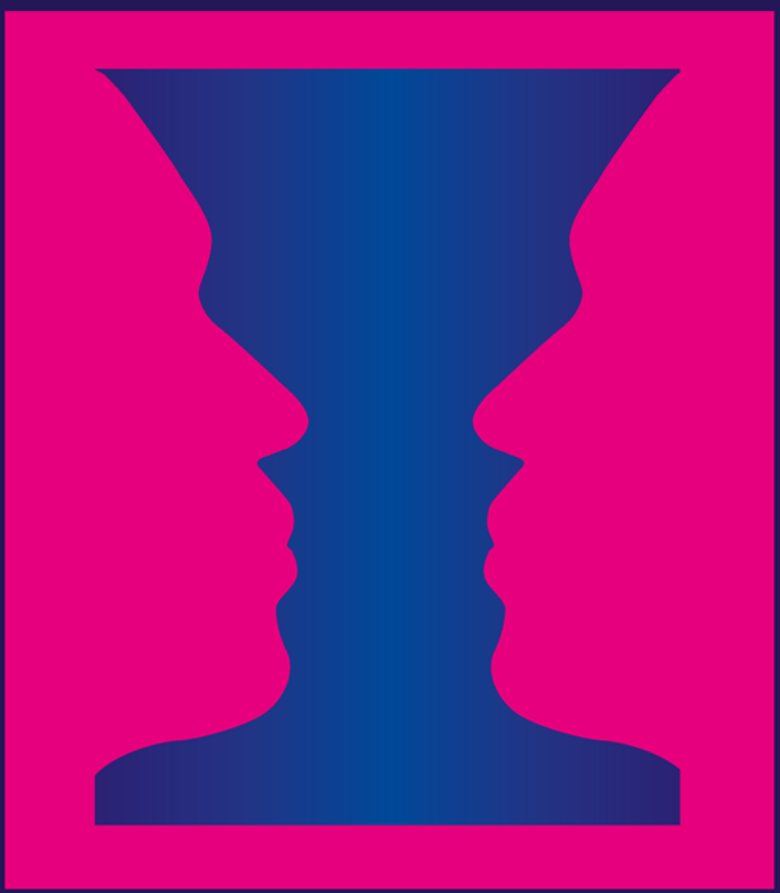
Moments of Meeting in Psychoanalysis

Interaction and Change in the Therapeutic Encounter



EDITED BY SUSAN LORD

RBP

ROUTLEDGE

"*Moments of Meeting in Psychoanalysis* is a stunningly rich collection of relational essays that challenge what cures: by naming the core of change as located in the therapist's subjectivity, the therapist's necessary authenticity, the capacity for bearing the unbearable, all of which result in healing. In a coherent and well-chosen volume, *Moments of Meeting* beautifully illustrates how clinicians can bear affects of shame, suffering, pain—even dying—and includes other modalities such as mindfulness, internal family systems and brief treatment. Infant research, Jungian theories, and contemporary psychodynamic relational theorists are well represented in a well-edited, thoughtful collection of essays that are historically organized and clinically alive. This is a book for beginners and advanced practitioners which adds to our knowledge of the most contemporary intersubjective theories and practice."

—**Joan Berzoff, EdD**, professor emerita, Smith College School for Social Work, editor with Laura Flanagan and Patricia Hertz, *Inside Out and Outside In*, and author, *Falling Through the Cracks.*

"This book addresses through a panoply of finely tuned chapters the 'hottest' topic in psychoanalysis today—what creates transformative moments in the psychoanalytic encounter. These authors, ranging from Jungian, relational, and self psychological, offer theory that is especially punctuated with numerous clinical examples of 'moments of meeting' in which patient and analyst profoundly, movingly connect on human themes and existential issues that become the fulcrum for change between and within both participants. The telling and close study of these illustrations contributes further to our understanding and delineation of these transformative moments. This volume is illuminating reading for psychoanalytic-oriented practitioners that will be greatly appreciated from the beginner to the seasoned professional."

—**James L. Fosshage, PhD**, founding president of the International Association for Psychoanalytic Self Psychology; co-founder, board director, faculty and supervisor, National Institute for the Psychotherapies (NYC); founding faculty of the Institute for the Psychoanalytic Study of Subjectivity (NYC); and clinical professor of psychology at the NYU Postdoctoral Program in Psychotherapy and Psychoanalysis.

"This collection is a hopeful reminder that 'arguing polarities is no longer useful.' The rich offerings gathered together by Susan Lord in this volume speak to the integration of a multiplicity of theories, models, concepts, and traditions of psychotherapy for purposes of calling attention to how being in relation is humanizing. The contributors speak of vulnerabilities, risk, and the 'very human' moments in therapy for both themselves and their clients. And it is precisely this focus that opens the door for transformation, leaving the image of the pathologized individual behind. We have been waiting a long time for this collection!"

—**Sheila McNamee**, professor of communication, University of New Hampshire; founding member, vice president, and board member of the Taos Institute.

"This book offers a feast of reflections on moments of meeting that emerge within the space of psychotherapy. Contributions range across the relational analytic psychotherapies, setting out beautifully rich descriptions of practice and layering different though connected theory understandings of what happens (often unpredictably) in significant moments in the space between patient and analyst. I read the various chapters as a systemic family therapist with an interest in psychoanalytic understandings. The practice moments and theory reflections sparked so many resonances, despite (and to some extent, because of) the differences between an analytic and systemic frame and the very different relational spaces of individual versus family therapy. How wonderful to be reminded of the shared territory of the different psychotherapies—of the lived experience of therapeutic processes, of the capacities and limits of what can happen within the therapeutic relationship in the space-between, and of the transformative potential of the intersubjective meeting of therapist and clients."

—**Carmel Flaskas, MA**, associate professor, School of Social Work, University of New South Wales, Sydney, Australia, and co-editor with Barry Mason and Amaryll Perlesz, *The Space Between*.

“Psychoanalysts have long had a visceral appreciation for those moments of heightened emotional connection with patients. Ineffable yet poignant, unbidden and surprising, infused with unconscious communication, these moments can pass without comment yet have their transformative effects. ‘Moments of meeting’ has become a catch-phrase, but what exactly are they? The broad range of perspectives in this wonderful collection (relational, self-psychological, Jungian, AEDP, IFS, and infant research—written by leaders in each area) attests to the heuristic value of this phrase as it bears on grief, aesthetics, transcendence, microprocessing, the ‘us’ in intersubjectivity, spirituality, introjections, and even emotional absence. This volume succeeds in bringing alive experiences we struggle to name and understand by defining the contours of these elusive, powerful experiences. You will find yourself having more of them after reading this book, and your practice will be better for it.”

—**Andrea Celenza, PhD**, training and supervising analyst,
Boston Psychoanalytic Society and Institute, faculty,
Massachusetts Institute for Psychoanalysis;
assistant clinical professor, Harvard Medical School.



Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

Moments of Meeting in Psychoanalysis

There are moments of connection between analysts and patients during any therapeutic encounter upon which the therapy can turn. *Moments of Meeting in Psychoanalysis* explores how analysts and therapists can experience these moments of meeting, shows how this interaction can become an enlivening and creative process, and seeks to recognise how it can change both the analyst and patient in profound and fundamental ways.

The theory and practice of contemporary psychoanalysis and psychoanalytic psychotherapy has reached an exciting new moment of generous and generative interaction. As psychoanalysts become more intersubjective and relational in their work, it becomes increasingly critical that they develop approaches that have the capacity to harness and understand powerful moments of meeting capable of propelling change through the therapeutic relationship. Often these are surprising human moments in which both client and clinician are moved and transformed. *Moments of Meeting in Psychoanalysis* offers a window into the ways in which some of today's practitioners think about, encourage, and work with these moments of meeting in their practices. Each chapter of the book offers theoretical material, case examples, and a discussion of various therapists' reflections on and experiences with these moments of meeting.

With contributions from relational psychoanalysts, psychotherapists, and Jungian analysts covering essential topics such as shame, impasse, mindfulness, and group work, this book offers new theoretical thinking and practical clinical guidance on how best to work with moments of meeting in any relationally oriented therapeutic practice. *Moments of Meeting in Psychoanalysis* will be of great interest to psychoanalysts, psychoanalytic psychotherapists, psychologists, social workers, workers in other mental health fields, graduate students, and anyone interested in change processes.

Susan Lord, LICSW, PhD, is a clinical associate professor in the social work department at the University of New Hampshire, Durham, NH, adjunct clinical faculty at Smith College School for Social Work, and past instructor in psychiatry at Harvard Medical School. She is the author of *Wealth and Social Responsibility* and of several book chapters and articles on work with complex childhood trauma and the use of mindfulness practices in psychotherapy. She is an associate editor of the *Journal of Family Therapy,* a Taos Institute Associate, and is in private practice in York, Maine.



Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

Relational Perspectives Book Series

Series Co-Editors: Lewis Aron & Adrienne Harris
Associate Editors: Steven Kuchuck & Eyal Rozmarin



The Relational Perspectives Book Series (RPBS) publishes books that grow out of or contribute to the relational tradition in contemporary psychoanalysis. The term *relational psychoanalysis* was first used by Greenberg and Mitchell (*Object relations in psychoanalytic theory*, 1983) to bridge the traditions of interpersonal relations, as developed within interpersonal psychoanalysis, and object relations, as developed within contemporary British theory. But, under the seminal work of the late Stephen A. Mitchell, the term *relational psychoanalysis* grew and began to accrue to itself many other influences and developments. Various tributaries—interpersonal psychoanalysis, object relations theory, self-psychology, empirical infancy research, and elements of contemporary Freudian and Kleinian thought—flow into this tradition, which understands relational configurations between self and others, both real and fantasied, as the primary subject of psychoanalytic investigation.

We refer to the relational tradition, rather than to a relational school, to highlight that we are identifying a trend, a tendency within contemporary psychoanalysis, not a more formally organized or coherent school or system of beliefs. Our use of the term *relational* signifies a dimension of theory and practice that has become salient across the wide spectrum of contemporary psychoanalysis. Now under the editorial supervision of Lewis Aron and Adrienne Harris, with the assistance of associate editors Steven Kuchuck and Eyal Rozmarin, the Relational Perspectives Book Series originated in 1990 under the editorial eye of the late Stephen A. Mitchell. Mitchell was the most prolific and influential of the originators of the relational tradition. Committed to dialogue among psychoanalysts, he abhorred the authoritarianism that dictated adherence to a rigid set of beliefs or technical restrictions. He championed open discussion and comparative and integrative approaches and promoted new voices across the generations.

Included in the Relational Perspectives Book Series are authors and works that come from within the relational tradition and extend and develop that tradition and works that critique relational approaches or compare and contrast them with alternative points of view. The series includes our most distinguished senior psychoanalysts, along with younger contributors who bring fresh vision. A full list of titles in this series is available at https://www.routledge.com/series/LEARPBS.

Moments of Meeting in Psychoanalysis

Interaction and Change in the Therapeutic Encounter

Edited by Susan Lord

Routledge
Taylor & Francis Group
LONDON AND NEW YORK

First published 2018
by Routledge
2 Park Square, Milton Park, Abingdon, Oxon OX14 4RN

and by Routledge
711 Third Avenue, New York, NY 10017

Routledge is an imprint of the Taylor & Francis Group, an informa business

© 2018 selection and editorial matter, Susan Lord; individual chapters, the contributors

The right of the editor to be identified as the author of the editorial material, and of the authors for their individual chapters, has been asserted in accordance with sections 77 and 78 of the Copyright, Designs and Patents Act 1988.

All rights reserved. No part of this book may be reprinted or reproduced or utilised in any form or by any electronic, mechanical, or other means, now known or hereafter invented, including photocopying and recording, or in any information storage or retrieval system, without permission in writing from the publishers.

Trademark notice: Product or corporate names may be trademarks or registered trademarks, and are used only for identification and explanation without intent to infringe.

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

Library of Congress Cataloging in Publication Data
A catalog record for this book has been requested

ISBN: 978-1-138-22921-1 (hbk)
ISBN: 978-1-138-22922-8 (pbk)
ISBN: 978-1-315-38996-7 (ebk)

Typeset in Times New Roman
by HWA Text and Data Management, London

For Karen Frarie



Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

Contents

List of contributors xvi
Acknowledgments xxi

Introduction 1
SUSAN LORD

PART I
Background/context **11**

1 My journey in infant research and psychoanalysis: microanalysis, a social microscope 13
BEATRICE BEEBE

2 Moments of truth in psychoanalytic treatment 45
JONATHAN H. SLAVIN AND MIKI RAHMANI

PART II
Jungian approaches to relational work **65**

3 Moments of complexity: non-local aspects of moments of meeting 67
JOSEPH CAMBRAY

4 The aesthetics of being 84
MARK WINBORN

5 States of grace: eureka moments and the recognition of the unthought known 100
CATHERINE CROWTHER AND MARTIN SCHMIDT

PART III
Relational analysis and psychoanalytic psychotherapy **123**

6 Moments of meeting and the problem of shame: a brief history of relational therapy 125
PATRICIA A. DEYOUNG

7 The therapist's capacity to tolerate the intolerable: my tears, not his 145
MARTHA STARK

8 Living inside the moment: a view from self psychology 161
DENISE DAVIS

9 Where did that happy ending come from? Dreaming moments of meeting 178
JOYCE SLOCHOWER

10 You, me, and us 198
DAVID POCOCK

11 Probing for realness and reciprocity in the early years of an analysis 209
MALCOLM OWEN SLAVIN

12 Sleeping/dying: "Now moments" in clinical space 222
EDIE BOXER

13 Mutual discoveries emerging from secrets, lies, deceptions, and truths 234
LINDA G. BEELER

14 Retirement from psychotherapy practice: a mutually generative rite of passage 248
ELIZABETH McKAMY

PART IV
Alternative relational modalities **265**

15 *Something more* than "'Something more' than interpretation": accelerated experiential dynamic psychotherapy (AEDP) works the experiential edge of transformational experience to transform the internal working model 267
DIANA FOSHA

16 Mindfulness, intimacy and presence: moments of meeting in psychotherapy 293
SUSAN LORD

17 Finding each other in a crowded room: internal family systems and group psychotherapy 308
ANNIE WEISS

Afterword 324
HAZEL IPP

Index 329

Contributors

Beatrice Beebe, PhD, is clinical professor of medical psychology (in psychiatry), College of Physicians and Surgeons, Columbia University, New York State Psychiatric Institute; faculty at the Columbia Psychoanalytic Center, the Institute for the Psychoanalytic Study of Subjectivity, and the NYU postdoctoral program in psychotherapy and psychoanalysis; co-author with Jaffe et al. of *Rhythms of Dialogue in Infancy* (Blackwell Publishing, 2001), co-author with Lachmann of *Infant Research and Adult Treatment: Co- Constructing Interactions* (Analytic Press, 2002), and co-author with Knoblauch, Rustin, and Sorter of *Forms of Intersubjectivity in Infant Research and Adult Treatment* (Other Press, 2005). Beebe is in private practice in New York City, specializing in adult psychoanalysis and mother-infant treatment. Currently, she directs a primary prevention program for mothers who were pregnant and widowed on 9-11.

Linda G. Beeler, LCSW, is in private practice in New York City; supervisor and affiliation at The National Institute for the Psychotherapies, faculty, supervisor, and training analyst at Psychoanalytic Psychotherapy Study Center; member of the International Association of Relational Psychoanalysis and Psychotherapy; member of AAPCSW; member of New York State Council on Divorce Mediation; and past clinical director of the Mental Health Department of HIP-New Jersey.

Edie Boxer, **MSW, PsyD**, is a graduate of the Institute of Contemporary Psychoanalysis in Los Angeles, California and was the co-president of ICP and a training and supervising analyst and teacher in the training program. Dr. Boxer works in Santa Monica and Woodland Hills, California, with adults and couples.

Joseph Cambray, PhD, is provost at Pacifica Graduate Institute in Santa Barbara and the president of the International Association for Analytical Psychology. He is a consulting editor of the *Journal of Analytical Psychology*, and co-editor of *Analytical Psychology: Contemporary Perspectives in Jungian Analysis* (Brunner-Routledge, 2004).

Catherine Crowther, PhD, is a Jungian psychoanalyst in private practice in London, UK. She is a training analyst for the Society of Analytical Psychology and has been actively involved in developing training in London. She was co-convener and supervisor for the International Association of Analytical Psychology programme training analysts in Russia for 17 years. Crowther has taught widely and written papers and chapters on various analytic subjects. She has co-edited a book with Jan Wiener, *From tradition to innovation: Jungian analysts working in different cultural settings*, published by Spring Journal Books in August 2015.

Denise Davis, LCSW, is co-chair of the International Association for Psychoanalytic Self-Psychology (IAPSP) Child and Adolescent Initiative; a member of IAPSPS's Advisory Council; and a regional editor for IAPSP's journal club. She is in private practice in Highland Park, Illinois.

Patricia A. DeYoung, MSW, PhD, is a founding faculty member of the Toronto Institute for Relational Psychotherapy. Her books include *Relational Psychotherapy: A Primer* (Routledge, 2003, 2015) and *Understanding and Treating Chronic Shame: A Relational/ Neurobiological Approach* (Routledge, 2015). She maintains a private clinical and supervisory practice in Toronto, specializing in relational modes of individual and couples therapy.

Diana Fosha, PhD, is the developer of accelerated experiential dynamic psychotherapy (AEDP), a healing-based, transformation-oriented model of psychotherapeutic treatment; she is founder and director of the AEDP Institute. Based in New York City, she has been on the faculties of the departments of psychiatry and psychology of NYU and St. Luke's/ Roosevelt Medical centers (now Mount Sinai) in New York City and of the doctoral programs in clinical psychology at the Derner Institute for Advanced Psychological Studies and The City University of New York.

Hazel Ipp, PhD, is a founding board member and supervising analyst at the Toronto Institute for Contemporary Psychoanalysis. She is joint editor-in-chief, *Psychoanalytic Dialogues*, and on the editorial boards of *Contemporary Psychoanalysis* and *the International Journal for Self Psychology*. She is a founding and current board member and past president of IARPP. She has a private practice in Toronto.

Susan Lord, LICSW, PhD, is a clinical associate professor in the social work department at the University of New Hampshire, Durham, NH, adjunct clinical faculty at Smith College School for Social Work, and past instructor in psychiatry at Harvard Medical School. She is the author of *Wealth and Social Responsibility* and of several book chapters and articles on work with complex childhood trauma and the use of mindfulness practices in psychotherapy. She is an associate editor of the *Journal of Family Therapy,* a Taos Institute Associate, and is in private practice in York, Maine.

Elizabeth McKamy, MSW, was trained at the Menninger Clinic, Washington Center for Psychoanalysis. She has authored papers on the pregnant psychotherapist and social work with the wealthy. She recently retired from her private practice in Topeka, Kansas.

David Pocock, PhD, is head of family therapy at the Child and Family Consultation Service in Swindon, UK, and a visiting lecturer to the Bristol University. He is a current assessor for the *Journal of Family Therapy* and past member of the editorial board and previous moderator for the AFT/JFT internet discussion forum. He is a psychoanalytic psychotherapist in independent practice and a member of the Severnside Institute for Psychotherapy, where he currently chairs the Study Day Group. His published work ranges across systems theory, psychoanalysis, and the philosophical underpinnings of psychotherapy.

Miki Rahmani, MA, is chief psychologist, South Jerusalem Mental Health Center, and faculty *emerita*, school of education, Hebrew University, Jerusalem, Israel. In more than 35 years of clinical teaching and consulting, she has taught annual courses, seminars, and workshops on the supervisory relationship, the supervisory process in clinical work and in education, and the treatment process.

Martin Schmidt, PhD, is a Jungian training analyst at the Society of Analytical Psychology, a psychologist, and a lecturer on the postgraduate arts therapies programmes at the Universities of Roehampton and Hertfordshire. He is in private practice in London and teaches widely both in the United Kingdom and abroad. His paper, *Psychic skin: Psychotic defences, borderline process and delusions* (JAP, Feb 2012, vol. 57, no. 1), won the Fordham prize for best clinical paper in 2012 and was nominated by the NAAP for the Gradiva award in New York in 2013. For many years, he has been a regular visiting supervisor/lecturer in Belgrade, Kiev, Moscow, and St Petersburg. He is honorary secretary of the IAAP and the regional organizer for Europe.

Jonathan H. Slavin, PhD, is clinical instructor in psychology, department of psychiatry, Harvard Medical School; adjunct clinical professor, postdoctoral program in psychotherapy and psychoanalysis, New York University; founding director, Tufts University Counseling Center (1970–2006); former president of the division of psychoanalysis (39), American Psychological Association; and founding president, Massachusetts Institute for Psychoanalysis. Dr. Slavin's published work has focused on fundamental experiential elements in the psychoanalytic relationship including love, sexuality, desire, truthfulness, and personal agency and their role in the repair of the mind.

Malcolm Owen Slavin, PhD, is past president and a founder of the Massachusetts Institute for Psychoanalysis. He teaches and supervises at many psychoanalytic institutes worldwide and is an editor for *Psychoanalytic Dialogues, Contemporary Psychoanalysis* and the *International Journal of Psychoanalytic Self Psychology*. He practices, supervises, and teaches psychoanalysis in broadly relational and existential terms, focusing on mutual recognition, creative re-narration, and the analyst's capacity to be opened, known—and to change—within the treatment relationship.

Joyce Slochower, PhD, is a visiting clinical professor, NYU postdoctoral program in psychotherapy and psychoanalysis; professor emerita, Hunter College and Graduate Center, CUNY; the Steven Mitchell Center; the National Training Program of NIP, Philadelphia Center for Relational Studies; and the Psychoanalytic Center of Northern California

in San Francisco. She is on the board of IARPP and the editorial boards of *Psychoanalytic Dialogues*, *Psychoanalytic Perspectives* and *Ricerca Psicoanalitica*. Dr. Slochower is the author of more than 60 articles on clinical theory and technique and two books: *Holding and Psychoanalysis: A Relational Perspective* (1996) and *Psychoanalytic Collisions* (2006), both published by the Analytic Press.

Martha Stark, MD, is Faculty, Harvard Medical School, Co-Director / Faculty, Center for Psychoanalytic Studies, William James College Faculty, Psychiatry Redefined, Faculty / Scientific Advisory Board, The Academy of Comprehensive Integrative Medicine; Founder / CEO, SynergyMed for MindBodyHealth: Integrating Traditional and Nontraditional Solutions ®. Author: 7 award-winning books on psychoanalytic theory and practice, including "Modes of Therapeutic Action" and "Relentless Hope: The Refusal to Grieve". She is in private practice in Boston, MA.

Annie Weiss, LICSW, is on the faculty of the Boston Institute for Psychotherapy and the Northeastern Society for Group Psychotherapy. She is in private practice in Newton, MA.

Mark Winborn, PhD, is a Jungian psychoanalyst affiliated with the Inter-Regional Society of Jungian Analysts, the National Association for the Advancement of Psychoanalysis, and the International Association for Analytical Psychology. He is in private practice in Memphis, Tennessee; is the Training Coordinator for the Memphis Jungian Seminar (a training affiliate of the I-RSJA); and serves on the American Board for Accreditation in Psychoanalysis. His books include *Deep Blues: Human Soundscapes for the Archetypal Journey* and *Shared Realities: Participation Mystique and Beyond.*

Acknowledgments

I have had the pleasure and privilege of so many moments of meeting in the development of this book and throughout my career. I am forever grateful that I have the privilege of doing this work. I am blessed to be surrounded by family, friends, and colleagues who support me and enliven my inner and outer worlds.

First, I would like to thank the contributing authors, who offered such vulnerability, richness, and depth in their chapters. It has been a pleasure to collaborate with them, and I am grateful for their work.

Thank you to Paul Russell, who taught me that relationship and risk taking are the keys to a well-lived life.

I am lucky to have wonderful UNH and Taos Institute colleagues, particularly Sheila McNamee and Sally Ward, whose wisdom, friendship, and support have encouraged me in my work.

My life has been enriched through so many years of vibrant conversation and relationship with my "family in the world": Maryann Plunkett, Jay O. Sanders, Duncan Adams, and Robert Cummins.

To my family, whose love and belief in me have held me and helped to make this work possible: Ray and Priscilla Lord, Nancy Fascione, Sarah Holbrook, Andy Lord, and Alicia Robinson. And especially to Karen Frarie, Tessa Smith, and Aleksa Smith.

Thank you to publisher Kate Hawes and editorial assistant Charles Bath at Routledge who expertly guided me through and supported this project.

A special thank you to Steven Kuchuck, the series editor whose support, kindness, generosity, and wisdom have been instrumental in bringing this book to fruition.

And to my clients, supervisees, and students who have been such an inspiration and have helped me to grow in so many ways across the years.

* * *

The authors gratefully acknowledge permission to reprint the following materials:

Beebe, B. (2014). "My journey in infant research and psychoanalysis: Microanalysis, a social microscope." *Psychoanalytic Psychology, 31*(1), 4–25. Copyright © 2014. Reprinted by permission of the American Psychological Association in Chapter 1.

Crowther, C., and Schmidt, M. (2015). "States of grace: Eureka moments and the recognition of the unthought known." *Journal of Analytical Psychology, 60*(1), 54–74. Copyright © 2015. Reprinted by permission of John Wiley & Sons, Inc. in Chapter 5.

Slavin, J. (2013). "Moments of truth and perverse scenarios in psychoanalysis: Revisiting Davies' 'Love in the Afternoon.'" *Psychoanalytic Dialogues*, *23*, 139–149. Copyright © 2013. Portions reprinted by permission of Taylor & Francis, LLC in Chapter 2.

Slavin, J., Rahmani, M., and Pollock, L. (1998). "Reality and danger in psychoanalytic treatment." *Psychoanalytic Quarterly*, *67*, 191–217. Copyright © 1998. Portions reprinted by permission of John Wiley & Sons, Inc. in Chapter 2.

Introduction

Susan Lord

This book brings together a rich and diverse mix of senior psychoanalysts and psychodynamic psychotherapists[1] from across a number of theoretical backgrounds and continents, to explore some of the intriguing and surprising human moments that propel change processes through therapeutic interaction. Each author offers theoretical material, case examples, and a discussion of their experiences with these moments of meeting in their practices. What has evolved is an exciting cornucopia of chapters that I am hopeful will bring you, the reader, to many moments of meeting with the authors, with the materials, and with yourselves as you read them.

I have always been fascinated by those electrified moments that can heat up the relational sphere and facilitate change in psychotherapy. These are unanticipated moments in which both client and clinician are profoundly moved and transformed in some way. They are moments of openness, vulnerability, intimacy, and a shared humanity that live at the center of psychoanalytic processes and are, I believe, what we as clinicians, clients, and human beings cultivate and seek throughout our lives. Moments of meeting are unique moments of strong connection and of "radical presence" (McNamee, 2015) that are intensified through the dynamics of relational work. As we become more intersubjective and relational in our practices, it becomes increasingly critical that we develop approaches that have the capacity to move us to more "present moments," "now moments," and "moments of meeting" (Stern, 2004, p. 220).

What is it about the phenomenon of being in relationship with another human being that can transform a moment and those present and participating in that moment? How can this interaction become an enlivening and creative process through which each participant is changed in some profound and fundamental way? How can we, as agents of

change, develop and facilitate these powerful and transformative moments of meeting in our practices so that change processes are able to happen more readily? It seems that to work relationally in ways that are mutually influential, we must be prepared to take risks in the service of connecting with our clients in real, humane, and authentic ways.

From its inception, psychoanalysis has focused on exploring elements of human relationships. As the profession has matured, we have become increasingly interested in developing theories and practices that focus in on the intricacies of our mutual interactions. We have become more willing to step out of our comfort zones and risk entering into the unknown spaces inside of ourselves and of our patients, as well as those third spaces in between (Benjamin, 2002, 2004, 2006; Flaskas et al., 2005; Ogden, 1994, 1996). To do so, we have not only embraced mutuality in our practices, we have embraced it in our development of theory, integrating ideas from other disciplines and traditions, including philosophy, systems theory, linguistics, and the arts, to name a few. Mitchell spoke of the variety of relational ideas in analytic literature as not representative of competing theories but as dealing with the many aspects of reality (2000).

> … human minds interact with each other in many different ways, and the variety of relational concepts pervading the recent analytic literature is best understood not as representing competing theories, but as addressing themselves to different, interwoven dimensions of reality (p. xv).

Evolution of theory and practice

I have written elsewhere about the evolution of theory and practice and the paradigm shift that we have come to, in which arguing polarities is no longer useful but, rather, a shared philosophy appears to be developing (Lord, 2015). It seems that we have achieved a level of organization at which disorganization is possible and are now able to call upon what is useful to each unique situation, embracing the integrated and chaotic whole of what develops in theory and in practice. Harris wrote about the importance of nonlinearity, the use of metaphor, and the potential of chaos theory to see complexity, structure, and coherence as outcomes of interaction in the evolution of relational theory (2005). Flaskas (2002), in her article on "border crossing," spoke of "the freedom of engaging with diversity and

tension in knowledge" (p. 221), and the "messy richness" in the recursive spiral of the relationship between theory and practice in psychotherapy.

Theory informs practice and organizes clinicians in their facilitation of change processes. The hope is that theoretical frames don't organize us in ways that constrain us in our interactive fields of practice. Stern (1985) observed that language can be a "double-edged sword" that at the same time facilitates and interferes with relationship as it "drives a wedge" between lived experience and its verbal expression (pp. 162–163). So much of what happens in the spaces in between has to do with coming forward nonverbally and energetically in ways that cannot be captured with words.

Berger and Luckmann in their seminal book, *The Social Construction of Reality: A Treatise in the Sociology of Knowledge* (1967), wrote about paradigm shifts, the dialectic between subjective and objective realities, and the importance of coming to terms with the two in some form of integration of shared meaning. Bateson (1979) spoke of reality as existing somewhere between the view of the observer and the context in which the observation was occurring. He talked about information lying in difference, and "the difference which becomes information by making a difference" (p. 68), highlighting the importance of *binocular vision*, a complicated "synthesis of information" (p. 69). Aron and Starr (2013) called for a "broader and more flexible definition [of American psychoanalysis], one that has practical implications for how psychoanalysis and psychoanalytic therapy are theorized, taught, and practiced, and that includes psychoanalysis as a social and humanistic enterprise" (p. 1).

Having come to the relational tradition through a back door, so to speak (my training has been in psychodynamic psychotherapy, family therapy, Jungian analysis, and social constructionism), I am interested in how so many traditions have arrived at such a similar place. For example, "Social constructionist theory and practice locates the source of meaning, value and action in the relational connection among people. It is through our social and relational processes that we construct the world" (Gergen, 2016, para. 2).

It seems that at this point in time, there is an increasing awareness of the oneness of humanity and, with globalization, technological advances, and our rapid capacity to share information, the world is becoming much more integrated in social and humanistic ways. We are no longer asserting our identity as a *this*, not a *that*, and are able to integrate a multiplicity of useful theories of many models and disciplines into our work, embracing the complexities of what it is to be human.

Background

The phrase "moments of meeting" originated with the Boston Change Process Study Group in the 1980s. At the time, members included representatives of the fields of psychotherapy, psychoanalysis, developmental psychology, and pediatrics. Nadia Bruschweiler-Stern, Alexandra Harrison, Karlen Lyons-Ruth, Alexander Nahum, Louis Sander, Daniel Stern, and Edward Tronick came together in the mid-eighties, and their rich collaboration focused on the lived experiences that brought about change through what they termed "co-creation" in psychotherapy.

In 1995, Sander wrote of a "moment of meeting" in which "two states of consciousness are "'matched,'" in the sense that "the way one would 'know' oneself would be matched by the way one was 'known' by an other" (p. 589). He later (2002) developed the concept of being "together-with" an other: "At the same time, the sense of fulfillment (Tronick, 1998) or "heightened affective moments" (Beebe and Lachmann, 1996) of the experience of specificity in "moments of meeting" between infant and caregiver provide the essential positive motivating pole in the nonlinear dynamic system they are constructing; that is, moving each partner to seek the positive affective accompaniment of being "together-with' the other" (p. 38). Influenced by microanalyses of moment-to-moment mother-infant interactions, Stern constructed a microanalytic interview for adults, as he was interested in what he called the "now moments" and "present moments" that he viewed as ingredients leading to "moments of meeting" (Boston Change Process Study Group, 2010; Stern, 2004).

Thirty years later, these moments of meeting continue to be at the center of relational work. We have become increasingly interested in the use of transference-countertransference dynamics, enactments, and more transparency and intersubjectivity in contemporary psychoanalysis. The process of working in this way and cultivating these moments can be quite anxiety-provoking for both analyst and patient. Relational psychoanalysis requires our clear commitment to coming forward and risking the fantasy of analytic neutrality and anonymity, much as we have always asked our patients to come forward and risk theirs. It can be an uncomfortable practice for analysts who have been classically trained not to reveal much of who they are. Aron (1996) purported that a significant factor that led analysts to develop such structured ways of working had to do with their anxiety about becoming known by their patients. He suggested, in fact,

that one of the reasons that analysts choose to become analysts is that they have their own issues about intimacy.

What is the relational tradition?

The relational tradition, a contemporary psychoanalytic perspective, evolved out of a long and rich history of theorists, including Freud, Klein, Fairbairn, Sullivan, Ferenczi, and Winnicott, who advocated approaches that recognized the importance of two-person mutual interactions in clinical work (Mitchell, 1988). Interpersonal, British object relations, self-psychological, existential, feminist, gender, and queer theoretical models that emphasize humanness, human relatedness, and subject-to-subject interactions in therapeutic processes are all threads that have impacted this tradition.

