The Analyst's "Self-Revelation":

Not Just Permissible, but Necessary

I prithee, speak to me as to thy thinkings,
As thou dost ruminate, and give thy worst of thoughts
The worst of words.

—William Shakespeare, Othello, act III, scene 3

Because Othello cannot not see that lago's diffidence is a conscious pose, he innocently urges him to reveal the secret that lago pretends is too terrible to disclose but also too painful to contain. Pleading with lago to share what is on his mind with complete honesty, Othello exhorts him to give his "worst of thoughts the worst of words." He thus, unwittingly, entangles himself in lago's masquerade and falls victim to his friend's duplicity (Shakespeare, 1604). The fact is, however, that, even when a person is not being consciously two-faced, speaking with complete affective honesty in a human relationship is not possible because we all contain parts, each doing its own job, that are relatively unknown to one another at any given moment. That is to say, it is not possible for anyone to obliterate all motives other than candor; honesty

'incorporated into this chapter is material adapted from "Ev'ry Time We Say Goodbye, I Die a Little: Commentary on Holly Levenkron's Case Study, 'Love (and Hate) with the Proper Stranger'' (Bromberg, in press) and from "Speak to Me as to Thy Thinkings: Some Reflections on 'Interpersonal Psychoanalysis' Radical Facade' by Irwin Hirsch" (Bromberg, 2002). Adapted by permission.
is always modified by various other aspects of self and self-interest even in the absence of conscious duplicity such as Iago's.

In psychoanalysis, the spirit of Othello's request to "speak to me as to thy thinkings" continues to remain an implicit injunction, even if not a "basic rule" (Freud, 1913), that an analyst hopes his patient will take to heart. It is not, however, a principle that is intended to organize an analyst's own stance—not if he hopes to relate therapeutically to his patient. As an unmodified and unmodulated analytic posture, free disclosure of the analyst's thinking will create an atmosphere that is inherently so unsafe, affectively, that the patient will minimize access to his unconscious processes in the interest of maintaining attachment. In some cases such a posture can be even a recipe for affective retrauma-tization of the patient.

From a postclassical perspective, however, it does not thereby follow that the analyst should avoid self-revelation. In fact, a recent emphasis in the relational literature has been on the therapeutic power of the analyst's self-revelation, affective openness, and affective honesty. In light of the obvious potential for free disclosure to lead to hyper-arousal in the patient, how is this new turn to be understood? The answer is that the emphasis on the analyst's affective openness has been consistently balanced in these writings by an equal emphasis on the analyst's simultaneously demonstrating his overriding and explicit concern for his patient's emotional safety. In other words, the analyst is shown to be involved with the affective impact of his openness and demonstrates this involvement as an intrinsic aspect of what he is revealing in his self-revelation. Notable examples of such papers are those by Aron (1998), Davies (1994, 1998b, 1999, 2004), Frank (1997), Gerson (1996), Hoffman (1994, 2000), Levenkron (in press), Maroda (2000), Mitchell (1998), Renik (1996, 1999), and Slavin and Kriegman (1998).

Ironically, the new emphasis on the analyst's subjective openness has been attacked by some as though it endorses an analytic stance equivalent to what Othello asked of Iago, as though it were a version of giving one's "worst of thoughts the worst of words" while believing it to be psychoanalysis. Clinical vignettes in which the analyst's limited self-revelation was straightforwardly described by the author have been targeted as if the analyst were endorsing a naive invasion of the patient's psyche. To some critics (e.g., Bernstein, 1999; Greenberg, 2001) these vignettes by relational analysts threaten to open the door to undisciplined analytic behavior and seem to sanction an "anything goes" attitude because of the analyst's ease with the open use of his own
thoughts and feelings. To other critics, the self-disclosure in these vignettes seems to simply represent illegitimate analytic technique. In my view, invoking the issues of legitimacy or permissibility deflects awareness away from the importance of these papers as a breakthrough in clinical theory. I refer especially to a growing recognition that the psychoanalytic theory of therapeutic action must be rethought in terms of the mind as a nonlinear, self-organizing system, and that this rethinking is leading to a reconceptualization of the analyst's self-revelation as not simply permissible but necessary. I believe that it is no longer useful to frame the topic of the analyst's self-revelation in the context of analytic technique (see Bromberg, 1994, pp. 261-266; 1998b, pp. 315-316), and indeed that it is time to revise the basic premise of what analysts call technique.

A friend of mine had just returned from a summer vacation at a music camp—a musician's version of the MacDowall Colony—where the members were sorted into trios, each of which would play together all summer. Although there were no formal auditions for acceptance into the camp, each applicant had to perform for a panel that then evaluated his or her level of musicianship to assure that each trio would comprise individuals of comparable ability. I asked my friend how this had worked out for her, and her reply fascinated me because she is a woman who, by nature, always sees the cup half full: "I met a lot of people who had good technique but there was no music coming out." When I asked what she meant by "no music coming out" she shrugged and answered, "It's something hard to describe, but it doesn't get better by learning better technique."

