatrogenic intensification and exaggeration of particular constellations of self/other organization within the therapeutic dyad. The goal of such an analytic agenda is to invite into interpersonal enactment those dissociated aspects of self/other experience that have been rendered unconscious by dint of the individual's striving toward a state of equilibrium and integration. By making them conscious within the analytic relationship, patient and analyst potentiate a more inclusive redefinition of particular aspects of self/other interaction.

If we hypothesize the regular occurrence of such heightened dissociative process within the transference — the “de-homogenization” and intensification of particular self/other dyads — then it stands to reason that the analyst will be as swept up into the disorienting vortex of such potentially fragmenting forces as will the patient. An intermingling of disentangled, highly evocative patient/therapist self states will seek out alliances and misalliances in the ever more complex arena of transference-countertransference enactment. Such an analytic process requires that the analyst maintain an awareness of the multiplicity of self/other organizations that may infuse the treatment relationship, as well as an openness to the emergence of her own partially dissociated self experiences in relationship with or in response to the patient's shifting transference experiences.

Given the intricately choreographed intermingling of multiple self states, the multitudinous intersecting points of patient/therapist strength and vulnerability, which call to each other within intensely evocative and highly interactive relational analyses, it is indeed surprising that so little has been written about the analyst's increased vulnerability to disorganizing and potentially fragmenting dissociative processes within the transference-countertransference space. Indeed, it is the aim of this paper to pursue just such a project: to explore via an extended clinical vignette and some preliminary theoretical musings the fate of the analyst's areas of pain and vulnerability within the clinical encounter. How do we manage our own shifting self states within the analytic work? How do we maintain an awareness of multiplicity as a backdrop against which iatrogenically intensified countertransferralent states will emerge and temporarily assume center stage? What form of safety, of holding, and potential space do we ourselves require in order to manage our vulnerabilities and fears in this most intimate of encounters? Can we keep our vulnerabilities out of our work? Indeed, should we? Does the analyst's safety-seeking affect or even implicitly guide her clinical choices? Does the patient assume any responsibility for the analyst's unconscious psychic safety?

I hope that there are few among us who still hold any illusions about their reasons for doing analytic work. The old notion that the analyst, by dint of training analysis, now holds some privileged access to superior mental health seems a form of rather arrogant self-protection and denial. We are who we are, most of us would now agree, in order to repair our ailing internal objects and heal ourselves and keep healing ourselves, over and over again. In a paper which seeks to deconstruct the myth of the invulnerable analyst, McLaughlin (1995) states:

...what each of us needs from the other, whether on the couch or behind it, is at depth pretty much the same. We need to find in the other an affirming witness to the best that we hope we are, as well as an accepting and durable respondent to those worst aspects of ourselves that we fear we are (p. 434). Traditionally, we have expected this to be true for the patient. We have come to find it to be true for the analyst as well. Acknowledging this, we can be more ready to see how our needs suffuse all that we are and do in the work, and how we must endlessly be self-observing to discipline and optimize these tendencies that are both our strength and our liability (p. 461).

In discussing the analyst's vulnerabilities to countertransferralent self state dissociation, I will make several assumptions. First, that as practitioners doing analytic work we seek to create not only a safe haven for our patients,
but strive, also, to create a transitional space in which we ourselves have the most optimal access to our own unconscious process. I refer to “safety” here not in the regressive sense of avoiding painful places but in the more Winnicottian ideal of holding, containment, and non-retaliatory expectations. Indeed, I will suggest that out of the myriad of possible directions at any given point involving clinical choice, we will often be unconsciously directed in pursuing aspects of the clinical encounter that we hope will optimize our own sense of safety, creativity, and the rich efflorescence of unconscious process and play.

Finally, I will suggest that rather than coming into the analytic endeavor eschewing our own need states and personal self-interests (see also Slavin and Kriegman, 1998), we must evolve a theory of clinical technique for relational analysis that recognizes the analytic encounter as one in which there are two participants coming together, attempting to create an optimal space in which to experience and process multiple aspects of who they both were, are, and might yet hope to become. We seek ways of reaching and touching each other, of nurturing, exciting, soothing, arousing, and ultimately healing the places that hurt. Within this intersubjective space, the analyst, too, wants to be reached, known, and recognized.

Of course, I realize that the clinical responsibilities to reach, recognize, and know are by no means symmetrical. The patient's feelings, needs, and conflicts over both are almost always in the foreground of the analytic work, and the most essential responsibility is the analyst's to help the patient. However, I will maintain, at least for myself at this point, that the most meaningful and potentially mutative psychoanalytic work proceeds on an unconscious trajectory toward a place in which the analyst's unconscious processes, the destabilization of her more integrated “professional self” (see Mitchell, 1997), the creative use of self-state shifts and temporary intensifications, can occur without the threat of overwhelming, potentially fragmenting anxiety, humiliation, or retaliatory expectation.