In 1999, Mitchell and Aron developed the term *relational psychoanalysis* to reflect "a blending of these diverse currents into a broad, multidimensional view of human intersubjectivity" (Mitchell, 2000, p. 65). Relationalists use transference-countertransference responses as a way of understanding both the therapist's and the client's subjectivity. Enactments, mutuality, self-disclosure, and the space of thirdness are all concepts of relational work (Berzoff, Flanagan, & Hertz, 2011).

Transparency

As we have come to a point of sharing ourselves in heretofore unheard of ways within the sanctuary of the therapeutic relationship, it seems important to discuss them transparently in the literature. Although there have been a number of journal articles in which therapists have discussed moments of meeting that have occurred in their practices, to my knowledge there have been no books that have focused exclusively on contemporary analysts and psychotherapists elucidating their views and experiences of such moments. Theories and practices have continued to evolve and have opened up interactions in ways that we cannot know without beginning to be vulnerable to one another in our conversations and in our writing.

This book offers a window into the ways in which some of today's practitioners think about, encourage, and work with these experiences within the sanctity of their consulting rooms. The following chapters cover a broad range of topics as they relate to moments of meeting, including love, anger, unresolved grief, emotional absence, secrets and lies, aesthetic

experience, creativity, therapeutic impasse, shame, empathic and evocative listening, synchronistic events, retirement, mindfulness and spirituality, the relational triangle, internal family systems therapy, and accelerated experiential dynamic psychotherapy.

Chapters

The book is divided into four sections: Part I, Background/Context; Part II, Jungian Approaches; Part III, Relational Psychoanalysis and Psychoanalytic Psychotherapy; and Part IV, Alternative Relational Modalities. We begin with Beebe's history of what was then an innovative area of infant microprocessing research, and look in on the evolution of relational theory and practice through the lenses of a variety of analysts and psychotherapists. We end by coming full circle to innovation, exploring a handful of creative relational practices that years from now will have become integrated into the rich ever-evolving fabric of the ongoing dimensions of relational reality.

In Part I, Chapter 1, Beatrice Beebe offers an almost-50-year history of her life's work, including her affiliations with Daniel Stern, Joseph Jaffe, and Frank Lachmann. She emphasizes her involvement in the infant microprocessing research that has contributed so much to relational psychoanalysis. In Chapter 2, Jonathan Slavin and Miki Rahmini trace the history of psychoanalysis and of relational theory and practice. They propose that over the past 30 years, we have "exactly reversed" our previous assumptions about what led to symptoms that patients presented with, and the idea that psychoanalysis should occur with as little human interaction as possible. They posit that we have come to a "moment of truth" in which we must embrace the knowledge that it is through real-world interaction and risk that "true change" becomes possible.

Part II, Chapter 3, begins the section on Jungian approaches to relational work, with Joseph Cambray's discussion of the intersubjective threads in Jung's work, moving them into synchronistic events associated with clinical work. He talks about the globalization of the psychoanalytic world, addressing some of the complexities that this has brought forth. Mark Winborn suggests that the experience of depth and the emergence of meaning, transcendence, coherence, and narrative flow can be readily viewed through the lens of aesthetic experience in Chapter 4. In Chapter 5, Catherine Crowther and Mark Schmidt discuss Jung's concept of the transcendent function and his understanding of the "gift of grace." These

are defined as events in the analytic hour that are marked by a profound sense of transformation of feeling tone through which the quality of relatedness in the analytic dyad becomes heightened.

The bulk of the book (Part III, Chapters 7–14) is focused on the writings of contemporary relational psychoanalysts and psychoanalytically trained psychotherapists. In Chapter 6, Patricia DeYoung offers a brief overview of the history of the self-psychological and interpersonal traditions of psychoanalysis, focusing on her relational approach to working with the issue of chronic shame. Martha Stark writes of introjective identification in Chapter 7, and an analysis during which she cried in sessions while her patient did not. She offers three models of therapeutic action, describing the processing of this patient's overwhelming unresolved grief and the tears that he was unable to shed.

Denise Davis comes from a self psychological viewpoint in Chapter 8, suggesting that self psychology's emphasis on empathic immersion gives the therapist access to the patient's subjective experience, which facilitates resonant responsiveness that catalyzes moments of meeting. Slochower writes in Chapter 9 of a treatment that she felt was without moments of meeting, in which the active changes occurred outside of the analytic relationship. She focuses on the aspects of change that are possible through emotional absence.

In Chapter 10, David Pocock, a British analyst, addresses mutuality in psychoanalytic relationships and the "us" that emerges, with feelings developing that are more than the sum of the two subjectivities experiencing them. He says that whatever emerges from a moment of meeting is a product of moment-to-moment mutual influence. Chapter 11 by Malcolm Owen Slavin offers another view of the mutuality in psychoanalytic relationships. He says that the experiences we call empathy, enactment, and projective identification take on radically different meanings when we view them as part of a larger, adaptive, relational process—one in which our patients search to find our capacity for realness and reciprocity. This, he says, is a process where we must inevitably reopen our own versions of the same internal set of existential issues with which our patients struggle. His narrative of a long-term analytic relationship is followed by a letter from his patient, who has read the narrative and is commenting on it.

In Chapters 12 and 13, Boxer and Beeler, respectively, explore aspects of mutuality in the analytic relationship. Boxer writes of the collaborative healing capacities of analytic relationships, focusing on ways that her

work with a difficult patient helped her to revisit and rework issues from her own experiences of loss and loneliness. Beeler addresses enactments, heightened affective moments, self- and mutual regulation, moments of spontaneity, and exchanges within an analytic encounter that promoted change within herself as well as in her patient.

McKamy writes about her own retirement in Chapter 14, offering several vignettes to illustrate the many moments of meeting that occurred with her patients during this planned rite of passage. These moments were heightened by the fact that she was ending her work with all of her patients at the same time, and she discusses some of the patterns she observed, offering lessons learned through the process.

Part IV, the Alternative Relational Modalities Section, begins with Chapter 15 by Diana Fosha, who developed Accelerated Experiential Dynamic Psychotherapy (AEDP) as a short-term method for treating trauma, having become frustrated with the length of time that it generally took. She writes about the something more than "Something More than Interpretation" that is facilitated in experiential and emotion-focused approaches, where "upward spirals can keep bringing in energy, vitality and coherence for the task of transformation."

I tend to enjoy long-term treatment, and my Chapter 16, on the use of mindfulness practices and spirituality in psychotherapy, focuses on speeding up and intensifying the processes of coming to the present moment in psychotherapy. It speaks of the love that develops between client and therapist and the importance of holding the space when love happens, proposing an intersubjective fourth as a space of spiritual love and healing. The final chapter by Annie Weiss describes the use of Internal Family Systems in group psychotherapy. She offers several clinical vignettes to illustrate the many moments of meeting in this kind of group work that can lead to profound growth and change for her and for her clients.

This book begins with some of the history of the evolution of relational work, exploring the finely focused attention to micro moments of interaction that developed in infant research, moving through the rich intricacies of the Jungian perspective, to narratives of exquisitely wrought moments of meeting told from within the sanctity of several relational psychoanalysts' practices. We end with examples of innovative alternative modalities that expand possibilities for harnessing the capacities of relational work to bring us to more present moments, now moments, and moments of meeting in our continually evolving work together.

It is my hope that these chapters expand your capacities for risk taking and enrich your practices and your lives as they have mine.

Note

1 The terms psychoanalyst and psychotherapist are used interchangeably throughout the book to signify clinicians who identify with psychoanalytic ideas and practices.

References

Aron, L. (1996) *A meeting of minds*. Hillsdale, NJ: Analytic Press.

Aron, L., & Starr, K. (2013) *A psychotherapy for the people: Toward a progressive psychoanalysis*. New York: Routledge.

Bateson, G. (1979) *Mind and nature: A necessary unity.* Boston, MA: Dutton.

Benjamin, J. (2002) The rhythm of recognition: Comments on the work of Louis Sander. *Psychoanalytic Dialogues, 12*(1), 43–53.

Benjamin, J. (2004) Beyond doer and done to: An intersubjective view of thirdness. *Psychoanalytic Quarterly, 73*, 5–46.

Benjamin, J. (2006) Two-way streets: Recognition of difference and the intersubjective third. *Brown University and Differences: A Journal of Feminist Cultural Studies, 17*, 117–146.

Berger, P. L., & Luckmann, T. (1967) *The social construction of reality: A treatise on the sociology of knowledge*. New York: Doubleday and Anchor.

Berzoff, J., Flanagan, L. M., & Hertz, P. (Eds.). (2011) *Inside out and outside in* (3rd ed.). Lanham, MD.: Rowman & Littlefield.

Boston Change Process Study Group. (2010) *Change in psychotherapy: A unifying paradigm*. New York, NY: Norton.

Flaskas, C. (2002) Comment—border crossing and the integrity of frameworks. *Journal of Family Therapy*, *24*, 222–231.

Flaskas, C., Mason, B., & Perlesz, A. (Eds.). (2005) *The space between: Experience, context, and process in the therapeutic relationship*. London: Karnac.

Gergen, K. (2016) Welcome to the Taos Institute. Retrieved from http://www.taosinstitute.net/

Harris, A. (2005) *Gender as soft assembly.* New York, NY: Routledge.

Lord, S. (2015) Theoretical frameworks for working with harder to reach families: Lines, curlicues, and spirals. *Journal of Family Therapy, 37*(2), 184–189.

McNamee, S. (2015) Radical presence: Alternatives to the therapeutic state. *European Journal of Psychotherapy, 17*(4), 373–383.

Mitchell, S. A. (1988) *Relational concepts in psychoanalysis: An integration*. Cambridge, MA: Harvard University Press.

Mitchell, S. A. (2000). *Relationality: From attachment to intersubjectivity.* Hillsdale, NJ: The Analytic Press.

Ogden, T. (1994) The analytic third: Working with intersubjective clinical facts. *International Journal of Psychoanalysis*, *75*(3), 3–19.

Ogden, T. (1996) *Subjects of analysis*. Lanham, MD: Jason Aronson.

Sander, L. W. (1995) Identity and the experience of specificity in the process of recognition: Commentary on Seligman and Shanok. *Psychoanalytic Dialogues*, *5*, 579–593.

Sander, L. W. (2002) Thinking differently: Principles of process in living systems and the specificity of being known. *Psychoanalytic Dialogues*, *12*(1), 11–42.

Stern, D. N. (1985) *The interpersonal world of the infant: A view from psychoanalysis and developmental psychology*. New York: Basic Books.

Stern, D. N. (2004) *The present moment in psychotherapy and everyday life*. New York, NY: Norton.

Part I

Background/context



Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

Chapter 1

My journey in infant research and psychoanalysis

Microanalysis, a social microscope

Beatrice Beebe

Video microanalysis taught me to see how the intricate process of mother-infant moment-to-moment communication works. It is a powerful research, treatment, and training tool. I owe my love of video microanalysis to Dan Stern.

Video or film microanalysis operates like a social microscope into the underworld just below perceptible view in real time. Mother-infant communicative events occur in less than a second (Beebe, 1982). They are so rapid and subtle that they are not quite grasped in real time. By slowing down the movements, frame-by-frame microanalysis identifies remarkably beautiful moments, such as both partners rising up and up into glorious sunbursts of smiles. It also reveals very disturbing moments, such as maternal anger or disgust faces, or infants becoming frantically distressed or frozen in alarm. By videotaping mothers and infants split-screen, one camera on each partner, we can see the moment-by-moment dialogue between the two.

From birth, infants live in a two-person social world, and they are capable of coordinating their behaviors with those of the partner (Peery, 1980; Trevarthen, 1979).

Each partner coordinates with the other, a bidirectional mutual regulation. Later I will describe how bidirectional regulation became a key contribution of infant research to a psychoanalytic theory of development and treatment.

This rapid face-to-face communication system that we study between mothers and infants also operates between adults. Because verbal language is not available for infants, we must try to understand their nonverbal language. Adult face-to-face communication is very similar to mother-infant communication. The nonverbal aspects of behavior, such as gaze shifts, slight changes in facial expression or head orientation, and eyebrow raises, are almost imperceptible, but are extremely influential in communicating.

This rapid, quasi-automatic social processing is largely nonconscious, out of awareness. It is an implicit, procedural, action-sequence form of processing. It is probably based on evolutionary adaptation to the need for rapid interpersonal processing and action in the service of survival. Frank Lachmann and I became fascinated with parallels between mother-infant communication and nonverbal communication in adult treatment. This fascination has fueled our collaboration for three decades.

The state of infant research as I entered graduate school in 1968

When I entered graduate school in 1968, at Teachers College, Columbia University, the empirical microanalysis of mother-infant face-to-face communication did not yet exist as a field. It was just beginning. Daniel Stern published his first paper in 1971; Colwyn Trevarthen in 1972; T. Berry Brazelton, Barbara Kozlowski, and Mary Main in 1974. Edward Tronick, Brazelton's student, soon became a leading figure in the late 1970s. Lynne Murray, Trevarthen's student, and Jeffrey Cohn, Ed Tronick's student, as well as Alan Fogel, Tiffany Field, and Michael Lewis, among others, were active at that time. These researchers began with low-risk community samples to understand the course of normal development. Two decades later, risk factors, such as maternal depression, began to be included (Field, 1995).

The decade of the 1960s had generated a body of work that Stone, Smith, and Murphy (1973) summarized as "the competent infant." This set the stage for the study of mother-infant communication, including the role of a competent, initiating, social infant. In 1968, Bell published a paper that helped shift the paradigm of child development research toward an interactive systems view. He argued that most of the research to date had emphasized parental influence upon children, a one-way influence model, to the relative exclusion of the child's influence on the parent. Bell reinterpreted this research within a bidirectional model.

With increasing recognition of the infant's social competence, researchers became interested in a bidirectional, or mutual, model of influence, within the dyad as a system. An important book entitled *The Effect of the Infant on the Caregiver* was written by Lewis and Rosenblum (1974) in an effort to highlight the neglected role of the infant in mutual regulation. However, in the 1970s and 1980s, infant researchers argued

vehemently over whether the bidirectional, mutual regulation model was correct. This was the intellectual Zeitgeist that I entered as I began graduate school in 1968 and became interested in infant research.

Not until two decades later was this debate resolved, with Cohn and Tronick's (1988) landmark paper that used time-series analysis to show that mother-infant interaction is indeed bidirectional. Until this time, everyone had used a different statistical method to try to assess bidirectional influence, and no one replicated his or her own work, or anyone else's. The approach of time-series mathematics revolutionized the study of social interaction in the 1980s and was critical in resolving this debate. It assesses moment-to-moment adjustments (interactive predictability) that each individual makes to the partner's prior behavior, while it controls for each partner's self-predictability. Metaphorically, it measures expectancies of "how I affect you," and "how you affect me." This became our method as well. Cohn and Tronick's (1988) resolution of this debate by documenting bidirectional mutual influence between mother and infant laid the empirical foundation for an interactive systems model of infant social development.

Graduate school at Teachers College

At Teachers College in 1968, I pursued a joint doctorate in developmental and clinical psychology. In my first year, George Rand, in developmental psychology, taught me about different theories of development and especially about Heinz Werner and Jean Piaget. George had studied with Heinz Werner. Both Werner and Piaget held an interactive model of development in which both organism and environment affect one another. This fit so well with the bidirectional model from infant research.

George was the first to encourage me to follow my interest in infants. I remember that I entered graduate school with the idea that I wanted to study "mother-infant reciprocity" and infant emotional development; however, initially I did not meet with a lot of encouragement to study infants. Even in a department of developmental psychology, infants were seen as rather undifferentiated. I was advised to study *children* whose emotional development would be really interesting.

Once I met Dan Stern, everything was different. There was no question that the study of mother-infant communication was hugely exciting and fascinating. I met Dan Stern at New York State Psychiatric Institute

(NYSPI), Columbia University Medical School, in 1969, in my second year of graduate school. I was asking everyone for a lead to an infant researcher. I heard about him on Fire Island, where he often went for summer vacation. I remember the day I met Dan. I arrived at the open door of his office, while he was on the telephone. As he carried on his verbal conversation on the telephone, he also carried on another nonverbal conversation with me, through his face and eyes, which were welcoming and interested. Already we were into nonverbal communication.

I worked for Dan Stern as a volunteer research assistant at NYSPI from 1969 to 1973. I later learned that Dan had been a postdoctoral fellow of Joe Jaffe at NYSPI, and they were working together at this time. I had no idea then that eventually I would spend four decades working closely with Joe Jaffe.

Dan, accompanied by several graduate students, was videotaping twins in their homes with one camera. Dan encouraged the students to play with the infants on camera as well. I played with infants, which set the stage for the study of "stranger-infant" interaction. At that time, we had no idea that stranger-infant interaction would turn out to be a powerful predictor of development.

Being the stranger playing with the infants in those home visits with Dan Stern shaped my interest in infant research. One of these visits was particularly memorable. I played with an infant whose face was full of joy. As I watched her face respond to mine, tears came to my eyes. I was so astonished and moved by how closely she tracked my face, how exquisitely she seemed to respond to me, how her face burst into what I later came to call the "gape smile," the hugely open-mouth smile, the apex of positive affect. That particular experience led me to do my dissertation with Stern. I wanted to study what I had observed in that infant, the process of positive affect, how it surges, ebbs, and crescendos. My dissertation was entitled, "Ontogeny of positive affect in the third and fourth months of life of one infant" (Beebe, 1973). The four frames below are taken from my dissertation and illustrate the process of positive affect crescendo. The fourth frame is the gape smile (Figure 1).

Dan was very playful. We, the other graduate students and I, loved going on these outings with Dan. In the lab, he always wanted to go get a cup of coffee and tell about his newest ideas. He had tremendous energy and enthusiasm and brilliance. Everything seemed possible with Dan.

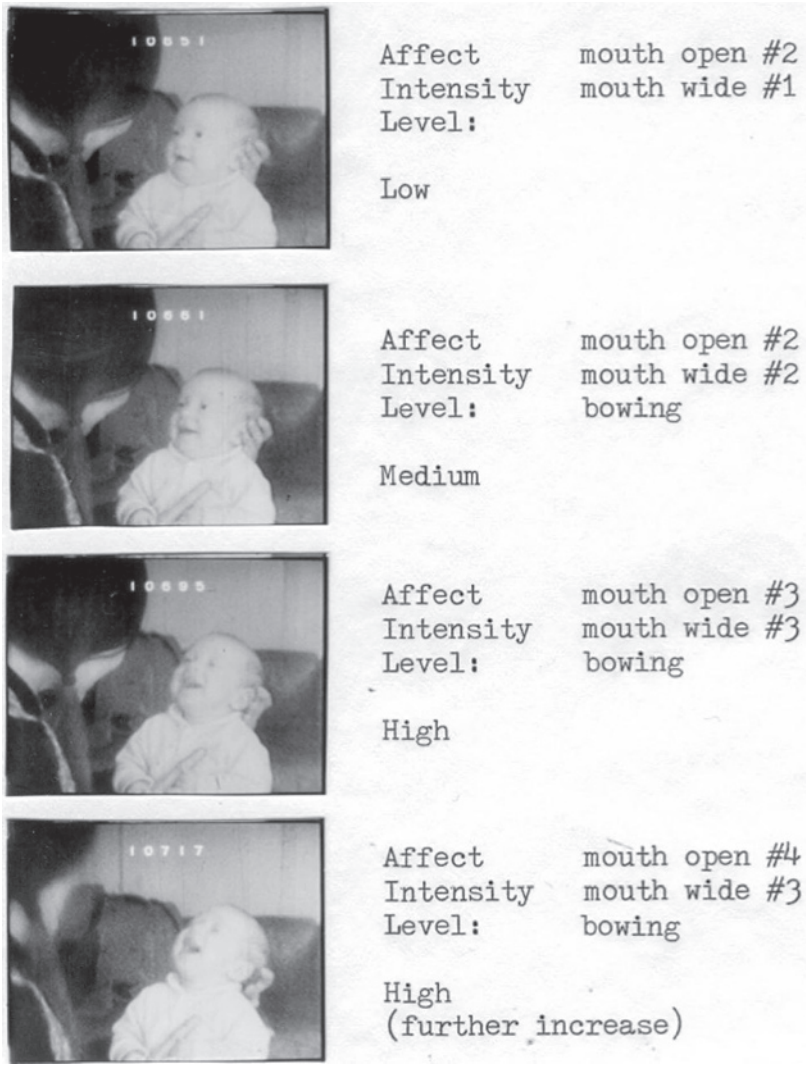


Figure 1 Sequence of infant positive affect. Note: 16mm film, 24 frames per second. Numbers printed at the top of the frame indicate 24ths of a second: 10651, 10661, 10695, 10717. Frames 1 to 2 are about ½ second apart; frames 2 to 3 about 1.5 second apart, and frames 3 to 4 about 1 second apart. Affect intensity levels are coded by degree of mouth open (1 to 4), degree of mouth widen (1 to 3), and presence or absence of bowing at the mouth corners, which indicates zygomaticus retraction, producing a smile. Note that the infant's head moving up is salient in the final frame.

Dan sponsored my PhD dissertation, along with Herbert Birch and Rosalie Schonbar at Teachers College. Herbert Birch was a brilliant developmental researcher. He backed my interest in doing a case study, a microanalysis of one mother-infant pair. Then, and even now, an empirical dissertation on a single case is rare. Sadly, Birch died just as I began the initial phases of analyzing my data. I wish he could have seen the work that he had so encouraged.

Microanalysis in 1969

In 1969, the use of video cameras was relatively new, and computers were still uncommon. Video was reel-to-reel and difficult to code. To perform a microanalysis, we converted video to 16 mm film, which had 24 frames per second. We used an editing viewer, a small metal box anchored to a board, through which one could view the film. The board had metal posts on either side of the box, onto which two film reels were securely attached. The film fit through the metal box, and a light projected the film onto the wall, but to see the film, one had to be in a darkroom. The setup was just like one for editing a film, except instead of cutting the film, we were analyzing it. Numbers were printed on the top of each film frame. With one's own hands, one could slowly move the film forward and back to watch movement unfold in time. We identified the beginning and ending frame of each little movement of mother and infant. These movements, such as slight shifts of gaze, head-up, or mouth-opening, typically last about a quarter to a third of a second (Beebe, 1982).

Today, digitized video makes this entire process so much easier, but the hand method of frame-by-frame analysis of film had one interesting advantage. My own body movement was involved in detecting the onset and offset of each behavior. For example, in the chase and dodge interaction (described below), as I rocked the film back and forth between the two reels, my body moved with the mother's movement as she loomed in close to the infant's face, and my body moved with the infant's head movement back and away from the mother, a split-second later. I believe my own visceral feedback helped me better comprehend how these movements might be experienced by the infant and by the mother. This is a form of embodied simulation. Performing the action of another person influences one's perception of the person's action and facilitates recognition of it (Oberman, Winkielman, & Ramachandran, 2007; Niedenthal, Mermillod,

Maringer, & Hess, 2010; Beebe & Lachmann, 2013). In my case, I was participating in the action through my body movements as I coded.

Stern's first paper

Dan Stern's first paper was in progress as I joined his research team. It was a film microanalysis showing the difference in interactive regulation between a mother and her dyzygotic twins (Stern, 1971). Stern's approach to microanalysis was influenced by ethology, which privileges the careful description of behavior in its natural habitat, detailing the form, sequence, and timing of behavior. Careful description is a prerequisite to understanding the social communication value of behavior. This ethological approach continues to influence the microanalysis of mother-infant communication.

When Dan had finished the coding of the mother and infant gaze and head orientation behaviors for his paper, we pasted the data all over the walls of Dan's office. We were so excited. In this very first paper, Dan positioned the interaction and its bidirectional regulation as central to the understanding of a relationship. He was interested in how each partner affected the other. Dan showed fascinating ways in which this mother interacted so differently with her two twins, and each twin, Fred and Mark, interacted differently with her. Mother and Fred had an approach-avoid spatial pattern, with split-second bidirectional contingencies. Mother and Mark had an approach-approach pattern, also with split-second coordination.

Dan presented his findings in the infant research meetings, the International Conference of Infant Studies (ICIS). We all felt on the crest of something so new, so important. I met Ed Tronick at the ICIS meeting in the spring of 1974. He has remained an important friend and colleague for four decades.

Stern (1974) framed the study of mother-infant interaction in the larger context of its importance for interpersonal object relations and attachment, still a central research issue today: "By providing a more fine-grained view of the instant-by-instant interactive events which make up the mother-infant relationship, we may be in a better position to modify and expand current working theories on the nature of developing object relations or attachments" (Stern, 1974, p. 402). Stern (1985) later developed these ideas in his groundbreaking work, *The Interpersonal World of the Infant,* which had a transforming effect on psychoanalysis.

My clinical training

Meanwhile, I also pursued the clinical side of my training. In 1971 to 1972, I did my clinical internship at Yale at the Connecticut Mental Health Center. There I met Sid Blatt. We shared an interest in the developmental theories of Heinz Werner and Jean Piaget. Sid was very supportive of my interest in infant research, and he continued to critique my papers for several decades. Blatt's 1974 paper was very influential at that time, but already he and I were debating the theory of infant development. The dominant theoretical Zeitgeist of Margaret Mahler, and symbiosis and separation-individuation, was being challenged by the emerging empirical research findings.

Psychoanalytic theories of development had underestimated the social capacities of infants. A decade later, I summarized the empirical research from the late 1960s to early 1970s this way:

> To appreciate the significance of microinteraction, we must expand the psychoanalytic view of early interaction, which focuses on feeding and the management of tension states, to include social interaction and play. . . . From birth the infant is innately structured for active and stimulus-seeking behavior. . . . Neonates show rooting, sucking, molding, and orienting behavior; the ability to scan visually, focus on, and track a moving object; the capacity to respond to visual stimuli by widened and brightened eyes, changes in respiration, a decrease in random movements, and fine nuances of facial expression. . . . Neonates not only seek and initiate social interaction. . . but can also modulate or regulate social stimulation in the face of aversive conditions with self-quieting measures, inhibiting their responsiveness or habituating to a disturbing stimulus. . . . These innately organized patterns of behavior equip the infant to engage in primary relatedness with the human partner
>
> (Beebe, 1986, p. 29).

The research I cited then included Stechler and Carpenter (1967); Ainsworth (1969); Kessen, Haith, and Salpatek (1970); Brazelton, Kozlowski, and Main (1974); Stern (1974); Fantz, Fagan, and Miranda (1975); Lewis and Brooks (1975); Als (1977); and Oster (1978). This research portrayed a very different infant from the infant of the autistic phase in Mahler's theory, which Stern critiqued. From different points

of view, Winnicott (1965); Bowlby (1969); and Spitz (1965) were also working with a view of the infant as capable of a primary social relatedness from birth.

The research on early social capacities set the stage for the burgeoning interest in mother-infant face-to-face communication in the 1970s and 1980s. We sought to understand how these infant capacities were used in the face-to-face exchange by 3 to 4 months, when infants' social capacities flower.

When I returned from Yale to finish my final year at Teachers College, in September, 1972, I was assigned Frank Lachmann as a supervisor. This was one of the luckiest turns of my life. Frank and I have continued to meet once a week since that time, now more than 40 years.

Frank and I spent the first decade of our relationship in supervision on the Burton case (1972–1982). We then wrote up the case (Lachmann & Beebe, 1983). At that time, the main psychoanalytic theorists were Margaret Mahler and Edith Jacobson. Heinz Kohut had just published his first book in 1971, but Frank in 1972 was already very familiar with Kohut.

In 1983, we took a year off from our supervision relationship, and I taught him my course on infant social development, which I was teaching at the Ferkauf Graduate School, Yeshiva University, where I taught from 1976 to 1992. By then, I was already studying in the New York University postdoctoral program in psychotherapy and psychoanalysis (1980–1986). We took notes that year as I reviewed the infant research with Frank, and we wrote a long, unwieldy paper. After we threw that paper out, we were ready to write. Frank and I wrote more than two dozen papers that included the relevance of infant research for adult treatment.

We published our first papers in 1988, one in *Psychoanalytic Psychology*, and one in *Progress in Self Psychology* (Beebe & Lachmann, l988a and 1988b, respectively). At that time, another leading psychoanalytic journal turned our work down.

In "The contribution of mother-infant mutual influence to the origins of self and object representations" (Beebe & Lachmann, 1988a), we proposed that early social experience is organized in an interactive framework. We summarized the research on early infant capacities, such as feature detection, visual recognition, memory, and the perception of cross-modal correspondences that defined our concept of presymbolic representation. We illustrated patterns of matching and of derailed exchanges in 4-month mother-infant mutual regulation. Matching patterns included matching of

affective direction and matching the temporal patterns of vocal and kinesic (movement) exchanges. Derailed patterns were illustrated with "chase and dodge" interactions, described below. We suggested that presymbolic self and object representations are based on a dynamic process of reciprocal, bidirectional adjustments: "What is represented is an emergent dyadic phenomenon, structures of the interaction, which cannot be described on the basis of either partner alone" (Beebe & Lachmann, 1988a, p. 305).

This view stands in contrast to the prevailing view at that time of separate, static, self, and object representations. Psychoanalysis began with a one-person view of psychic organization. As Blatt (1986, pp.1–2) noted,

> Even as late as 1960, many psychoanalysts still viewed the individual essentially as a closed system. . . . Beginning around 1960, major movements both in England and the United States began to consider psychological development as occurring in an open system in which there was an interaction between the unfolding biological predispositions of the child and the patterns of care provided by caring agents.

Frank and I (Beebe & Lachmann, 1988a) argued that a two-person field organizes infant experience from the beginning. Our view is very different from some current prevailing views that the mother's response to the infant organizes the infant's experience. Instead, both infant and mother cocreate the nature of the infant's experience, although the mother has the greater range, flexibility, and capacity. Moreover, we have always been careful to conceptualize the individual's own contribution to the dyadic cocreation. We think of dyadic bidirectional regulation as existing in dynamic relation to the self-regulation of each partner of the dyad (Beebe, Jaffe, & Lachmann, 1993; Beebe & Lachmann, 1994, 2002).

The papers that Frank and I wrote between 1988 and 2000 were reworked into our first book, *Infant Research and Adult Treatment: Coconstructing Interactions* (Beebe & Lachmann, 2002). In that book, we also revisited the Burton case, reformulating the treatment based on what we had learned together from infant research.

Through our collaboration, we contributed to the creation of a home within psychoanalysis for the relevance of the ideas that emerged from empirical infant research. This was possible in large part because of the enormous support that we received from the psychoanalytic communities that encouraged our work: the New York University postdoctoral program

in psychotherapy and psychoanalysis; the Institute for the Psychoanalytic Study of Subjectivity; the Columbia Psychoanalytic Center; the Postgraduate Center; the International Association of Psychoanalytic Self Psychology; the Los Angeles Institute for Contemporary Psychoanalysis; and the Washington, DC Institute for Contemporary Psychoanalysis, among others.

Largely because of my relationship with Frank, I have continued to try to integrate my infant research work with my love of psychoanalysis. Frank became my anchor in psychoanalysis as I struggled with the challenge of integrating these two fields. Frank and I have just published our second book, *The Origins of Attachment: Infant Research and Adult Treatment* (Beebe & Lachmann, 2013).

Later in my life I came to realize that I needed both the fields of infant research and of psychoanalysis in an effort to integrate my parents' very different intellectual interests and personalities. My father was a researcher, a radiation epidemiologist who designed the follow-up studies of Hiroshima, Nagasaki, and Chernobyl. My mother was a school psychologist, and she went to Teachers College, in the same program I attended some four decades later. She was the psychologist for Beauvoir, the preschool associated with the National Cathedral Schools in Washington, DC. Later, for several decades, she was a school psychologist in Rockville, Maryland, responsible for 30 schools.

"Chase and Dodge": Postdoctoral fellowship with Stern, 1973–1975

I continued to work with Dan Stern in a postdoctoral fellowship at NYSPI. From 1973 to 1975, I analyzed the "chase and dodge" film, a total of 8 minutes. Steve Bennett, who was a member of Dan's team, sat with me for many hours viewing the film frame by frame. In this film, we identified repeating sequences in which the mother's "chase" movements (moving her head and body in the direction that the infant just moved) were followed by infant "dodge" movements (moving his head back and away). In the moments when the infant turned to look at her, the mother typically made a "mock surprise" expression and loomed into his face, which set off the infant's dodge behaviors, but the opposite sequence was significant as well: Infant dodge movements were followed by maternal chase movements. This was an early example of bidirectional influence,

the idea that each partner's behavior affects that of the other. It is not only the mother who "drives" the interaction. Moreover, each responded to the other with split-second timing, within approximately 1/3 s from the onset of the partner's prior behavior. The infant had a virtuoso repertoire of withdrawal and avoidance maneuvers. To every maternal overture, the infant could move his body back, duck his head down, turn his head away, or pull his hand out of mother's grasp, exercising a virtual veto power over the mother's efforts to engage him in a face-to-face encounter. This pattern illustrates the infant's role in the interaction. Moreover, rather than tuning out, the infant remained exquisitely sensitive to the mother's every movement, an acute vigilance. At the time, I thought of this study as illustrating a new concept of infant coping and "defense."

I presented the chase and dodge findings at Downstate Medical School in 1975 in a conference run by Norbert Freedman. A decade later, Freedman was my supervisor during psychoanalytic training. I also met Fred Pine at that conference. He and I continued to discuss the ideas, and he continued to critique my papers over the next several decades. In the early years, when it was a struggle to get our ideas accepted and published, Fred Pine's recognition of my work was very important to me.

In the paper I presented at Downstate, "Engagement-disengagement and early object experiences" (Beebe & Stern, 1977), instead of the idea that mothers and infants are in a symbiotic union, and then the infant differentiates, Stern and I proposed the idea of a continuum of engagement and disengagement experiences being coconstructed simultaneously. The infant is continually getting experience with forms of "being with," such as direct mutual gaze, with gradations of positive affect, building up to the apex of positive affect, the gape smile. However, the infant is also getting experience with forms and degrees of disengagement, looking away, degrees of orienting the head and body away—from slight angles away from vis-à-vis to increasing angles away, to 90-degree aversion, arching, or turning all the way around to the environment.