Technique is something that one applies with the experience of command over it. In classical psychoanalysis, technique has traditionally been framed as a set of rules to guide the therapist's behavior—a set of rules that organizes an analyst's conduct in a way that, if the rules are followed, should allow an authentic analytic process to take place. Early classical analysts were not unaware of the danger of "painting by the numbers," and, although the rules were framed as a technique, analysts tried to apply them with sufficient humaneness that the patient wanted to remain a patient. Thus, technique has served as a baseline of analytic behavior from which certain strategic, but analyzable, departures (parameters) may be acceptable under predefined conditions with certain patients. Further, as prescriptions for behavior, the rules seem to have had the added benefit of allowing the analyst's unconscious deviations from them (countertransference) to be assessed in terms of their seriousness.
Freud's (1923) view of mental functioning was premised on the idea of a psyche that is self-contained. Given this view of the psyche, a patient's productions under optimal clinical conditions are held to be generated endogenously while the analyst works with the implied (but one-sided) interaction between the patient's psyche and the analyst's presence as a fantasy object of projected imagery. It follows naturally that the subjective contents of the analyst's mind should as much as possible be kept from the patient for two reasons: (1) because such revelation is an interference with the analytic process, and (2) because it is unnecessary to the analytic process. The second reason, historically, has been a relatively minor theme in classical Freudian writing because its logic has always been implied in the first reason, but, in postclassical analytic theory and practice, a vigorously discussed issue in the literature is whether or not the analyst's self-revelation may be indeed necessary to a patient's psychological growth.

Postclassical theory is moving increasingly in the direction of a psychoanalytic model of mental functioning in which our view of what is conscious and what is unconscious is informed by a conception of the mind as a nonlinear, relational process of meaning construction. This model is organized by the shifting equilibrium between stability and growth in one's range of self-representation; that is, by a dialectic between the need to preserve self-meaning (the ongoing experience of safely being oneself) and the need to construct new self-meaning in the service of relational spontaneity and creativity. In this model, the analyst's presence as a real person is not intentionally diminished, because the concept of endogenous unfolding of transference projections has no clinical meaning. Because unconscious material is held to be coconstructed rather than revealed, the analyst's role is not to avoid personal participation in the process, but continually to monitor and use the immediate and residual effects of his personal participation as an inherent part of his stance.

I argue that the analyst's existence as a real person is not only inevitable, because it is not something under his control, but is necessary. Why? Because the analyst's experience while with his patient is linked to his patient's experience as part of a unitary affective, cognitive, and interactional configuration that is at once subjective and intersubjective. Some aspects of that configuration are dissociated in each person and must be processed jointly in the immediacy of the analytic interaction to achieve cognitive symbolization through language.

I fully recognize that I am risking criticism from those analysts who define "wild analysis" as allowing what is in your mind to come out
before you have worked on it and "cleaned" it up, and from those who believe that there is a correct analytic stance and that this is not it. To be sure, even among analysts who work from a more conservative stance, the latter allegation today has few sponsors. But I go further here. I assert not only that the analyst's self-revelation is permissible but that it is a necessary part of the clinical process if the therapeutic efficacy of analytic treatment is to be most enduring and far-reaching. I submit that the most effective psychoanalysis is inevitably a process of living through and working through enactments, some of which can be volcanic. Further, I submit that the analyst's self-revelation, from a postclassical stance, is not inherently an intrusion of the analyst's subjectivity into the patient's psychic processes.

**Intrusiveness Reconsidered**

At this point in the history of psychoanalysis, how one approaches the issue of the analyst's self-revelation and the centrality of the analyst's affective aliveness is highly dependent on whether or not one accepts that the movement from classical to postclassical theory is based on clinical observation as well as an understanding of the mind that is challengingly different from Freud's. It is from the vantage point of this current understanding that a postclassical position on self-revelation must be considered. Self-revelation is equivalent to intrusiveness only if the frame of reference is that of an analyst trying to change a patient. If the analytic rationale is that of the analyst's sharing his experience to facilitate the goal of intersubjective negotiation, then self-revelation is quite another matter.

Intrusiveness, within the classical model of a self-contained mind, means that the analyst is interfering with finding what is inside the patient, as though what is inside can emerge in a relatively pure form (if the analyst does not contaminate it) largely uninfluenced by the context in which it emerges. Intrusiveness, in a postclassical model, means temporarily interfering with the process of intersubjective negotiation provided the intrusiveness is understood to be a therapeutic part of the analytic process as long as it does not foreclose intersubjectivity or shut it down for too long. Relationally, when an analyst is being "intrusive," he is not forcing his input into the patient's mind and thereby preventing him from accessing what it unconscious. Rather, he is forestalling, temporarily, the coconstruction and use of intersubjective space—a process that is based on the analyst's responsiveness to his patient's
subjectivity, which allows it to then interact with his own. The concept of intrusiveness, to an interpersonal/relational analyst, has to do with the analyst's temporary inability at a given moment to retain his own subjectivity and allow it to be modified in response to his patient's subjectivity.

How, then, does a relational analyst maintain self-discipline without renouncing the spontaneous use of his own subjectivity? Hoffman (1994) addresses this question through his concept of "throwing away the book," a clarifying frame of reference that speaks to what he calls "psychoanalytic discipline in a new key" (p. 193). In the context of this chapter, the "new key" to which Hoffman refers is a clinical stance that, in conjunction with Renik's (1999) formulation of the analyst's "playing his cards face up," makes it easier to comprehend the emphasis among relational writers on the value of the analyst's self-revelation. Both Hoffman and Renik recast the clinical application of technique within an overarching process of relational negotiation—what Hoffman calls a dialectic between ritual and spontaneity. "Technique," from this vantage point, boils down to what is useful to a particular analyst's work with a particular patient at a given point in time.

The complex meaning of Hoffman's phrase "throwing away the book" has been well articulated by Slavin and Kriegman (1998), who write that "there are inevitably times when, as Hoffman (1994) says, the therapist must 'throw away the book' in order to demonstrate a genuine willingness to place the patient before some of the rules of therapy" (p. 277). However, they continue, it is inevitable that any new therapeutic approach, including one that sponsors spontaneity and self-revelation, will inevitably become biased toward the needs and views of those who advocate it.