Clinical Example

Consider the following series of clinical vignettes involving a patient I will call Daniel. Daniel was twenty-seven years old when he first came seeking psychotherapy with the vague sense that he needed some help

“putting things together.” Indeed, my first impression of him was of a young man for whom nothing quite went together: clothes somewhat wrinkled and mismatched, long arms and legs that didn't quite work together in coordinated motion, thoughts that seemed scattered and undirected. He came for the first time on a bitterly cold day, and some of the first things that struck me were the thin socks and sandals he wore on his feet. Though I asked him about this, he simply replied offhandedly, “Oh, I never, ever get cold.” Daniel was exceedingly bright, remarkably well read, and potentially attractive under his somewhat rumpled, ragged, and disorganized exterior: an interesting combination of creative genius and neglected little boy. I entertained both fantasies.

Daniel took to analysis as if he had been waiting for this moment all his life. Within the first month he was coming three and then four times a week, a schedule he has maintained to this day. However, despite the manifest eagerness, there was an odd, disconnected quality to the story of his life as it emerged in the first months of working together. In telling his story, Daniel seemed to be relaying a series of separate, unrelated events—well remembered, even emotionally full, but oddly disjointed from other occurrences or from any overriding attributions of meaning that would enable him to draw conclusions or construct any patterns of motivation and significance. There was a kind of intermediate dissociative process between the awareness of certain events and the attribution of meaning to those events. For example, Daniel told of coming home from school one day, around the age of fifteen, to find his mother lying on the kitchen floor with the gas on, all the windows closed, and a towel stuffed into the doorjamb. “You mean she had attempted suicide?” I naïvely asked. The patient looked shocked and then tearful. “Do you really think that's what she was doing?” He was incredulous.

And so, much of the early work involved weaving together the disparate, dissociated pieces of Daniel's story. Mother was episodically severely depressed, hospitalized intermittently, and given shock treatments when all else...
As the facts of Daniel's story deepened within the context of our particular analytic relationship, some of the clues seemed to fail. The prevailing images were of mother lying in a darkened bedroom, heavily sedated, completely unavailable; of Daniel, himself sitting outside her bedroom door listening to her crying, feeling simultaneously enraged and utterly inept;

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- 189 -

of a sadness and despair that was too heavy, too large for him to begin to comprehend, let alone manage. Occasionally, mother would emerge from her internal hell and swoop down upon Daniel in a feverish, desperate, frenetic attempt at “keeping her out,” of managing her yearning and desire. He came to understand through the analytic work that fending her off was more than his badness, more, even, than his rage at her. It was also a self-protective awareness that taking her in would only lead to another abandonment, another heartbreak. And he already felt himself to be on the edge. He remembered the despair that would inevitably follow his inability to “be nourished” by mother during her episodic appearances, and he began to speculate about the connection between such moments and his current bouts of depression and interpersonal withdrawal. Daniel expressed frustration at the time constraints of analytic hours, my coming and going like his mother — “swooping down upon me with so many goodies, only to disappear again at the end of the hour!” We watched with a growing mutual interest the intricate dance of desire, yearning, dependency, humiliation, and withdrawal that defined the borders of our analytic relationship.

Daniel rarely spoke about his father, but when he did, he sketched the image of a man who was often away from home, avoiding contact with his depressed, mentally ill wife, drinking too much, highly critical and emotionally unavailable to his needy young son. “My job was to take care of mother so that he didn’t have to,” Daniel would explain. “I was expected to do her bidding, to do all of the things my father refused to, to be compassionate and understanding where he could be outraged and disgusted.” I was troubled by Daniel's description of his relationship with father, for although his words were insightful, he would become somewhat dissociated whenever he spoke of him. His eyes would become heavily veiled and opaque, a metaphor (originally by a patient of mine) as “dead eyes.” “Dead eyes” look inward only; they see only internal spaces, as if transfixed by some kind of horror. “Dead eyes” always make me worry, in a now familiar way, that somewhere a child has been betrayed. But Daniel spoke only of neglect

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- 190 -

and loneliness.

My relationship with Daniel became very intense very quickly. From the outset there seemed a meeting of metaphor and of mind that led to the creation of an imagistically and affectively fertile analytic space. He seemed to take in everything I said with appreciation and gratitude, often commenting on how remarkable it was that I knew “exactly” what to say and how to say it, so that he could use piece of his emotional life that had before seemed overwhelming. Indeed, he had learned well how to breathe life into a needy and depressed mother, but unlike his mother, Daniel’s appreciation affected me. If Daniel’s “father eyes” were “dead eyes,” his “transference eyes” bespoke an intensity of desire and faith that began to make me feel both deeply nourished and decidedly uncomfortable. Was I promising too much? Were my comments too deep and penetrating? Could this kind of idealization be worked through slowly or was it destined to splinter and shatter irrevocably? Indeed, would the whole thing become eroticized in a way that would spiral out of control? Had that happened already?