At that time, we did not know whether this chase-and-dodge pattern might be predictive in development, although we suspected that it would be. Most of our work was case studies. We despaired of ever getting sufficient numbers of dyads with microanalysis data to test the predictive significance of chase and dodge. However, with armies of students, in 2010 my team published a research monograph on the origins of attachment, based on a microanalysis of mother-infant interaction in 132 dyads

at 4 months (Beebe et al., 2010). In this work, we documented that the chase-and-dodge pattern at 4 months indeed predicts a form of insecure attachment at 12 months: resistant attachment.

Joe Jaffe

Shortly after my postdoctoral fellowship, Dan Stern moved from Columbia to Cornell. I stayed at NYSPI to work with Joe Jaffe. Joe performed many of the mathematical analyses for Dan's early papers. I worked closely with Joe, running a mother-infant filming lab, for about four decades (1975–2012). During part of this time, I held a full-time teaching job at Ferkauf Graduate School, Yeshiva University (1976–1992). I also had a small independent practice, which is ongoing.

Joe Jaffe died in August 2012, and Dan Stern died in November 2012. So I have lost my two main infant research mentors/colleagues/friends.

Dan Stern was an idea person, a tremendously creative thinker and theoretician. Joe Jaffe was also a very creative theoretician, but he was devoted to an empirical exploration of the theories. In his hands, the data led the theories. Joe's love of empirical research was an excellent fit with my own interests. Although I never conducted the mathematics myself, I always understood and appreciated it, probably because of my father's background in mathematics and biostatistics.

Joe Jaffe's far-ranging research interests included theoretical biology; biomathematics; speech rhythms and automated methods of analyzing speech rhythms; the biological foundations of language; cerebral laterality; infant development; and psychoanalysis. He studied neurology with Morris Bender. He was a graduate of the William Alanson White Institute for Psychoanalysis, where he was supervised by Clara Thompson and was a classmate of Emmanuel Ghent. At the White Institute, Jaffe became interested in timing disruptions in psychotherapy. He came to NYSPI in 1961.

Joe considered timing and rhythm to be basic organizing principles of all communication. This idea influenced Stern's work and my own. Joe felt that the words were not enough; he wanted the music. I came to see that the timing of behavior, regardless of its content or modality, constitutes a continuous message system about the state of relatedness between two partners (Beebe et al., 2000; Jaffe, Beebe, Feldstein, Crown, & Jasnow, 2001). Temporal patterns refer, for example, to rhythm, pausing, simultaneity, and turn taking. All temporal information is embedded in the

rich visual, auditory, kinesthetic, multimodal display of communication. Coordinating temporal patterns between partners, such as matching rhythms, or predictably responding within a rapid timeframe, is one critical way in which social relatedness is organized. Moreover, timing is usually out of awareness and conscious control, but subtle changes in timing, such as a long hesitation, alter the experience of relatedness.

For example, Joe's interest in timing influenced a paper by Beebe, Stern, and Jaffe (1979). Using 16 mm film (24 frames per second) to examine mother-infant movements of head, gaze, and face during face-to-face communication at 4 months, we identified coactive and alternating timing organizations in the movement patterns, similar to coactive and alternating timing organizations Stern had identified in vocal patterns (Stern, Jaffe, Beebe, & Bennett, 1975). When movements are coactive, there is an overlap between actions, during which mother and infant are moving quasi-simultaneously. During coaction, the mean duration of the onset from either individual's movement to that of the partner is about 1/4 s. These rapid onset times are too fast for a stimulus-response explanation. We interpreted them as indicating that mother and infant were in a predictive system with each other, based on expectancies of prior events.

When mother and infant alternated movements, we discovered a fascinating rhythm. Alternating movements contain no overlap between the actions of the two partners. Instead, each partner has a two-part cycle of a movement, followed by a movement "hold." The average onset times for mother and infant movement were identical, approximately 1/2 s. Repetition of such a cycle of an event plus a hold defines a rhythm, and the mean duration of this rhythmic cycle was matched by mother and infant. This finding paralleled Jaffe and Feldstein's (1970) similar finding in adult speech, a rhythmic matching of vocalization-pause cycles. This rhythmic matching suggested that alternating sequences were also based on expectancies.

The concept that mother and infant were in a predictive system with each other, based on expectancies, later received a great deal of support both from experimental studies (Haith, Hazan, & Goodman, 1988) and studies of social interaction (Tronick, 1989). The concept of expectancies became key to Stern's (1985) later work on interpersonal world and the origin of the self and to Beebe and Lachmann's (2002) work on the presymbolic origins of self and object representations.

Joe Jaffe and Stanley Feldstein published their pivotal work, *Rhythms of Dialogue*, in 1970 (still in print today). Stanley Feldstein was a key

collaborator of Jaffe and later of mine. Examining the coordination of speech rhythms in face-to-face conversation between adults, this research documents that silences (pauses) provide important information. The way partners exchange speaking turns, specifically the degree to which they match the durations of the pauses at the point of the turn switch, is correlated with empathy, interpersonal attraction, field independence/dependence, and partner novelty. Moreover, interruptive speech, without pauses at the moment of the turn switch, leads to the breakdown of effective dialogue. This book informed all our work on mother-infant communication.

Rhythms of dialogue in infancy and the optimal midrange model

In the early 1980s, Jaffe and I, collaborating with Stanley Feldstein, Cynthia Crown, and Michael Jasnow, set out to apply the adult rhythms of dialogue model to mothers and infants. We spent several years meeting on weekends and writing a grant that finally succeeded in getting funded. We collected a cohort of mothers and infants from 1985 to 1990, which culminated in a research monograph, "Rhythms of Dialogue in Infancy" (Jaffe et al., 2001). We documented that the degree to which the mothers and infants, and strangers and infants, coordinated vocal turn taking (matched durations of switching pauses at the point of the turn exchange) predicted 12-month infant attachment and infant cognition. Thus, in infancy as well as adulthood, the way partners exchange turns provides a potent assessment of the emotional quality of the relationship. This work defined a fundamental dyadic timing matrix that guides infant development.

However, it was not high coordination in infancy that was optimal for infant attachment at 1 year. Instead, midrange degree of coordination of vocal turn taking was optimal. We dubbed this finding "the optimal midrange model." It stands in contrast to most theories, which argue that more coordination, more attunement, and more synchrony are optimal in development. Our finding is consistent with Winnicott's (1965) concept of "good enough" mothering. High coordination is seen as excessive monitoring, or "vigilance," a dyadic effort to create more moment-to-moment predictability. It can be seen as a coping strategy elicited by novelty, interactive challenge, or threat. Low coordination is seen as inhibition of monitoring, or withdrawal. Midrange coordination leaves

more "space," more room for uncertainty, initiative, and flexibility within the experience of correspondence and contingency—optimal for secure attachment (Beebe et al., 2000; Jaffe et al., 2001). Mary Sue Moore made a major contribution to our understanding of the vocal rhythm data in relation to attachment.

We are now following up into young adulthood these dyads that we filmed from 1985 to 1990 (Beebe et al., 2013). In the last half-decade, Hope Igleheart, and Miriam and Howard Steele have become key collaborators. Although this study is still in the early stages, we have found 32 dyads, and the offspring are in their early twenties. Again, we are finding that the ways that mothers and infants, and particularly strangers and infants, coordinate vocal turn taking (switching pauses) in infancy predicts aspects of the adult attachment interview at young adulthood.

The role of the stranger

Beginning with the home visits in 1969 when I accompanied Stern and played with the infants, I became interested in the role of the stranger. In a case study with Lou Gerstman (Beebe & Gerstman, 1984), we showed similar coordination in mother-infant and stranger-infant interactions. We suggested that the infant's ability to coordinate with a stranger is a more general social perceptual capacity available for use with any adult partner at this age. Another study of three infants documented significant mutual influence to match durations of behaviors in both stranger-infant and mother-infant interactions, using time-series analysis (Beebe, Jaffe, Feldstein, Mays, & Alson, 1985).

A powerful role of the stranger later emerged in *Rhythms of Dialogue in Infancy* (Jaffe et al., 2001). Vocal coordination between infant and stranger predicted attachment at 1 year just as well as that between infant and mother. Moreover, stranger-infant interactions identified a wider range of attachment outcomes than did mother-infant interactions. This finding suggests that the 4-month infant has the flexibility to respond differently to the stranger than to the mother.

Stranger-infant interaction continued to predict the development of these infants better than mother-interaction. Sara Markese, originally a lab assistant who later received her PhD degree from CUNY, wrote her dissertation using vocal coordination in infancy to predict attachment as these infants turned 4 years old. Primarily the patterns of stranger-infant

vocal turn taking, rather than those of mother-infant, predicted 4-year attachment representations (Markese, Beebe, Feldstein, & Jaffe, 2007). In our follow-up study of these infants to young adulthood, noted above, again it was predominantly stranger-infant vocal coordination in infancy that predicted aspects of the adult attachment interview.

Why is the stranger-infant interaction so powerful? The challenge of novelty, which can be seen as a slight perturbation, can amplify aspects of a system's organization. This is similar to the perturbations of Tronick's (1989) still-face experiment, or of the Ainsworth Strange Situation paradigm for assessing attachment. Thus, stranger-infant interactions may reveal aspects of development that mother-infant interactions do not.

The origins of attachment: Beebe et al., 2010

In 1992, I stopped teaching at Ferkauf Graduate School. This gave me much more time for research collaboration with Jaffe. That year I also made a move from having dissertation students within a graduate school program to having dissertation students on a less formal basis. Students gravitate to me from various universities around New York City. In collaboration with the formal chair at their home university, I informally sponsor the dissertation research. In a mutually beneficial partnership, students code aspects of our research videotapes by microanalysis, and I run a dissertation supervision group. This arrangement has continued for more than two decades. These dissertation students make a creative and critical contribution to our research.

In 1992, Jaffe and I began a new longitudinal study of a low-risk community sample. It was designed to examine self- and interactive regulation in facial-visual communication, my first love. We were interested in how 4-month mother and infant self- and interactive regulation worked together, as a dyadic system. We were also interested in how 4-month self- and interactive regulation might be altered if mothers were depressed or anxious or if infants were on the way to insecure 12-month attachment.

We ran the study on a shoestring. Assisted by a dozen doctoral students, some from the Yeshiva program and some new, we filmed 132 mother-infant dyads at 4 months and followed them up at 1 year with the Ainsworth attachment assessment, completing the data collection in 1997. It took the doctoral students a decade to code the 132 dyads at 4 months, using hand-coded second-by-second microanalysis of videotapes. We coded attention,

emotion (facial affect and vocal affect), orientation, and touch. Another 10 doctoral students coded the stranger-infant interactions at 4 months, over the same decade. Some of my students thought I was crazy to conduct such an intensive microanalysis on such a large data set.

By 1997 to 2000, most of the graduate students who had worked on this project had completed their dissertations and were moving on. I began recruiting students between college and graduate school as volunteer lab assistants to help me run the lab and the research, each agreeing to a 2-year commitment. Since 2000, these remarkable, creative, and dedicated students have made an enormous contribution. I usually have a dozen or more students, and we are cozily crowded into four rooms. I could not have produced the last decade's research without them. Sara Markese, who joined the lab as one of these volunteer research assistants in 2000, stayed for 8 years helping to run the lab. She has continued to be an active research collaborator. Michael Ritter, who also joined in 2000, contributed 5 years helping to run the lab.

Beginning with the first grant submission in 1994, I finally received an NIMH R01 grant in 1999 to analyze this remarkable microanalysis data set. This grant enabled me to collaborate with a brilliant statistical team led by Patricia Cohen, which included Karen Buck, Henian Chen, Howard Andrews and, recently, Sanghan Lee. In the decade of the 1960s, Pat Cohen's husband, Jack Cohen, had been the statistician for Jaffe and Feldstein's (1970) book. Pat Cohen and this remarkable group of statisticians translated our 19,800 seconds of data of mother-infant behaviors at 4 months into our measures of self- and interactive regulation. The research could not have flowered without their collaboration.

We were able to predict attachment outcomes at 1 year from just 2 1/2 min of videotaped mother-infant interaction at 4 months (Beebe et al., 2010). This illustrates the power of microanalysis. It also illustrates the fact that relatively small amounts of nonverbal communication carry enormous information. Ambady and Rosenthal (1992) showed that observations of less than 5 min of expressive behavior permit accurate predictions. In their meta-analysis of 44 studies of adult communication, they found that 30-second behavioral observations were just as accurate as 5-minute observations.

The most interesting aspect of my study has been the prediction of disorganized attachment at 1 year from 4-month microanalyses. Disorganized attachment at 1 year predicts dissociation in young adulthood (see Carlson, 1998; Lyons-Ruth & Jacobvitz, 2008; Ogawa,

Sroufe, Weinfeld, Carlson, & Egeland, 1997; Dutra, Bureau, Holmes, Lyubchik, & Lyons-Ruth, 2009). Mothers of disorganized-attachment infants bring their own unresolved loss, mourning, or abuse (Main & Hesse, 1990). Thus, disorganized attachment provides a life-span trauma model. Our microanalysis findings provide a rich picture of mother-infant communication difficulties at 4 months that predict 1-year disorganized attachment (Beebe et al., 2010; Beebe et al., 2012b; see Beebe & Lachmann, 2013).

Four-month infants on the way to disorganized (versus secure) attachment showed discrepant, contradictory, and conflicted patterns of communication with their mothers, in the context of intense, sometimes frantic, infant distress. These infants showed more discrepant affect, such as smile and whimper in the same second. They showed lowered self-predictability of facial-visual engagement, making it harder for them to sense their own next engagement "move," a destabilization. Mothers of future disorganized (versus secure) infants looked away from their infants for longer periods and looked away unpredictably. These mothers also emotionally withdrew, lowering their interactive coordination with infant facial-visual engagement. These mothers were less likely to follow their infants: less likely to become facially positive as their infants became positive and less likely to dampen toward interest, neutral, or "woe face" as their infants sobered or became distressed. Mothers of future disorganized (versus secure) infants at moments remained overly facially stable, or inscrutable, similar to a "still-face." When infants were facially or vocally distressed, mothers of future disorganized (versus secure) infants were more likely to show smiles or surprise faces: a facial "denial" of infant distress. We inferred that it was difficult for infants to feel that their mothers sensed and acknowledged their distress and that it was difficult for mothers to empathically acknowledge infant distress. We conjectured that these mothers could not acknowledge infant distress because they could not bear their own.

Based on the findings, I proposed that 4-month infants on the way to 12-month disorganized attachment come to experience and represent *not being sensed, known, or recognized* by their mothers; and difficulty *knowing themselves,* particularly in states of distress (Beebe et al., 2010). They come to expect and represent experiences of confusion about their own basic emotional organization, about their mothers' emotional organization, and about their mothers' response to their distress. These experiences set a trajectory in development that may disturb the fundamental integration of the person.

One salient aspect of these findings concerns cross-modal discrepancies. Cross-modal correspondences facilitate information processing (Bahrick & Lickliter, 2002) and are the foundation of an early aspect of intersubjectivity, an experience that "you are like me" (Meltzoff, 2007). Cross-modal discrepancies within the infant, for example, moments in which infants are facially positive but vocally negative in the same second, disturb infant information processing and emotional coherence. Interpersonal cross-modal discrepancies (for example, moments in which mothers respond with smiles or mock surprise faces to infant facial or vocal distress) not only disturb infant information processing but disturb the possibility of infant experiences of feeling known and recognized.

Cross-modal discrepancies are not limited to the origins of disorganized attachment; they appear in many of our studies. For example, in our community sample, 25% of the mothers endorsed depressive symptoms when the infants were 6 weeks old. At 4 months, in the depressed (versus nondepressed) group, infants and mothers showed striking cross-modal discrepancies in face-to-face communication. Both depressed mothers and their infants showed a peculiar "noninterpersonal" gaze pattern of more time spent looking at the partner but lowered interpersonal coordination of looking patterns. Both partners showed vigilant emotional coordination with the other. Thus, both partners showed attention/emotion discordance, in lowered attention coordination but heightened emotion coordination (Beebe et al., 2008; Beebe et al., 2012a). Cross-modal discrepancies in infancy may be one salient feature of the origins of psychopathology.

However, 4-month infants at risk for 1-year disorganized attachment were much more distressed, and their interactions with their mothers were much more disturbing, than were infants whose mothers were depressed or anxious. I wanted to better understand the details of these interactions that predicted disorganized attachment. With the help of Jennifer Lyne and Kari Gray, my research assistants (and both former filmmakers), I used the research findings to identify the exact moments of interactions of dyads who illustrated particular findings in the origins of disorganized attachment. For example, we located moments of maternal gaze aversion, infant simultaneous discrepant smile and whimper, or maternal over-stabilized, inscrutable faces. We created frame-by-frame analyses of the various patterns of disturbance. We identified the change points of each partner's behavior that best illustrated the clinical "drama" of that dyad.

This visual grounding gave the work a visceral, intuitive, and immediate form of comprehension. With the help of my study groups, psychoanalysts interested in infant research, I watched the details of these interactions over and over. These study groups made it possible to understand the research findings in a way that made them come alive clinically. In the study groups, we also explored analogies between the research findings and adult treatment. For example, we thought about infant cross-modal discrepancies of smiling and whimpering in the same moment and patients who tell very distressed stories while smiling.

These frame-by-frame microanalyses of the origins of disorganized attachment are so powerful that they have completely changed the way I teach and lecture. Each real-time video can be compared with the frame-by-frame microanalysis to identify subtle and complex aspects of the interaction that are too rapid to be grasped by the naked eye in real time. This advance has enabled me to understand the clinical and theoretical implications of my research at a far deeper level.

Self-regulation and its relation to interactive regulation

One goal of the grant that I received in 1999 was to understand how 4-month mother and infant self- and interactive regulation worked together as a dyadic system. Our dyadic systems views of mother-infant communication theorize that self- and interactive regulation operate together as a system. For example, Fogel (1993) suggests that all behavior is unfolding in the individual while at the same time modifying and being modified by changing behavior of the partner. Sander (1977) suggests that both partners generate complexly organized behavior that must be coordinated in a bidirectional process of mutual modification. Interactive regulation has seen four decades of empirical investigation, but self-regulation has been neglected.

In the 132 mother-infant dyads we filmed from 1992 to 1997, we evaluated both self-and interactive regulation. We translated the terms *self-* and *interactive regulation* into *self-* and *interactive contingency,* to more closely link these terms to our time-series methods of data analysis and to indicate that self-contingency is not identical to the more general concept of self-regulation. Each person's behavior is affected both by his or her own immediately prior behavior ("self-contingency"), and by that of the partner ("interactive contingency").

Self-contingency taps *one* dimension of self-regulation; that is, the procedural anticipation of where one's own behavior is tending in the next second. It generates expectancies of the degree to which one can anticipate the rhythm of one's own behavior: how predictable, how stable, how variable one's behaviors are, from moment to moment. It spans the range from midrange degree of predictability, to overly stabilized, tending toward steady state, to insufficiently predictable or labile, tending toward loss of predictability. The process of self-contingency is so basic that it is rarely noticed, like breathing. It accrues to one's experience of temporal coherence over time.

Self-contingency turned out to be extremely important. It was often even more sensitive than interactive contingency in picking up disturbances (for example, in the effects of maternal depression or maternal anxiety on mother-infant communication [Beebe et al., 2008, 2011]). In the origins of insecure attachment, self-contingency helped me to conceptualize infant disturbances in knowing oneself (Beebe et al., 2010).

It is easy to mistake self-contingency for an organismic variable, a process contained entirely with the individual. Actually, it is a complex amalgam of the individual and the dyad. A person's self-contingency process is specific to a particular partner. For example, in this data set, we examined how infants interacted with strangers (graduate students) compared with their mothers. We found that changing the partner altered both infant self-and interactive contingency (Beebe et al., 2009).

We also documented that, for both mothers and infants, an individual's self-contingency is itself influenced by the way the individual coordinates with the partner (Beebe et al., 2012c). For example, less facially stable individuals are likely to coordinate more strongly with partner's facial affect (and vice versa). Thus, the process of regulating oneself via self-contingency depends upon the way one responds to the partner via interactive contingency, and vice versa. The implication is that an individual's self-contingency is not solely a process contained within the self; it is bound up with coordinating with the partner. Thus, the individual's own self-organizing process, as defined by moment-to-moment degree of predictability, is more influenced by the partner than we have previously realized. This work supports the dynamic systems perspective that the dyad is the fundamental unit of analysis in face-to-face interaction and that self- and interactive regulation constitute a system in which each affects the other.

Several new collaborators are represented in this study: Daniel Messinger, Lorraine Bahrick, and Amy Margolis. As Joe Jaffe became

older in the last decade, I have sought new collaborators: Michael Myers, Martha Welch, Christina Hoven, Amie Hane, Kristin Buss, Ann Bigelow, Alexandra Harrison, and Donald Pfaff.

Microanalysis in mother-infant treatment

Microanalysis is extremely useful in mother-infant treatment (Beebe, 2005). By watching videotapes with an experienced clinician, parents can learn to observe the infant's "nonverbal language," and the effects of each partner on the other.

Often, a careful frame-by-frame analysis will reveal aspects of the difficulty that cannot be discerned by watching the videotape in real time. Frame-by-frame analysis itself is rarely part of the treatment; however, it powerfully informs the treatment.

One mother despaired because she felt her infant did not love her, did not even know her. She complained that he never looked at her. This is the "Linda and Dan" case, treated by Cohen and Beebe (2002). A videotape of the interaction run in real time showed that it was true that the infant was mostly looking away from the mother's face. Overall, the mother's stimulation was very high and intense and probably too much for this infant.

However, microanalysis revealed a more complex story. Whenever the infant did look at the mother's face, the mother interrupted the moment. The first time the infant looked at the mother's face, in that same split-second the mother looked at the camera, with a sad face, as if to say, look what a hard job I have. By the time she looked back at the infant, he was already looking away. The second time the infant looked at the mother, she failed to greet him; her face was rather blank, but in the next moment she smiled. Even though she was late in greeting him, the infant lit up, with an open-mouth positive attention face, not quite a smile: the most positive face of the interaction. However, the next time the infant looked, the mother responded with a sad partial-grimace face, and the infant immediately looked away. Meanwhile, even as the infant moved his head away and looked away, over and over he reached for the mother's hands and lightly fingered them. This description is based on 33 seconds of film.

Two critical aspects of this interaction were not visible when the film was run in real time: the ways that the mother disrupts the moment of the infant looking at her and the ways in which the infant continues to reach for her despite looking away. This information can richly inform the treatment strategy.

Mothers, infants, and young children of September 11, 2001: A primary prevention project

In this pro bono Project for Mothers, Infants, and Young Children of September 11, 2001, a group of eight core therapists worked with approximately 40 families in which the mothers were pregnant and widowed in the disaster or the mothers were widowed with an infant born in the previous year. These therapists are Beatrice Beebe, Phyllis Cohen, Anni Bergman, Sally Moskowitz, K. Mark Sossin, Rita Reiswig, Suzi Tortora, and Donna Demetri Friedman. We all knew one another in various ways before 9/11. This highly trained group of therapists specializes in adult, child, mother-infant, and family treatment and in nonverbal communication. The demands of the crisis led us to expand our psychoanalytic training, fostering new approaches to meeting the needs of these families. We sought out these families, offering support groups for mothers and their infants and young children in the mothers' own neighborhoods and bringing the families to mother-child filming sessions at NYSPI. The eight of us, in collaboration with Joe Jaffe, Sara Markese, Adrianne Lange, Andrea Remez, and Marsha Kaitz, wrote a book about this project (Beebe, Cohen, Sossin, & Markese, 2012).

We developed a 2-hour multi-therapist session, with one mother, an effort to reach these women who were so traumatized, often dissociated and frozen. Working mostly with Phyllis Cohen and Mark Sossin in this multi-therapist approach, but also at times with Anni Bergman, Sally Moskowitz, and Rita Reiswig, we developed a collaborative way of building on one another's comments, which one mother called the "tri-effect." Rather than feeling intimidated, the mothers have appreciated the level of involvement and the range of views of the therapists. This format has become one of the most personally rewarding forms of therapy that I have participated in, perhaps because as therapists we provide a holding environment for one another as we face the most wrenching, agonizing work that we have ever performed.

In retrospect, I was drawn to this 9/11 work not only because I lived in New York City and was so personally affected by it but because of my father's involvement in the atomic bomb casualties of our time.

Mother-infant microanalysis informs my work as a therapist with adults

In the last two decades, I have become increasingly aware of how my microanalysis of mother-infant communication has affected my work as a psychoanalyst with adult patients. For example, in the mother-infant treatment of Linda and Dan (Cohen & Beebe, 2002), noted above, Dan at 17 months interacted face-to-face with his mother in the split-screen setup. The mother shifted his attention and substituted her own agenda for his, over and over. Then Dan interacted with me, while his parents were seated behind him, so that he was not separated from them. In the video, although Dan at first seems happy to play with me and the toys, very quickly he begins to act strangely. He moves the doll in slow motion and finally becomes completely still. At first I do not seem to understand, and I give him my usual big smiles, but then a surprise expression appears on my forehead, followed rapidly by a frown. I become quiet. Only when he darts a glance at me do I move at all: I briefly show him a soft, reassuring face. I essentially give him control over the interaction. I allow myself to be completely organized by him. As long as he looks away, I wait, and I join his dampened state. Only when he glances at me do I show any movement. This interaction repeats over and over for 2.5 minutes.

I noticed something similar in my behavior with "Dolores," in the adult treatment case, "Faces-in-Relation" (Beebe, 2004). In that treatment, I experimented with taking a few videotapes of my face only, during the second year of the treatment, when Dolores could not look at me and fell silent. In the videotape, my movements are very, very slow. Only after I examined the videotape did I realize how quiet I had become. I dampen my arousal down to match hers. My body is still but not frozen or collapsed. Dolores is very fearful, and I am careful not to frighten her.

At one moment, my hand slowly moves upward on the side of my head, in a self-soothing gesture; my face shows intense focus, and subtle, soft shifts of expressiveness. I speak very softly and slowly. I wait for a long time before she responds; these are very long switching pauses in the Jaffe-Feldstein vocal rhythm model. When she speaks I strain to understand her. When I reply, out of my awareness, I match the cadence and the rhythm of her words. In these ways, I show her that I join her state. After having watched myself interact with infants over the last four decades, I am aware that I slow down when I interact with infants, and I reduce my level of

activity. Howeer, I had been unaware that I did this for Dolores, and I did it in an even more dramatic fashion.

Dolores and I watched the tapes together. Because she did not look at me during our sessions, seeing my face seeing her and hearing my sounds responding to her heightened her experience of my response and her own visceral experience. She came to recognize herself in my face recognizing her. Later, we discussed more of her experience of watching the videotapes, and she told me, "You have such good faces. I have those good face-feelings. That is what is inside me. I sometimes have bad face-feelings too. Your good faces, the 'still-lake-face,' the 'resting-face,' – I like best your 'just-watching-all-the-time face;' it makes me safe."

The next book: "The Mother-Infant Interaction Picture Book: The Origins of Attachment"

Because video microanalysis is such a powerful way to learn to see the details of human behavior—the moments of resonance as well as disruption—I decided to try to find a way to make it more available. Our research films are confidential. We cannot circulate them. In order to protect mothers' confidentiality, I found a talented artist who could draw the frames of the films, preserving the emotions on the faces, but altering, for example, the hair, jaw, nose, or eyebrows. This book will be entitled, "The mother-infant interaction picture book: The origins of attachment." Frank Lachmann and Phyllis Cohen are my co-authors.

Conclusion

The infants and mothers are my teachers. I learned a great deal from watching mother-infant interaction, but I learned something different by interacting with the infants myself: how to slow down, how to tolerate long periods of very little happening, how to do less. I learned how to match the rhythm and cadence of the infants' facial and head movements, breathing rhythms, or hand gestures. All of this I learned out of awareness. I became aware of it only gradually as I studied the videotapes of my own interactions with the infants and much later as I studied the videotapes of my interactions with Dolores.

My study groups, and the seminars I teach at the various psychoanalytic institutes, are a wonderful playing field to test the ideas, to understand the

films and frame-by-frame analyses better, and to nurture the integration of infant research and adult treatment.

My PhD dissertation students are a critical part of my research program. They are the closest to my understanding of how to conduct microanalysis. They stretch my understanding of how the approaches of time-series analysis may best be used in their particular studies. They are ready to "launch" into the working world of psychology, and they are quickly becoming my colleagues and my friends. My former doctoral-level students are an active part of our research community, and some are from Yeshiva from the late 1980s and early 1990s, such as Sara Hahn-Burke and Nancy Freeman.

My lab assistant group is my research family. These devoted, creative, enthusiastic students make everything happen. In a cocreative process, many decide to go on to graduate school interested in infant and child development and its integration with psychoanalysis.

My largest extended family are the many generous individual people who have supported my research and the 9/11 clinical project out of their own funds. This is my opportunity to thank so many people who have esteemed my work. Many are psychoanalysts. I am enormously grateful for this support, which over the years has provided several hundred thousand dollars. Especially as federal funds become harder to obtain, these people have made it possible to keep my work going.

Acknowledgments

Federal grants that have funded the research work include NIMH R01 41675, NIMH RO1 56130; private foundations include the Koehler Foundation, the American Psychoanalytic Association, the International Psychoanalytic Association, the Bernard and Esther Besner Infant Research Fund, the Margaret Mahler Foundation, and The International Association for Psychoanalytic Self Psychology. Federal grants and private foundations that funded the 9/11 clinical work included The Liberty Fund (FEMA), the Robin Hood Foundation, the Kenworthy-Swift Foundation, the American Psychological Foundation-Visionary Grant, the Scott-Hazelcorn Foundation, the Margaret Mahler Foundation, the Lovinger Family Foundation, and the Jerome and Adrienne Kay Family Foundation.

References

Ainsworth, M. D. S. (1969). Object relations, dependency, and attachment: A theoretical review of the infant-mother relationship. *Child Development, 40,* 969–1025. doi:10.2307/1127008

Als, H. (1977). The newborn communicates. *Journal of Communication, 27*(2), 66–73. doi:10.1111/j.1460-2466.1977.tb01828.x

Ambady, N., & Rosenthal, R. (1992). Thin slices of expressive behavior as predictors of interpersonal consequences: A meta-analysis. *Psychological Bulletin, 111*(2), 256–274. doi:10.1037/0033-2909.111.2.256

Bahrick, L., & Lickliter, R. (2002). Intersensory redundancy guides early perceptual and cognitive development. *Advances in Child Development and Behavior, 30,* 153–187.

Beebe, B. (1973). Ontogeny of positive affect in the third and fourth months of life of one infant. *Dissertation Abstracts International, 35*(2), 1014B.

Beebe, B. (1982). Micro-timing in mother-infant communication. In M. R. Key (Ed.), *Nonverbal communication today.* Series edited by Joshua Fishman, Contributions to the sociology of language. vol. 33, 169–195. New York: Mouton.

Beebe, B. (1986). Mother-infant mutual influence and precursors of self- and object representations. In J. Masling (Ed.), *Empirical Studies of Psychoanalytic Studies*, Vol. 2. (pp. 27–48). Hillsdaly, NJ: The Analytic Press.

Beebe, B. (2004). Faces in relation: A case study. *Psychoanalytic Dialogues, 14,* 1–51.

Beebe, B. (2005). Mother-infant research informs mother-infant treatment. *Psychoanalytic Study of the Child, 60,* 7–46.

Beebe, B., Cohen, P., Sossin, K. M., & Markese, S. (Eds.). (2012). *Mothers, infants and young children of September 11, 2001: A primary prevention project*. London: Routledge.

Beebe, B., & Gerstman, L. (1984). A method of defining "packages" of maternal stimulation and their functional significance for the infant. *International Journal of Behavioral Development, 7,* 423–440. doi:10.1177/016502548400700403

Beebe, B., Igleheart, H., Steele, M., Steele, H., Lyons-Ruth, K., & Feldstein, S. (2013, July 31). *From Infancy to Adulthood: Vocal Rhythm Coordination in Infancy, 12-Month Attachment, and Young Adult Follow-up*. Report to the American Psychoanalytic Association Research Fund.

Beebe, B., Jaffe, J., Chen, H., Buck, K., Cohen, P., Feldstein, S., & Andrews, H. (2008). Six-week postpartum depressive symptoms and 4-month mother-infant self- and interactive contingency. *Infant Mental Health Journal, 29*(5), 442–471. doi:10.1002/imhj.20191

Beebe, B., Jaffe, J., Feldstein, S., Mays, K., & Alson, D. (1985). Interpersonal timing: The application of an adult dialogue model to mother-infant vocal and kinesic interactions. In T. Field (Ed.), *Infant social perception* (pp. 217–248). New York: Ablex.

Beebe, B., Jaffe, J., & Lachmann, F. (1993). A dyadic systems view of communication. In N. Skolnick & S. Warshaw (Eds.), *Relational perspectives in psychoanalysis* (pp. 61–81). Hillsdale, NJ: Analytic Press.