Hoffman seems to be addressing some of the problems introduced by this tendency toward bias when he recommends the maintenance of a "dialectic" between the therapist's acceptance of ritual authority and anonymity, on one hand, and spontaneous deviation (including self-revelation) from those rituals on the other. . . . We believe that if we appreciate Hoffman's paradoxical dialectic, we are likely to practice with a new sensibility rather than a new set of rules and technical guidelines [Slavin and Kriegman, 1998, p. 278].

What Slavin and Kriegman describe as a new sensibility I would portray further as a process-based (rather than a content- or outcome-based)
conception of therapeutic action, a central aspect of which is the joint processing of collisions between the patient's and analyst's subjectivities. I hold that a therapeutic posture that systematically tries to avoid collisions of subjectivities is eventually experienced by a patient as disconfirming. The patient feels that the analyst is not holding him in mind, and comes to feel this because the analyst is not feeling, personally, the impact of the dissociated parts of the patient's self that are trying to find relational existence. Because the analyst is not reacting personally to them they are not being held in mind, and these self-states are thus robbed of a human context in which to be recognized and come alive.

Since, from my vantage point, optimal processing should thereby include the analyst's private experience (what constitutes his "self-disclosure"), the analyst must be especially attuned to a patient's shifting equilibrium between affective safety and affective overload. If the analyst's commitment to this attunement is honored, a transitional reality can begin to take shape between patient and analyst that has room for the subjective experience of each partner and space for relational negotiation that is affectively alive. This in turn enhances the patient's capacity for intersubjective functioning in areas of personality where the capacity to bear intrapsychic conflict had been preempted by dissociation. The analyst's self-revelation is, in this sense, an ingredient in the source of therapeutic action that advances the all-important therapeutic climate of affective honesty. Holly Levenkron (in press) makes essentially the same point in an illuminating paper to which I will recur repeatedly in the rest of this chapter. She argues that this climate has been achieved "when the analyst can state her point of view by offering her experience of the patient." I would add that an analyst must also try to offer, when possible, his "experience of his experience"—which frequently is a key factor making such revelation palatable to the patient. When the analyst reveals the elements of his internal struggle that went into deciding what to say, he is revealing even more clearly that the motive for the disclosure is more one of sharing than covert indoctrination designed to look like sharing. I am suggesting, in other words, that the value of affective honesty is enhanced by one's openness to sharing the full complexity of one's subjectivity, including any self-doubt about whether to share it. But not every confrontation can or need take that form.

However, I cannot overemphasize the importance of Levenkron's statement concerning self-revelation that the "analyst's ability to do this with some semblance of mental 2 struggling with I humbling fact that earned by struggling with foreclosing her own analyst's ability to make use of then ing the right to tl If one does n( ing the analyst's lute prohibition < the intricacies of principle should make best use of ditions for analvt each dyad must s any patient confi son, including th as affectively safe pacity to process I choose to openh about his patient, self as a real perse rience this disclo authentically belie cal process even tl how this will take does not try to figi the classical sense his patient to acc eility. Honoring th patients to hang ii can tolerate reflec me, because their trade it off for the some patients the i moil no matter he his own view, and and strenuous.
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ance of Levenkon's nalvst's ability to do this with someone has to be earned." To an analyst holding a relational view of mental growth, the right to reveal his subjectivity is earned by struggling with his own limitations. It is earned by struggling with the humbling fact that he cannot, alone, find the right response. It is earned by struggling with the patient's experience of him while not foreclosing her own view. As Levenkron makes clear, it is in all this that an analyst's ability to survive intense affective confrontations and make use of them as enactments takes place. Put in these terms, earning the right to this analytic stance is what this chapter is about.

If one does not believe that the labyrinth of considerations attending the analyst's self-revelation is avoidable by endorsing either absolute prohibition or unrestricted freedom, then it is easier to recognize the intricacies of self-revelation as part of a broader question: what principle should most influence an analyst's judgment about how to make best use of his own existence as a real person? The specific conditions for analytic growth always differ for each analytic couple, and each dyad must strike its own balance between safety and risk. But for any patient confrontation with the analyst's existence as a real person, including the analyst's deliberate self-revelation, is experienced as affectively safe enough only within the window of the patient's capacity to process the evoked affect cognitively. When the analyst does choose to openly and knowingly reveal his thoughts and feelings about his patient, at that moment he is simultaneously revealing himself as a real person. Other things being equal, for his patient to experience this disclosure as both safe and enlivening, the analyst must authentically believe that the patient's knowing will facilitate the clinical process even though the analyst himself does not know in advance how this will take place. If the analyst remains genuinely curious and does not try to figure things out on his own, he will not be intruding in the classical sense of intrusiveness, because he will not be trying to get his patient to accept his subjectivity as a substitute for the patient's reality. Honoring this principle, I think, allows many seemingly fragile patients to hang in while facing an analyst's seeming intrusion; they can tolerate reflecting on what is taking place as both not-me and as me, because their own subjectivity is not at risk by their having to trade it off for the 'truth' being offered by an other. Nevertheless, for some patients the experience of otherness is a prelude to affective turmoil no matter how negotiably the analyst believes he is presenting his own view, and with these patients the work is especially difficult and strenuous.
Enactment and Self-Revelation

Enactment is a phenomenon that is not about denial or avoidance of internal conflict; it is part of the natural functioning of a mind that is simply doing what evolution has adapted it to do in two discrete modes of information processing. One mode, the "subsymbolic" (Bucci, 1997a), is organized at the level of body experience as "emotion schemas" that make their presence known affectively, through a person's "ways of being"; the second mode, the "symbolic," is organized at the level of cognitive awareness and is communicated through verbal language. When emotional experience is traumatic (more than the mind can bear), it remains unsymbolized cognitively, and the mind recruits the normal mental function of dissociation as a means of controlling both the triggering of unprocessed emotion schemas that were created by trauma and the release of ungovernable affective hyperarousal that could threaten to destabilize its functioning. Enactment in psychoanalysis is a dyadic dissociative process through which the patient's trauma-derived emotion schemas make themselves known and potentially available to consciousness. When enacted dissociated experience is processed relationally, internal conflict and its potential resolution increasingly become possible.