Although I worried about the atmosphere of mutual seduction that seemed to be going on between us and the almost manic fervor with which Daniel embraced his unconscious, the analysis, and me, I was also aware that something deeply and mutually enriching and emotionally resonant lay at the heart of this analytic process. I tried to move between these two experiences, one of deep immersion and faith in our ability to work through what would come and the other of impending transference-countertransference catastrophe, with at least a modicum of equanimity, but this state of mind was often illusive.

As the facts of Daniel's story deepened within the context of our particular analytic relationship, some of the clues which had eluded understanding emerged more clearly. With time, I was allowed to peer into Daniel's “dead father
eyes” to a relationship of truly profound neglect and sadistic emotional abuse. It appeared that Daniel's father would disappear for weeks at a time, even when his wife was most depressed, leaving his son in an essentially empty house, with a mother utterly incapable of caring for him. Even this barren environment was, however, to be preferred to times when father ruled absolutely

and vindictively through the intoxicated haze of alcohol-induced psychotic rages. Father's raison d'être at these times became the relentlessly sadistic humiliation of his young son. Daniel described with excruciating attention to psychic twists and turns the consummate skill of his father's cruelty and his own childhood victimization. Here at last was a place of some emotional intensity and intrapsychic concordance between Daniel and me, for such childhood experiences of burning humiliation and inexpressible rage were not unfamiliar pieces of my own growing up years. Not identical, to be sure, but close enough in their affective harmonies to resonate deeply and to open intricate intrapsychic passageways between us. Such shared areas of what Elkind (1992) has termed “primary vulnerability” must, it seems to me, unconsciously guide the analyst's sense of direction even before it can be articulated consciously. When such points of unconsciously resonating psychic vulnerability are brought to the fore, I believe that we can retrospectively see how they become nodal organizing lynchpins in the organization of transference-countertransference processes and clinical decision making.

In looking backward from this point, I could see how I had always tended to deal first with Daniel's basic proclivity to experience need and desire as profoundly humiliating. In the past I had intellectually explained this by believing that as long as need and humiliation were so intricately intertwined, everything he took in from me would be internalized with a commensurate sense of sense of shame and defeat. It was a repeated attempt to climb out from under the paranoid-schizoid position to a place of some enhanced mutuality where the profound neglect that marked this patient's inner world could find nourishment outside the borders of shame. I believed myself, at this point, to be in touch with the multiple voices in which Daniel could speak and with which I could respond. Again in retrospect, I believe I was more in concordant touch (Racker, 1968) with the patient's experiences of shame and humiliation than with the potential for a complementary countertransferential reaction; that where such experiences have been inflicted, there lies in wait an identification with the aggressor that could make him the object of my own wish to humiliate and shame, and could also make me the victim of his rageful need to do unto others precisely what had been done to him.

My own experience of a kind of dissociated countertransference response came one afternoon when Daniel was relaying in gut-wrenching, affectively nuanced detail the extent of his father's sadism. He began to recall an incident which had been unavailable to him before, and as he spoke, he began to shake rather violently and uncontrollably. He seemed frightened by this unexpected reaction, and I tried to reassure him by suggesting that the shaking might be intimately involved in some way with the memory he was trying to articulate. Indeed, what Daniel was about to describe was an incident that occurred when he was about seven or eight years old. His father returned home one night, particularly drunk and particularly enraged, only to find his wife again sedated and unavailable. Daniel remembered crying because he was tired and hungry, and there had been no one home to feed him or put him to bed. Father flew into a rage and began beating his son, calling him a sissy and a weakling, saying that he needed a man to toughen him up, to teach him how hard life could really be. At that point, Daniel recalled how his father had ordered him to remove all of his clothing, including his shoes and socks, and had locked him on the family's back porch for what he remembered as an interminable length of time. It was the middle of winter and the porch was covered with ice encrusted snow. Daniel was still trembling. “It was so cold,” he whispered.

Now, although I have heard many such horrific stories from my patients over the years, many in their concrete manifestations far worse, this story, coming from this patient, in the context of our particular relationship, was among the hardest to listen to. The next thing I knew, I was standing next to Daniel's chair wrapping a blanket around his shoulders, not quite sure how I had ended up there. I did remember reaching with a disembodied arm into the cabinet where I kept the blanket for my own occasional use, and then getting up out of my chair, but these were not
considered actions. For me this was the most striking aspect of this countertransference enactment. Not that it occurred — for I could easily imagine thinking about doing something like this and then deciding that it was or was not the best course of action at the particular moment. (This could be debated at another point in a discussion of action and interpretation. Did the action open up or close off exploration?) But for the purposes of this paper, it was

the lack of just this kind of thoughtful consideration, the lack of conscious awareness that several alternatives might be open to me, the inability to consider the multiple meanings that such a gesture would have to my patient, that seemed remarkably inconsistent with the way my work usually goes. This was clearly an action that had proceeded from one naked, exposed, and humiliated child to another. It was an action that occurred from well within one particular transference-countertransference constellation and not, as we prefer to work, from an ever-moving point amidst several simultaneously interacting perspectives.