Beebe, B., Jaffe, J., Lachmann, F., Feldstein, S., Crown, C., & Jasnow, J. (2000). Systems models in development and psychoanalysis: The case of vocal rhythm coordination and attachment. *Infant Mental Health Journal, 21*(1–2), 99–122. doi:10.1002/(SICI)1097-0355(200001/04)21: 1/2<99::AID-IMHJ11>3.0.CO;2-#

Beebe, B., Jaffe, J., Markese, S., Buck, K., Chen, H., Cohen, P. et al. (2010). The origins of 12-month attachment: A microanalysis of 4-month mother-infant interaction. *Attachment & Human Development, 12*(1–2), 3–141. doi:10.1080/14616730903338985

Beebe, B., & Lachmann, F. (1988a). The contribution of mother-infant mutual influence to the origins of self and object representations. *Psychoanalytic Psychology, 5*(4), 304–337. doi: 10.1037/0736-9735.5.4.305

Beebe, B., & Lachmann, F. (1988b). Mother-infant mutual influence and precursors of psychic structure. In A. Goldberg (Ed.), *Progress in self psychology,* vol. 3, (pp. 3–26). Hillsdale, NJ: L. Erlbaum.

Beebe, B., & Lachmann, F. (1994). Representation and internalization in infancy: Three principles of salience. *Psychoanalytic Psychology, 11,* 127–165.

Beebe, B., & Lachmann, F. (2002). *Infant research and adult treatment: Co constructing interactions*. Hillsdale, NJ: Analytic Press. doi:10.1080/15289168.2002.10486420

Beebe, B., & Lachmann, F. (2013). *The origins of attachment: Infant research and adult treatment*. New York: Routledge Press. doi:10.1093/acprof:oso/9780199988341.003.0006

Beebe, B., Lachmann, F., Jaffe, J., Markese, S., Buck, K., Chen, H. et al. (2012a). Maternal depressive symptoms and 4-month mother-infant interaction. *Psychoanalytic Psychology, 29*(4), 383–407. doi:10.1037/a0029387

Beebe, B., Lachmann, F., Markese, S., Buck, K., Bahrick, L., Chen, H., et al. (2012b). On the origins of disorganized attachment and internal working models: Paper II. An empirical microanalysis of 4-month mother-infant interaction. *Psychoanalytic Dialogues, 22,* 352–374. doi:10.1080/10481885.2012.679606

Beebe, B., Margolis, A., Markese, S., Jaffe, J., Buck, K., Chen, H.et al. (2009, August 6). *Mother–infant vs. stranger–infant: Depression and attachment*. Report to the International Psychoanalytic Fund, New York State Psychiatric Institute.

Beebe, B., Messinger, D., Bahrick, L., Margolis, A., Buck, K., & Jaffe, J. (2012c). *Self regulation is dependent on partner influence, and vice-versa: A dyadic systems view of mother-infant communication*. Presentation, International Conference Infant Studies. Minnesota, June 9.

Beebe, B., Steele, M., Jaffe, J., Buck, K., Chen, H., Cohen, P., et al. (2011). Maternal anxiety and 4-month mother-infant self- and interactive contingency. *Infant Mental Health Journal, 32*(2), 174–206. doi:10.1002/imhj.20274

Beebe, B., & Stern, D. (1977). Engagement-disengagement and early object experiences. In N. Freedman & S. Grand (Eds.), *Communicative structures and psychic structures* (pp. 35–55). New York: Plenum Press. doi:10.1007/978-1-4757-0492-1_3

Beebe, B., Stern, D., & Jaffe, J. (1979). The kinesic rhythm of mother-infant interactions. In A. W. Siegman & S. Feldstein (Eds.), *Of speech and time: Temporal patterns in interpersonal contexts* (pp. 23–24). Hillsdale, NJ: Erlbaum Assoc.

Bell, R. Q. (1968). A reinterpretation of the direction of effects in studies of socialization. *Psychological Review, 75,* 81–95. doi:10.1037/h0025583

Blatt, S. (1974). Levels of object representation in analytic and introjective depression. *Psychoanalytic Study of the Child, 24,* 107–157.

Blatt, S. (1986, August 25). *Discussion of American Psychological Association Symposium: Early interactions in the construction of self and object representations*. Washington, DC.

Bowlby, J. (1969). *Attachment and loss,* vol. I: *Attachment*. New York: Basic Books.

Brazelton, T. B., Kozlowski, B., & Main, M. (1974). Origins of reciprocity: The early mother-infant interaction. In M. Lewis & L. Rosenblum (Eds.), *The effect of the infant on its caregiver* (pp. 49–76). New York: Wiley.

Carlson, E. (1998). A prospective longitudinal study of attachment disorganization/disorientation. *Child Development, 69*(4), 1107–1128.

Cohen, P. M., & Beebe, B. (2002). Video feedback with a depressed mother and her infant: A collaborative individual psychoanalytic and mother-infant treatment. *Journal of Infant, Child, and Adolescent Psychotherapy, 2*(3), 1–55. doi:10.1080/15289168.2002.10486404

Cohn, J., & Tronick, E. (1988). Mother-infant face-to-face interaction: Influence is bi-directional and unrelated to periodic cycles in either partner's behavior. *Developmental Psychology, 24,* 386–392. doi:10.1037/0012-1649.24.3.386

Dutra, L., Bureau, J., Holmes, B., Lyubchik, A., & Lyons-Ruth, K. (2009). Quality of early care and childhood trauma: A prospective study of developmental pathways to dissociation. *Journal of Nervous and Mental Disease, 197*(6), 383–390. doi:10.1097/NMD.0b013e3181a653b7

Fantz, R., Fagan, J., & Miranda, S. (1975). Early visual selectivity. In L. Cohen & P. Salapatek (Eds.), *Infant perception* (pp. 249–346). New York: Academic Press.

Field, T. (1995). Infants of depressed mothers. *Infant Behavior and Development, 18,* 1–13. doi: 10.1016/0163-6383(95)90003-9

Fogel, A. (1993). Two principles of communication: Co-regulation and framing. In J. Nadel & L. Camaioni (Eds.), *New perspectives in early communicative development* (pp. 9–22). London: Routledge.

Haith, M., Hazan, C., & Goodman, G. (1988). Expectation and anticipation of dynamic visual events by 3.5 month old babies. *Child Development, 59,* 467–479. doi:10.2307/1130325

Jaffe, J., Beebe, B., Feldstein, S., Crown, C. L., & Jasnow, M. (2001). Rhythms of dialogue in infancy. *Monographs of the Society for Research in Child Development, Series 264, 66*(2), 1–132.

Jaffe, J., & Feldstein, S. (1970). *Rhythms of dialogue*. New York: Academic Press.

Kessen, W., Haith, M., & Salpatek, P. (1970). Human infancy: A bibliography and guide. In P. H. Mussen (Ed.), *Carmichael's manual of child psychology* (vol. 1). New York: Wiley.

Lachmann, F., & Beebe, B. (1983). Consolidation of the self: A case study. *DynamicPsychotherapy, 1,* 55–75.

Lewis, M., & Brooks, J. (1975). Infants' social perception: A constructionist view. In L. Cohen & P. Salapatek (Eds.), *Infant perception: From sensation to cognition* (vol. 2, pp. 101–148). New York: Wiley-Interscience. doi:10.1016/B978-0-12-178602-1.50010-5

Lewis, M., & Rosenblum, L. (Eds.). (1974). *The effect of the infant on its caregiver*. New York: Wiley Interscience.

Lyons-Ruth, K., & Jacobvitz, D. (2008). Disorganized attachment: Genetic factors, parenting contexts, and developmental transformation from infancy to adulthood. In J. Cassidy & P. Shaver (Eds.), *Handbook of attachment: Theory, research and clinical applications* (2nd ed., pp. 666–697). New York: Guilford Press.

Main, M., & Hesse, E. (1990). Parents' unresolved traumatic experiences are related to infant disorganized attachment status: Is frightened and/or frightening parental behavior the linking mechanism? In M. Greenberg, D. Cicchetti, & E. Cummings (Eds.), *Attachment in the preschool years: Theory, research, and intervention* (pp. 161–182). Chicago: University of Chicago Press.

Markese, S., Beebe, B., Feldstein, S., & Jaffe, J. (2007). *Rhythms of dialogue in infancy and attachment representations at 4 years* (Unpublished doctoral dissertation). The City University of New York, New York.

Meltzoff, A. (2007). Like me: A foundation for social cognition. *Developmental Science, 10*(1), 126–134. doi:10.1111/j.1467-7687.2007.00574.x

Niedenthal, P., Mermillod, M., Maringer, M., & Hess, U. (2010). The simulation of smiles (SIMS) model: Embodied simulation and the meaning of facial expression. *Behavioral and Brain Sciences, 33,* 417–480. doi:10.1017/S0140525X10000865

Oberman, L., Winkielman, P., & Ramachandran, V. (2007). Face to face: Blocking facial mimicry can selectively impair recognition of emotional expressions. *Social Neuroscience, 2*(3-4), 167–178. doi:10.1080/17470910701391943

Ogawa, J., Sroufe, L., Weinfeld, N., Carlson, E., & Egeland, B. (1997). Development and the fragmented self: Longitudinal study of dissociative symptomatology in a nonclinical sample. *Development and Psychopathology,* (9), 855–879.

Oster, H. (1978). Facial expression and affect development. In M. Lewis & L. Rosenblum (Eds.), *The development of affect* (pp. 43–75). New York: Plenum Press. doi:10.1007/978-1-4684-2616- 8_3

Peery, C. (1980). Neonate-adult head movement. *Developmental Psychology, 16,* 245–250. doi: 10.1037/0012-1649.16.4.245

Sander, L. (1977). The regulation of exchange in the infant-caretaker system and some aspects of the context-content relationship. In M. Lewis & L. Rosenblum (Eds.), *Interaction, conversation, and the development of language* (pp. 133–156). New York: Wiley.

Spitz, R. (1965). *The first year of life*. New York: International Universities Press.

Stechler, G., & Carpenter, G. (1967). A viewpoint on early affective development. In J. Hellmuth (Ed.), Exceptional infant (vol. 1: *The normal infant)*. Seattle: Straub & Hellmuth.

Stern, D. (1971). A microanalysis of mother-infant interaction. *Journal of the American Academy of Child Psychiatry, 10,* 501–517. doi:10.1016/S0002-7138(09)61752-0

Stern, D. (1974). Mother and infant at play: The dyadic interaction involving facial, vocal and gaze behaviors. In M. Lewis & L. Rosenblum (Eds.), *The effect of the infant on its caregiver* (pp. 187–213). New York: Wiley.

Stern, D. (1985). *The interpersonal world of the infant*. New York: Basic Books.

Stern, D., Jaffe, J., Beebe, B., & Bennett, S. (1975). Vocalizing in unison and in alternation. Two modes of communication within the mother-infant dyad. Annals of the New York Academy of Sciences, 263, 89–100. Reprinted in L. Bloom (Ed.), *Readings in language development* (pp. 115–127). New York: Wiley, 1978.

Stone, L. J., Smith, H. T., & Murphy, L. B. (Eds.). (1973). *The competent infant: Research and commentary*. New York: Basic Books.

Trevarthen, C. (1979). Communication and cooperation in early infancy: A description of primary intersubjectivity. In M. Bullowa (Ed.), *Before speech: The beginnings of human communication* (pp. 321–347). London: Cambridge University Press.

Tronick, E. (1989). Emotions and emotional communication in infants. *American Psychologist, 44*(2), 112–119. doi:10.1037/0003-066X.44.2.112

Winnicott, D. (1965). *Maturational processes and the facilitating environment*. NewYork: International Universities Press.

Chapter 2

Moments of truth in psychoanalytic treatment

Jonathan H. Slavin and Miki Rahmani

> The psycho-analyst knows that he is working with highly explosive forces and that he needs to proceed with as much caution and conscientiousness as a chemist. But when have chemists ever been forbidden, because of the danger, from handling explosive substances, which are indispensable, on account of their effects?
>
> (Freud, 1915, pp. 170–171)

> Since an analyst acting on his or her personal motivations is inherent in productive technique, how are we to say where analytic work leaves off and exploitation of the analytic situation by the analyst begins? There is no avoiding this very disconcerting question. In struggling to answer it, we cannot afford to deny the fact of an analyst's personal involvement.
>
> (Renik, 1993, pp. 564–565)[1]

Psychoanalysis confronts a moment of truth

It has taken the better part of a century, but psychoanalysis seems to have come to a certain moment of truth. Indeed, a large part of the fabric and structure of the psychoanalytic process in the past 100 years was constructed to avoid this truth. Now, with new findings about how the brain is shaped by actual experience in the relational world[2] and, by now, several decades of revised developmental and clinical theory from a relational perspective, psychoanalysis has arrived at a moment in which it must acknowledge, finally, that some of its most fundamental tenets about the origins of human suffering, and the therapeutic processes that must take place to alleviate that suffering, are based on incorrect assumptions and understandings. Embracing the implications of these changes, we believe, will enhance the power of psychoanalysis to cure—albeit with

a quite different appreciation of the risk involved in the psychoanalytic undertaking—while nevertheless enabling greater clarity and resilience for some of its most fundamental truths.

In this chapter, we examine how psychoanalysis came to a point that ultimately resulted in the denial of certain truths of human experience and a misunderstanding of the necessary ingredients for change and cure. Only with a grasp of the actually quite sound reason for the way psychoanalysis developed can we move forward in embracing the revisions in treatment processes and theory that are taking place before our eyes.

Put simply and, for heuristic purposes, perhaps exaggeratedly, for a long time our theory represented that, by and large, the conflicts and symptoms that led people to present themselves for psychoanalysis had little to do with what had really happened to them in their real external lives. Moreover, until relatively recently, our theory held that psychoanalysis should take place as much as possible without full human involvement.

However, the accrual of knowledge and changes in our thinking during the last 30 years almost exactly reverses our previous assumptions; things happen in the real world of human interactions that deeply affect the minds and developmental course of people's lives. Moreover, the very personal engagement with the unique, individual mind of the therapist is absolutely critical to the change that the patient seeks in psychoanalytic treatment. We hope to show that often the crux of these issues is arrived at—sometimes dramatically but often more quietly and implicitly—in certain "moments of truth" in the therapeutic relationship that contain moments of potential danger to the treatment—and to each of the parties involved—alongside the possibility for real, fundamental, change.

The flight from reality

It hadn't started this way, we know, the abandonment of patient's developmental experience treated as experientially objective emotional facts. Freud's original view, the very origin of psychoanalytic theory, was that bad things really happened to people; viz. the sexual abuse of children. As Freud understood it, the repression of these traumatic events resulted in symptom formation. And in his first take on a psychoanalytic process, he believed that finding out some version of what "really" happened could result in a cure. However, in 1897, Freud famously announced a fateful change in his thinking: He had abandoned the "seduction theory."

Developmental events, reality, became important only to the extent that the patient's experience of them was shaped by the internal drive forces at play. What was "real" for psychoanalysis had changed. The internal world became real, or more real, and the individual's actual interpersonal world became as Loewald (1973) put it, "… fleeting, ephemeral, insubstantial in comparison with the enduring inner reality" (p. 69).

In a provocative paper on transference, Szasz (1963) points out that a parallel shift away from the "reality" of experience occurred in relation to Freud's understanding of the treatment relationship. Szasz recounts the episode in which Anna O throws her arms around Breuer, who flees the scene, and transfers the patient to Freud. Szasz suggests that because Breuer had no context for understanding what had happened, this episode precipitated his flight from psychoanalysis.

Freud was able to avoid a similar fate by what Szasz implies was a deft piece of mental gymnastics. He introduced the concept of transference. In so doing, Freud inserted a major shift in our thinking: What is "real" is not the feelings that the patient voices about the analyst. Rather, what is real is the patient's feelings toward someone not in the room. It is not the analyst who has engendered these feelings, but it is the patient who harbors them long before the encounter with the analyst.

As Szasz describes it, the discovery of transference was not simply the discovery of a new fact of psychic life, it was also an important defense for the analyst. The concept of transference enabled analysts to believe that what was being stirred in the patient was not about them; they were not provoking it, and this enabled them, in contrast to Breuer, not to flee. As Freud (1925) later put it, "In every analytic treatment there arises, without the physician's agency, an intense emotional relationship between the patient and the analyst *which is not to be accounted for by the actual situation*" (p. 42, emphasis added). The possibility that analysts might have some responsibility for the feelings of their patients was relegated to the arena of intrusion of personal countertransference. We believe it is critical to appreciate the connection between the two spheres of denial of reality, the denial of the role of trauma and other developmental experience in structuring the patient's mind on the one hand and the denial of personal influence and personal feelings in the treatment situation on the other.

Early efforts to reintroduce these elements of "real" experience, in development and in terms of the transactions that take place in the treatment relationship, encountered an extreme reaction (Aron and Frankel, 1994).

Ferenczi (1932) was the first to call attention to the damage abuse and trauma do to the individual's psychic integrity and capacity to trust one's own mind[3] (J. Slavin and Pollock, 1997), an issue we will return to later. His ideas and technical experiments in treatment (Ferenczi, 1932) challenged both of the realities that had been excluded. He reintroduced the reality of trauma and the analyst as a real object in the healing process. These ideas undermined the defensive function of the concept of transference that had enabled analysts to believe that their own personal participation was not a factor in what developed between them and their patients. Challenging this defense threatens to introduce something dangerously real into the psychoanalytic enterprise, namely, the possibility of real feelings, real love, real hate, and, also, real exploitation (Renik, 1993).

Freeing the mind: Freud's liberation psychoanalysis

At the same time that Freud was revising his thinking about the role of reality in the psyche, he was also revising his thinking about the influence of the analyst's personality on the patient's mind from another perspective. In this framework, Freud was guided by a view of the nature of the individual human mind framed in the pristine understandings derived directly from the Enlightenment and from its progeny, the flourishing, positivist science of the late nineteenth and early twentieth centuries.

As we have discussed in detail in a series of previous papers (J. Slavin, 2007, 2010, 2014, 2016), Freud was engaged with his patients, and in his theory, with a project of liberation. He sought to free his patients not simply from their debilitating symptoms and conflicts but to free their minds from the entrapping and stultifying internalized voices of authority so that they might find their own. It is a theme that resonates in Freud's theory of development and of the nature of neurotic disability. Indeed Freud (1905) argues that the advancement in human thinking, and "the progress of civilization" (p. 227) depends on our ability to detach ourselves from the inner authority of previous generations (J. Slavin, 2010, 2016).

Freud's liberation project (J. Slavin, 2016) is central to his understanding of the problem of the influence of the analyst's mind on the patient, most clearly described in his paper on transference-love (1915) and in the last of his "technique" papers ("Constructions in Analysis," 1937). In the former paper, after struggling for pages with how the analyst ought to deal with the love (and sexuality) that so often erupt in what he considered initially a

problematic way—and developing *en route* the concepts of neutrality and abstinence to preserve the integrity of the treatment process and protect the analyst—in the very last sections he arrives at his core understanding about why, apart from ethical reasons, the analyst should not reciprocate the patient's plea for love. Surprisingly and essentially, it is not the slippery slope nor the preservation of neutrality *per se* but rather the preservation of the patient's freedom and the integrity of the patient's mind:

> The aim [the analyst] has to keep in view is that this woman, whose capacity for love is impaired by infantile fixations, should gain *free command* over a function which is of such inestimable importance for her; that she should not, however, dissipate it in the treatment, but keep it ready for the time when, after her treatment, the demands of real life make themselves felt.
>
> (p. 169, emphasis added)

Freud's thinking is true to the science of his time, keeping the field pure so that the thing itself,[4] in its very essence, can emerge. As we noted in an earlier work, (J. Slavin, 2010), it is as if Freud presaged a perspective not unlike Winnicott's concept of the true self: that something essential and true of the person would emerge if only it were left unblemished. Perhaps more than the danger to the analyst, or the danger of reality, Freud's commitment to the integrity and freedom of the individual mind framed the foundation of his theoretical views of the treatment process.

Our hands are not clean,[5] nor should they be

In our view, the goal of ensuring the integrity of the patient's mind remains fundamental to what must guide us in the analytic process, whatever our framework. Our problem is how best to accomplish this, understanding that there is no way that a pristine field can be created in the treatment relationship.

It has taken almost three quarters of a century—if we begin with the work of Sullivan, later Winnicott, and eventually the development of relational perspectives in psychoanalysis (Greenberg & Mitchell, 1983; Mitchell, 1988)—to arrive at a fuller understanding of how real relationships and the real minds of others shape and affect the individual mind. However, on the basis of these changes in our thinking, the basic assumptions we hold about reality in development and reality in treatment are just about

the complete reversal of the original conceptualizations of these questions. Our thinking has changed so much that it is striking to remember that there was no conception in classical psychoanalysis for understanding how the actual interactions with other people from birth on affect the mind—and, as now we know, given the accelerating developments in neuroscience, affect the brain (J. Slavin & Rahmani, 2016).

As our views have changed about the decisive role of actual relational experience in development, they have also changed—albeit at times reluctantly—in a parallel way about the treatment process. The period of the early 1980s to the present has been one of increasingly clear acknowledgment of the *fact* that the analyst, as a person, as a personal subject, inevitably affects the treatment relationship and the mind of the patient (Ehrenberg, 1982; Hoffman, 1983; Aron, 1991; Renik, 1993; Mitchell, 1997; Borgogno, 2004; J. Slavin, 2010).

However, the acknowledgment of the irrefutable impact of the analyst's individuality (Renik, 1993; J. Slavin, 2010) has posed an extraordinarily difficult challenge. There was a heady sense of relief in early relational perspectives in recognizing the mutuality of influence and the impact of the analyst's subjectivity in the treatment process (Hoffman, 1996). Finally, something everyone knew was being acknowledged, and analysts were free of the restrictive chains of the fantasy of some sort of pure neutrality. It wasn't, as some critics had it, that now relational analysts were participating in all sorts of outrageous, undisciplined, rule-breaking ways. Rather, it was simply acknowledging what was obvious. Our hands were not clean (Hoffman, 1996), and we no longer had to deny it.

The relief was short-lived. It soon became clear that all of the dangers that had been contained in earlier thinking and technique came flooding back. It was not simply a matter, as Renik (1993) noted, of the possibility of exploitation, presumably by the analyst's unconscious agenda, but more fundamentally, where—in a new paradigm of complex, unconscious, reciprocal, and mutual influence (Hoffman, 1991; Mitchell, 1998)—would we find the proper discipline (Mitchell, 1998) for a therapeutic process? How could one differentiate some more insidious countertransference intrusion from a presumably ordinary, inevitable mutuality?

It seemed as if our theory could finally acknowledge certain irrefutable facts. What patients had experienced in their relational lives became, in complex ways, part of their minds. Equally accepted was the idea that there was no way of eliminating the analyst as a person and a participant,

with inevitable consequences of leaving some imprint of the analyst's personality on the outcome (McLaughlin, 1995; Mitchell, 1998). We arrived at a certain grim acceptance of this fact.

It is the next step that our discipline has had the greatest difficulty coming to terms with, indeed embracing: That is the focus of our discussion. As we see it, the influence of the analyst's personal mind on the reconfiguration of the mind of the patient is not simply inevitable but is critical to the power of the therapeutic process. In a series of papers (J. Slavin, 2010, 2012, 2014), we have argued that it is exactly the personal subjectivity, in plain English the personal and individual mind of the analyst with all its idiosyncratic twists and peculiarities, that patients not only need, to begin a revision of their own minds, but actually seek out.

An enduring truth in psychoanalysis has been that the core struggles that patients have experienced are in some inevitable way repeated in the treatment relationship. Transference is one of the great scientific discoveries of psychoanalysis. Traditionally, we have viewed this as an expression of pathology, which can ensnare the analyst in complex and even maddening enactments that provide the greatest therapeutic challenges (J. Slavin & Rahmani, 2015). Much more rarely have we viewed this as a natural and necessary effort to take the measure of their analyst's minds, to learn something of the usefulness and trustworthiness of the new mind that will be used to transform their own (Aron and Atlas, 2015; J. Slavin, 1994; J. Slavin & Rahmani, 2015; M. Slavin & Kriegman, 1992, 1998). Too often, for analysts, this effort to know and use the analyst's mind has brought up the fearsome subject of self-disclosure (discussed further below), without recognizing the core of health and the effort to seek revision of frozen, internalized relational pathways. How many countless therapies have broken down over the analyst's struggle to avoid and block the awkward moments of searching, questioning, probing, overt and covert, that are regularly visited upon them by their patients?

It has proven so strangely difficult in psychoanalysis to recognize that it is only through the power of a personal relationship with another mind (J. Slavin, 2010) that patients can reconfigure what was shaped and contorted in earlier, equally powerful, personal relationships in the family. Echoing M. Slavin and Kriegman (1992), we can say that through the evolved gift of transference, humans are able form new relationships with virtually the same power for transformation as the original ones. How else can psychotherapy work? How else might the brain be changed?

Moments of truth and perverse scenarios

> . . . psycho-analytic treatment is founded on truthfulness. In this fact lies a great part of its educative effect and its ethical value. It is dangerous to depart from this foundation. … Since we demand strict truthfulness from our patients, we jeopardize our whole uthority if we let ourselves be caught out by them in a departure from the truth.
>
> (Freud, 1915/1958, p. 163)

In a now-classic paper, "Love in the Afternoon," Davies (1994) used the term *perverse scenario* to describe the near impasse that can occur between analyst and patient and was occurring in her work with her patient, when both engage in a collusive denial of the analyst as a subject of "her own erotic sensation and desire" (p. 161). Embedded in this discussion are two groundbreaking ideas: First, that analysts—like the parents of oedipal period children—are true subjects and participants in the erotic developments that occur among them. Indeed, her account of parents' role in oedipal dynamics represents a true relational reconstruction of the oedipal period and secures a place for the centrality of sexuality in human development from a relational point of view.

The second idea is the "perverse scenario" that occurred in her work with her patient, which provides an essential lens in our understanding of pathological outcomes in development and complex dynamics that recur in treatment. Conflicting, but intertwined, agendas between parents and children are an inevitable, natural, if difficult, and painful part of the construction of our individual minds (M. Slavin and Kriegman, 1992; J. Slavin, 1994). Indeed, the negotiation of these conflicts, notably in adolescence (M. Slavin, 1990; J. Slavin, 1994), is essential to the growth of the individual if she or he is to be able to find his or her own mind as an adult. In contrast, in the "perverse scenarios" that may develop in the early years between parents and children and persist in life, conflicting agendas and interests, overt and subtle, are denied, projected, and obfuscated so that the individuals are often forced to choose between the plain data of their minds, *of believing in their minds*, or twist their minds so as not to endanger a brittle and conditional relationship. One too common version of this occurs in the sexual abuse of children, but that is not the only way such dynamics can unfold.

In her paper, Davies described such a perverse scenario. Her patient had been trapped as a boy with a needy, hungry mother who would repeatedly seduce him into story reading in bed and other enactments that had covert, but very provocative, erotic meaning. However, if the boy responded with some reciprocal excitement, he was humiliated and shamed.

What exactly is perverse here? Surely the malignant eroticization of the experience between parent and child. As problematic as that is, more fundamental to the perverse scenario is the insidious mode of denial and projection that makes impossible any effort to locate it as an experience that the child can hold in mind and feel as real. How can one hope to find one's mind and believe in it if one can never know where the erotic desire is or whether the fixed views of who one is, and what love is, are represented as embracing but feel suffocating? The result is subsequent ongoing damage to the child's—and later the adult's—psychic integrity, the inability to see and take ownership of vital features of one's real self, a true destruction of agency (Pollock & J. Slavin, 1998; J. Slavin & Pollock, 1997).

The complex roots of a perverse scenario may not be as overt or as sexualized as in Davies' example, but we know that patients often speak of—or maybe more often, the analyst helps them discover within themselves—the scars and footprints of subtle but powerful impingements of parents' constructions of them, a "confusion of tongues," as Ferenczi (1932, p. 156) termed it. Whatever their origin—the legacy of trauma in the parents' psyche, even if never openly enacted with their children, the experience of holocaust or other family horror, echoing in almost imperceptible ways across generations, family secrets lurking in the shadows of interactions with children, or parents' covert needs to mold their children to heal, or hate, their own injured selves—the "perverse scenario" is the enactment of a silent, unidentifiable process in core relationships in one's life that find their way destructively into the adult lives of our patients and also, painfully but possibly usefully, into the treatment relationship.

How can a perverse scenario be transformed? Having tried all other means and with the treatment sinking into irreparable impasse, Davies faced a moment of truth: to continue with traditional but failed efforts or address the falsification of the data of her patient's mind and senses, the perverse scenario, and the airlessness she has correspondingly experienced, by openly stating what seemed thick in the room?

This question is not for Davies alone in this electric moment. Rather, we ask whether these "perverse scenarios" inevitably emerge as frequently in

treatment as they do in our patient's lives, sometimes showing themselves starkly, at other times lurking more subtly and insidiously: to say what is not being said, to ask the unaskable question, to acknowledge a fact that has caused both of them to avert their eyes. They are part of our daily work: "Are you attracted to me?" "I had the feeling you were distracted." "Did I insult you with that comment? You looked hurt." "Do you remember what we were talking about last time?" Or, from the analyst's side, to say, in some decent and non-humiliating way, what is preying on one's mind: "I see that you (or we) teared up just now. Should we talk about it?"

Such "moments of truth," perhaps less dramatic or overtly sexual in content, are nevertheless just as fateful in determining whether the rift in our patient's psychic integrity will be healed. All too often, the question of how to proceed in such instances is framed in terms of "self-disclosure," that great bugaboo of psychoanalysis (Renik, 1995) that has prevented us from wrestling with something that may be much more basic. In these moments of truth, we have an opportunity to experience for ourselves the nature of the perverse scenario that has twisted and tortured our patients' minds. And then we confront the question of whether our choice in addressing it will perpetuate the feeling of being lost in a lie and of hopelessly trying to fight one's way out of life-paralyzing, relational, and internal circles (J. Slavin, Rahmani, & Pollock, 1998) or enable the patient to unravel her or his mind, as Ferenczi (1932) put it, "to reexperience the past no longer as hallucinatory reproduction but as an objective memory" (p. 160). No less important is the impact of this moment of truth on the analyst and his or her mind. How often, when we face and make split-second decisions on these questions, do we recognize that we are also deciding something about the integrity of our own minds and the nature of our work?

Foliage

Dr. S was the first person L ever told about the sexual abuse she had suffered between the ages of 5 and 10.[6] She recalled it for the first time in the midst of a seminar she had taken with him. Something in the way Dr. S spoke about it made her feel that he would believe her. Although she had been in numerous treatments since childhood, the issue of abuse had never been suspected.

L was in a subsequent seminar with Dr. S. He took an interest in her and became a mentor. From time to time in their discussions, L expressed

her unhappiness with her treatment with a therapist who seemed not to know how to deal with her history of abuse nor with her involvement in emotionally and sometimes physically abusing relationships.

As their conversations deepened, L gave Dr. S a beginning glimpse of the degree of psychic pain she suffered. Although L was an extremely talented professional whose difficulties did not seem to affect her work, she otherwise lived in a frightening and lonely world, connecting hungrily to abusive relationships with men, feeling like a small child overwhelmed with nameless and chaotic "bad feelings" that seized her in an uncontrollable way. As the enormity of L's suffering became clear, Dr. S recommended that she seek consultation and consider changing therapists. For L, the prospect of starting with someone unknown was beyond tolerating. She said she could think about it only if it were with Dr. S. Dr. S felt compelled by L, by the extent of her pain, by her attachment to him, and by the warm and loving feelings he felt for her. However, he also felt concern about the appropriateness of working with someone who had come to know him in other ways.

As L's despair grew worse, Dr. S referred her to a consultant and talked the situation over with two trusted colleagues. The consultant felt that L needed to learn that someone other than Dr. S could help her. However, both of Dr. S's colleagues believed that his emotional attachment was an important communication about what L needed.

At their follow-up meeting, Dr. S told L that one of the things that had occurred in her life was that she could not trust anything about herself, her feelings, or her perceptions. Her clear feelings at this moment, and also his, now told them that it made sense to try to work together. He suggested that they work together for a while and see whether, indeed, it felt right. L agreed.

A frightened, cowering child lost in an overwhelming world, this was L's life since childhood, and this was the experience inside her mind. One of L's earliest memories, around age 3 was of riding her tricycle around the block. Suddenly she couldn't find her house, she didn't know in what direction to go. She pedaled furiously around and around the block in an increasing, heart-stopping panic, crying tearfully as she hunted for where she lived. At about age 5 or 6, L began to be sexually abused by a family acquaintance several years older. She has dim, partly dissociated memories of lying on the couch as he would touch her genitals.

L was the younger of two daughters whose parents existed in a verbally abusive and masochistic relationship: father making nasty and deeply

hurtful comments that were later passed off as jokes, and mother silently absorbing them. They took little notice of the impact on L. When L was 10, her parents departed for a vacation while the children were left in the care of grandparents. L went into a frenzied, psychotic panic. She sat on the floor of the bathroom for hours, day after day, unable to eat, swirling in her mind. No one recognized what was going on. L's fear of repeating this kind of experience cemented her entrapment with boys, with whom she became involved at age 12. She would do anything, if only they would not abandon her. Her memories of her sexual experiences are filled with a sense of immense shame and humiliation, not only for what she did but for the feeling that she was participating in her own degradation.

L recalled an episode in childhood of walking into her parents' bedroom when they were both on the bed naked and looking at her father's penis. She recalls him saying, "What are you looking at?" As she told it, it seemed as though a provocation was literally put in her face, and then she was asked why she was provoked. Like the hurtful "jokes," the episode seemed emblematic of an insidious toying with a child's reality.

The initial months of work with L were overwhelming. She lived in a haunted, dissociated world of globally bad feelings and no coherent sense of the trustworthiness of her own senses. She felt, she said, like an immigrant to this planet. She needed to be seen almost every day and was in frequent phone contact with Dr. S.

Patient[7]: I don't feel good … ummm … [moaning] I don't feel good. … bad. … I don't feel good. … bad and it hurts [moaning, sobbing]…. I hurt my arms…. I don't feel good … I can't get it back … I can't get it back. …

Analyst: We're going to make it, okay.

Patient: You think so? [sobbing]

Analyst: Yes. I do think so. Did you bang your arm?