This postclassical understanding of mental functioning and therapeutic growth is especially relevant to Levenkron's (in press) observation that the analyst's "revealing is often a relief to the patient even if it opens up rage and painful feelings, because it makes things clear; 'being real' and connecting with another person cannot always occur through loving gestures." I believe this statement to be not only accurate, but also a significant aspect of the relational process through which cognitive control over hyperaroused affective experience becomes regulated by the patient's self-reflective functioning. Self-regulation of dissociated, and thus potentially out-of-control, affective experience can take place only by activating and cognitively symbolizing in the session itself what Bucci (1997a) calls subsymbolic experience that formerly could be only enacted. It is relieving because it increases a patient's trust in her own capacity to think about an otherwise overwhelming experience without the experience itself threatening to possess her. It is not, then, too difficult to comprehend why the analyst's self-revelation, even if it opens up rage and painful feelings, is relieving if it leads to increased self-reflectiveness.

In Levenkron's (in press) words, the "clinical craft . . . lies in contacting a part of ourselves which we can eventually own, that enables us
to reflect upon, either verbally or nonverbally, what we have discovered about our own participation from within these interactions." The analyst's self-disclosure is thus as negotiable as any other aspect of his communications. I would put it that the relationship between what is enacted nonverbally and what is put into words during the processing of an enactment, including the analyst's revelation of his own subjective experience, touches on what Leston Havens (personal communication) has amicably referred to as "Bromberg's Common Property Principle": that is, the analyst's feelings about his patient are not his personal property because they are part of an unsymbolized context within which the analyst and patient hold pieces that are linked subsymbolically but not yet by language. Recognition that an analyst's personal feelings and thoughts about his patient are not his personal property does not lead to an "anything goes" stance as a technique, but it does indeed speak to an inevitability, namely, that the dissociated experience being relationally enacted is "known" subsymbolically. Bucci (1997a, b, 2001, 2002) has described the workings of subsymbolic communication in both clinical and nonclinical situations:

The basic forms of emotional communication that operate in the analytic context also underlie all interpersonal interaction. In normal functioning as in pathology, we are constantly sending out and receiving subsymbolic signals; these often occur without accompanying verbal messages and are difficult to make explicit. A fundamental difference between normal and pathological functioning is that in the former, the subsymbolic communication is connected, or readily connectable to the symbolic components... whereas in pathology the subsymbolic representations are largely dissociated from the symbolic modes that would provide meaning for them [Bucci, 2001, p. 68, italics added].

During the analytic process, a main part of the analyst's job is to find words to get his own experience of enacted communication out on the table in a manner that facilitates the patient's ability to do the same. In his groundbreaking work, Levenson (1972, 1983, 1991) took Sullivan's (1953, 1954) original illumination of the interpersonal bridge that links affective experience and language to a place that showed how working in the moment with transference and countertransfer-ence experience provides the most powerful context for therapeutic growth. Levenson was the first "perspectivist," illustrating in his writing how the analyst's being pulled into an enactment is not a technical...
error but an inevitability. He showed how working one's way out of the mess of an enactment is a core ingredient of therapeutic action, and how neither patient nor analyst can free himself from the grip of a "mess" without the other's help. Levenson delineated the way an analyst's personal participation in enactments—even as the analyst simultaneously seeks a mutual language with the patient to symbolize therapeutically the experience—provides the most powerful context in which self-representation and representation of other are enriched and expanded in analytic treatment. Most relational analysts now accept this frame of reference, and many nonrelational analysts have adapted it to their own metapsychology.

The process of consensually finding the "right words," language that symbolizes a new shared reality, is the basis for the development of intersubjectivity where it did not exist. Finding the right words can be considered one aspect of interpersonal engagement. But other aspects of interpersonal engagement, including both spontaneity and the analyst's abiding respect for the patient's experience of safety, are no less important. It is the blend, not any single ingredient, that is unique to each analytic couple, and it is the affective aliveness that is generated by mutual spontaneity in a human interaction that holds it together as part of a relational analytic process.

I thus argue that what has been labeled the analyst's self-revelation, if used as a negotiable element in the ongoing relationship, is not only permissible but also necessary: a part of the developmental process that Fonagy (Fonagy and Target, 1996; Fonagy et al., 2002) calls mentalization, through which subsymbolic experience is allowed to become a part of the relational self rather than being interminably enacted. There is no technique for accomplishing this change in the "contents" of the mind. If one sees the mind as a nonlinear, self-organizing system, facilitation of mutative change is inherent to the process, not to the content, a clinical observation that is consistent with the research conclusion of the Boston Process of Change Study Group (Lyons-Ruth, 1998; Lyons-Ruth et al., 2001) that it is the process of communication ("implicit relational knowing") rather than the content of the communication that is the foundation for the therapeutic action of psychoanalysis.