But Daniel was no slouch. As he left the session he stared at me intensely. “You know this place,” he said. I nodded. “It explains a lot about the way we can talk to each other,” he continued. “Yeah, I think it does,” I responded. I then asked him if he had a blanket at home in case the shaking came back. “No, you forget,” he said with his usual sense of irony, “I'm the guy who never gets cold.” “I didn't forget,” I replied. “I was just thinking that if our work goes well, you may find yourself needing one.”

It would be hard to communicate how recognized and known I felt by my patient in this session, particularly in the last few moments; how healing this exchange felt for me, both in what I took from Daniel's understanding of my countertransference and in what I felt able to give to him. The problem lay in the fact that it was one-dimensional and in my lack of preparedness for what came in the session that followed. My total immersion in this one transference-countertransference paradigm left me blind to the other unattended-to places within this particular intrapsychic landscape, places more clearly discernible from outside the transference-countertransference enactment of the moment.

From the minute Daniel entered his next session, it became apparent that the mutuality and intimacy of the day before had been transformed. He stared at me with icy rage. “You're pitiful,” he began. “You think you're so self-aware...all of you analysts...that you can be so giving and caring...Well I know it's all a crock of shit...You do what you do so that you can feel good about yourself...it has nothing to do with me...You must have been feeling pretty good about yourself last night...did you bother to think how I was feeling?”

As it was difficult to capture the power of the day before, it would be equally difficult in this paper to capture my shock, my hurt, the visceral sense of being deeply wounded that I felt in this moment. Daniel, of course, had no way of knowing that he was no longer speaking to his analyst, but had reduced her in his outrage to a humiliated young girl, not only caught feeling secretly good about herself, but arrogantly confusing a generous and caring gesture with the basest and most self-serving of motives. My patient had no way of knowing that he was treading dangerously close to troubled waters, and I was destabilized enough to be of little help in making this apparent or using it constructively. Struggling mightily to emerge from the role of victim to this sadistic humiliator, I, unfortunately, turned the tables again, retreating to that purely interpretive position on high, available to all of us at our most vulnerable moments. “Well,” I countered (in what was surely one of my worst clinical moments), “it would appear that you've had some difficulty holding on to the intimacy that we were able to create here yesterday. I suppose that it's something we'll have to keep working on.”

It was quite a mess, and it stayed that way for some time. I did much thinking, talking, dreaming, and remembering in my efforts to help the two of us out of the place into which our work had descended. Daniel, for his part, was fighting, too, to rediscover the trust and balance that had been so reliable a part of our work before these events transpired. Once past the hurt, we were both able to acknowledge how broadened a picture of what it meant to be a humiliated child had been provided by our mutual enactments; how both of us could see and respond to the hurt child within the other, but how each of us, too, had demonstrated an ability to turn this victimization into a finely honed weapon of assault. What did it mean to take pleasure in giving to another? To what extent was it generous, to what
extent selfserving? Were these two mutually exclusive? Did they cancel each other out? The different self states which marked different transference-countertransference constellations each took their place in the foreground to be explored, felt to the fullest, fantasized and imagined about with a freeness that had not been possible before. Having already enacted the best and the worst that we could be with each other, there seemed so much less reason to hide in our attempts to understand

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- 195 -

the multiple meanings of our interaction.

Ultimately, Daniel and I were able to reconstruct his internal experience on the night I had reached out to him with the blanket. Although he recalled feeling seen and touched and nourished, he also described a parallel experience of being too quickly penetrated and then exposed in his inability to reject my offer of warmth. He could acknowledge having seen through to a vulnerable place within me; how angry this made him, probably because of his mother's depression; and how frightened he had been of seeing me, of feeling himself to be an equal, of feeling himself to be a man, of feeling his own potential to touch, penetrate, hurt, or overwhelm. Ultimately, what he could not see through the haze of his humiliation, and what I had been unable to help him to see through the haze of my own, was how touched and nourished I had felt by his understanding of my experience in that session and in the broader context of our work as reflected in that session. It was, in the end, this insight, the ability to hear and truly apprehend his effect on me, that seemed to carry the greatest potential to change what had transpired between us from an experience of penetrating exposure and vulnerability, a paranoid-schizoid flip-flopping of only one needer and only one giver, to a moment of true mutuality and intersubjective recognition in which Daniel and I both felt held and nourished.