Patient: I hurt my hand. I just hit the walls … Last night. Hard! Because I'm angry! I know that I'm angry. I know I don't feel good because I'm angry! I know that. I don't want to be angry though. … I don't want to be angry! Why? Why? Everything's still here and the world is all here [tearful] but it doesn't look the same! I have to make it look the same for today because I have to go to work and I have to get it back, fast.

Analyst: Take your time and slow down. We'll get it back together. Let's take one step at a time.

Patient: Okay. [dazed] I can't do it [sobbing]. I woke up and I was just like "Oh shit!" It was sooo horrible. … I woke up and I was just like "oh no, oh no, oh no."… I can't do this.

Analyst: You wanted to be dead.

Patient: That's right. God didn't mean for me to live because it hurts too much. It's not right. It's not normal. It's too much.

Analyst: I'm thinking about the time that your parents went on vacation and you lost it when you were ten. And that there must have been a way that their readiness to just go, despite the fact that they could see that you were crazy, or at least should have seen that you were completely out of reality. … It must have felt like the coldest thing. And I think when you feel that deep coldness in someone else …

Patient: I feel so sad.

Analyst: I know. I really know.

For more than a year, L gripped tightly to the relationship with Dr. S. She went from one abusive relationship to another, although with clearer recognition of the meaning of her urgent feelings with men. She lost a dangerous amount of weight. She despaired of ever having a moment of peace in her own mind.

There was some relief when L decided to confront the person who had abused her. Although his acknowledgment of the abuse helped affirm her fragile sense of reality, it proved only temporary. She woke up every morning with a sense of dread. She took high doses of medication, but there was no peace except in the meetings with Dr. S. Occasional disruptions in their relationship (for example, when Dr. S. questioned L's decision to miss an appointment to see an abusive boyfriend) stirred enormous panic.

For Dr. S, each hour with L felt compelling, and he was gripped by the rawness of her pain and by her courage to persevere. A major change occurred when the treatment was in its second year. L was hospitalized for a physical illness, and Dr. S visited her. He found himself taking her in: frail, thin, vulnerable, and yet at the same time compelling and sexually appealing. Dr. S was totally unaware of this reaction until L became aware of his gaze. She looked about herself frantically as if to find what might be in disarray and said, "What are you looking at? What's wrong? Everything seems to be swirling." Dr. S suddenly became conscious of what he had been doing. In an instant of thought, he knew that he could not sacrifice L's reality testing to protect himself. He said, "We need to look at what

happened." L screamed in terror and said that she could not. She held her head in her hands, sobbed intensely, and vehemently insisted that they could not talk about it. L suddenly looked up, a look of horror on her face. "I had this crazy thought," she said. "I thought I need to call Dr. S and talk to him about this, but then I thought Dr. S is here, and it made me want to go away and die."

Dr. S insisted again that they talk about what happened. She listened as he described his experience, all of it. He said she must have felt horrified at the thought of his having any sexual feelings for her, but even more horrifying, he said, was her expectation that he would not acknowledge his feelings or what had just happened. He said, "You felt you had to violate your own mind and bury part of what you saw in me in order to hold on to me as the Dr. S you could call." She became calm. "The world looks clearer," she said. They spoke at some length—the first of many such discussions—about what had happened and what L had felt.

Two weeks later, L came to see Dr. S on a bright fall day. She looked out the window and said, "Foliage." Dr. S repeated, "Foliage?" She said, "People always used to talk about the foliage, but I never knew what they meant. I was not on this planet. It's really beautiful, the foliage." Dr. S said, "It is really beautiful." It was clear to L that what had occurred in the hospital had anchored her in the world in a way that felt truly different. In the next weeks she felt calmer, less constantly panicked. Some time later, recollections emerged of L's father's lifelong preoccupation with the contours of her body and her own feelings, from an extremely early age, of wanting to feel "sexy."

In the following months, there was a dramatic change in L's life. While she could still experience "bad feelings," for the most part her daily life felt far more real and less filled with urgent, hungry anxiety. And L was able to begin to explore the importance to her of the power she had experienced for much of her life in the unconscious use of her body to try to hold desperately onto a relationship.

In an hour during the fourth year, L discussed the ending of a relationship with a boyfriend who was verbally abusive but on whom she had felt extraordinarily dependent:

Patient: I need to be with somebody who can appreciate me. Who I am. And it's so sad to me because I know it's not him. And I'm so sad. But on the other hand, … it's like I get to be free from some of the things

that were imprisoning me… The terror, the desperation that kept me in what was sometimes not a healthy relationship. …[Pause] I'm scared about feeling sad again.

Analyst: I know.

Patient: Because I know I'm going to. But can I feel more sad than I already felt when we came to the decision about breaking up?

Analyst: Yes. You could have been like you were when I first started seeing you.

Patient: That's what I was thinking when I was driving here. I was thinking that I am a different person. I am a totally … I am a different … I am a person! I feel like not only am I a different person, but I almost didn't exist. You know? So really so much has happened for me in the past three years.

Analyst: Are you trying to make your therapist cry?

Patient: [Laughs] Yeah … No [cries].

At one point, when Dr. S made a suggestion about how to handle a difficulty with a problematic supervisor, L said, "I think that is a very good idea. I have to address it and I will … in my own way." Dr. S felt a distinct thrill in hearing her say she would do it in her "own" way. It seemed like a real change had occurred in her capacity to possess and own her own self.

Patient: The first worst thing was to have the boyfriend mad at me. The second worst thing was to have my mom mad at me.

Analyst: It wasn't exactly a big discovery to see that you were the most terrified person in the world I'd ever met. It's like you didn't have to do a lot of convincing. So I think something was seeable but it wasn't seen. … I wish I knew how this all helped you.

Patient: Yeah, that's the part that … well we can figure it out. But I'm glad it has! [laughs] It's … so basic though …

Analyst: Say what you were going to say.

Patient: I think I feel like you really care about me. All you did was listen and believe me and care about me a lot. That's it [tearful]. I mean, a lot … more than that. But that's like so small … [tearful].

Analyst: I know.

Patient: But it did a huge thing for me, you know.

Reality, danger, and psychic integrity

In discussing the complexity of unraveling what really happens in an analytic session, Szasz (1963) noted, "No one, psycho-analysts included, has as yet discovered a method to make people behave with integrity when no one is watching. Yet this is the kind of integrity that analytic work requires of the analyst" (p. 442).

In fact, two people are watching: the patient and the analyst. In most therapies, there will be moments—sometimes intense and emotionally dramatic, as presented in the story of L and Dr. S; in others, moments more subtle, fleeting, even ordinary—in which both patient and therapist will see, whether consciously admitted or not, that something has passed between them that presents the possibility of denying something plainly there, or acknowledging a difficult, possibly painful truth.

There is something truly gripping and portentous as we think of these "moments of truth" that arise in the human encounter we call psychotherapy. It's worth noting that the first usage of the phrase "moment of truth" in English is by Ernest Hemingway (1932). A translation of the Spanish *el momento de la verdad*, it signifies the point in a bullfight when the matador faces the bull and must decide whether this is the moment to risk all. It is a critical moment, a time in which one is put to the ultimate test and the fate of both is determined. Perhaps, then, it is a phrase worthy of the moment in which the fate of the minds of both patient and therapist hangs in the balance.

For the patients, it represents the possibility of recovering the validity of their minds, of believing in the truthfulness of their perceptions and, at the heart of the matter, the trustworthiness of other people. Will this be another encounter with an important figure prepared to sacrifice their minds to protect themselves? For the analyst, it represents a moment of stark recognition of the fragility of the patients' integrity of mind and their desire to protect and heal it, and at the same time their own fragility as human beings and the recognition that their own, hardly healed, minds and personalities—from which no further analysis can likely cleanse them—will have an indelible impact on the mind of the person before them.

The etymology of words can sometimes reveal important nuances in human experience. It is worth noting the dual usage of the word "moment" in English. It is a brief point in time and also something weighty and important, as in a discovery of great moment: momentous. Both derive from the Latin root *movere*, "to move."[8] Thus, in a fraction of time, in a

moment, something momentous can occur. In the context of this paper, we are suggesting that something momentous can and does happen in a fraction, or moment, of time, in the choices analysts make in what they say or don't say to their patients.

Although such moments may not stand out dramatically, as in the vignette of L and Dr. S or Davies and her patient, nor have any overt connection to a personal revelation by the analyst, in many, if not all, therapies the analyst will nevertheless be faced with having to make moment-by-moment, clinically informed, theoretically grounded, and inevitably risky choices: to say something difficult, unsettling, precarious in terms of the treatment relationship, that the analyst, in his or her best therapeutic judgment, and with no assurance of success, believes the patient needs to hear. To paraphrase Renik (1993), there is no avoiding such choices nor the danger that inheres in them. Perhaps in these "moments of truth" we see most vividly that what really happens between patient and analyst really matters. In our view, there is no other way in which true healing and change can take place. What "really" happened has to be met by something that is really happening and is "really" different. As Freud (1914a) noted, "one cannot overcome an enemy who is absent or not within range" (p. 152).

Acknowledgments

This chapter represents a significant revision and updating of two prior published papers by the authors, portions of which are reprinted here. (1). Slavin, J., Rahmani, M., & Pollock, L. (1998). Reality and danger in psychoanalytic treatment. *Psychoanalytic Quarterly*, *67*:191–217, reprinted by permission of John Wiley and Sons, Inc. (2) Slavin, J. (2013). Moments of truth and perverse scenarios in psychoanalysis: revisiting Davies' "Love in the afternoon." *Psychoanalytic Dialogues*, *23*:139–149, reprinted by permission of Taylor & Francis, LLC (http://www.tandfonline.com).

Notes

1 Taken from Renik, O. (1993). Analytic interaction: Conceptualizing technique in light of the analyst's irreducible subjectivity. *Psychoanalytic Quarterly*, 62:553–571. Reprinted as an epigraph by permission of John Wiley & Sons, Inc.

2 We use brain and mind interchangeably given current findings in psychological neuroscience. For a more detailed discussion see J. Slavin & Rahmani, 2016.

3 More accurately, we should say the first after Freud who, in his initial trauma theory, pointed to the destruction of a sense of agency as a result.
4 In describing his scientific outlook and attitude Freud (1914b) noted, "I learnt to restrain speculative tendencies and to follow the unforgotten advice of my master, Charcot: *to look at the same things again and again until they themselves begin to speak*." (p. 22, emphasis added)
5 A phrase from Irwin Hoffman (1996) on the inevitability of the analyst's personal influence on the treatment situation.
6 A more detailed presentation of this clinical material can be found in J. Slavin, Rahmani, & Pollock (1998).
7 Verbatim text is transcribed from tapes made of the analytic sessions with the patient's foreknowledge and permission. L used the couch for many of the sessions transcribed here.
8 http://www.etymonline.com/index.php?allowed_in_frame=0&search=moment

References

Aron, L. (1991). The patient's experience of the analyst's subjectivity. *Psychoanalytic Dialogues, 1,* 29–51.

Aron, L., and Frankel, J. (1994). Who is overlooking whose reality? Commentary on Tabin's "Freud's shift from the seduction theory: Some overlooked reality factors." *Psychoanalytic Psycholology,* 1(1):291–302.

Aron, L., & Atlas, G. (2015). Generative enactment: Memories from the future. *Psychoanalytic Dialogues*, 25:309–324.

Borgogno, F. (2004). On the patient's becoming an individual: The importance of the analyst's personal response to a deprived patient and her dreams. *Psychoanalytic Dialogues*, 14:475–502.

Davies, J. M. (1994). Love in the afternoon: A relational reconsideration of desire and dread in the countertransference. *Psychoanalytic Dialogues*, 4:153–170.

Ehrenberg, D. (1982). Psychoanalytic engagement. *Contemporary Psychoanalysis*, 18:535–555.

Ferenczi, S. (1932). *The Clinical Diary of Sándor Ferenczi*, ed. J. Dupont (trans. M. Balint & N. Z. Jackson). Cambridge, MA: Harvard University Press, 1988.

Freud, S. (1897). Letter 692 (Extracts from the Fliess papers). *S.E.,* 1: 259–260.

Freud, S. (1905). Three essays on the theory of sexuality. *S.E*., 7: 123–246.

Freud, S. (1914a). Remembering, repeating and working-through (Further recommendations on the technique of psychoanalysis II). *S.E.,* 12: 145–156. London: Hogarth Press, 1958.

Freud, S. (1914b). On the history of the psycho-analytic movement. *S.E.,* 12: 1–66. London: Hogarth Press, 1958.

Freud, S. (1915). Observations on transference-love. *S. E.*, 12: 159–171. London: Hogarth Press, 1958.

Freud, S. (1925). *An Autobiographical Study*. *S. E.*, 20: 7–74.

Freud, S. (1937). Constructions in analysis. *S.E.,* 23: 255–269.
Greenberg, J., & Mitchell, S. (1983). *Object relations and psychoanalytic theory*. Cambridge, MA: Harvard University Press.
Hoffman, I. Z. (1983). The patient as interpreter of the analyst's experience. *Contemporary Psychoanalysis,* 19:389–422.
Hoffman, I. Z. (1991). Discussion: Toward a social-constructivist view of the psychoanalytic situation. *Psychoanalytic Dialogues*, 1:74–105.
Hoffman, I. Z. (1996). The intimate and ironic authority of the psychoanalyst's presence. *Psychoanalytic Quarterly*, 65:102–136.
Loewald, H. (1973). On internalization. In: Loewald, H., *Papers on Psychoanalysis*. New Haven and London: Yale University Press, 1980.
McLaughlin, J. T. (1995). Touching limits in the analytic dyad. *Psychoanalytic Quarterly*, 64:433–465.
Mitchell, S. A. (1988). *Relational concepts in psychoanalysis: An integration*. Cambridge, MA: Harvard University Press.
Mitchell, S. A. (1997). *Influence and autonomy in psychoanalysis*. Hillsdale, NJ: The Analytic Press.
Mitchell, S.A. (1998). The analyst's knowledge and authority. *Psychoanalytic Quarterly*, 67:1–31.
Pollock, L., & Slavin, J. (1998). The struggle for recognition: Disruption and reintegration in the experience of agency. *Psychoanalytic Dialogues*, 8:857–873.
Renik, O. (1993). Analytic interaction: Conceptualizing technique in light of the analyst's irreducible subjectivity. *Psychoanalytic Quarterly*, 62:553–571.
Renik, O. (1995). The ideal of the anonymous analyst and the problem of self-disclosure. *Psychoanalytic Quarterly*, 64:466–495.
Slavin, J. (1994). On making rules: Towards a reformulation of the dynamics of transference in psychoanalytic treatment. *Psychoanalytic Dialogues*, 4:253–274.
Slavin, J. (2007). Personal agency and the possession of memory. In: Mendels, D. and Soreq, H. *Memory: An Interdisciplinary Approach*. Bern, Switzerland: Peter Lang Publishers.
Slavin, J. (2010). Becoming an individual: Technically subversive thoughts on the role of the analyst's influence. *Psychoanalytic Dialogues*, 20:308–324.
Slavin, J. (2012). It is all personal: Further thoughts on therapeutic action: Commentary on paper by Noelle Burton. *Psychoanalytic Dialogues*, 22:679–686.
Slavin, J. (2013). Moments of truth and perverse scenarios in psychoanalysis: Revisiting Davies' 'Love in the afternoon.' *Psychoanalytic Dialogues*, 23:139–149.
Slavin, J. (2014*)*. "If someone is there" On finding and having one's own mind. *Psychoanalytic Perspectives,* 11:23–34.
Slavin, J. (2016). "I never felt I should think about Freud": From authority to liberation in psychoanalytic work. *Psychoanalytic Perspectives,* 13: 321–325.

Slavin, J., & Pollock, L. (1997). The poisoning of desire: The destruction of agency and the recovery of psychic integrity in sexual abuse. *Contemporary Psychoanalysis*, 33:573–593.

Slavin, J., Rahmani, M., & Pollock, L. (1998). Reality and danger in psychoanalytic treatment. *Psychoanalytic Quarterly*, 67:191–217.

Slavin, J., & Rahmani, M. (2015). Legitimate guiding forces of one's behavior in the world.*Psychoanalytic Dialogues*, 25:325–334.

Slavin, J., & Rahmani, M. (2016). Slow dancing: Mind, body, and sexuality in a new relational psychoanalysis. *Psychoanalytic Perspectives*, 13:152-167.

Slavin, M. O. (1990). The dual meaning of repression and the adaptive design of the human psyche. *Journal of the American Academy of Psychoanalysis*, 18:307–341.

Slavin, M., & Kriegman, D. (1992). *The adaptive design of the human psyche: Psychoanalysis, evolutionary biology, and the therapeutic process*. New York: Guilford Press.

Slavin, M., & Kriegman, D. (1998). Why the analyst needs to change: Toward a theory of conflict, negotiation, and mutual influence in the therapeutic process. *Psychoanalytic Dialogues,* 8:247–284.

Szasz, T. S. (1963). The concept of transference. *International Journal of Psychoanalysis*, 44:432–443.

Part II

Jungian approaches to relational work



Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

Chapter 3

Moments of complexity

Non-local aspects of moments of meeting

Joseph Cambray

Introduction

Following a set of key publications by the Boston Change Process Study Group (BCPSG), in a small group of psychoanalysts/developmentalists,[1] begun in 1995, debates about the sources of psychotherapeutic change arose. A paradigmatic shift in clinical understanding can be traced to the 1998 publication by Stern et al., of a paper on "Non-interpretative mechanisms in psychoanalytic therapy: The 'something more' than interpretation." Their adamant placing of the therapeutic relationship, including its non-conscious elements, especially implicit relational knowing, at the heart of transformational change in psychotherapy unleashed a storm of controversy within analytic communities of various lineages. The centrality of mutative interpretations and applications of theory driven insights, regardless of analytic school, was significantly challenged by the new relational paradigm. The BCPSG analysts, who were also infant researchers, challenged the legitimacy of understanding human psychological growth and change based on retrospective adult psychoanalyses.

A trajectory of dyadic transformations emerged from the BCPSG's research on microprocessing, moment-by-moment analyses of videotapes of analytic encounters. They identified a progression from "present moments," of being attentive to the lived subjective experience of a moment, to engaging in affectively charged "now moments," when emotions about what was occurring between the participants entered, to unique, transformative "moment(s) of meeting" when in the midst of a now moment, a new, more authentic way of being together transcended expected outcomes of such an encounter (Stern, 2004). The latter is marked by a sudden qualitative change in the way the therapy partners experience one another in the implicit

relational domain. Now moments tend to occur "when the traditional therapeutic frame risks being, or is, or should be, broken" and passes through "an unknown and unexpected intersubjective space" which as noted can lead to a "moment of meeting" (Stern et al., 1998, p. 912). Additionally a now moment is understood by the group as being "a potential emergent property of a complex dynamic system" (Stern et al., 1998, p. 912), which they relate to the Greek concept of *kairos* (Stern et al., 1998, p. 911) a seizing of the right moment. Therapeutic action pivots on the responses to such charged now moments, which when skillfully handled can foster increasing psychological complexity and richness in the dyad. In this chapter, I expand the use of a complex system's approach to therapeutic change, taking it into some non-local field considerations; however, several more observations will be given before shifting to my main theme.

Asymmetries between partners in the mutual processes described by the BCPSG are openly acknowledged by them, including the unpredictable and co-creative nature of these types of encounters (Nahum, 2005). In this, we can detect an echo of Jung's 1929 observations:

> …the relation between doctor and patient remains a personal one within the impersonal framework of professional treatment. By no device can the treatment be anything but the product of mutual influence… For two personalities to meet is like mixing two different chemical substances: if there is any combination at all, both are transformed. In any effective psychological treatment the doctor is bound to influence the patient; but this influence can only take place if the patient has a reciprocal influence on the doctor. You can exert no influence if you are not susceptible to influence.
>
> (Jung 1966, par.163)

In this same essay, Jung recognizes the potential value of understanding induced countertransferential reactions. Opening to and processing such influence is essential according to Jung:

> …the doctor is as much "in the analysis" as the patient. He is equally a part of the psychic process of treatment and therefore equally exposed to the transforming influences. Indeed, to the extent that the doctor shows himself impervious to this influence, he forfeits influence over the patient; and if he is influenced only unconsciously, there is a gap

> in his field of consciousness which makes it impossible for him to see the patient in true perspective. In either case the result of the treatment is compromised.
>
> (Jung 1966, par. 166)

This stance, emphasizing the radically interactive nature of the therapy process, lead Jung toward a field model, which he also extended into the construction of dreams: "In the deepest sense we all dream not *out of ourselves* but out of what lies *between us and the other*" (C. G. Jung, letter to James Kirsch, 29 September 1934; 1973).

By 1946, Jung was able to write a monograph on transference using alchemical symbolism to more fully articulate his view of the field in a historical, cultural, and symbolic context (1966). Using patterns derived from folklore and anthropology, he constructed a graphic representation of the interactive transference/countertransference field as a fourfold diagram showing six pathways of bidirectional influence. More deeply, the interactive field model of therapy Jung developed was based on the understanding of fields of force which had developed throughout the nineteenth century, primarily to describe of physics of electricity and magnetism (Cambray, 2009). As I've shown elsewhere, these formulations of nature were incorporated into psychology through the writings of William James, who was himself a strong influence on Jung (Cambray, 2011). In his correspondence with physicist Wolfgang Pauli, beginning in 1932, Jung further elaborates his field model, attempting to incorporate aspects of relativity and quantum theory through the concept of the psychoid unconscious and synchronicity.

The concept of the psychoid had been introduced by the vitalist philosopher Hans Driesch in his 1907–1908 Gifford Lectures and modified by Eugen Bleuler, Jung's chief during his Burgholzli days, in an attempt to describe the intersection of body, psyche, and phylogeny. By 1946, Jung redefined the idea, shifting it from noun to adjective, while seeking to locate it outside any realm accessible to consciousness, it has:

> no psychic quality in the proper sense of the word…but only a 'quasi-psychic' one such as the reflex-processes possess…and…is meant to distinguish a category of events from merely vitalistic phenomena on the one hand and from specifically psychic processes on the other.
>
> (Jung 1946/1969, par. 368)

However, he is not content to let the psyche simply merge into the material realm, but sees the psychoid as a bipolar notion, extending into spiritual considerations:

> Just as, in its lower reaches, the psyche loses itself in the organic-material substrate, so in its upper reaches it resolves itself into a 'spiritual' form about which we know as little as we do about the functional basis of instinct. What I would call the psyche proper extends to all functions which can be brought under the influence of a will.
>
> (Jung 1946/1969, par. 417)

For Jung, it is this psychoid realm beyond the "upper end" of the psyche that serves as the source of archetypal and religious experience: "The archetype as such is a psychoid factor that belongs, as it were, to the invisible, ultraviolet end of the psychic spectrum. It does not appear, in itself, to be capable of reaching consciousness" (Jung 1946/1969, par. 417).

In this chapter, psychoid aspects of the interactive field are considered, especially as they manifest through synchronistic phenomena.

The synchronicity hypothesis in its full form was a late contribution to Jung's oeuvre. His first formal presentation of concept in any detail was at the Eranos conference in 1951; the following year he published his longer signature essay on the topic. Defining a new principle for science and philosophy in Western thought, with parallel in Chinese philosophy, he framed synchronicity as meaningful coincidence, with personal, clinical, and research examples. Numerous critiques and reevaluations have been made since it first came out; for example, see those by Aziz (1990) and by Main (2004) for friendly but careful, critical readings. In the last 15 years, a reassessment of the hypothesis in terms of complex adaptive systems has been undertaken by me and others in the post-Jungian community, as will be discussed. The parallel exploration of "moments of meeting" in terms of complex system naturally juxtaposes the two lines of thought for consideration and hopefully fruitful expansion of each.

Post-Jungian applications of moments of meeting

There is a burgeoning literature from therapists of many different theoretical orientations who are adopting and adapting the BCPSG model

to function in conjunction with their own frameworks, this book being one example. Post-Jungian contributions have been steadily growing as well, often seeking some sort of conceptual marriage, perhaps after a tussle. In this section, I offer several representative examples. For instance, Linda Carter finds important resonances with Jung's view of the transcendent function (combining conscious and unconscious elements into a symbolic third) with Tronick's view on dyadic expansion of consciousness. Though she is careful to discuss the difference in orientation between the models, BCPSG's more extroverted, relational formulations compared with Jung's tendency to privilege intrapsychic experience (2010).

Crowther and Schmidt look at a range of phenomena associated with a state of "grace" and Eureka moments (2015). They find significant intersections of moments of meeting, emergence (a complex systems descriptor for holistic features not observable in components), experiences of the self, and synchronicities. The potential for transformations in consciousness are again linked with effective use of the affective charge associated with the reorganization of the field in which these changes occur. In physical systems, these types of sudden, dramatic changes are generally discussed as phase changes, which point to the complex dynamics operating. From the perspective of ordinary, naive consciousness, they are marked by feelings of shock or surprise, which can be read as an affective clue to the reorganization underway.

George Hogenson has written a series of papers seeking to address some of the concerns in attempting to integrate the BCPSG's model into post-Jungian discourse. In "From moments of meeting to archetypal consciousness: Emergence and the fractal structure of analytic practice" (2007), he looks at temporality in analysis. The argument brings forth interpersonal and intrapsychic complex dynamics at play, which lead to various sorts of emergent phenomena akin to moments of meeting. These processes exhibit self-similarity on multiple levels and hence have a fractal quality about them. Hogensen concludes with examination of the role symbolic density plays in the non-linear transformations of personalities that are characteristic of successful analytic work. The movement into greater depth and density in such cases is marked by an intensification of archetypal qualities, which helps to shape the interactive field in directions holding the greatest potential for therapeutic action.

In a contribution seeking to explore the relationship of synchronistic experience with infant developmental processes, Hogenson (2009)

concludes that the meaning-making coincidence model may easily combine with the moments of meeting approach of the BCPSG through the application of a complexity perspective. To support his views Hogensen draws on the developmental studies from Beebe and Lachman's mother/infant research, as had Carter previously (v.s.). As valuable and important as this work is, there is not space to include it here, though Beebe is one of the contributors to this volume, and readers wishing to pursue this can find much of value in her chapter. Nevertheless, the convergence of analytic approaches being employed by Hogenson raises some paradigmatic questions about the nature of surface and depth, inverting the usual formulations. In this way, synchronicities and moments of meeting become the primary material from which consciousness is built in the early development of the individual. Therefore, a combined approach, about which I've written in terms of "moments of complexity" (Cambray, 2011), may offer a useful extension to our understanding of the psyche, especially as observed within analytic practice.

Moments of complexity (MoC) and non-locality

The limitation of an interpersonal perspective associated with a moments of meeting approach were brought home to me in a case that began in a striking coincidence involving a future client with whom I did not have a relationship at the time of the coincidence. As I've written in the case of Melanie (Cambray, 2011), it was during a social, lunchtime meeting with her psychiatrist that I first was introduced to details of the case, because of an unanticipated but dangerous and problematic situation that had arisen just as we were in the midst of our lunch. Only months later did I actually meet Melanie for the first time in the aftermath of a partial recovery from a debilitating psychotic episode. The details of what I learned in my lunchtime meeting echoed throughout the clinical work, punctuated with a string of now moments that converted to moments of meeting and a number of synchronistic phenomena, often happening in close conjunction with these moments.

Perhaps one of the more striking coincidences in Melanie's case happened years after our work had ended. We had not had any contact for more than 20 years and lived in different regions of the country. I had just been asked to present a paper on therapeutic action and had immediately thought of my work with Melanie as her case had a number of specifically Jungian elements in it, which would help me to elaborate some of the unique features of this

psychodynamic approach. However, I had not asked Melanie for permission to present her material and therefore ruled it out and sought an alternative case. Nevertheless, about six weeks later, as I previously reported (Cambray, 2011), I received a phone call from her, asking for a one-time consultation in a few weeks when she would be in my region of the country. Still cautious, I entered the consultation undecided as to whether to raise the issue of using her material, unless or until a clear indication of the topic was raised by her. In fact, this occurred about halfway through the meeting, when she asked me to explain how I had made a key clinical decision about continuing to treat her after another psychological crisis had manifested. The decision had emerged from my recognizing a profound unconscious link between us through a synchronistic experience associated with a dream she had had in the week before the crisis had reached its climax.[2] While we had done some work on the dream at the time, I had not processed the synchronicity with her then because of her frail psychological condition. As this was no longer the case and her question went directly to this point, we had an open discussion, which I have already published (Cambray, 2011).

From this case and other anecdotal material, I believe it would be useful to expand the notion of moments of meeting to include a broader range of clinical phenomena that have generally been treated as marginal at best, such as synchronistic experiences. The theoretical framework that best holds these concerns is the analytic field. In the psychoanalytic literature, this topic is usually traced back to Madeline and Willy Baranger (1964), with significant contributions by Robert Langs (1976). More recently, there has been much activity in reconsidering the transference/counter-transference situation in these terms (e.g., Thomas Ogden's formulations of the analytic third as emerging from the field [2004] and Antonino Ferro and Roberto Basile [2009] edited book on the topic) but the field remains dyadic, a bipersonal construction as Langs described it. As already mentioned, the BCPSG's work and the authors who have embraced this perspective have been articulating this view of the field. One significant emendation to this view has been the work of psychologist Tronick with his conception of mental development through a dyadic expansion of consciousness in the mother/infant pair (2009).

As mentioned, Jung offered an archetypal field model; this originated out of nineteenth-century models of fields in physics, particularly electromagnetic theory (see Cambray, 2009, ch. 2). William James had first introduced such models into psychology in his 1901/1902 Gifford lectures (1961) and his influence on Jung is well documented as he quoted the

relevant passages in his essay "On the Nature of the Psyche" (1946/1969, par. 382, n. 47). While Jung attempted to include quantum and relativity field theories in his field model, he was not wholly successful as Pauli pointed out to him in their correspondence. Several Jungians other than I have expanded Jung's notion of the analytic third and have discussed archetypal fields (e.g., see Schwartz-Salant (1991); Mansfield and Spiegelman (1996); and Hogenson (2007) among others.

What I would like to suggest here is further consideration of the non-local aspects of the analytic field. While the dyadic models have delocalized the psyche from a one-person phenomena to a bipersonal field, they tend to remain highly focused on interactions happening solely within the therapy room, at times with an uncomfortable or uncertain nod to "uncanny" occurrences, such as precognitive dreams, or seeming telepathic communications. A more radically non-local model is needed to describe these and a range of other phenomena, but this is hard to conceive from within most modern scientific paradigms. The most fruitful approach to date has been through incorporation of complex systems into our models of the psyche. One important application of complexity research has been ecology. Hidden connections abound in ecological systems, leading to surprising—even bewildering—phenomena that are not at all apparent in the appearance of things. A MoC model is best served by grounding it in an ecological perspective on the psyche.

Toward an ecology of the psyche

Depth psychology's affinity with the unseen aspects of ecological systems, its nascent ecologizing, is reflected in a well-known quote from *Memories Dreams and Reflections*:

> Life has always seemed to me like a plant that lives on its rhizome. Its true life is invisible, hidden in the rhizome. The part that appears above ground lasts only a single summer. Then it withers away—an ephemeral apparition. When we think of the unending growth and decay of life and civilizations, we cannot escape the impression of absolute nullity. Yet I have never lost a sense of something that lives and endures underneath the eternal flux. What we see is the blossom, which passes. The rhizome remains.
>
> (Jung 1963, p. 4)

Derived from the Greek term "*rhiza*" translated as root, a rhizome is a continuously growing horizontal underground stem that puts out lateral shoots and adventitious roots at intervals. Typical, well-known rhizomatic plants are bamboo, ginger, aspen trees, ginseng, and so on. The dense underground network of a rhizome can be quite extensive, with many smaller roots in a network converging in spots to produce the nodes that are associated with the above-ground, observable growth. Further, rhizomes also tend to interact with numerous other root systems in their vicinity, forming vast numbers of connections.

A contemporary direction derived from Jung's use of this simile is the study of the complex networks of unconscious connections that extend and support various individual representations "above ground" (e.g., ordinary conscious perceptions of self emerge from a non-local psyche). The psyche analogized as a highly entwined, non-local network is mostly invisible at the surface but profoundly distributed beneath and, by implication, embedded in a larger ecological system. Ancillary to this view, seeming boundaries between mind, body and world become much more fluid. Psyche's network conjoins us all in the natural and cultural worlds.

Rhizomatic interactions can serve multiple purposes in nature, many of which are currently being investigated in botany. For example, dying trees are now known in certain circumstance to "download" their essential nutrients to mycorrhizal networks (fungi), which have infiltrated tree roots without injuring them. In fact, a Douglas fir regularly "makes and delivers food to the fungus; the fungus, in turn, dramatically increases the plant's water and mineral absorptive powers via its vast network of filaments. They provide far more surface area for absorption than the meager supply of short root hairs the tree could grow alone" (Frazier, 2015). The mycorrhizal networks also serve as a conduit and communication pathway between trees, even of different species. They can transmit warnings about predation, pathogens, and nutrient distribution, allowing cooperative coordination previously undetected between the various components of the network. Thus, older trees have been shown to support the growth and health of seedlings. Frazer cites the work of Suzanne Simard who is studying the role of mycorrhizas in stabilizing the forest soils in the face of climate change and how their networks have scale-free topologies and act as fundamental agents of self-organization in the complex adaptive systems of forest ecosystems (see, e.g., Simard and Austin, 2010; Simard et al., 2012).

From these detailed, scientific explorations on plants, we have hints of how profoundly complex the psyche must be—if fungi and trees have such a rich interconnected life, what then of sapient beings with their cortices of neural nets engaging with one another and their worlds. Should we not be learning from the ground up about the way biological intelligence has evolved methods of communication that foster cooperative, integrated modes of engaging with others? If we are able to suspend our knowing sufficiently to open to an appreciation of these ways of being, I believe our models of the psyche will be enriched well beyond our current imaginings.