Contrary to the long-held axiom of classical theory about making the unconscious conscious as a necessary condition for change, the Boston group's findings support the view that "process leads content, so that no particular content needs to be pursued; rather the enlarging
of the domain and fluency of the dialogue is primary and will lead to increasingly integrated and complex content" (Lyons-Ruth et al., 2001, p. 16). When patient and analyst can each access and openly share their dissociated experience that has been too dangerous to their relationship to be formulated cognitively, the process through which this takes place begins to enlarge the domain and fluency of the dialogue and leads to increasingly integrated and complex content that becomes symbolized linguistically and thus available to self-reflection and conflict resolution. How much self-revelation by the analyst is enough and how much is too much cannot be known in advance, and it is the ongoing and often painful effort to struggle with its unpredictability that defines affective honesty, not simply the analyst's subjective assessment of the honesty with which his words are spoken at a given moment.

**Developmental Trauma, Nonrecognition, and Shame**

The early developmental history of certain patients with whom I have worked suggests that the psychodynamics of parental nonrecognition plays a key role in creating a seriously dissociative mental structure in adults. I am speaking about the early failure of responsiveness by the mother or father to some genuine aspect of the child's self, not necessarily open disapproval or abusiveness (which communicates that this aspect of the child's self is "bad"), but a masked withdrawal from authentic contact that leaves the child experiencing part of herself as having no pleasurable value to a loved other and, thus, no relational existence as part of "me." Nonrecognition leads to a structural dissociation of apart of the self. If too broad a segment of the core self is encompassed, there will be impairment in the early attachment process and in the capacity for mutual regulation and "implicit relational knowing" (Stern et al., 1998). In my view, the prolonged experience of nonrecognition best defines what is called developmental trauma or relational trauma.

Most frequently it is the parents' dissociated shame, generated by their own damaged self-experience, that makes it impossible for a parent to provide recognition of qualities in the child that the parent has disavowed in his or her own self, and in turn leaves the parent unable to modulate the shame the child feels in the face of his nonrecognition.
Thus, in domains large and small, the parent begins to dissociate from the immediacy of the relationship and from the shared pleasure that it potentially holds. And we should be clear that a powerful developmental casualty is in the offing when a parent dissociates his or her shame to such degree that the dissociation shuts down the parent's ability to take pleasure in being with the child. It embodies an act of non-recognition that is as traumatizing as the pain caused by a parent who is actively abusive, and sometimes it is more debilitating.

Donald Fridley (2001), a contemporary traumatologist, explicitly acknowledges that "in many ways it is the blunt denial, disavowal, or dismissal of the child's emotional states which contributes to the child's confusion, shame, and feelings of worthlessness that has as much or more impact on the future than the fact of the physicality of the trauma itself (p. 5). If the other systematically disconfirms (Laing, 1962) a child's state of mind, particularly at moments of intense affective arousal, by behaving as though the self-meaning of the experience to the child is irrelevant, the child grows to mistrust the reality of her own experience. The child becomes correspondingly impaired in her ability to process cognitively her own emotionally charged mental states in an interpersonal context—to reflect on them, hold them as states of intrapsychic conflict, and thus own them as "me." Dissociation, the disconnection of the mind from the psyche-soma, then becomes the most adaptive solution to preserving selfhood. The child's own need for loving recognition becomes despised and shame ridden. The need becomes a dissociated "not-me" aspect of self that, when triggered, releases not only the unmet hunger for authentic responsiveness, but a flood of shame, the affect associated with failure in who one is, not failure in what one does. Failure in what one does leads to anxiety and lowered self-esteem or to guilt and depression, but failure in who one is leads to shame, the signal of impending self-destabilization, the shock of no longer being "me."

Dissociation as an Interpersonal Process

As I stated at the start of this chapter, speaking with "complete affective honesty" in a human relationship is not possible, nor would it be desirable if it were possible. In psychoanalytic treatment, affective honesty is achieved through the analyst's struggle to communicate, not by a self-granted license to "tell it like it is." Affective honesty must be balanced with affective safety, and it is this balance that ought to be the organizer of safety, in other words, rather than stance (see Brockett's stance is the analyst's does not tell him the truth value, a gesture between It ought to be equally with issues like to return to what Levenkron describes was framed in place in both and. dissociative reac kor's telling All break and apologet unknown to Ali deal with her fee ever, seeming to was in a distress abandoned. Levenkron believes was framework. All deal with her fee ever, seeming to was in a distress abandoned. Levenkron believes was framework. All
the organizer of one's analytic stance. Attunement to your patient's safety, in other words, must be experienced from within the relationship, rather than by trying to empathically "provide" it as a technical stance (see Bromberg, 1989). What organizes a postclassical analytic stance is the analyst's comprehension that his subjective experience does not tell him what is "really" going on as though it had some objective truth value, and thus places self-disclosure within the context of negotiation between subjectivities.

It ought to be clear from the foregoing that an analyst wrestles equally with issues of disclosure and nondisclosure. And here I would like to return to Levenkron's (in press) paper, specifically to an incident she describes with her patient that makes this unusually clear. Levenkron describes an event that took place with her patient Ali that I believe was framed by a major dissociative switch in self-state that took place in Ali and, as so frequently happens during enactments, led to a dissociative reaction in her therapist. The incident followed Levenkron's telling Ali, unexpectedly, that she was going to take a weeklong break and apologizing for the short notice. The reason for this break, unknown to Ali, was that Levenkron wished to give herself space to deal with her feelings surrounding her impending divorce. Ali, however, seeming to have missed all the nonverbal cues that her therapist was in a distressed state, behaved as if she were being gratuitously abandoned. Levenkron writes that Ali "got in touch with the aspect of herself that, when insecure and envious, becomes filled with rage." I hope you do not feel it is unsporting of me to second-guess Levenkron's reported experience, but I feel that this characterization does not give quite enough weight to the magnitude of what appears to me to be a dissociative switch in Ali.