I cannot provide any closure to this story. Daniel's is still a treatment in progress. But I will close with an exchange we had toward the beginning of this winter. Daniel was talking about something I could not quite attend to when suddenly I blurted out, “You're wearing boots!” Gone were the socks and the sandals. He grinned broadly. “I've been waiting to see how long it would take you to notice.” “Has it been very long?” I felt a moment of concern. “Oh, I think I'll let you worry about that,” he said, reaching for a healthier, more playful, even flirtatious version of his rage.

Conversely, did his rage, contempt, and assaultiveness on the following day suggest an attempt to understand his own transference-countertransference enactment between us? Did these reactions imply that the transference-countertransference enactment between us had been a therapeutic one? Conversely, did his rage, contempt, and assaultiveness on the following day suggest an action that had been too penetrating, too affectively overwhelming, either incorrect or at the very least premature?

The difficulty here is not in articulating an answer, but with the question as so formed. For it rests upon a model of mind that I believe to be no longer compatible with contemporary psychoanalytic theory in general and our understanding of the transference-countertransference matrix in particular. The question presumes a linearly organized mind in which we address ourselves as analysts to the outermost layer of preconscious material primarily. From this place, the patient can respond in a more or less integrated way to both the affective attunement and the psychodynamic accuracy of the analyst's intervention. As clinicians working with this model, we look for a well-modulated emotional response and an enhancement of associative material in order to feel confident that we are on the right track.

My own clinical experience would suggest, however, that no intervention and no patient response are ever so

**Discussion**

The psychoanalytic milieu in which I grew up and was trained would require that I look carefully at Daniel's response to my clinical intervention and ask honestly how this reaction speaks to the “rightness” or “wrongness” of what transpired between us. Did the emotional attunement of that night, Daniel's ability to speak openly and directly about parts of me that he had not allowed himself to engage before, his sense of being held and warmed — did these reactions imply that the transference-countertransference enactment between us had been a therapeutic one? Conversely, did his rage, contempt, and assaultiveness on the following day suggest an action that had been too penetrating, too affectively overwhelming, either incorrect or at the very least premature?

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My own clinical experience would suggest, however, that no intervention and no patient response are ever so
immediate or so clearly tied to the patient's subsequent response. Though we construct our clinical interventions with certain conflicts in mind, we have, in fact, little control over where they ultimately land. Much like the seeds of a wind-blown dandelion that scatter and take root in places unknown, that which emanates in interpretive form from the analyst's particular intervention, her own construction of conscious, preconscious, and unconscious experience with the patient, seeds the patient's conscious, preconscious, and unconscious places in myriad ways that may not become fully knowable (to the extent that they are ever fully knowable) for years to come. Likewise, the patient's response resonates with so many different parts of us that we are never in a position to objectively evaluate any one particular intervention from any one point in the treatment situation. We are confronted with a model of mind based on a loose organization of multiple experiencing and reacting centers, and a new psychoanalytic humility born of the need to acknowledge that we can never be quite sure, at any given moment, who within the patient is listening and who within the analyst is speaking.

So my own answer to the question of whether this particular intervention with Daniel was right or wrong would be to suggest that it was neither right nor wrong but both right and wrong to each of those parts touched by the moment. It emanated from multiple parts of my own being and immediately reorganized, like the turn of a child's kaleidoscope, the operative organizing relational matrices which gathered themselves around it. The analytic function, to my way of thinking, does not involve constructing the precisely accurate intervention at any one clinical juncture, but, rather, the holding within the analytic space of multiple patient/analyst levels of reaction and meaning, separating those reactions out from reactions wedded to the past, and thereby creating a new, more openly creative space for constructing emergent levels of emotional reactivity and meaning.

Daniel, the seven-year-old boy, provided me with a unique opportunity to forever change the way in which he would remember that horrible night of such traumatic overstimulation and psychic desolation. He opened a psychic doorway between us to a new kind of maternal experience that could nourish and warm him, an experience that would ultimately carry the potential to enliven both his body and spirit. I am convinced that Daniel, the boy, will never again remember that night with his father with quite the same affective despair, for it will always be associated in memory with another night, between us, in which his terror and need were more fully apprehended and responded to. For Daniel the seven-year-old and me as mother, that particular clinical moment could not have been more “right.”

However, Daniel also saw a frightened and humiliated young girl who responded out of her own need to be rescued and warmed, a girl who was too young and too frightened herself to be of much use in taking care of him. He was left with the frightening perception that we were children together, and still no one was at home to be a parent, to care for him. Perhaps no one was “running” the analysis. He did not want a sibling or another damaged adult whose needs he would have to worry about. Daniel with another damaged child and Daniel with his damaged, depressed mother were two other relational paradigms that organized themselves around this clinical moment and informed the emotional response to it. In holding these relational experiences, we were able to understand more deeply those aspects of his current interpersonal world that resonated with these transference-countertransference paradigms. We came to understand his attraction to and contempt for “needy” others, the way in which the stimulation of “neediness” within him was always ensconced within a passive feminine identification and accompanied by a profound sense of shame and mortification.