Similarly, there are many examples of collective biological intelligence, often referred to as "swarm logic," that demonstrate collective, coordinated behaviors without explicit, or even implicit, leadership but through proximity relationships mediated by various kinds of signals. Again, scaling up to sapient beings, it is reasonable to assume that the number of channels available for signaling will increase and become more flexible and complex, as is most obviously the case in the human use of language and symbols to communicate abstract concepts. As informational and neurosciences have matured over the last 70 years in conjunction with growing understanding of the way the mind forms in interaction with others early in life, it has become evident that the deeper layers of the psyche have an intertwined polycentricity. Composed of multiple streams, somatic states with affects and images and cognition, words and movements, all coordinated, perhaps even choreographed unconsciously, with numerous others in varying environments, the fuller ecology of the psyche is still to be articulated. The internet with its enormous connectivity is a significant factor in shaping and giving images for this new ecological perspective.

Internet psychotherapy and MoC

The rapid growth and sophistication of the internet, along with the devices to access it, have begun to alter and broaden the way in which psychotherapy is being conceived and conducted. The advent of easy, inexpensive telecommunication software, such as Skype, is increasingly moving the therapy world into cyberspace. This is especially true in places where therapeutic resources are sparse or in the process of developing, such as in mainland China. While new legal and ethical dilemmas have arisen out of the non-locality of the medium, there are numerous other challenges to our conceptions of perceptual reality. Fortunately, there

are a growing number of publications seeking to address a range of therapeutic concerns activated by communications through cyberspace. Recently, a two-volume set of thought-provoking essays on the topic have been published, edited by Jill Savege Scharff (2013, 2015), and a volume by a single author-analyst about her work on Skype cross cultures (Isaacs Russell, 2015). From reading these and other articles and books, the general impression is that analytic work does seem possible using telecommunications, though with some modification in large part due to the nature of the medium and the equipment currently available. My own experience working therapeutically in cyberspace confirms these findings, though I would like to discuss some of the complexities not always taken into consideration, in particular the impact of bilocality and, with groups, the possibility of multiple loci.

Many of the elements that constituted the traditional frame of psychotherapy are undergoing significant modification. First, there are the scheduling constraints, finding days and times that are mutually available, even if standard 45- or 50-minute session times are sustained. Generally, one or both partners may find themselves engaging outside usual business hours for their locale. There can be different days to hold in mind, when appointment times cross the international date line, and the need for awareness of the variable application of daylight savings time (there are no standard dates for this to begin and end, and some countries do not use it, not to mention crossing the equator, which inverts seasons). Local orientation is not sufficient for either party just to begin the connection. Then, there is the quality of connectedness in terms of equipment and signal, which can be further complicated by affects engendered by the process, as I discuss in more detail later.

Psychological dislocation based on the bilocality of the environments in using these media has deconstructed the physical containment of the therapy office. The foreground tends to be dominated by the upper torso and head with gaze and eye-contact shifted to the webcam's perspective. This can be used therapeutically (Sehon, 2013), at times functioning as if between the experience of being on the couch and directly face to face. The background, however, can be more disparate: day/night differences in some cases; weather differences; outside noises, some perceivable, some not; if there are windows in the rooms of each participant then what can be seen out those windows may enter the field, and so on. The room that each participant is in and their attire can vary from what would be seen in the office. There

is a tendency for the greater informality on Skype, and analysands are often in their own homes, sometimes in different rooms, so there is a window into those spaces that in traditional therapy would have been far less likely to be seen. While these and related elements are usually not the focus of the treatment, they do impact feelings, for example, of familiarity, perhaps at times a compensation for working across languages and cultures.

The mutually available environment of the other does set up a temporarily conjoined pair of ecological frames, separate yet virtually available. This can be acknowledged, discussed, or ignored but is part of the field in which the dyad moves. There is a decentering of the psychological space of the therapy in this; the emergent, analytic third engendered in the treatment is not localizable in either room, as it has been felt and been handled in traditional settings, but must be enfolded into the gestalt of the encounter that includes a co-constructed therapy space replete with explicit and implicit cultural components. This delocalizing of the analytic third may be subtly shifting consciousness toward a larger or broader view of the psyche itself. Perhaps this reflects a movement that has been under way since the development of the teletechnologies in the second half of the nineteenth century and which informed early metaphors of psychoanalysis, such as Freud's ideas of listening to the unconscious of the patient as if hearing through a telephone receiver, already the beginnings of delocalization. As the therapy community spends more time in virtual encounters, we are likely to record the changing nuances in how we perceive psychic reality.

This brings me to my final topic, the curious behavior of telecommunications software during times of heightened affective charge, such as now moments. For the last several years, I have been observing and recording the disruptions and moments of failures of the internet connectivity as parallel to affective states. To start, there is no simple one-to-one correlation, but there are clear trends. Some have noted the "uncanny" qualities of these moments (Dettbarn, 2013) and are prone to see them as manifestations of repressed dynamics. Others have looked at synchronicities occurring in clinical practice, though often without specific mention of the impact of telecommunication (Roxburgh et al., 2015, 2016).

My anecdotal observations are that a frequently crescendoing affect in the background of a therapy discussion can be matched by a temporary loss of connectivity. On a number of occasions, this loss has either been reversed by a short wait or by a reconnecting call. What is more striking is

how various forms of these losses have occurred only once during the 50 minute session, which then proceeds without interruption or loss of quality of signal for the rest of the session. This has become evident to a number of clients to whom it has happened, so that open discussion of the event becomes part of the process. It is important not to jump to conclusions or misattribute every disruption as an indicator of affect charge that must emerge from the material. However, the pattern recurring in numerous sessions for a single client, and for different clients under a range of circumstance, does cause me to raise the question of whether these and related events reflect MoC.

Jung's attempts at an astrological experiment, which "failed," point to a similar dynamic. In that study, the initial positive response was statistically significant, but as the excitement of the researchers wore off, the results began to lose significance and returned to baseline (Jung, 1960).[3] While there are several potential explanation for the skewed statistics, Jung's more general conclusion seems valuable. He noted that synchronistic events, which I would reclassify as MoC, occur when an archetype has been constellated and that this brings affectivity into play. He says, "This observation has been thoroughly confirmed, and it suggests that the psychic factor which modifies or even eliminates the principles underlying the physicist's picture of the world is connected with the affective state of the subject" (1960, para. 980).

Since Jung did not develop a scale of synchronistic events based on their frequency versus their intensity, the degree of constellation of the archetype has also not been assessed. I believe this to be a shortcoming and suggest that embracing an MoC perspective will allow research on now moments with select conversion to moments of meeting to be coupled with an exploration of the conditions under which such events are actually reflective of a more complex dynamic unfolding. This could be subsequently unpacked to explore both the degree of archetypal constellation and whether this is linked to the intensity (and frequency?) of MoC events. One tool that may assist in such studies would be the creative use of internet technologies that can be measures of multiple variables operative during events, such as a Skype analysis.

Conclusion

The utility of the moment of meeting approach to defining therapeutic action has received wide endorsement, especially within relational

psychoanalysis. The application of this approach within the Jungian community has similarly been steadily growing over the last decade, though perhaps at a slower pace. This paper has attempted to review these gains as a context for further developments.

One of the more distinctive features of the Jungian view of the psyche is the degree of non-locality embraced by the theory. When combined with an interactive field model and complexity theory, this leads to a potentially useful extension of the moments of meeting perspective toward what I am calling a moments of complexity viewpoint. Seemingly enigmatic events, which occur in deep analyses, can through this perspective be better integrated into general therapeutic practice.

The turn toward complexity has occurred in part as a consequence of rapid enhancement of information sharing, especially with the rise of the internet and the many related phenomena. As increased stabilization of signals, with greater bandwidth, has become available, the use of electronic telecommunications such as Skype has gained an ever-greater place in the practice of psychotherapy.

Because of the inherent non-local aspects in telecommunication, the phenomena explored in this chapter are, I believe, becoming more commonly observed by clinicians from many different orientations. The hope is that a broader multi-school synthesis will emerge to produce a truly twenty-first-century psychotherapy. This book seems an important contribution towards that end.

Notes

1 Daniel Stern, Lou Sander, Karlen Lyons-Ruth, Nadia Bruschweiller-Stern, Alexander Morgan, Jeffrey Nahum formed the initial core group (see: http://www.changeprocess.org/).

2 The dream involved the image of a centipede, which circumambulated her and then crawled on her arm; this was celebrated by a powerful woman in the dream and was followed by the centipede opening up a box. The dream and its details and the interpretation are more complex than can be elucidated here. However, the significant element here was my research on the amplification of the image of the centipede: “In Tahiti the two indigenous centipedes are regarded as shadows of the medicine gods, and are never disturbed or killed. If one can be induced to crawl over a sick person, that person will surely recover” (Leach, 1972, p. 206). While on the surface this might seem fortuitous, without cultural validity, the striking issue for me was that my wife at the time was a person with direct Tahitian heritage—this was

completely outside the conscious awareness of the client. The amplification helped orient me to the healing potential in the client's unconscious, which I was able to share with her at the time of the meeting discussed here.

3 As a part of his "Synchronicity" monograph (1960), Jung conduct a survey of married couples looking at conjunctions and oppositions between their sun, moon, Mars, Venus, ascendant and descendent signs. The initial results suggested significant correlations but this effect washed out as a greater number of results came in. Jung, however, did not attribute this solely to statistics but noted the affect of the investigators seemed an important component. Initially, as they obtained results that were confirming of the hypothesis, enthusiasm and interest ran high. After a while, they tapered off and, with the decreased investment of libido, the results seemed to fall off as well. Jung felt the affective component was a feature that had not previously been taken into account and argued for inclusion of a subjective factors (see 1960, ch. 2).

References

Aziz, R. (1990). *C. G. Jung's psychology of religion and synchronicity*. Albany, NY: State University of New York Press.

Baranger, M., and Baranger, W. (1964). El 'insight' en la situacion analitica [Insight in the analytic situation]. *Rev Urug Psicoanal* 6(1) [(1969). Reprinted in M. Baranger and W. Baranger, *Problemas del campo psicoanalítico,* 165–177. Buenos Aires: Kargieman].

Cambray, J. (2009). *Synchronicity: Nature & psyche in an Interconnected universe* (Fay Lecture Series). College Station, TX: Texas A & M University Press, 2009.

Cambray, J. (2011). Moments of complexity and enigmatic action: A Jungian view of the therapeutic field. *Journal of Analytical Psychology,* 56(2):296–309.

Carter, L. (2010). The transcendent function, moments of meeting, and dyadic consciousness: Constructive and destructive co-creation in the analytic dyad. *The Journal of Analytical Psychology*, 55(2): 217–227.

Crowther, C., and Schmidt, M. (2015). States of grace: Eureka moments and the recognition of the unthought known. *Journal of Analytical Psychology*, 60(1):54–74.

Dettbarn, I. (2013). Skype as the uncanny third. In: Scharff, Jill Savege (ed.) *Psychoanalysis Online*., London: Karnac, 15–25.

Frazier, J. (2015). Dying trees can send food to neighbors of different species via 'Wood-Wide Web.' In *Scientific American*, May 19

Ferro, A., and Basile, R., eds. (2009). *The analytic field: A clinical concept*. London: Karnac.

Hogenson, G. (2007). From moments of meeting to archetypal consciousness: Emergence and the fractal structure of analytic practice. In: Casement, Ann (ed.), *Who Owns Jung?* London: Karnac.

Hogenson, G. (2009). Synchronicity and moments of meeting. *Journal of Analytical Psychology*, 54(2):183–198.

Isaacs Russell, G. (2015). *Screen relations: The limits of computer-mediated psychoanalysis and psychotherapy*. London: Karnac.

Jung, C. G. (1929/1966). Problems of modern psychotherapy. In *The Practice of Psychotherapy*, *Collected Works* 16, Princeton, NJ: Princeton University Press.

Jung, C. G.. (1946/1966). The psychology of the transference. In *The Practice of Psychotherapy*, *Collected Works* 16, Princeton, NJ: Princeton University Press.

Jung, C. G.. (1946/1969). On the nature of the psyche. In *The Structure and Dynamics of the Psyche*, *Collected Works* 8, Princeton, NJ: Princeton University Press.

Jung, C. G. (1960). Synchronicity: An acausal connecting principle. In *The Structure and Dynamics of the Psyche, Collected Works 8*, Princeton, NJ: Princeton University Press.

Jung, C. G. (1963). *Memories, dreams, reflections*. New York: Vintage Books.

Jung, C. G. (1973). *Letters. vol. 1: 1906–1950.* (Ed. Gerhard Adler and Aniela Jaffé. Trans. R. F. C. Hull). London: Routledge and Kegan Paul.

Jacoby, M. (1984). *The analytic encounter: Transference and human relationship*. Toronto: Inner City Books.

James, W. (1961). *The varieties of religious experience*. New York: Collier Books.

Langs, R. (1976). *The bipersonal field*. New York: J. Aronson.

Leach, M., ed. (1972). *Funk & Wagnalls Standard Dictionary of Folklore, Mythology, and Legend*. New York: Funk & Wagnalls.

Main, R. (2004). *The rupture of time: synchronicity and Jung's critique of modern Western culture.* Hove and New York: Brunner-Routledge.

Mansfield, V., and Spiegelman, J. M. (1996). On the physics and psychology of the transference as an interactive field. *Journal of Analytical Psychology*, 41(2):179–203.

Nahum, J. P. (2005). The something more than interpretation revisited: Sloppiness and co-creativity in the psychoanalytic encounter. *Journal of the American Psychoanalytic Association*, 53(3):693–729.

Ogden, T. (2004). The analytic third: Implications for psychoanalytic theory and technique. *Psychoanalytic Quarterly*, 73(1):167–196.

Roxburgh, E. C., Ridgway, S., and Roe, C. A. (2015). Exploring the meaning in meaningful coincidences: An interpretative phenomenological analysis of synchronicity in therapy. *European Journal of Psychotherapy and Counselling*, 17(2):144–161.

Roxburgh, E. C., Ridgway, S., and Roe, C. A. (2016). Synchronicity in the therapeutic setting: A survey of practitioners. *Counselling and Psychotherapy Research*, 16(1):44–53.

Savege Scharff, J., ed. (2013). *Psychoanalysis online: Mental health, teletherapy, and training*. London: Karnac.

Savege Scharff, J. (2015). *Psychoanalysis online 2: Impact of Technology on development, training, and therapy*. London: Karnac.

Sehon, C. (2013). The screen as catalyst for psychic transformation. In : Scharff, Jill Savege (ed.), *Psychoanalysis Online*., London: Karnac, 137–146.

Simard, S. W., & Austin, M., eds (2010). The role of mycorrhizas in forest soil stability with climate change. In *Climate change and variability*. Sciyo. INTECH Open Access Publisher, 275–302.

Simard, S. W., Beiler, K. J., Bingham, M. A., Deslippe, J. R., Philip, L. J., and Teste, F. P. (2012). Mycorrhizal networks: Mechanisms, ecology and modelling. *Fungal Biology Reviews* 26:39–60.

Stern, D. N., Sander, L. W., Nahum, J. P., Harrison, A. M., and Tronick, E. Z. (1998). Non-interpretative mechanisms in psychoanalytic therapy: The "something more" than interpretation. *International Journal of Psychoanalysis,* 79:903–921.

Stern, D. N. (2004). *The present moment in psychotherapy and everyday life.* New York, London: W. W. Norton & Company.

Schwartz-Salant, N. (1991). Vision, interpretation, and the interactive field. *Journal of Analytical Psychology*, 36(3):343–366.

Tronick, E. Z. (2009). Multilevel meaning making and dyadic expansion of consciousness theory: The emotional and the polymorphic polysemic flow of meaning. In: Fosha, Diana, Siegel, Daniel J., and Solomon, Marion F. (eds), *The Healing Power of Emotion: Affective Neuroscience, Development & Clinical Practice.* pp. 86–111; New York: W. W. Norton & Co.

Chapter 4

The aesthetics of being

Mark Winborn

In this chapter, I focus on a particular facet of "moments of meeting," specifically, the role of aesthetic experience in facilitating moments of meeting in analytic therapy.[1] Moments of meeting can be considered in terms of the meeting of two individuals in an analytic dyad but also in terms of the discovery of one's own otherness or in the encounter with something transcendent. Even when not focused upon consciously, aesthetic sensibilities operate in the background of these moments, forming a milieu for other aspects of the analytic experience, especially the domains of experience more commonly attended to: meaning, affect, and relationality.

Aesthetics

Aesthetics can be narrowly defined as a branch of philosophy dealing with taste, the nature of art, and the appreciation of beauty. According to Glover (2009), the field of aesthetics is primarily concerned with four interwoven areas: the nature of the creative process, the experience of the artist, the interpretation of artistic creations, and the nature of the aesthetic encounter. Aesthetic formulations are frequently applied in the fields of art theory, literary theory, film theory, and music theory. However, the field of aesthetics has become quite broad, and there is significant debate about what constitutes the domain, or domains, of aesthetics (Tomlin, 2008; Mitias, 2012).

Budd (2008) indicates that aesthetic considerations cover a large number of categories: "aesthetic judgments, aesthetic pleasures, aesthetic values, aesthetic attitudes, aesthetic interest, aesthetic sensitivity, aesthetic properties, aesthetic character, aesthetic appreciation, aesthetic responses, and so on" (p. 17). Menke (2008) defines aesthetic experience as "a mode of self-reflection" (p. 66) that forms a dialectical tension with philosophical thought. For Hagman

(2005), aesthetic experience is, "not a quality of objects or sensations; it is an emergent phenomenon that arises in the transitional psychological zone in which our creative engagement with the world is lived" (p. 1). Hagman goes on to emphasize that aesthetic experience is fundamentally subjective, yet connected to objective qualities of the phenomenon being engaged. From this perspective, every aspect of our experience has an aesthetic dimension that organizes affect, perception, and relationship, thereby shaping how we register and engage the world around us.

I've previously written (Winborn, 2015) from a more general perspective on the need for an aesthetic sense in the analytic process. In that earlier work, I review the attitudes toward aesthetic experience reflected in the writings of Freud and Jung. Freud's views were fundamentally dismissive or overtly negative toward aesthetics while Jung's views are quite ambivalent about the role of aesthetics (Winborn, 2015, pp. 95–97). Later developments in the psychoanalytic literature are also reviewed regarding the place of aesthetics and its role in the psychoanalytic process (Segal, 1952; Meltzer, 1973; Meltzer & Williams, 1988/2008; Likierman, 1989; Hillman, 1983, 1998; Hillman & Ventura, 2007). In addition, I review evolutionary aspects of aesthetics (Dissanayake, 1995; Dutton, 2010); the neuroscientific exploration of aesthetic experience (Changeux, 2005; Damasio, 1994, 2009; Vartanian & Goel, 2004; Ramachandran & Hirstein, 1999; Ramachandran, 2009; Honan, 2011; Lacey, Stilla, & Sathan, 2012); the aesthetics of interpretation and narrative in analysis (Ogden, 1999; Spence, 1982; Beebe, 2010); and aesthetic metaphors in the analytic process, such as poetry (Ogden, 1997, 1998) and music (Nagel, 2013; Rose, 2004; Knoblauch, 2000).

Much of the dialogue about therapeutic process has focused on contrasts and differences within various schools and traditions of analytic therapy. This dialogue/debate has occurred throughout the history of psychoanalysis, resulting in a variety of schisms, skirmishes, or disagreements within the field. Conflicts arise over the influences on psychological development, the etiology of psychological disturbance, what is being analyzed, the role of the analyst, and what the vehicle or process of transformation is in analytic therapy. Often these debates emerge as rather dichotomized splits between an older position, which focuses on interpretive interventions as the main therapeutic catalyst (Oremland, 1991), and more recent positions that associate the process of transformation with affect regulation (Fonagy, Target, Gergely, & Jurist, 2002), relationality (Mitchell, 1998), or attachment patterns (Holmes, 2010). As Applebaum (1966) puts it:

> One reason for the persistently unsolved problem of the relations between intellect and emotion in the clinical process would seem to be their dichotomization, for conceptual and heuristic reasons. The data of psychoanalysis are unitary…. But the knowing of psychoanalytic data is neither solely factual nor solely emotional… the dichotomization between fact and emotion, as applied to insight, is bridged by Richfield who, quoting Bertrand Russell, makes the distinction between knowledge by *description* and knowledge by *acquaintance*
>
> (p. 464).

Bion and the aesthetic vertex

Bion's model of the psychoanalytic endeavor offers us an avenue out of this pattern of dichotomization that splits our field and limits our clinical vision. Bion achieves this by integrating a consideration of aesthetic experience in his model of analytic process. The emphasis Bion (1999) places on mutual aesthetic experience in analytic therapy can be seen in the following:

> It is very important to be aware that you may never be satisfied with your analytic career if you feel that you are restricted to what is narrowly called a "scientific" approach. You will have to be able to have a chance of feeling that the interpretation you give is a beautiful one, or that you get a beautiful response from the patient. This aesthetic element of beauty makes a very difficult situation tolerable. It is so important to dare to think or feel whatever you do think or feel, never mind how un-scientific it is (concluding paragraph).

Bion (1990) utilizes the metaphor of space to describe the atmosphere necessary to create the freedom of experience and perspective required for the psychoanalytic encounter:

> Not geographical space, not classical space, not geocentric space, but this other space – let us call it scientific space, or religious space, or aesthetic space…If we want to know something about religion, or aesthetics, or science, we have to tolerate infinity
>
> (p. 22).

According to Bion, any psychoanalytic experience is inherently limited unless it is approached from multiple vertices. As Grinberg, Sor, and Tabak de Bianchedi (1993) describe Bion's model: "Each vertex refers to a particular 'point of view,' 'angle,' or 'perspective' from which one tries to understand and then to communicate a particular experience" (p. 105). Therefore, each encounter would be experienced differently depending upon which vertex one is operating from. While there are many possible vertices to consider, including one's individual subjectivity, Bion proposed that analytic encounters can be experienced and reflected upon from any of three primary vertices: the religious vertex, the aesthetic vertex (sometimes also referred to as the artistic vertex), or the scientific vertex (Williams, 2005). The interaction between these vertices is summarized by Panajin (2015):

> For Bion, the disciplined mind had to embody three vertices: scientific, aesthetic, and religious. The scientific vertex allows appropriate distance to observe the evolution of the emotional experience both in the patient and the analyst….The aesthetic vertex needs the aesthetic object, which holds the tension between artistic, religious and scientific vertices until the evolution of the symbol that contains what is meaningful at any given moment. The artistic vertex allows a pattern to emerge and appreciates the "beauty of a harmony and the facts we choose that contribute to this harmony" (Poincare). The religious vertex is the appreciation of the unknown, the awe, the mystery of the unknown as we tolerate it. The epistemology of not knowing and being able to enjoy the state of waiting
>
> (p. xvii).

Therefore, each vertex has its unique strengths and deficits. According to Bion (1990):

> It would seem absurd if the tension between these three groups—science, religion and art—which are all fundamentally devoted to the truth, was either so slack or so tense that it was unable to further the aim of truth
>
> (p. 62).

He perceived science, art, and religion as complementary vertices of knowledge or "devotion to the truth" that were "equally important to

psychoanalysis and that needed to be brought into fruitful communication" (Williams, 2005, p. 127). Taken together these three vertices make up the psychoanalytic vertex that Bion suggests is always oriented toward "O," which is Bion's term of the unknowable, transcendent, emerging, evolving edge of experience—much as Jung describes the Self and the archetypes.

Bion, like Jung, articulates a prospective aspect of psyche. For Jung, this is conceptualized as the individuation process, and for Bion it takes the form of "coming into being," most specifically the effort of the mind to "come into being." Although Bion often wrote cryptically and intentionally left many of his concepts unsaturated, Symington (2001) captures the essence of Bion's references to "coming into being":

> What generates the 'individual psychological birth' is a creative act. This is what brings the person into being. It implies that if this does not occur, then a person does not come into being. Wilfred Bion's writings are sprinkled with references to the difference between being a person and being just like a person…it is a creative act that brings the person into being. What existed before was a number of bits or fragments, and the creative act welds them together into a person…. Bion's clinical technique aimed to assist in bringing this about. As these different parts of the personality surfaced, so he named them, making it possible thereby for that generative creative act to occur which would weld them into that compound that we call a person (p. 195).

A focus on aesthetics in the analytic setting moves us away from correctness, rightness, or accuracy of interpretation and into a perspective which places value on narrative suitability, beauty, and evocativeness. However, Ogden (1999) rightly warns against an overt effort to make beautiful sounding or poetic interpretations but rather encourages sensitivity to the feel, flow, and tone as an interpretation emerges in response to reverie. An aesthetic sense revolves around "goodness of fit" with the patient (i.e., whether my "style" meshes well with their "style)." This can be seen in the patient's experience of my analytic space and how they choose to utilize the space. Thus, the consulting room and our interactions come to reflect the mutual creation of our aesthetic responses.

Williams (2012) writes,

> This refined the picture of the container-contained within the psychoanalytic transference, making it clear that it was the "fitting together" of the analyst's attention and the patient's cooperativeness, that constituted the container and made the psychoanalytic process itself into the aesthetic object
>
> (p. 5).

We might think of aesthetic containment as a process by which experiences of ugliness, not just pain or emotional disturbance, can be transformed and new aesthetic creations of the mind can emerge. As Mitrani (1998) points out, a sense of containment is created in the infant's entire experience of the mother: her smell, tone of voice, sense of the mother's body, and the receptivity of the mother's mind to the emerging mind of the infant. In similar fashion, the aesthetic sensitivity of the analyst is manifested in terms of the physical aspects of the room, tone of voice, aesthetic reverie, embodiment, and choice of words. We can think of this as related to Winnicott's (1965) concept of the "environmental mother" or Sandler's (1960) concept, "the background of safety."

At this point, I distinguish between a meditation on beauty and a sensitivity to aesthetics. An aesthetic focus may include a focus on attributes of beauty and ugliness, aesthetic responsiveness and anesthetic non-responsiveness, or harmony and dissonance. As Lee (2003) indicates, we must look "beyond the beautiful" and to recognize that "beauty takes many forms and to deny elements of dissonance in therapy is to deny the essence of the work itself. By expanding our views on the aesthetic, so we will broaden our views on therapy itself" (p. 3).

The aesthetic vertex comes prominently into focus when the analytic process is viewed through the metaphor of improvisation in jazz (Barrett, 2000; Knoblach, 2000, 2005). Jazz improvisation is a unique form of musical creation that relies on a minimum of guidelines (typically an agreed-upon chord structure, tempo, and time signature) to structure what the musicians will play— allowing them just enough structure to avoid falling into chaos and cacophony while allowing sufficient freedom of expression that original musical creations can emerge spontaneously from the interactive-reactive engagement of the musicians. Under conducive circumstances, the unfolding musical result will be experienced as having an element of surprise, an organic sense of connectedness between the musicians, and the musicians involved often report a shared "groove"

that transcends their individual efforts. Largely aesthetic considerations determine whether an individual musician's contribution to the emergent music is seen as valuable or well-fitting contribution.

The neural activity of improvising jazz musicians has been studied utilizing fMRI technology (Limb & Braun, 2008; Donnay, Rankin, Lopez-Gonzalez, Jiradejvong, & Limb, 2014). The authors found that improvising music activates areas of the brain normally involved in syntactical (the internalized rules of grammar that determine how words and phrases fit together) processing of language, while deactivating the areas associated with semiotics (associated with the specific meaning of words and sentences). In literature, syntax is seen as one of the tools used by writers to create the tone, atmosphere, and mood of a story (i.e., one could say the intangibles of the story). Cureton (1980) argues that it is often syntactical elements in poetry that shape the overall aesthetic appeal of poetry. The authors of the jazz research argue that their findings support a hypothesis that neural regions for syntactic processing are not domain-specific for language but instead may be domain-general for communication. Overall, their findings are in keeping with Bromberg's (1991) assertion that each analytic dyad "create their own unique intersubjective aesthetic of unconscious communication" (p. 420). A focus on aesthetics provides a bridge or link between the domains of syntax and semantics, interpretation and relationality, embodied experience and thought. The aesthetic vertex provides an integrative, unifying instrument that infuses the other domains of analytic experience.

A clinical example

Sensing and engaging the aesthetic vertex has been a central part of the analytic process with Michael. When Michael initially began analytic therapy, I was struck by the sense of anxiety and impending devastation that permeated his being. Every breath and movement seemed labored. For months, his speech was fragmented, halting, and disrupted—often punctuated with deep sighs or self-directed curses muttered under his breath. His thoughts would begin to careen tumultuously almost as soon as he began a sentence, the words he initiated frequently being overtaken by competing thoughts or efforts to suppress forbidden thoughts. It was often difficult to follow the semantics of Michael's efforts to verbalize his distress, but it was possible to register the aesthetic revulsion that Michael experienced toward his own life and being. The dissonance and rhythmic

disruption of his speech communicated as much as, if not more than, the content of his speech. It seemed clear that Michael perpetually existed in the realm of the "catastrophic chaos" (Bion, 1970, 1977) where "nameless dread" (Bion, 1994) predominates. I also sensed that much of what Michael so painfully struggled to articulate was not yet represented in his mind, reflecting non-represented bits of experience (Botella & Botella, 2005; Levine, Reed, & Scarefone, 2013; i.e., beta elements [Bion, 1970]).

Another salient aesthetic feature of our interactions was Michael's imploring eyes, which brought to mind the oversized dark eyes characteristic of Margaret Keane's paintings. As we began, and for months afterward, those eyes reflected a desperation and despair. His eyes seemed to plead for something yet unformulated in his own thoughts (Bollas, 1987).

During our early sessions, I offered little in the way of historical reconstructions or the formation of hermeneutic links. More often I offered small bits of assistance in the articulation of experiences he seemed unable to describe or for which he was conflicted about speaking aloud. Often his words were so sparse or halting that I relied heavily on my reverie that Bion (1978) associates with the container/contained relationship between mother and infant and the mother's ability to utilize her alpha function in the service of the infant's emerging mind (see also Winborn, 2014). Reverie creates space for aesthetic experience to emerge and temporarily interrupts the focused activity of the analyst's mind that seeks to be therapeutic. For example, during one session, Michael mentioned that he felt he was always striving. Inwardly, I was struck by a deep sense of weariness from struggle and said, "It's exhausting always living on the edge of apocalypse" to which he replied simply, "It is." Another time, Michael was speaking again about his feeling of ambivalence toward his wife and I interpreted, "She's simultaneously your savior and your obstacle to feeling whole."

As Michael's narrative emerged, he revealed that he and his parents immigrated to the United States when he was still a young child, although he has memories from his country of birth. As he reports it, the move resulted in a huge rupture in his life, which he now recalls as a loss of homeland, religious culture and belief, identity, and extended family. The move to the United States is also experienced by Michael as a catalyst for longstanding conflicts between his parents, which he felt it was his duty to mediate. He experiences his mother as being beautiful but distant; never interested in his thoughts, and seeking only to control his actions. His father is portrayed as a worrying monologist, full of opinions, generally unavailable, and critical

of Michael's physical clumsiness as a child. Ultimately, he has the sense that neither parent has been available to him throughout his life, leaving him with an intense desire: to be listened to, interacted with, for intimacy, for masculine mentoring, and craving aesthetic sustenance. Yet, at the same time, Michael also fears encountering these experiences. Michael describes a long period, from college throughout most of his adult life, in which he has just barely been surviving on a psychological level.

For Michael, there has been little respite from an ongoing sense of struggle, deadness, decay, danger, despair, and lack of beauty in his life. During an early session, Michael said, "I feel there's something unattractive in me. My effort is to hide or contain that ugliness so I won't be abandoned." Each day feels as if everything he has could disintegrate or unravel in a moment. Making decisions in the face of these fears is debilitating, and he often experiences himself as paralyzed, unable to shift from a passive survival of life. Often, his anxiety is manifest through his worry that he will not get sufficient sleep to function, that he will become constipated, or that he'll be unable to perform sexually. In fact, all of life feels like a performance for him: a performance that he always feels he is on the verge of failing. Everything feels as if it hangs in the balance. Everything about himself and his life is unpleasant aesthetically to him—lacking in form pleasing to him. Early on, Michael confessed an intense longing for beauty that is constantly eroded by preoccupation with minor imperfections.

The central role of the mother in mediating and developing an aesthetic capacity is reflected in Michael's narrative. There is a conceptual thread of developmental theory that focuses on the infant's early relationship to the mother as the beginning of aesthetic experience and capacity. This thread originates with Meltzer's (1973) concept of the "aesthetic conflict" and continues through to Bollas' (1978) "aesthetic transformational object"; Likierman's (1989) "aesthetic halo"; and Mitrani's (1998) integration of related concepts from Tustin, Bion, and Meltzer. Meltzer (1988) proposes, "This is the aesthetic conflict, which can be most precisely stated in terms of the aesthetic impact of the outside of the 'beautiful' mother available to the senses, and the enigmatic inside which must be construed by creative imagination" (p. 22). Bollas (1978), expanding on Meltzer's work, states:

> The epistemology of the aesthetic moment is prior to representational cognition, and speaks that part of us where the experience of rapport with the other was the essence of being….The mother's idiom of care

> and the infant's experience of this handling is the first human aesthetic. It is the most profound occasion where the content of the self is formed and transformed by the environment. The uncanny pleasure of being held by a poem, a composition, a painting, or, for that matter, any object, rests on those moments…when the infant's internal world is given form by the mother. This first human aesthetic informs the development of personal character….and will predispose all future aesthetic experiences that place the person in subjective rapport with an object.