What I read has a different feel than someone's simply becoming filled with rage, which would better capture the experience of a mood change. Ali's response seems much more a switch in self-state—fundamentally a dissociative phenomenon and not simply a change in affect. And that is what I believe made Ali's response especially upsetting to Ali's therapist. An affective change in itself is seldom that destabilizing to the other person; for it to have the kind of impact described by Levenkron, it almost always embodies a switch in the self-state that holds the affect. Levenkron observed Ali at that moment "turning her face to the wall and saying a few sentences that were tangential; she spoke in a slow, halted, breathy voice." This is the kind of description analysts give when they are trying to depict the nuances of what it is like to be with someone who is no longer feeling like the same person.
Levenkron writes that her own reaction was to get angry, but that she "wasn't aware of it." Why wasn't she aware of it?

As an enactment begins, an analyst will inevitably shift his self-state when the patient shifts his. Dissociation is a hypnoid process, and inasmuch as analyst and patient are sharing an event that belongs equally to both of them—the interpersonal field that shapes the immediate reality of each and the way each is experiencing himself and the other—any unsignaled withdrawal from that field by either person will disrupt the other's state of mind. Thus, when an enactment begins (no matter by whom it is initiated), no analyst can be immediately attuned to the shift in here-and-now reality, and he inevitably becomes part of the dissociative process, at least for a period of time. The analyst's dissociation is not a "mistake" on his part; it is intrinsic to the normal process of human communication [Bromberg, 1996a, p. 285].

Levenkron (in press) states that she began to get angrier and angrier and did not want to soothe Ali. "At that moment," she recalls, "I wanted it out on the table where I could see it." Levenkron confronted her patient angrily. Ali stood her ground, "I can't stand the way you talk to me! You are so fucking mean! Who do you think you are, Levenkron? No one talks to me that way, only you! You're sorry for the short notice, well what about me?" As Levenkron then puts it, "it was out on the table."

Am I saying here that I think Levenkron should have done something different? Do I think that Levenkron should have soothed her patient? Do I think she should have taken a different stance? Actually, I don't. I think that the analyst entered a dissociated state of her own that was reciprocal to her patient's and that, when she did so, something unpredictable happened that ultimately became quite therapeutic. But at that moment, patient and analyst were in a dissociative cocoon together, so they could not access anything other than the dominant affect that organized their respective self-states. Levenkron is explicit about that fact; she describes it "as if we were a couple who was having a fight." I would argue that it was not "as if they were a couple having a fight, but that in their dissociative cocoon they became a couple having a fight.

What is most important, however, is that they were not just having a fight. They were participating in an enactment that had a powerful therapeutic function; the analyst can come vice versa—vice versa at first. Levenkron welling up in 1 accused of ab was unable to time off to try stood but as Levenkron writes."] happened to n certainly, how h Levenkron st about what I've analyst fre her destabiliz; a license to r to sidestep th< ambivalence.

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then puts it, "it was something unjuite-parent stance? Actually, I ted state of her own that she did so, something unjuite-therapeutic. But at creative cocoon together, dominant affect that is explicit about that ct; having a fight." I could a'ing a fight, but at in having a fight. y were not just having it that had a powerful therapeutic function because it opened a space through which an analyst can come to know her patient's "not-me" self-states firsthand, and vice versa—a personal channel that is frequently very painful for both at first. Levenkron, in the heat of the "unfair" attack by Ali, found tears welling up in her eyes because she was feeling tortured by having been accused of abandoning her patient in order to have a good time. She was unable to reveal that it was just the opposite—that she was taking time off to try to heal her wounds. She felt an intense need to be understood but was not allowed that solace. At that moment she was as close as she had ever been to feeling Ali's own pain of separateness. Levenkron writes, "I had a powerful urge to tell her every bad thing that ever happened to me; that is, just how hard my life had really been and, certainly, how hard it was at that time." The urge was poignant, and Levenkron struggled with it, but she chose not to act on it. By writing about what went into the struggle, she takes out of the shadows what an analyst frequently faces at such a moment unless the analyst "handles" her destabilization by invoking a prescriptive rule that provides either a license to reveal or a prohibition against it. Either allows the analyst to sidestep the painful but affectively honest experience of struggle, ambivalence, and conflict.

It should be pointed out that Levenkron's dissociated state was as complexly organized as Ali's. Because she was "containing" some of Ali's pain, Levenkron could not escape her own pain without affectively abandoning Ali, and this she would not do. Pain and confusion reigned for the analyst because she was forced to process simultaneously two experiences of their relationship and two self-states of her own that were incompatible and unresolvable by conflict resolution because the combination was too affectively intense to be either internally or externally negotiable. She writes,

I thought I was protecting her from feeling guilty for attacking. I was also avoiding what I imagined to be a sadistic retort from her. . . . At that time I could not formulate what was a pull I fought against to tell all, as when the emotional and articulated demands of your patient to intrude into your privacy are so great that you "have" to tell—for the wrong reasons.

Sometimes, containing a patient's experience of threatened annihilation takes an analyst to the brink of knowing the patient better than one wants to know her.
The Analyst's Right to Privacy

Levenkron, in the preceding vignette, did not "self-disclose," but she was not pleased with herself for having "used nondisclosure as a foil to avoid an abuse of my privacy and admission of my vulnerability." Levenkron comments, "Although nondisclosure here was a clear expression of my subjectivity, I am not advancing a 'technical mandate' of nondisclosure.... In my withdrawal and silence, I was unaware of how I was enacting my self-protection and my right to privacy. I dissociated my ability to voice my boundaries—to talk to her about why I could not talk to her." Such a dissociative moment is part of the natural clinical process for any analyst who knows that spontaneity and alive-ness ebb and flow relationally. But in her willingness to reflect on what contributed to her dissociation, and to think about the various meanings of what it meant to her personally (including a wish to avoid an abuse of her privacy and admission of her vulnerability), she is here openly stating that the implications of not revealing are as significant as those clinical moments in which an analyst does disclose.