Daniel the seven-year-old also saw me as the sadistic, self-serving father, exploitive and cruel, stripping him of his defenses and reducing him to a shivering shell. He fought with me, competed with me, wanted nothing to do with me. At times he viewed the analysis itself as a trap in which to ensnare and humiliate him. He attributed to me the basest of Machiavellian motives; he raged at me and at times withdrew out of fear that he might do me real damage. Indeed, where I felt humiliated by his rage, my contemptuous response was not completely dissimilar to his father’s, and where my agenda was to be a nurturing mother, it was clear that my needs as well as his were served. Here we were able to explore his episodic rage reactions, as well as the tremendous difficulties with authority that had plagued Daniel's
professional and academic lives. Equally important was Daniel’s ability to begin to apprehend the aggressor inside of himself, that part of him who could be brutally contemptuous and penetratingly perceptive in his reactions when threatened.

But Daniel was not a seven-year-old boy. And Daniel as adult man experienced my “too accurate” perception of his terror and despair as intensely humiliating — its stimulation of years and years of unmet preoedipal yearning as penetrating in a way that threatened his very organization of self, particularly with regard to male gender. In response to his emotionally absent mother and his abusive, sadistic, out-of-control father, Daniel had fashioned a male gender identity based on an omnipotent denial of all need states, a form of complete control and mastery of his destiny and desire. Any crack or fissure in this fortress automatically reduced Daniel to the shivering little boy on the back porch, and there was sorrowfully little middle ground between the success of his omnipotence and the dissolution of his experience of a masculine self. To want the blanket, to want me as giver of warmth, was incompatible with being and feeling like a man. these were the present interpersonal issues which emerged in Daniel as adult man in relation to an emotionally responsive mother. However, where Daniel’s need to reject such nurturance became overwhelming, I believe that I resorted to the position of the little boy, who couldn’t stop trying to reach out and heal his depressed mother. I could feel and almost frantic need to get through and sense some emotional responsiveness on his part. I could feel anxious and alternately despondent and enraged when these efforts failed. Where my efforts to heal became too penetrating, I believe that this was the operative transference-countertransference paradigm.

As Daniel is not a little boy, so I am not his mother. We therefore struggle as well with the relationship between adult man and adult woman as separate centers of mature desire and agency. Daniel is convinced, and remains convinced as I write, that for me to have seen him so often reduced to states of humiliation and terror, to have witnessed his inability to cure his mother and to control and ultimately defeat his raging father renders him, in my mind, an eternally defeated, whining, and hopelessly pitiful child. He believes that I will never see him as an attractive and sexually potent man. Likewise, to desire me as a woman he will never have immediately sends him back to the frigid porch, defeated, humiliated, and castrated. On my part, as adult woman within this analytic relationship, I search for ways that are neither too stimulating nor too possessive in which to let Daniel know that the defeated little boy is only one small part of my overall vision of him. I struggle with how to let him know that I admire the courage which he has brought to our analytic project and with which he has faced such devastating childhood terrors; that I am touched and not repelled by the vulnerability I have been permitted to see;

and that I feel honored rather than burdened by being chosen to accompany him on this most extraordinary internal journey. I believe that it is part of my job as his analyst to let him know that these things enhance rather than reduce his potency and attractiveness as a man. But I must do this in a way that does not bind him to me in incestuous re-enactment, but rather sets him free to express his desires where they can be more fully met.

These are only a few of the many, many relational matrices that organized themselves around this one particular clinical moment between Daniel and me, and this was only one out of countless moments that have transpired and continue to transpire between us. The clinical work which emerged from these interactions involved the full participation of the entire “cast of characters” I have described. The bereft little boy, the humiliated little girl, the mortified little boy, the depressed mother, the “swooping down” overwhelming mother, the available nurturing father, the absent father, the sadistic and abusive father, etc., all became an improvisational troupe of players whose active participation in the analysis of different transference-countertransference processes enabled the clinical material to live itself out in the room, in a sense bringing the unconscious to life in what transpired between us. Each participant took his or her turn in the foreground of the clinical work and was afforded the opportunity via this kind of “therapeutic dissociation” (Davies, 1996) of remembering the past, experiencing the present, and imagining the future, unencumbered by the need to create an illusion of integration and linearity. I have tried to use this clinical material to demonstrate the constant breaking apart, reorganization, and reinterpretation of self/other states that become the basis
of any relational analysis: the dissociation, multiplicity, and reintegration that create the emergence of new modes of emotional reactivity and meaning schemes for both patient and analyst alike.