Likierman (1989) continues the extension of Meltzer's conceptualization by arguing that all that is experienced as "good" early in life is experienced first as sensory-aesthetic experience that forms a buffer against bad experiences, a buffer that also has the potential to serve as a bridge into an integrated whole-object experience of the depressive position.[2] As Likierman (1989) puts it, "We endow all that we value with an unconscious aesthetic 'halo', so that the 'good' is never conceptualized without accompanying unconscious aesthetic phantasies" (p. 148). Clearly, the implications for Michael are devastating. Michael's mother exists in his mind as an object of beauty but one unavailable to him: a mother imago with which he has no internalized sense of rapport. The "transformational object" that could potentially serve as Michael's portal to aesthetic experience is undeveloped, and the "aesthetic halo," which optimally serves as a buffer against "bad" experience, does not exist.

It is difficult to pinpoint specific critical turning points or interpretations in the analytic process that have occurred with Michael. My sense is that most of the transformation that has occurred has come from the session to session metabolization of his terror and my engagement with his sense of the unaesthetic in his life. Transformation in Michael's case has not come through insightful interpretations, although interpretation is a necessary part of communicating the aesthetic. Nor has transformation come with deep insights into the workings of Michael's internal object world, although such insights have been useful as well. The transformational process has begun as a result of recognizing Michael's *aesthetic deficit*, attempting to bring an aesthetic attunement to his analytic process and through interpretations framed around the aesthetic vertex. It has also been transformative for Michael to discover bits of poems, literature, music, and movies that he could utilize to amplify his own experiences and internal states, even when the experience being depicted in these various pieces of art was painful or

superficially unappealing. These discoveries allowed him to invest some of his own experiences with the aesthetic he associated with the poem or other material—acquiring a bit of the "aesthetic halo" articulated by Likierman (1989) or the "transitional aesthetic object" described by Bollas (1978) that had previously been undeveloped in his psyche.

Throughout Michael's analytic process, there has been a recurrent fear of ridicule, disparagement, rejection, and abandonment in the transference. His use of the couch, beginning 3 months into the process, initially intensified those fears. Over time, Michael has become more revealing of fantasies involving darker, erotic themes (some of which have included me). My engagement with him around these fantasies, rather than rejecting or humiliating him as he anticipated, has resulted in Michael's more overt expression of enjoyment of the sessions and a greater sense of safety in exploring his interior life more openly.

Over time, Michael's eyes have somehow become eyes carrying more recognition of my presence in the room as an "other," mixed also at times with curiosity, connection, and gratitude. His speech has become less interrupted; more flowing and developed. While his speech can still be punctuated with some inwardly felt pain or struggle, he is able to communicate in a way that is more aesthetically engaged, from both his perspective and mine. As Michael began to speak more fluidly, I found myself needing to intervene less. Much of the time he is able to sustain his own thoughts. I am able to listen in a different way now, having to expend much less energy attempting to hold together my mind and thoughts in the presence of his disjointed thinking and speech. My thoughts less frequently feel under attack by the witnessing of his attacks on his thoughts.

Slowly there are becoming more moments in which Michael's recognition of the aesthetic element in his life is emerging: as he listens to music in the evening, as he allows his thoughts to drift to the beautiful complexity of space, as he reflects on the nature of the universe, or in his deepening appreciation for works of literature. Gradually, Michael's dream life has also begun to shift. His nocturnal dreams frequently reflected the waking nightmare he could never wake up from. For many years, his dreams revolved around recurrent images of decay, attack, bullying, and loss. As his waking experience has shifted, his dreams have begun to reveal themes of renewal and glimmers of transcendence.

My capacity to process, share in, and respond to Michael's experiences on an aesthetic level has been central to the transformations I have observed in his

affect, speech patterns, interactive style, and his opening to life as something beyond dread or mere survival. Ultimately, it is the openness to the aesthetic vertex that has allowed Michael and me to facilitate his ongoing project of "coming into being" and for him to begin to develop a sense "of being" that can sustain him rather than remaining caught in a pervasive sense of deadness and incipient doom. As Dimen (2013) puts it, "The psychoanalytic session is a chance to say the unspeakable and think the unthinkable. To imagine what does not yet exist" (p. 61). Only by metabolizing and facilitating the unrepresented bits of experience and by engaging experiences that have seemed horrifying and unaesthetic to Michael has space begun to open in his mind for things of beauty and experiences of transformation.

As the case of Michael illustrates, the aesthetic vertex is encountered on a variety of levels: (1) the implicit level of communication that focuses on the sensuous and non-sensuous feel of the interaction and setting; (2) through interventions or interpretations intended to speak to the aesthetic level of experience; (3) and through the aesthetic quality of mutually enjoyed discussions around books, poems, movies, music, or art—which Ogden (2007) notes can sometimes be engaged in as "talking as dreaming."[3] This is not to say that Bion's other vertices—the religious vertex and the scientific vertex—have not been present during Michael's therapy. There were certainly instances when reconstructive or transference interpretations were offered and other times where his Michael's religious vertex—the search for the transcendent experience beyond the grim appearance of his day to day existence—was the most prominent vertex in the room. However, the aesthetic vertex was ever present, even when these other vertices were in ascendance. It is an extended meditation on the aesthetic aspects of Michael's experience and our interactions, a long series of aesthetic moments, that has allowed Michael to begin welding together the bits of unintegrated experience and to begin his process of "coming into being."

Conclusion

Aesthetic sensitivity and responsiveness in the analytic process from both analyst and patient offers a connection between domains of analytic experience that often appear superficially in conflict. A sensitivity to aesthetic experience in the analytic encounter creates a bridge between relationality and interpretation, allowing these domains to become mutually reinforcing, interactive experiences. The resulting aesthetic

moments are a combination of affectively engaged relational meeting and symbolized interactions in verbalized form and in actions.

While the aesthetic vertex is not so palpable in the analytic encounter with all patients, it remains part of the matrix for all analytic processes. When analytic therapy is going well, the analytic dyad often creates or discovers a shared space of positive aesthetic experience, even of beauty. When the process is not going well, the dyad often enters a field characterized and dominated by a sense of ugliness or the absence of beauty. As Civitarese (2014) indicates, "The beautiful also always confronts us with the spectacle its own transience and loss" (p. 1076). The aesthetic struggle, which goes on during the analytic encounter between the polarities of beauty and ugliness, outlines a process of "coming into being." It is in this mode that we can speak of an "aesthetic of being."

Notes

1 Throughout this chapter, I most often use the phrase *analytic therapy* to refer to both psychoanalytic psychotherapy and psychoanalysis. I support Waska's (2007) position which argues that a distinction between psychoanalysis and various psychoanalytic therapies based on issues such as frequency and the use of the couch largely serves a divisive political agenda within psychoanalytic communities rather than delineating actual differences in processes based on technical and clinical issues. Hence, I choose the term *analytic therapy* to refer to therapeutic processes that focus primarily on the role of the unconscious in psychic life.
2 The concept of the depressive position is a psychological developmental state articulated by Melanie Klein in which whole-object relatedness predominates and in which object loss can be tolerated and grieved.
3 Ogden (2007) describes "talking-as-dreaming" as an intermediary form of non-interpretive "improvisational" (p. 587) activity engaged in by analyst and analysand. As proposed by Ogden, for those patients initially unable to dream themselves into existence, "talking-as-dreaming" can lead to the ability to dream and to utilize dreaming in the process of coming into existence.

References

Appelbaum, S. A. (1966). Speaking with the second voice—evocativeness. *Journal of the American Psychoanalyses Association*, 14:462–477.

Barrett, F. J. (2000). Cultivating an aesthetics of unfolding: Jazz improvisation as a self-organizing system. In S. Linstead and H. J. Hopfl (eds.), *The aesthetics of organizations.* London: Sage Press.

Beebe, J. (2010). Psychotherapy in the aesthetic attitude. *Journal of Analytical Psychology*, 55:165–186.
Bion, W. R. (1970). *Attention and interpretation*. New York: Basic Books.
Bion, W. R. (1977). *Transformations.* New York and London: Aronson.
Bion, W. R. (1978). *Second thoughts: Selected papers on psychoanalysis.* Northvale, NJ, and London: Aronson.
Bion, W. R. (1990). *Brazilian lectures: 1973 São Paulo, 1974 Rio de Janeiro/São Paulo*. London: Karnac.
Bion, W. R. (1994). *Learning from experience.* New York and London: Aronson.
Bion, W. R. (1999). Wilfred Bion: A seminar in Paris—1978. Retrieved from http://braungardt.trialectics.com/sciences/psychoanalysis/bion/seminar-in-paris/
Bollas, C. (1978). The aesthetic moment and the search for transformation. *Annual of Psychoanalysis*, 6:385–394
Bollas, C. (1987). *The shadow of the object: Psychoanalysis of the unthought known.* New York: Columbia University Press.
Botella, C., & Botella, S. (2005). *The work of psychic figurability*. London: Routledge.
Bromberg, P. (1991). On knowing one's patient inside and out: The aesthetics of unconscious communication. *Psychoanalytic Dialogues,* 1:399–422.
Budd, M. (2008). Aesthetic essence. In R. Shusterman and A. Tomlin (eds.), *Aesthetic experience*. New York and London: Routledge.
Changeux, J. (2005). Creation, art and the brain. In J. Changeux et al. (eds.), *Neurobiology of Human Values*. Berlin: Springer-Verlag.
Civitarese, G. (2014). Bion and the sublime: The origins of an aesthetic paradigm. *International Journal of Psychoanalysis*, 95:1059–1086.
Cureton, R. (1980). The aesthetic use of syntax: Studies on the syntax of the poetry of E. E. Cummings. (Doctoral dissertation, Linguistics, University of Illinois at Urbana-Champaign.)
Damasio, A. (1994). *Descartes' error: Emotion, reason, and the human brain.* New York: Avon Books.
Damasio, A. (2009). *Evolutionary origins of art and aesthetics: Art and emotion.* CARTA Conference, Salk Institute, San Diego, CA.
Dimen, M. (2013). *Sexuality, intimacy, power*. New York and London: Routledge.
Dissanayake, E. (1995). *Homo aestheticus: Where art comes from and why*. Seattle, WA: University of Washington Press.
Donnay, G. F., Rankin, S. K., Lopez-Gonzalez, M., Jiradejvong, P., & Limb C. J. (2014). Neural substrates of interactive musical improvisation: An fMRI study of "trading fours" in jazz. PLoS ONE 9(2):e88665.
Dutton, D. (2010). *The art instinct: Beauty, pleasure, and human evolution*. New York: Bloomsbury USA.
Fonagy, P., Target, M., Gergely, G., & Jurist, E. (2002). *Affect regulation, mentalization, and the development of the self.* New York: Other Press.
Glover, N. (2009). *Psychoanalytic aesthetics*. London: Karnac.

Grinberg, L., Sor, D., & Tabak de Bianchedi, E. (1993) *New introduction to the work of Bion*. Northvale, NJ, and London: Aronson.

Hagman, G. (2005). *Aesthetic experience: Beauty, creativity, and the search for the ideal.* Amsterdam, New York: Rodopi.

Hillman, J. (1983). *Interviews*. Dallas, TX: Spring.

Hillman, J. (1998). The practice of beauty. In B. Beckley and D. Shapiro (eds*.), Uncontrollable beauty: Toward a new aesthetics*. New York: Allworth Press.

Hillman, J., and Ventura, M. (2007*). We've had a hundred years of Psychotherapy—and the world's getting worse*. New York: Harper-Collins.

Holmes, J. (2010). *Exploring in security: Towards an attachment informed psychotherapy.* New York and London: Routledge.

Honan, D. (2011) *This is your brain on Shakespeare*. Retrieved from http://bigthink.com/how-to-think-like-shakespeare/this-is-your-brain-on-shakespeare

Knoblauch, S. (2000). *The musical edge of the therapeutic dialogue*. Hillsdale, NJ: The Analytic Press.

Knoblauch, S. (2005). Body rhythms and the unconscious: Toward and expanding of clinical attention. *Psychoanalytic Dialogues,* 15:807–827.

Lacey, S., Stilla, R., and Sathian, K. (2012). Metaphorically feeling: Comprehending textural metaphors activates somatosensory cortex. *Brain & Language*, 120:416–421.

Lee, C. (2003). *The architecture of aesthetic music therapy.* Gilsum, NH: Barcelona Publishers.

Levine, H., Reed, G., & Scarfone, D. (2013). *Unrepresented states and the construction of meaning: Clinical and theoretical considerations*. London: Karnac.

Likierman, M. (1989). Clinical significance of aesthetic experience. *International Review of Psychoanalysis*, 16:133–150.

Limb C. J., & Braun A. R. (2008) Neural substrates of spontaneous musical performance: An fMRI study of jazz improvisation. *PLoS ONE* 3(2): e1679. doi:10.1371/journal.pone.0001679

Meltzer, D. (1973). On the apprehension of beauty. *Contemporary Psychoanalysis*. 9:224–229.

Meltzer, D. (1988). The aesthetic conflict: Its place in the development process. In D. Meltzer & M. H. Williams, *The apprehension of beauty: The role of aesthetic conflict in development, art and violence*. London: Karnac.

Meltzer, D., & Williams, M. H. (1988/2008). *The apprehension of beauty: The role of aesthetic conflict in development, art, and violence.* London: Karnac.

Menke, C. (2008). The dialectic of aesthetics. In R. Shusterman and A. Tomlin (eds.), *Aesthetic experience*. New York and London: Routledge.

Mitias, M. M. (2012). *Possibility of aesthetic experience*. New York: Springer.

Mitrani, J. (1998). Unbearable ecstasy, reverence and awe, and the perpetuation of an "aesthetic conflict." *Psychoanalytic Quarterly*, 67:102–127

Mitchell, S. (1998). *Relational concepts in psychoanalysis: An integration.* Boston, MA: Harvard University Press.

Nagel, J. (2013). *Melodies of the mind: Connections between psychoanalysis and music.* London: Routledge.
Ogden, T. (1997). Some thoughts on the use of language in psychoanalysis. *Psychoanalytic Dialogues*, 7:1–21.
Ogden, T. (1998). A question of voice in poetry and psychoanalysis. *Psychoanalytic Quarterly*, 67:426–448.
Ogden, T. (1999). The music of what happens in poetry and psychoanalysis. *International Journal of Psychoanalysis*, 80:979–994.
Ogden, T. (2007). On talking-as-dreaming. *International Journal of Psychoanalysis*, 88:575–589.
Oremland, J. (1991). *Interpretation and interaction: Psychoanalysis or psychotherapy.* Hillsdale, NJ: Analytic Press.
Panajian, A. (2015). *Preface*. In P. S. Sandler (ed.), *An introduction to W. R. Bion's a memoir of the future: volume two: Facts of matter or matter of fact?* (xiii–xx). London: Karnac.
Ramachandran, V. S., & Hirstein, W. (1999). The science of art: A neurological theory of aesthetic experience. *Journal of Consciousness Studies*, 6:15–51.
Ramachandran, V. S. (2009). *Aesthetic universals and the neurology of art.* CARTA Conference, San Diego, CA: Salk Institute..
Rose, G. (2004). *Between couch and piano: Psychoanalysis, music, art and neuroscience*. New York: Brunner-Routledge.
Sandler, J. (1960). The background of safety. *International Journal of Psychoanalysis,* 41:352–356.
Segal, H. (1952). A psycho-analytical approach to aesthetics. *International Journal of Psychoanalysis*, 33:196–207.
Spence, D. (1982). *Narrative truth and historical truth: Meaning and interpretation in psychoanalysis.* New York: W. W. Norton.
Symington, N. (2001). *The spirit of sanity*. London: Karnac.
Tomlin, A. (2008). Introduction: Contemplating the undefinable. In R. Shusterman and A. Tomlin (eds.), *Aesthetic experience*. New York and London: Routledge.
Vartanian, O., & Goel, V. (2004). Neuroanatomical correlates of aesthetic preference for paintings. *Cognitive Neuroscience and Neuropsychology*, 15:893–897.
Waska, R. (2007). *The concept of analytic contact.* London: Routledge.
Williams, M. H. (2005). The three vertices: Science, art and religion. *British Journal of Psychotherapy*, 21:429–441.
Williams, M. H. (2012). The genesis of the "aesthetic conflict." Retrieved from http://www.artlit.info/pdfs/GenesisAesthetic.pdf
Winborn, M. (2014). Watching clouds together: Analytic reverie and participation mystique. In M. Winborn (ed.), *Shared realities: participation mystique and beyond.* Skiatook, OK: Fisher King Press.
Winborn, M. (2015). Aesthetic experience and analytic process. *International Journal of Jungian Studies,* 7:94–107.
Winnicott, D. W. (1965). *The maturational processes and the facilitating environment*. New York: International Universities Press.

Chapter 5

States of grace

Eureka moments and the recognition of the unthought known

Catherine Crowther and Martin Schmidt

Introduction

We were invited to work together to present a joint paper to the Society of Analytical Psychology in February 2013. This is the result of our collaboration, which takes the form of a dialogue between us.

At the outset of this project, we found that we share an interest in moments in analysis when there is a sudden realization, a shared expansion of consciousness evoked by the emergence of a thought or image, which profoundly changes the quality of relating between patient and analyst. Either the patient or the analyst thinks and/or says something that does not feel composed by either one; rather, the feeling is that conditions have been created to receive it. The feeling tone of the session becomes transformed with the awareness that something greater than the ego or the rational mind is at work. One of the ways in which we came to think about these phenomena is in terms of 'states of grace'. By this, we mean states of mind wherein one feels gifted with an understanding that has arrived rather than has been constructed. A number of psychoanalytic authors come to mind who talk about these kinds of phenomena in different ways, such as Bion's (1962b) 'thoughts prior to thinking'; Bollas's (1987) 'unthought known'; Money-Kyrle's (1971) 'recognitions'; the Stern et al. (1998) 'moments of meeting'; and Tronick's (1998/2007) 'dyadic expansion of consciousness'. The Jungian tradition explores them in reference to experiences of the Self, especially concepts such as Cambray's (2006) 'meaning encountered as emergence' and 'feelings of aha'; Meredith-Owen's (2008) 'archetypal intimations'; and Colman's (2013) 'mad thoughts'. Yet, there remains something powerfully mysterious and ineffable about these experiences of grace. It seems they cannot be reduced solely to individual dynamics but invite us to consider the larger question of their spiritual and transcendent operations.

Martin: Jung on grace

Jung saw grace as central to the analytic process, informing many of his ideas including the transcendent function, synchronicity, the numinosum, and two kinds of thinking. He described it as 'a special psychic state' that cannot be achieved through volition but allows for the coming together of the external and internal worlds: 'the coincidence of idea and reality in the form of a special psychic state, a state of grace, should not be deemed impossible, even if the subject cannot bring it about by an act of will' (Jung 1948/1951, para.65).

The concept of grace is intriguing. It seems to me to be one of those words (like love, art, soul, spirit, God, Self) that operates as a true symbol, in the Jungian sense, in that although very hard to define, is commonly used, charged with its own psychic energy, and alludes to a range of qualities and phenomena that challenge our thinking. When Jung describes a symbol as 'an intuitive idea that cannot yet be formulated' (Jung 1922/1931, para.105), he is classifying it as a type of unthought known.

Jung prescribes that in order for a patient to live, he or she needs faith, hope, love, and understanding (Jung 1958/1969, para. 499). He identifies these, 'the four highest achievements of human endeavour' as 'gifts of grace that are neither to be taught nor learned. . .since they come through experience. . . Experiences cannot be made. They happen' (Jung 1958/1969, para. 501).

States of grace, in Jungian terms, facilitate the transcendent function and generate experiences of the self, expand consciousness, recalibrate the psyche, and allow truth to be realized. In these states of mind, thinking is not something that we do but something that happens.

Catherine: Grace as the product of years of devotion

In thinking about these phenomena, I have wondered whether they are the product of years of devotion to our craft. Warren Colman (2013) emphasized the important part played toward his evolution as an analyst by the discipline of his analytic training and his long years of practice. They provided the backbone of his analytic self, and over time allowed him more freedom from his analytic superego in sessions, and more able to take himself by surprise.

During the London Olympics of 2012, I found myself watching the diving heats. Each athletic young man would gather himself in composed concentration before each dive. He would then slowly raise himself to a vertical handstand on the very edge of the high diving board and poise there for an agonisingly long 5 seconds before flinging himself into a whirling, somersaulting ball in the air and stretching out into a perfect, silent arrow of a dive, leaving hardly a ripple in the pool. It looked sublimely natural. I realized that the exultant freedom and flow of the body, the apparent abandonment of all constraint, the instinctive accuracy and intuitive touch were all combined into a moment of bodily creativity—yet they were not 'free' in a pure sense but the integral result of rigorously tough training, effort, repetition, and discipline together with a strong goal-seeking desire.

By analogy, I hope we can tease out more understanding of how the interplay between training and freedom can create the conditions for moments of grace to appear in analytic sessions. Fordham's paper 'On not knowing beforehand' (1993) has the notion of putting aside all one's theories in a safe filing cabinet before the session so that the analyst is liberated to be present in imaginative interaction in the room anew each time, ready to dive into the pool.

Martin: Eureka moments and the element of surprise

I am not sure whether these phenomena are always the product of years of analytic experience. In supervision, these events are often reported by trainees who are shocked and surprised when they emerge. Synchronicity by nature is shocking, and I would like us to think about this, too.

This element of surprise resonates with what Cambray has called strong feelings of 'aha' (Cambray 2006, p. 15). He noticed that the primary emotion he detects in himself when 'experiencing the meaningful recognition of images as emergent patterns' (Cambray 2006, p. 12) is surprise. When Colman entertained what he called his 'mad thought', he described the emotional experience in the room as that of 'shocked amazement that occurs with the more remarkable examples of synchronicity' (Colman 2013, p. 204).

Stewart describes 'surprise-startle' as a 'resetting affect' by which he means an archetypal dynamic of the primal self serving 'the function of centering and reorientation'. He adumbrates, 'Startle serves to center

consciousness and leads to reorientation . . . it leads to a centering of the total organism which imposes an immediate and total cessation of any movement or sound' (Stewart 1987, pp. 41–42).

It seems we need to be shocked. Hogenson (2001) suggests that synchronicities can be understood in terms of critical self-organizing events and may emerge in analytic work with intensifications of what he refers to as 'symbolic density' wherein certain phenomena and events are highly charged with meaning.

Using a clinical illustration, I now look more closely at some of these phenomena starting with a 'Eureka moment'. This case is one I have previously documented (Schmidt 2005):

The analysis in question had been volatile. My patient had terminated it in fits of rage three times during our first 4 years together. He felt that I didn't care enough about him and that I misunderstood his anxiety and despair. After each rupture, I would find myself encouraging him to return to the analysis. Each time, we would make some headway in trying to make sense of his frustration until a similar pattern recurred. He would feel misunderstood, become angry, and recommence, undermining the analysis by missing sessions and threatening to leave. Then, in the fifth year of analysis, this pattern culminated in a remarkable session, which I will describe.

He settled into his chair and told me that he intended this to be his final session. I became very angry, exasperated at the sense of returning to square one and at a loss for what to say. However, interestingly, this time I didn't feel like encouraging him to continue. On the contrary, I felt some relief that the analysis might be coming to an end, but I also held misgivings about my capacity to help him. I stayed with my feelings that his wish to terminate the analysis was the right one. Perhaps it was true that I was a poor analyst, or the wrong one for him, or that analysis itself was not the treatment of choice.

After about 10 minutes, he said, 'Haven't you got anything to say?' Previously, we had explored what it might be that he felt I could not give him, but now I shared with him my ambivalence. I replied that I was also considering whether he was indeed correct and that there was value in thinking about whether the analysis should end. There was then another long silence, which he interrupted by saying that he really was going for good now unless I said something. I felt pressured and was unable to think or speak.

Then an image occurred to me of an infant sitting on my lap. The toddler was playing a game with me that involved trying to put its finger in my mouth and withdrawing it before I bit it. I played this game as a child and remember the excitement and anxiety attached to the fear of being bitten and the fits of giggles and relief that came from avoiding the parent's snapping teeth. As he started to leave, I found myself saying:

'I don't know what this is worth, but I have just had a very strong image of something which I think may be meaningful which I would like to share with you'. I then relayed to him my fantasy. He was astounded and said: 'That is the dream I had last night. I dreamt that I was sitting on your lap playing that finger biting game with you!'

We were shocked. The atmosphere of the session was immediately transformed. We both felt excited and relieved by this shared experience. There was a sudden realization that, whatever else it might mean, this powerful unconscious communication felt that it was meaningful enough in itself for us to continue the analysis just to try to understand it further. We both were aware of something very mysterious at work.

Over the following weeks, we explored the nature of the dynamics between us represented by the finger-biting game. We thought about the image in many ways including in terms of his wish for intimacy and his fear of castration. He had found it hard to progress in his career and complete his courses of study. We talked about his envy of my career and his wish for professional status. It was as if, in this unconscious communication, he was able to risk intercourse with me—putting his finger/penis inside me. Would I be able to receive this penetration, or would I bite it off? Was it possible for us both to prosper, or would a stunted stalemate be the only recourse available to him?

I understood this Eureka moment as an example of Jung's symbol-forming transcendent function at work, for it brought about a dramatic and mutual change in our psychological attitude. For both of us there was a renewed faith in the analysis. He now felt that I understood him, and this has been reflected in the relationship ever since. The old pattern of defensive attack and withdrawal has waned. He has been able to complete his professional studies and find employment. The phenomenon also reaffirmed my belief in my own capacity to be of value to him.

> Catherine: That is such a good example of a dramatic Eureka event between you and your patient, an astonishing synchronicity that revivified your relationship. It is worth recalling the excitement of

> Archimedes' original Eureka moment. The word in Ancient Greek means 'I have found it'. Archimedes reportedly proclaimed 'Eureka!' when he stepped into a bath and noticed that the water level rose—He suddenly understood that the volume of water displaced must be equal to the volume of the part of his body he had submerged. He then realized that the volume of irregular objects could be measured with precision, a previously intractable problem. He is said to have been so eager to share his discovery that he leapt out of his bathtub and ran through the streets of Syracuse naked. His discovery was significant in allowing the density and thus the purity of gold to be calculated—a nice link with alchemy, perhaps.

What this story has in common with the Eureka moments we are describing in analysis, as well as surprise and drama, is the sense of recognition, of a mystery dissolving, the 'Of course!' or 'Aha!' of an 'unthought known'. Carter comments that it 'points to the emergence of conscious awareness of what had previously resided outside awareness; there is a shift from the non-conscious, non-verbal domain into explicit, conscious awareness' (Carter 2014, personal communication).

This seems to be true across many different spheres of human exploration. I heard a mathematician, Robert Kaplan, on BBC Radio 4 recently talking inspiringly about the place of imagination and play in mathematics (Kaplan 2012). A process of recursive abstraction is generated whereby once a symbol is created to represent an idea (for example, the concept of zero), that symbol itself gives rise to new operations that in turn lead to new ideas. The beauty of mathematics is that even though we invent it, we seem to be discovering something that already exists. Kaplan emphasized the way that seemingly chance discoveries expand our awareness and generate ideas and meaning, just as your Eureka encounter did with your patient.

Jung, too, was intrigued by the mystery and numinosity of numbers—commonly perceived as establishing order in the human world and yet always confronting us with elements of unpredictability (Jung 1952/1960). He speculates that numbers 'were as much found as invented, and that in consequence they possess a relative autonomy analogous to that of the archetypes'. They, therefore, have 'the quality of being pre-existent to consciousness, and hence, on occasion, of conditioning it rather than being conditioned by it' (Jung 1952/1960, para. 871).

I am reminded of Zinkin's question, 'Your Self: did you find it or did you make it?' (Zinkin 2008) in which he declared his belief that 'the self comes into existence only through interactions with others' (p. 394), showing his early interest in intersubjectivity and infant research. He examined what makes it possible for the Self to be realized and expressed in analysis. Pursuing the same question ourselves more than 20 years later, although we are looking at the dramatic examples of Eureka, I am equally interested in the quieter, nuanced manifestations of intersubjective moments of mutuality and self-recognition that seem to be delivered through the operation of grace.

Martin: Subtle states of grace and the analytic attitude

Far more common in my analytic practice are moments wherein the experience of a state of grace is much more subtle. Here the maintenance of an analytic attitude and the use of interpretation (putting words to feelings in an attempt to create meaning) facilitate states of grace to emerge.

It seems inevitable during intensive analytic work that we reach entrenched positions where the defenses of the analyst meet those of the patient head on. A miserable, obdurate impasse ensues where interpretation is seen as an offensive, an attempt to break through enemy lines. Then, after months, or even years of stalemate, something seems to lift and is accompanied by an enormous sense of relief for both patient and analyst. It is often hubris, fuelled by the fear and envy of one another, which stifles our capacity to create the conditions in which new ideas can be conceived and received. A shift seems to occur when I find that the patient wants to, and is able to, support me by showing kindness and gratitude in a way that had been absent before. I am surprised to discover that the patient, despite appearances and protestations, has secretly deeply valued my dogged refusal to abandon the analytic attitude, which has allowed me to stay with him or her in the quagmire. What then often follows is an expression of heartfelt appreciation for my efforts. Now, I am able to see how, as a result of my fears and narcissistic wounds, I have defended against a shared emotional experience by trying to 'think' a solution to 'the problem' rather than being open to a different kind of encounter that requires the capacity, as Colman succinctly puts it, to

'think feelingly' (Colman 2013, p. 211). The analytic landscape moves, and I am able to feel more compassionate again with a new space to play and interpret.

I remember, and treasure, numerous wonderful sessions wherein I have become able to relax into a state of reverie. A weight is lifted from my shoulders, and I no longer need to struggle but instead just 'feel myself into' the session. Both the patient and I notice this and become aware of the silence and the beautiful quality of the light in the room. We share a powerful sense of well-being, a kind of suspended state of animation without memory, desire, or the need to understand. Bion's (1967) maxim becomes palpable here. It makes me aware of what is possible in analysis when we are able to stop trying or, as Colman puts it, 'the irony implicit in Bion's remarks is that only someone who has given up trying to be an analyst can actually become one' (Colman 2013, p. 201).

For the analysis to progress, I find that it is very important for the patient to feel able to give to the analyst and that the analyst can receive with appreciation. This personal graciousness, on both parts, then allows for the sharing of a state of grace that feels less proprietorial and more transcendent. It is vital for patients to feel that the analyst can experience their generosity. As Klein gracefully expounds:

> Gratitude is closely bound up with generosity. Inner wealth derives from having assimilated the good object so that the individual becomes able to share its gifts with others. This makes it possible to introject a more friendly outer world, and a feeling of enrichment ensues
>
> (Klein 1957, p. 189).

This is a two-way process; the patients need to feel that they have something of value in themselves to give and that this can be accepted gratefully and graciously by the analyst. It is not enough just to be the recipient of the analyst's generosity. Only then, as Carter (2010) adumbrates, is the experience authentically intersubjective and mutual.

> Catherine: So often we find that a moving session emerges as the result of many years of building toward it. The sense you describe of your mutual surrender and melting into the moment surely describes the emergence of simultaneous Self-experiences within an intersubjective field that had taken a long time to plough.

Your language suggests orgasm, and it is striking how sexual metaphor can so often capture the experience of two minds and feeling states coinciding in the moment. Colman (2013) was startled to find himself having a sexual image in thinking about a dream during a supervision session—his sudden intuition that a vibrating house was having an orgasm. Thoughts about orgasm were able to generate new life (i.e., awareness of possibilities) between the two people. Colman acknowledges his 'mad thought' may have arisen through his familiarity with the well-practised sexual metaphors in psychoanalytic thinking, but he conveys vividly how, in the moment, he was taken by, not creating, an idea. He echoes our own experience of wonder at such a Eureka moment when he writes 'There was an odd sense of being both strange and familiar to myself in seeing that the person who could do this was "me"' (Colman 2013, p. 205).

Colman makes an analogy between analytic practice and artistic or athletic performance. Considering the unsettling effect of an analyst's non-rational, spontaneous interventions (our Eureka moments), he notes that 'such insights appear to come out of the self and have a distinctly non-ego character'. Nevertheless, he reminds us that it is a self that learns from experience via the ongoing sequence in Fordham's deintegration-reintegration model or gathers 'implicit relational knowing' in the language of infant research (Stern et al., 1998, p. 205). He speculates about the necessary balance between long years of work to integrate experience and the 'spark that comes from the inner depths of an artist or an analyst's individual being' (Stern et al. 1998, p. 203).

Another gift from BBC Radio 4 that helped me to think about the environment in which surprising insights and synchronicities can emerge was a discussion in which a novelist, Joanna Kavenna, listed the ingredients for allowing her creativity to come to her. She needed a city to stimulate her, collaboration with other writers, relaxation in the shower, going for walks, and she added, 'You have to work at it'. (Kavenna 2012).

Martin: The roots of grace

Whilst listening to your reflections on sexual metaphor and minds coinciding, it struck me that we employ the same word to describe the coming together of male and female gametes to make an embryo as we do to describe the meeting of preconceptions with realizations (Bion 1962b) to form thoughts, namely: conception. Sometimes babies are hard to make and take years of trying, and sometimes they just happen unexpectedly!

I loved your earlier metaphor of the Olympic diving, which you described as the product of rigorous training, desire, repetition, and discipline. Whilst these constitute an important part of the picture, I think moments of grace can also visit us at any time, regardless of how experienced we are. After all, grace in the religious sense is understood to be 'the unmerited gift of God' to assist and equip man (Abi 2011). Jung, too, makes many references to the mystery of the 'gift of grace' and 'God's grace' in his writings stating that '. . . the wrath of God was changed to love and the water of Grace now bathes the whole world' (Jung 1938/54, para. 110). He qualifies this by also saying that 'the religious experience of grace is an irrational phenomenon, and can't be discussed any more then can the "beautiful" or the "good"' (Jung 1938/54, para. 143).