I see this as quite a service to all therapists. In this regard, I think it important to note that an analyst's "dissociative moments" often, as in this case, reflect not only the analyst's self-protection but also a concomitant protection of the patient. I would argue that the emotional state that Levenkron was in when she dissociated and became thereby unable to reveal to Ali why she could not talk to her was too affectively intense to be therapeutically usable. If she had tried to speak from that state, it would have probably elevated even further Ali's already hyperaroused affect and reinforced Ali's dissociated "tough-kid" self as her only reliable means of controlling fear and shame that would otherwise have been unregulatable. So one could hypothesize that Levenkron's dissociation at that moment was not just a protection of her own right to privacy, but an adaptive relational solution to what she described as "being unable to remove myself from the explosions going off inside of me that would give me the distance I needed to speak to her in a calm way." Such a dissociative moment often provides an opportunity for things to calm down and is problematic only if the analyst, unreflectively, uses it as a permanent hiding place rather than a temporary sanctuary.

Privacy, most simply, is a dimension of the ongoing process of negotiation between incompatible domains of self-experience. From this vantage point, the right to privacy is part of the human condition. Privacy can be surrendered by choice, but the right to it cannot, and this is
as true for the analyst as for the patient. Privacy and self-revelation are parts of an overarching configuration that defines the analytic relationship for both parties through an inevitable dialectic that takes place intrapsychically and interpersonally. My view (see Bromberg, 1997) is that, except for very rare instances, patients respect the analyst's personal right to privacy with regard to his history and life experiences. Almost any situation where that seems not to be true represents a transference-countertransference enactment in which the analyst has been unable to recognize and reveal his own dissociated experience of the patient, who then, often desperately, tries to penetrate the analyst's mind to find herself within it. Let me repeat: I believe that a patient's pressure to force the analyst to give up his right to privacy is organized not simply by a need to know the analyst, but by a wish to know what the analyst knows about the patient but has dissociated. When an analyst is successful in dissociatively "privatizing" some aspect of his experience of the patient, the analyst is, in fact, depriving the patient of her potential to discover safely her full relational existence. The enactment then increases in power, and, as the analytic space becomes filled with energy generated by the enactment, the patient more and more becomes the self that had been excluded from their relationship. That self gradually forces its way into the analyst's perceptual consciousness (Bromberg, 1998b) and finally ignites in him a personal response to a part of the patient that until then existed only in the enactment.

Personal and "Really" Personal

What we discover about our own participation from within these interactions at times may include the vivid emergence of memories from our own past—childhood relationships or "forgotten" events—that suddenly appear like ghosts that we thought had been exorcized in our own analyses but that we suddenly realize are very much alive in the moment and are quite relevant to what is taking place with that patient. What is it about such experiences that makes them such a source of debate about how to use them? Do they fall into a category austerely separate from "process" thoughts and feelings, a category so potentially dangerous that they should be ipso facto exiled from revelation, even by an analyst who might comfortably share his process experience? Or, if not, then how does an analyst decide whether or when to reveal personal biographical information? Obviously, it is a choice more complex than that entailed in the revelation of process feelings and,
justifiably, calls forth greater concern not only about the welfare of the patient and the treatment, but also about the analyst's own personal privacy.

In my view, an analyst's disclosure of such information should be in response to a deeply felt sense that it will deepen an ongoing, affectively alive relational context in which here-and-now process experience is already being shared, and the analyst can feel this added element as consistent with that context. I believe strongly that such disclosure should not be made to create affective aliveness. Like any other choice an analyst makes with a given patient, self-revelation derives its meaning from the ongoing context of the relationship in which it takes place, not from its utility as a technique. Its usefulness to the analytic process is organized by the quality of its openness to negotiation, particularly the degree to which the analyst is free of internal pressure (conscious or unconscious) to prove his honesty or trustworthiness as a technical maneuver designed to counter the patient's mistrust. The value of an analyst's revelation of personal history rests on its spontaneously surfacing in the analyst's mind as part of the moment. That is, its value rests on its being something from his personal past that enters unbidden and very much alive into the present. Often it is something that the analyst recognizes emotionally—sometimes cognitively as well—as having contributed to a dissociative state of his own that increased his difficulty in experiencing and responding to an emotional state of his patient that was enacting its existence.

The patient does not need a dramatic act of self-disclosure by the analyst. For the analyst, the issue of whether, when, and what to reveal is mostly a matter of the analyst's feeling that, if he does share his experience and invites his patient to do likewise, a useful exploration of the relational context is likely to be enhanced at that moment. Do conditions seem to exist that could lead to something "new but not new" being constructed, or is the patient at that moment too affectively destabilized to use his mind in thinking about what is taking place intersubjectively because his brain will not process what is too emotionally risky?

When the analyst is revealing personal history, I believe it is his obligation to be attuned even more sensitively than when revealing his process experience. He has to try to be aware of the even greater complexity of the patient's response to his possible motivation for the revelation than of the content of what was revealed. He must consider particularly closely whether the patient is currently dissociating her own response to his behavior in order to keep from feeling affectively overwhelmed by what is taking place between them. It is almost always necessary to a...
necessary to address that question *openly* because an analyst's self-revelation can sometimes, in subtle ways, increase a patient's dissociation. It is not an analytic error when this happens unless both analyst and patient, for too long a period of time, fail to process such moments together. In fact, the postclassical reconsideration of "error" as applied to clinical process bears directly on understanding why the wisdom of the recent psychoanalytic admonition to "strike while the iron is cold" is no more valid, prescriptively, than "strike while the iron is hot"; more often than not, it is only *by failing* to know when the temperature is right that the analyst learns when the iron is too hot. And it is only through this dialectic that the patient comes to know that the analyst is learning from her and, most important, cares about what he is learning. Simply put, by recognizing the nonlinearity of what we call mutative change, we also accept that it takes place not through thinking, "If I do this correctly, then that will happen," but, rather, through an ineffable coming together of two minds in an unpredictable way.