**Conclusions**

I am aware that the clinical material I have chosen for this paper raises the important question of how much control the analyst can and should maintain over her own unconscious process within the intersubjective domain and over the ultimate direction of the psychoanalytic process in general. As I stated at the outset of this paper, I believe unequivocally in the analyst's responsibility for the fate of the psychoanalytic endeavor with each patient. But where we must become immersed in our own and our patients' internal processes simultaneously, where we must live and breathe there in order to know those places more fully, temporary suspensions of intellectual, verbal, fully conscious processes will occur for the analyst as well as for the patient. As *Freud* (1915) stated so long ago,

> It is very remarkable thing that the Ucs. of one human being can react upon that of another, without passing through the Cs. This deserves closer investigation, especially with a view to finding out whether preconscious activity can be excluded as playing a part in it; but, descriptively speaking, the fact is incontestable (p. 194)

It is not my intention to suggest that such experiences of relatively unmediated responsiveness become a reified aspect of psychoanalytic technique, that they are to be actively sought after or mimicked in the analytic situation. My point, rather, is to suggest that they are endemic to the analytic situation and will indeed occur regardless of one's theoretical orientation, model of mind, or years of personal analysis. They are, I believe, intrinsic to the mutual deep immersion in intrapsychic and intersubjective spaces potentiated by psychoanalytic work at the deepest levels of experience. My point is to suggest that they will occur whether we pay attention to them or not, and, in line with our psychoanalytic values, I believe that where prospective control and decision making over the direction of the analytic process temporarily eludes us, a scrupulous retrospective attempt at understanding and integration becomes part of our professional task.

Our new psychoanalytic milieu has ceased to value verbal insight and understanding above all else. Though we continue to rely on such processes, we have finally come to understand and accept the ineluctably interactive nature of psychoanalytic work. We seek a level of emotional resonance and empathic attunement that will facilitate

> As any treatment progresses, the analyst's immersion in her own internal psychic process must deepen and more freely engage in a fanciful and creative play with that of the patient. This is not a way of thinking more accurately about the nature of the particular analytic process, but rather a completely different manner of experiencing, a way of being with the patient and with oneself that brings into enhanced focus those aspects of unconscious or unformulated experience (see *Stern, 1983*) which could not otherwise be psychically represented and elaborated. The creation of such a “psychic dreamspace” (*Davies, 1997*) recognizes the limits and borders of rationality and form, the constraints of language and definition. Though we no longer hold to the unconscious as a fixed psychic structure containing the archives of the patient's historical past, we do seek the creative efflorescence of unconscious fantasy that retains a kind of primary process sensibility, as first described by *Freud* (1915). In this sense such a dreamspace of mutual unconscious participation and influence involves a sense of timelessness, a multiplicity born of the absence of internal contradiction, an emphasis on the processes of displacement, condensation, projection, and introjection, and the
preeminence of psychic over external realities. In short this is a place in which fantasy rules, omnipotence survives, and boundaries fade. The impossible, the unimaginable, and the irreconcilable reign freely.

Like the explorers of old, we travel with our patients across this great and hazardous divide, from conscious to unconscious, from secondary to primary process modes of experience, in order to bring back the riches of far-off, fanciful places that we could not otherwise begin to imagine. We avail ourselves of what is beautiful, exotic, and enriching. We bring back such riches, integrating them into too old and too familiar ways of life, creating new schemas, emergent modes of being and being with, of construing experience and imbuing it

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- 203 -

with fresh meaning.

As analysts we become, with time, more seasoned travelers, familiarizing ourselves with the terrain of conscious and unconscious spaces and with all of the intermediary stops along the way. We recognize that the quality, shape, and texture of each journey, the relative success with which we are able to traverse potential space, to reconfigure conscious and unconscious experience, to bring rationality to chaos and fanciful imaginings to our thought, all rest on the unique pairing of each particular patient/analyst dyad. As fellow psychoanalytic travelers on this highly personal and perilous journey, patient and analyst together come to realize with some trepidation and dread that we are oftentimes dependent upon each other for safe passage through these transformational straits. We must therefore negotiate in ever more effective and reliable ways how we will confront conflict and survive dangerous encounters. With each successful negotiation, the patient becomes less afraid of all that is new. However, the analyst grows safer too and becomes able to rely upon the developing analytic skills of the patient. Here I believe the analyst becomes a more hearty explorer, willing to take greater risks, to confront more intense dangers in order to enrich and enliven the quality of the overall journey. She comes to understand via a finely tuned unconscious communication that the patient has become able to provide certain critical holding functions for her, and she thus becomes capable of undertaking forays into the deeper recesses of her own unknown and irrational places.