**Clinical Transition from Dissociation to Capacity for Conflict**

As the analyst is forced to experience and respond to those aspects of the patient the analyst wished to disavow, the patient begins to inhabit a self that feels whole in the analyst's mind and thus starts to feel simultaneously more whole in her own. At that point, a comfortable dialectic between the experience of insideness and the experience of human relatedness begins to replace, for both partners, the issue of the right to privacy. I have called this phase of the work the transition from dissociation to capacity for conflict. The essential quality of the transition is that the patient's self-experience is less subject to disorganization by the return of unprocessed affect. As a consequence, the patient's personality is less vulnerable to the single dissociated "truth" that relational ruptures can never be repaired, and thus the continuity of the attachment bond on which selfhood depends begins to be trusted as more reliable, and thereby becomes more secure.

A brief discussion of Levenkron's report of a later session in Ali's treatment illustrates this point. It is a session again marked by their personal reactions to one another, but it demonstrates the kind of therapeutic shift that can take place when an intersubjective space that has been fought for and earned now allows the open processing of collisions between subjectivities. In the face of Levenkron's impending
vacation, Ali was talking about the painfulness, as a bodily experience, of the separation, but this time she was not holding Levenkron as an objectified other; Levenkron, in turn, remained exquisitely attuned to Ali's affective state without needing to give her own destabil-ization special priority. She was able to communicate to Ali from within their cocreated space without her thoughts being felt by Ali as unbearable. That is to say, Levenkron was able to stay, experientially, in this transitional space and at the same time reflect on her own and on Ali's subjectivity:

No one ever talked to you about being separate, but what is more important for us is that no one ever separated from you in a loving way. At this point in the session I was able to tell her that I hadn't realized how frightening it had been for her, but this time as she left for vacation I did feel it, and said I was sorry for not understanding how scared she was of losing me. We had not talked about this openly before. I had the strangest remembrance at that moment. I recalled that when my own mother was dying, she would not let me cry; furthermore, she would not even consider that I needed to be protected in anyway. She just denied her own death and wouldn't let me in on it. I was terrified, and when I later saw that I could survive her death, I wished I could have shared more with her.

That, to me, is a fascinating moment because it addresses the issue of the difference between self-revelation of process experience and self-revelation of biographical data. It is one of those moments when the line between them is especially permeable. Levenkron, apparently, did not share with Ali the spontaneous remembrance of her mother's dying, but I could easily imagine that sharing this remembrance at that moment might have been quite therapeutic. This is one of the few clinical vignettes I have read where I was able to feel how arbitrary the distinction can sometimes become between an analyst's disclosure of process experience and disclosure biographical data, and why whether to reveal or not to reveal is such a difficult judgment call. Had Levenkron chosen to reveal that remembrance, she might have had a very positive effect in underscoring, without making explicit, the degree to which she was in close emotional contact with Ali's dissociated desire for emotional contact and was not put off by it. That is to say, her revelation could have been potentially quite shame reducing. But, then again, maybe not!
The Analyst's "Self-Revelation"

One last time, I want to insist that self-revelation is not a technical issue but a relational one. It has to do with the process of facilitating the development of new mental representation, a process that is co-constructed by the participation of two minds that are alive to each other, each allowing the experience of the other to be known—a point vividly made by Alvarez (1992) in her book, Live Company. Whether or not an analyst chooses to reveal is not a debate about whether or not it is reasonable to deliberately reveal something because the patient already, at some level, "knows" what you feel. If analysts accept the view that patients already know what we are feeling about them as part of shared subsymbolic experience, then the primary clinical question is whether or not openly revealing our feelings will advance the symbolization process and lead to the construction of new mental representation. From this frame of reference, as Ginot (1997) has argued cogently, "self-disclosure is not... a way to promote a sense of intimacy through seemingly similar shared experiences. Rather, the emphasis here is on revealing emotional data growing from and organically related to the intersubjective matrix" (p. 373). The subjective reality of a patient's unsymbolized states of consciousness, especially with regard to the patient's experience of the analyst, must be felt and, in some useful way, acknowledged by the analyst. If there can be said to be an interpersonal or relational analytic technique, it is mainly in the ability of the analyst throughout the course of each analysis to negotiate and renegotiate the meaning of what constitutes useful acknowledgment. Levenkron (accepted) writes,

One time, Ali and I discussed our interactions with increasing comfort, partially because the development of candor is a natural evolution of any successful negotiation, and partially because we both learned that articulating what we experienced did not lead to unreparable ruptures in attachment. In this light, disclosure of our thinking becomes collaborative and therefore negotiable, rather than power-based.

Levenkron is here saying that increased analytic collaboration depends on two principles: first, being candid is a natural part of negotiation (it is most definitely not the application of a technical procedure implemented by "telling it like it is"); second, in the process of negotiated confrontation, the two partners learn that their confrontations do not lead to their breaking apart, and thus the patient can more and more safely trust that relational ruptures are repairable (see Tronick and Weinberg, 1997).
Levenkron concludes her account thus: "I hope I have shown that the process of what we call 'working through an enactment,' ideally, does not take place through post hoc analysis, but rather, that the working through is the analysis and occurs as we live it: this is the negotiation." To this I can only say, Amen.