It is not my intention to suggest that we burden our patients with such a responsibility for our well-being, that we communicate to them as a formal part of psychoanalytic technique that such is their responsibility. This would be unconscionable. Rather, I am suggesting that the analyst will often unconsciously make clinical choices which are designed to heighten her sense of safety. As I was inclined to focus my work with Daniel around issues of shame and humiliation even before the full unconscious meaning of these issues became clear to both of us, I believe that analysts are often able to understand only in retrospect how they have chosen to emphasize certain clinical issues over others in order to pave the way for the more emotionally intense countertransference issues that they unconsciously recognize as lying ahead. Here, the analyst unconsciously maximizes her own ability to

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- 204 -

rely upon the patient's analytic skills when the psychoanalytic terrain becomes individually impassable. She may seek, first, to work through patient issues which touch upon her own areas of conflict and vulnerability, so that she can more effectively immerse herself in a deepening and intensifying analytic process. Surely we must recognize that it is not the patient's job to care for her analyst, to make her feel safe when the going gets rough. However, it is our job to recognize that as the therapeutic relationship deepens, taking a turn at caring for the analyst is precisely what the patient wants to do, and needs to be able to do in order to survive otherwise impassable hurdles (Searles, 1979). I often tell my patients that there are some life experiences which are simply too traumatizing and too overwhelming to be experienced and processed alone. We do not seek to become dependent upon each other; at these moments we simply are. The nature of the journey renders us inextricably intertwined for its duration. We create a place of such mutuality and interdependence, for only within such an interdependent place can we truly articulate and define the borders of our own agency and desire. Perhaps the recognition that such mutuality lies at the heart of a deepening analytic process is what we have always meant by the evolution of a therapeutic alliance.

**Loewald (1979)** describes his vision of the analytic relationship:

As a special form of psychotherapy, psychoanalysis constitutes a unique mode of personal
relationship. It shares certain aspects with other kinds of personal relationships, for instance with those between child and parent, patient and physician, student and teacher, between friends, and between lovers (p. 372).

The psychoanalytic method of treatment requires simultaneously unusual restraints and endurance of frustration together with an uncommon quality and degree of spontaneity and freedom — and all this, although in different ways, from both partners (p. 373).

Perhaps, as presaged by Loewald, the question which most consumes contemporary analysts is how often and how far we may allow ourselves to wander on any given analytic journey, with any given analytic patient, without becoming dangerously lost along the way. Given our emphasis on mutuality (Aron, 1996), on the intrinsically interactive influence of patient and analyst upon each other (Mitchell, 1997),

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-205-

on the qualities of unconscious immersion, playfulness, and spontaneity, how do we define the “safe-enough” borders that mark the appropriate limits of this most unusual relationship?

“Safe-enough” analyses are not easily defined. They depend in large measure upon the particular dyad involved. However, the effort to formulate the question and the commitment to ask it of ourselves on a regular basis becomes, for me, more essential than the impossible task of articulating a precise and theoretically reified answer. What answer we can begin to frame as a working model of both possibilities and limits in the psychoanalytic relationship will, it seems to me, be composed of an oscillating rhythm of points and counterpoints, a balance between moments of adventure and risk that enhance one's sense of mastery and competence and the moments of necessary retreat to safe havens in which we regroup and refuel in preparation for the next challenge. Hoffman (1998) has referred to this as the dialectical interplay between ritual and spontaneity in psychoanalytic work.

Any analysis consists of infinite moments, some remarkable, most not, in which conscious controls are temporarily loosened and suspended, in which new constellations of self/other experience emerge into consciousness, followed by attempts at defining, naming, and integrating these previously unconscious schemas into an enhanced understanding of our current interpersonal experience. I become concerned when I read about “mutual analyses,” “mutual regressions,” or “analyst surrenders” that do not make clear that although we lose ourselves again and again in our own unconscious vulnerabilities, the regression in psychoanalysis is primarily (though not exclusively) the patient's, and the focus must keep returning (though it will and must wander) to the patient's unconscious process. This is the only way I know to ensure that the analytic work we do will involve a full affective, cognitive, physiological integration of previously dissociated relational experience, and not a downwardly spiraling, out-of-control regression, more consistent with dissociated re-enactments and retraumatizations.

Such a psychoanalytic journey, from self state to self state, between past and present, from unconscious to conscious to conscious modes of experience, oscillating in focus between self and other, is a dizzying, destabilizing, and occasionally overwhelming project. As analysts we

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-206-

strive to keep our itinerary in mind, to maintain our orientation, to know more or less in what direction we are heading. We attempt to strike the optimal balance between the reliable and trustworthy main highways that will clearly get us where we are going and the scenically enriching back roads that will determine the beauty and quality which we will ultimately remember about the experience. I believe that the analyst must be prepared, given the complexity of what she is about, to feel lost and out of control, to sometimes “wander” in an effort to find herself again. Indeed, if we do not lose ourselves along the way, we will conduct a trip in which we see only the known and familiar spots; we will never happen upon those special moments of unexpected delight hidden off the beaten track. All of us who have traveled can remember with unequaled delight those moments of meandering, somewhat lost, of turning an unfamiliar corner to be amply rewarded for our momentary anxieties by the breathtaking vision of exquisite and completely unanticipated vistas. For me, my psychoanalytic work with a patient never feels quite right unless our journey has included at least
several such moments, experienced and shared together.

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