Grace has a number of etymological roots. Latin gives us *gratia* or *gratus* meaning 'thankful, pleasing' where it shares a root with 'gratitude'. The entire canon of Kleinian thinking about what constitutes mental health can be condensed to the question of whether we are envious of the other or grateful for who we are and what we have:

> In contrast with the infant who, owing to his envy, has been unable to build up securely a good internal object, a child with a strong capacity for love and gratitude has a deep-rooted relation with a good object and can, without being fundamentally damaged, withstand temporary states of envy, hatred, and grievance, which arise even in children who are loved and well mothered. Thus, when these negative states are transient, the good object is regained time and time again. This is an essential factor in establishing it and in laying the foundations of stability and a strong ego . . . One major derivative of the capacity for love is the feeling of gratitude. Gratitude is essential in building up the relation to the good object and underlies also the appreciation of goodness in others and in oneself. Gratitude is rooted in the emotions and attitudes that arise in the earliest stage of infancy, when for the baby the mother is the one and only object. I have referred to this early bond as the basis for all later relations with one loved person
>
> (Klein 1957, p. 187).

The earlier Greek root of grace is *charis,* meaning 'that which brings delight, joy or good fortune'. It is related to 'charity' and 'charisma', which mean 'gracious gift'. In the Old Testament, the Hebrew root is *chen*,

meaning 'favour, charm and the moral quality of kindness' *(HarperCollins Bible Dictionary* 1997).

Grace is a core concept in spiritual development. In Hindu and Bhakti devotional literature, grace is the ultimate key required for self-realization. In this sense, grace is not just God's loving kindness, favour, or mercy, but the divine life itself through which God relates to man. This is expressed by the theologian Ryle (2013) when he proclaims that grace is 'the empowering presence of God enabling you to be who He created you to be, and to do what He has called you to do'. If we substitute 'Self' for God, this resonates with Jung's thinking about individuation.

Catherine: The relational aspects of grace

I agree. But I believe our self-discovery in thinking and/or feeling is dependent upon relationship. I have become intrigued by the detailed work of Daniel Stern and the Boston Change Process Study Group (BCPSG). They have much to contribute to recognizing the analyst's ventures 'off piste', diverging from what they had inherited as 'proper technique' in the psychoanalytic tradition. They are famous for their attempt to understand and notate the 'something more' than interpretation that occurs in analytic sessions and in particular to paint a picture of the affective ecology of the interchanges between patient and analyst that slowly build towards an emotionally charged and often unsettling 'moment of meeting' (Stern et al. 1998). They try to pin down those moments of authenticity wherein the analyst and patient both contribute to some spontaneous, meaningful exchange that carries the specific signature of their own co-created experience, unique to this particular dyad. Awareness of the present moment can spontaneously turn into a charged 'now moment':

> These moments are pregnant with an unknown future that can feel like an impasse or an opportunity. The present becomes very dense subjectively as in a 'moment of truth'. . . . A 'now' moment is an announcement of a potential emergent property of a complex dynamic system. Although the history of its emergence may be untraceable, it is prepared for with fleeting or pale prior apparitions, something like a motif in music that quietly and progressively prepares for its transformation into the major theme. Still the exact instant and form of its appearance remain unpredictable.
>
> (Stern et al. 1998, p. 912)

If it is mutually recognized and grasped, the opportunity becomes 'lit up' as an affectively rich 'moment of meeting' in which 'each partner has actively contributed something unique and authentic of his or herself as an individual' (Stern et al. 1998, p. 913). The elements of surprise, unpredictability, and heightened emotion of the Eureka moment are there again. They also add something about affect attunement, relational fittedness, ways of being with another, that are derived from their studies of infant-mother interaction and their observation that any human being's development of a sense of self is realized only through relating. In Tronick's words, 'I interact, therefore I am' (Stern et al.1998, p. 296).

Tronick poses a 'dyadic consciousness hypothesis':

> Each individual, in this case the infant and mother or the patient and the therapist, is a self-organising system that creates his or her own states of consciousness (states of brain organisation), which can be expanded into more coherent and complex states in collaboration with another self-organising system.
>
> (Tronick 2007, p. 402)

The BCPSG and Tronick are not the only writers to recognize that there is something significant about a 'real' relationship popping up alongside, or on the shoulders of, the professional relationship (and, as we would argue, each probably intrinsic to the other), but they have made the present moment, the here and now, the second-by-second interactions at a micro-level their own special field of study, as opposed to meta-theory. This is the 'local level', being the matrix in which 'implicit relational knowing' is experienced between two people, which may—but equally may not—be in the transference.

They have latterly become even more interested in the pathways to these special, memorable moments that proceed through the ordinary, quieter, apparently unremarkable activity of an analysis that they call 'moving along'. They value what they call the 'sloppiness' and 'fuzziness' of analytic interaction: 'We view sloppiness not as errors or mishaps in the dialogue, but rather as a generator of potentially creative elements that may alter the direction of the dyad's evolution in unexpected, even previously unimaginable, ways' (BCPSG 2005, p. 721).

It is sometimes a rupture or misunderstanding in an interchange, and especially the recovery from it, that can allow a resetting of direction and

coherence, so that true learning from experience about each other can gradually take place. According to Beebe and Lachmann (2002), 'there can be a deepening of intimacy following disruption and repair. This process … has emergent capacities for creating new and unpredictable forms of shared implicit knowing in the interactants as new ways of being together are co-created in the treatment' (Beebe and Lahmann 2002, p. 698).

And, they add, 'In some instances, these changes may not require that the interactants explicitly reflect on what has transpired' (Beebe and Lahmann 2002, p. 697).

They assume that the simultaneous and continuously revised effect on each other cannot be ignored and that their approach 'has changed our clinical sensibilities' (Beebe and Lahmann 2002, p. 721). We would say that Jung anticipated these insights about mutuality. I am struck that the BCPSG acknowledge the influence of dynamic systems theory and emergence on their thinking but are sadly unaware of Jungian complex theory. Jung's famous gate diagram of course includes the analyst's and patient's unconscious processes influencing each other at the deepest level (Jung 1946/1954, para. 422).

Catherine: Case example of a possible moment of meeting

I have been a member for a couple of years of a small practitioner research group of psychoanalytic psychotherapists doing a pilot study of 'significant moments in psychotherapy'. What can be defined as a 'moment of meeting' is proving rather elusive, and the discussion is often stimulating. What seems crucial is the shared emotional experience, even if there is no verbal acknowledgement:

I have been seeing a man in his early forties for nearly 3 years. He is in a deep black hole of depression since being made redundant from his work as a well-paid senior professional. He has intermittently tried and failed to get a new job and now believes—angrily—that he is a misfit who is unemployable. I know very little about his day-to-day existence, except that he reads a lot. He has become increasingly isolated and hermit-like and tells me that some weeks I am the only person he talks to.

He is extremely still, silent, and uncommunicative in sessions and usually gets out his rumpled cotton handkerchief at the start of the session and holds it throughout. Sometimes he is close to tears. I am very conscious

of his sense of humiliation and the coiled spring of his rage, but he never visits this upon me. Our relationship feels 'virtual' and unacknowledged with almost all communication going on implicitly. He has told me there is nothing happening in his mind and that he has no imagination, but my sense is that he is highly alert, watching and waiting for me to start something going, which I often do after a long silence, usually speculating about his experience within the session or telling him things going on in my mind, in a tentative way, hoping to find some response in him.

On this occasion, I told him that sitting with him during the silence had reminded me of my experience of infant observation. Watching over a baby sleeping was a very intense, concentrated experience, full of my thoughts and feelings about what the baby was experiencing. It had made me wonder what the baby's self was like.

More silence. . . He remained immobile, but I had a heightened sense of his presence, listening avidly. Maybe this was a 'now moment'.

During the next prolonged minutes of silence, to my surprise what floated into my mind was the blank page in the novel *Tristram Shandy* by Lawrence Sterne (1759-67/1996). The idea felt like a visitation from out of the blue. I told him this image had arrived in my mind and added that the blank page was full of potential. Suddenly he livened up, raised his head, and said with a hint of humour, 'I always preferred the Flourish!' We both burst into laughter in a shared moment of delighted surprise—such a contrast with the many previous sessions. I think this was a moment of meeting. I certainly felt we had connected in a completely new way.

For those of you who are not familiar with *Tristram Shandy,* the marvelously existential eighteenth century novel, both the Blank Page and the Flourish are graphic illustrations of Sterne's zany challenge to convention by writing a novel about writing a novel. He is just as concerned with examining the present moment as the Boston Change Process Study Group! He draws attention to the actual fabric of the book, the paper of the pages, and the false activity of story telling. (Sterne prefigures the American psychoanalyst Spence's (1982) scepticism about 'narrative smoothing' in our analytic accounts).

The Flourish that my patient liked is a squiggle on the page and carries the story along. I found a blogger on the internet who describes it well:

> Colonel Trim waves his stick in the air as a description of the ups-and-downs and the ins-and-outs of marriage, a wordless argument

> in favour of celibacy, since he lacks the language skills necessary to describe the vagaries of married life. In fact, the twisting line is much more eloquent and succinct than using words to explain.
>
> (Ronosaurus Rex 2010)

I can see why my patient identified with this image.

The next week's session was also unusual because he did speak much more. He began talking knowledgeably about patterns in literary culture during the seventeenth century that anticipated *Tristram Shandy.* He told me that writing at this time began to reflect a sense of selfhood within the individual, in which internal states of mind could be recognized and valued. I was moved to hear how he was talking so eloquently about this delicate subject, which felt so close to what he was apparently unable to express on his own account. I said something like this, but his sudden silence indicated he could not let the conversation develop along such personal lines, and so I backed off again, and we ended the session at a safer distance.

I had the strong sense that our 'moment of meeting' of shared laughter from the previous week's session had generated something new with more fluid, even emotional, possibilities. I can't report that subsequent sessions progressed so serendipitously, but I do feel it is likely that this completely unpredicted and shared interaction had a lasting mutually beneficial effect on our experience of being together.

Martin: Thinking, the transcendent function and truth

Your moment of meeting in laughter sounds like it transcended an impasse. The sudden relief of tension resonates with Jung's concept of the transcendent function and how it can free us from a stalemate and also feel like a state of grace. I was touched by how you were able to reach out to him in his isolated despair with images that he was able to meet.

When under pressure from our patients' distress, we often adopt what Jung calls 'directed thinking' which is task-orientated, ego-driven, problem-solving, logical, rational, and operates using speech for the purpose of communication (Jung 1912/1952, para. 17). It produces innovations and adaptations, is scientific but exhausting. I felt you offered your patient what Jung refers to as 'dreaming or fantasy thinking', which he saw as effortless, spontaneous, and guided by unconscious motives. It 'uncovers

creative forces and contents, just as dreams do. Such contents cannot as a rule be realized except through passive, associative and fantasy-thinking' (Jung 1912/1952. 20n).

In Bion's model, thoughts exist before thinking, 'Thinking has to be developed as a method or apparatus for dealing with "thoughts"' (Bion 1962a, p. 83). Philosophically, he observes that 'thinking. . . is embryonic even in the adult and has yet to be developed fully by the race' (Bion 1962a, p. 85). He argues that thoughts are 'waiting' for thinkers to be able to have them. Jungian emergent theorists, such as Cambray (2006, 2011); Carter (2010); Colman (2013); Hogenson (2001, 2005); and Knox (2011), argue that these 'thoughts' may not be so much forms waiting to be incarnated as ideas that emerge as a result of the interactional dynamics of the complex systems involved. I think that the conditions necessary for thinkers to have, receive, or allow these thoughts to emerge are states of grace.

Bollas' (1987) concept of the 'unthought known' is another version of this. He suggests that there are things that we know that we are unable to think about. Indeed, we need the correct conditions to allow thinking to emerge. This explains those occasions when we may read or hear something that we somehow 'know' to be true but have not been able to fully think about before. At the heart of Bollas's thinking is Winnicott's dynamic of the true self (comparable to Jung's individuation) coupled with Freud's concept of the primary repressed unconscious. The exciting departure Bollas makes from Freud is to suggest that rather than the transference just being seen as a reliving of earlier states of being, it is the experience of something completely new. Here he is suggesting that the unthought known is not just the 'return of the repressed' but an expression of the 'true self'. This is more akin to Jung's synthetic position rather than Freud's reductive one. In other words, in analysis, we are trying to create conditions in which the self, and the grace of its truth, can be experienced and realized.

Bion has fascinating things to say about the truth. Descartes argued that thoughts presuppose a thinker, but Bion qualifies this by saying that is only valid in the case of a lie:

> The lie requires a thinker to think. The truth, or true thought, doesn't require a thinker—he is not logically necessary . . . Nobody need think the true thought: it awaits the advent of the thinker who achieves significance through the true thought.
>
> (Bion 1970, pp. 102–103)

Catherine: Conditions that facilitate states of grace

That makes me ponder what conditions are necessary for a thinker to be ready to receive the true thought, to get to a place of openness to that state of grace, whenever it may appear. The transcendent function appears to concern the emergence of meaning and its presumed therapeutic advantage in facilitating individuation. We are presuming that surprising, synchronistic happenings in analysis do indeed carry meaning, as Hogenson says (2009).

I think ideas of structure, framework, and boundaries have a vital part to play in such creative moments. The existence of discipline and theory in our analytic practice are prerequisites of constructing the frame in which psychological revelation and curiosity can take place. Rather than a set of formulaic 'rules' that patients sometimes caricature, boundaries—and especially thinking about boundaries as a container—constitute the scaffolding that helps to stabilize the building up of an experience of inner space, wherein creativity, self-discovery, and relationship with the other can grow. As the BCPSG point out, 'now moments' tend to occur 'when the traditional therapeutic frame risks being, or is, or should be, broken' (Stern et al. 1998, p. 912), and this alteration is what draws the participants immediately into the present, subjectively and affectively. The existence of the analytic structure is essential because its momentarily altered state makes conscious the current condition of their shared implicit relationship and allows it to become personal and saturated with potential meaning.

Cambray (2011) recognizes powerful connectedness between people in a wider interactive psychological field even outside the formality of sessions, which shows itself in coincidences over time and space and often only conscious to himself, not the patient. He uses the words 'serendipity' and 'enigma' as characterizing a broader category of 'moments of complexity' that pose a challenge to our notion of analytic boundaries. He welcomes them as expanding and enlarging our view of analysis, 'helping to broaden but not degrade boundaries' (Cambray 2011, p. 307). Significantly, awareness of field theory helps him with his countertransferential anxieties, making him accepting of the impact of unconscious processes.

Ogden sets the conditions for being receptive to these intense intersubjective moments that he calls 'aliveness' in analysis (Ogden 1997, 2001). He gives himself the discipline of catching his apparently random reverie during sessions and treating them as 'analytic objects' to

be thought about. He senses his unconscious experience of being with the patient through 'the most mundane, quotidian, unobtrusive thoughts, feelings, fantasies, ruminations, daydreams, bodily sensations and so on that usually feel utterly disconnected from what the patient is saying or doing at the moment' (Ogden 2001, p. 21).

Famously, he found himself taking his pulse in a session to reassure himself he was alive and healthy. Out of these reverie states (which seem different from conventional monitoring of countertransference reactions), he comes to spontaneous realizations of their relevance to his patients and gives examples of what we would recognize as Eureka moments and which he connects with the creation of the 'analytic third'. His important interventions were not pre-planned or theoretically founded but came as a surprise to him:

> I had in these instances a sense of 'I-ness' (a feeling of who I was in that moment with that patient). . .This 'I-ness' was not entirely known to me before I heard it in my voice and felt it in my body. It was a voice highly personal to me, and at the same time unmistakably the product of the shared unconscious experience generated by the patient and me in the course of the analysis.
>
> (Ogden 2001, p 156)

Martin: Experiences of self and the unthought known

It sounds as if Ogden were describing in his sense of 'I-ness' what many Jungians might call an 'experience of the self', and it is interesting that he speaks of this as not being entirely known to him before. Again, Bollas's (1987) 'unthought known' comes to mind, where we become able to think about, as if for the first time, something we have always somehow 'known'. An unthought known was realized for me at a time when I was seriously considering different options of where to train. It came while reading Jung's quotation:

> I had learned that all the greatest and most important problems of life are fundamentally insoluble. They must be so, for they express the necessary polarity inherent in every self-regulating system. They can never be solved, only outgrown.
>
> (Jung 1929/1938, para.18)

This was truly an epiphany for me. I felt exhilarated. Somehow, I had always known this but now was able to really think it. It confirmed my intuitive feeling that we are not able to magically conjure up solutions to life's problems and reinforced my sense that a Jungian training would be the right one for me.

Meredith-Owen (2008) beautifully describes a similarly overwhelming experience of an unthought known when he talks about his feelings after first reading Money-Kyrle's 1971 paper on 'the aim of psychoanalysis' :

> The only analogous experience I can think of was once turning on the car radio at random, only to find myself listening for the first time to what turned out to be a passage of a late Beethoven quartet. . .I felt profoundly moved, yet almost quite uncomprehending . . . I felt a distinct sense of 'recognition', though of what was still obscure to me.
>
> (Meredith-Owen 2008, p. 460)

He amplified this recognition in Jungian terms as, 'a response to something innate . . . the mobilizing of a potential informing . . . an archetypal intimation' (Meredith-Owen 2008, p. 460). He continues to provide a case illustration that sounds like a graceful state where his patient experiences himself more as 'the recipient of something rather than the author per se' (Meredith-Owen 2008, p. 477). This was accompanied by the patient expressing himself in non-proprietorial terms such as 'I found myself saying. . .' or 'The thought came to me. . .' (Meredith-Owen 2008, p. 476).

Envy and gratitude: Towards a synthesis of Jungian and Kleinian positions

In congruence with the Kleinian position, Money-Kyrle's paper identifies envy as the chief obstruction to achieving mental health:

> All adult thinking, all later acts of recognition, are hampered by the difficulties which beset the first ones, and we have all had some difficulties with these. Amongst these first ones, and without being sure that I have selected all that are significant, I will select three: the recognition of the breast as a supremely good object, the recognition of the parents' intercourse as a supremely creative act, and the recognition of the inevitability of time and ultimately death.
>
> (Money-Kyrle 1971, p. 103)

Klein recognized that the antidote to envy is gratitude, and Meredith-Owen saw that implicit in all three of Money-Kyrle's evocations is 'an acknowledgement of our indebtedness, of our need to relinquish omnipotent assumptions and allow ourselves to receive and appreciate if we are to evolve and mature' (Meredith-Owen 2008, p. 460).

It is envy that prevents us from being the grateful and, I would add, the graceful recipients of creativity. After all, in Judeo-Christian mythology, it is envy that spawns Satan when Lucifer, the fairest of the angels, grew envious of God and fell from grace. Kalsched points out that the diabolic (that which splits asunder) is the antonym of the symbolic (that which brings together; 1996, p. 16).

Meredith-Owen furnishes us with a rich formulation which brings together the Jungian and Kleinian positions:

> The dawning awareness of the analysand's own agency in their ongoing dismay (the Kleinian position) together with a patient receptivity towards any evidences of spontaneous, Self-generated creativity (the Jungian element) may in the end combine to afford the missing template for maturation/individuation.
>
> (Meredith-Owen 2008, p. 478)

I add a further relational dimension to this formulation: Namely, that analysts, too, need to be aware of their own agency in their own ongoing dismay; their own limitations; and to be receptive not only to Self-generated creativity but to the generosity of the patient to create conditions in which a shared state of grace may occur.

Conclusion

In this chapter, we have attempted to explore states of grace in analysis together with phenomena, such as Eureka moments, and the unthought known related to them. We use a Jungian approach to link some of the varied theories about these phenomena and explore some of the conditions that facilitate them.

The concept of grace is hard to grasp because, like all symbols in the true Jungian sense, it defies definition. Are states of grace found, received, created, or co-created? They can feel like gifts that arrive unexpectedly and are gratefully received, but they can also seem like the fruitful rewards

of years of shared work. We have left the door open for further thinking about this mystery.

Jung celebrates the mysterious and also anticipates Bollas when he states:

> It is important to have a secret, a premonition of things unknown. It fills life with something impersonal, a numinosum . . . He must sense that he lives in a world which in some respects is mysterious; that things happen and can be experienced which remain inexplicable; that not everything which happens can be anticipated. The unexpected and the incredible belong in the world. Only then is life whole.
>
> (Jung 1963, p. 328)

References

Abi, O. (2011). *Grace of God.* Houston: Omega Publishers.

Beebe, B., and Lachmann, F. (2002). *Infant research and adult treatment: Co-constructing interactions.* Hillside, NJ, and London: The Analytic Press.

Bion, W. (1962a). *Learning from experience.* London: Basic Books.

Bion, W. (1962b). A Theory of thinking. *International Journal of Psychoanalysis,* 43, 306–10.

Bion, W. (1967). Notes on memory and desire. *The Psychoanalytic Forum,* 2, 272–273, 279–90.

Bion, W. (1970). *Attention and interpretation.* London: Karnac.

Bollas, C. (1987). *The shadow of the object: Psychoanalysis of the unthought known.* London: Free Association Books.

Boston Change Process Study Group (BCPSG). (2005). The "Something More" than interpretation revisited: sloppiness and co-creativity in the psychoanalytic encounter. *Journal of the American Psychoanalytic Association,* 53, 693–729.

Cambray, J. (2006). Towards the feeling of emergence. *Journal of Analytical Psychology,* 51*,* 1–20.

Cambray, J. (2011). Moments of complexity and enigmatic action: A Jungian view of the therapeutic field. *Journal of Analytical Psychology,* 56, 296–309.

Carter, L. (2010). The transcendent function, moments of meeting and dyadic consciousness: constructive and destructive co-creation in the analytic dyad. *Journal of Analytical Psychology,* 55, 2, 217–27.

Carter, L. (2014). Personal communication.

Colman, W. (2013). Reflections on knowledge and experience. *Journal of Analytical Psychology,* 58, 200–18.

Fordham, M. (1993). On not knowing beforehand. *Journal of Analytical Psychology,* 38, 127–37.

HarperCollins Bible Dictionary (1997). Ed. P. J. Achtemeier. San Francisco: Harper Collins.

Hogenson, G. (2001). The Baldwin effect: a neglected influence on C.G. Jung's evolutionary thinking. *Journal of Analytical Psychology,* 46, 591–611.
Hogenson, G. (2005). The Self, the symbolic and synchronicity: Virtual realities and the emergence of the psyche. *Journal of Analytical Psychology,* 50, 271–84.
Hogenson, G. (2009). Synchronicity and moments of meeting. *Journal of Analytical Psychology,* 54, 183–197.
Jung, C. G. (1912/1952). Two kinds of thinking. *CW* 5.
Jung, C. G. (1922/1931). On the relation of analytical psychology to poetry. *CW* 15.
Jung, C. G. (1929/1938). Commentary on "The Secret of the Golden Flower". *CW* 13.
Jung, C. G. (1938/1954). The vision of Zosimos. *CW* 13.
Jung, C. G. (1946/1954). The sychology of the transference. *CW* 16.
Jung, C. G. (1948/1951). The self. *CW* 9ii.
Jung, C. G. (1952/1960). Synchronicity: An acausal connecting principle. *CW* 8.
Jung, C. G. (1958/1969). Psychology and religion: West and East. *CW* 11.
Jung, C. G. (1963). *Memories, dreams, reflections.* London: Collins and Routledge & Kegan Paul.
Kalsched, D. (1996). *The inner world of trauma.* London: Routledge.
Kaplan, R. (2012). BBC Radio 4 The Forum (29 December 2012) on The Real and the Virtual.
Kavenna, J. (2012). BBC Radio 4 Start the Week (30 April 2012) on Creativity.
Klein, M. (1957). *Envy and gratitude: A study of unconscious forces.* London: Hogarth Press.
Knox, J. (2011). *Self-Agency in psychotherapy. Attachment, autonomy and intimacy.* New York and London: W. W. Norton.
Meredith-Owen, W. (2008). "Go! Sterilize the fertile with thy rage". Envy as embittered desire. *Journal of Analytical Psychology,* 53, 459–80.
Money-Kyrle, R. (1971). The aim of psychoanalysis. *International Journal of Psychoanalysis,* 52, 103–6.
Ogden, T. H. (1997). *Reverie and interpretation: Sensing something human.* London: Karnac Books.
Ogden, T. H. (2001). *Conversations at the frontier of dreaming.* London: Karnac Books.
Ronosaurus Rex. (2010). Tristram Shandy ****s up the Page. Metablog on Metafiction. http://ronaldbrichardson.com/metafiction/tristram-shandys-audacious-layout/
Ryle, J. (2013). Divine grace. *Wikipedia,* en.wikipedia.org/wiki/Divinegrace.
Schmidt, M. (2005). Individuation: Finding oneself in analysis—taking risks and making sacrifices. *Journal of Analytical Psychology*, 50, 595–616.
Spence, D. (1982). *Narrative truth and historical truth: Meaning and interpretation in psychoanalysis.* New York: W. W. Norton.
Stern, D. N., Sander, L. W., Nahum, J. P., Harrison, A. M., Lyons-Ruth, K., Morgan, A. C., Bruschweiler-Stern, N., and Tronick, E. Z. (1998). Non-

interpretive mechanisms in psychoanalytic therapy: The "something more" than interpretation. *International Journal of Psychoanalysis,* 79, 903–21.

Sterne, L. (1759-67/1996). *The life and opinions of Tristram Shandy, gentleman.* (Wordsworth Classics). Ware, Hertfordshire: Wordsworth Editions Ltd.

Stewart, L. (1987). A brief report: Affect and archetype. *Journal of Analytical Psychology,* 32, 35–46.

Tronick, E. Z. (1998). Dyadically expanded states of consciousness and the process of therapeutic change. *Infant Mental Health Journal,* 19, 3, 290–9.

Tronick, E. Z. (2007). *The neurobehavioral and social-emotional development of infants and children.* New York: W. W. Norton and Co.

Zinkin, L. (2008). Your self: Did you find it or did you make it? *Journal of Analytical Psychology,* 53, 389–406.

Part III

Relational analysis and psychoanalytic psychotherapy



Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

Chapter 6

Moments of meeting and the problem of shame

A brief history of relational therapy

Patricia A. DeYoung

In June of 2015, on a ferry between the Toronto IARPP Conference and an island party, one of my colleagues chatted with two long-time luminaries of relational psychoanalysis. To their friendly questions, she replied,

> "I'm a therapist here in town and also on faculty at an institute that teaches relational psychotherapy."
> "An analytic institute?"
> "No," she said. "We don't train analysts. We teach people to be relational therapists from the ground up, so to speak."
> "They don't have to qualify as analysts at all? They don't get an academic grounding in a specific analytic theory first?"
> "That's right. We try to cover the gist of relational theories, though. What matters to psychotherapy."
> "Wow, what a concept! It's hard to imagine how that could work."

That ferry ride in the rain wasn't the time or place to explain how such training could work. Nor is this. I tell the story to mark my professional location. I'm not an analyst or a psychoanalytic trainer/supervisor; I'm a relational psychotherapist who uses psychoanalytic theory to understand and guide my practice. In this chapter, for example, with the clinical problem of chronic shame in mind, I raise the qualities of therapeutic meeting that emerge differently in the self-psychological and interpersonal traditions of psychoanalysis, and then I note their convergence in contemporary theories about neuroscience, mentalization, and dynamic systems.

All these perspectives support clinical practice that addresses the deeply held patterns of self-with-other relations that make clients' emotional and relational lives difficult. Such practice may or may not be psychoanalysis, strictly speaking. It might be psychoanalytically informed psychotherapy

offered face to face with less frequency and shorter duration of treatment than analysis requires. And while there may be few institutes that specialize in synthesizing relational psychoanalytic theory for use in psychotherapy, I believe such syntheses are being developed daily in the minds, offices, and study groups of relationally-minded social workers, clinical counselors, and psychotherapists across the globe.

This is the viewpoint from which I argue that as therapists we don't have to choose between "empathic immersion in the client's experience" and "active interpersonal engagement with the client." And—to begin at the end of this historical journey—this is exactly what the Boston Group (BPCSG, 2010) has come to: A moment of meeting can emerge only from within a shared implicit relationship created through empathic attunement. Then regular "now" moments ask for something more from the therapist, an ability to risk spontaneous responses that create moments of person-to-person meeting. Profound change happens when an empathic therapist is able to step fully into such moments of encounter.

Relationally minded therapists have known this since Carl Rogers (1942, 1961) put equal emphasis on having unconditional positive regard for clients and on being transparently genuine with them. Healing through genuine presence and an empathic, prizing, *agape* kind of care still serves as ethical mythos for our practice, but how do we enact such care therapeutically? How does this unconditional positive regard help a client to change? This is the side of relational practice that self-psychologists and intersubjective theorists have explored in detail, if not exactly in these words.

The other side of relational practice—being genuine with our clients—is also far more complex than it sounds. What kind of transparency is helpful? How does our being authentically present in therapy help a client to change? Interpersonal/relational psychoanalysts have been speaking to these questions for more than 60 years. [1]

And then there's the crucial practical question: For whom does this treatment of empathic care and authentic interactive presence work? For whom would it be the treatment of choice?

Rogers might have replied: For those who have not yet become "persons"—with a flow of genuine feeling, an authentic sense of being, and positive self-regard. Intersubjectivist self-psychology might answer: for narcissistically injured selves, shaky, riddled with deficit, selves whose psychological organizing principles provide them little comfort, stability,

or joy. Interpersonal/relational psychoanalysis might reply: for those who live stunted, constricted half-lives, denying or dissociating parts of self they can't bear to know, those who have yet to become the choosing subjects of their own existence.

I would say that each of these answers describes from a particular perspective the lives of persons who struggle with chronic shame. In this chapter, I use the challenge of working with chronic shame as clinical context for my core theoretical point: The empathic-developmental and the interactive-interpersonal modes of psychoanalytic practice are powerful and complementary—because both move toward moments of meeting that are simultaneously attuned and interactive. This double kind of meeting is exactly what shame needs for healing; understanding this quintessentially relational malady clarifies for us the nature of relational cure.

Chronic shame

A contemporary understanding of shame belongs at the end of this historical journey, but a brief definition will serve as touchstone along the way. This is the gist of it: chronic shame—the pervasive, debilitating conviction that one is fundamentally flawed—seems to be a static one-person problem. However, this conviction originates in self-with-other experience; something interpersonal *happened* and keeps *happening* to cause this shame (DeYoung, 2015b).

When a developing person fails to find recognition and affirmation in the relational spaces wherein she meets her significant formative others, she concludes: "There's something terribly wrong with me—and this 'wrong' must be as terrible as I feel." She links her fear and confusion not to the absence of attuned connection but to her "terrible" need to be known and loved. Her longing to *matter* becomes her shame, an ugly secret to be protected by social masks and emotional disconnections. Moments of meeting no longer promise comfort or support. Instead, they threaten exposure of "needy" emotions and a free-fall into annihilating shame.

Nevertheless, because of the havoc shame wreaks with her quality of life, this person may risk the exposure of in-depth psychotherapy to get relief. To be of any help, her therapist must understand the relational crux of her suffering, her simultaneous longing and dread to be known. Only within this interpersonal milieu of dilemma and risk of further shame can reparative moments of meeting emerge.

Meeting and shame in the self psychological tradition

In both major relational traditions, the self-psychological/intersubjective and the interpersonal/relational, the problems psychoanalysis treats are caused not by a person's unresolved conflict between instinctual drives and their management but rather by something seriously amiss in a person's experience of relatedness with other human beings. "Cure" or change for the better comes not through bringing conflicts to consciousness but rather through discovering new forms of relatedness that in themselves create new health and freedom. The analyst facilitates this change not through objective interpretation but through subject-to-subject meeting.

Within this major paradigm shift, however, the two perspectives have offered disparate storylines. Kohut (1971, 1984), the father of self psychology, allowed the problem of narcissism to clarify for him the nature of psychoanalytic cure. As a classically trained analyst, he first sought to unmask patients' narcissistic illusions through interpretation. The longer he listened to these patients, however, the more he came to understand their illusions as necessity: as tenacious attempts to undo states of ongoing deficit originating in faulty parent-child relationships and carried forward as insatiable relational "hungers"— to be protected, admired, or special, for example.

The self-deficits of self-psychology are in fact relational deficits carried forward as longings unrequited. At the core of the pain is a failure of interpersonal meeting, a disorienting lacuna where a child's need for attuned response to core strivings should have been met by a parent's capacity to understand the child's subjectivity "from the inside out." In the absence of feeling known person to person, a child's inner world fills up with incoherence and powerlessness; defenses against those feelings become the grandiose and idealizing illusions associated with narcissistic personalities.

Rather than try to strip away such illusions, the self-psychologist seeks to return to those lacunae, so very well protected, wherein meeting failed. The "way back" is through an empathic immersion in the patient's world that privileges his or essential goodness and rightness: his or her desires and intentions are growth-seeking, his or her negative emotions are responses to misunderstanding, his or her defenses are necessary self-protections. ("Unconditional positive regard" comes to mind.)

In this sustained empathic ambiance, the narcissistically wounded patients begin to hope that their therapist might meet them without judgment where they are shamefully vulnerable. Their longings, stifled long ago, stir to life. Could this therapist be their safe home? Could this therapist enjoy their way of being, smile at them with pride? Could they and this therapist share passions, concerns, laughs? In the language of self psychology, self-object transferences are mobilized (Kohut, 1984; Wolf, 1988). Through these merger-like connections with another firmer, empathic subjectivity, a shaky, fragmented subjectivity finds coherence and stability, not only in the moment of connection but internalized over time as self-structure.

Kohut offered his patients not one-way provision for needs nor archaic, "play-acting" wish-fulfillment but rather an invitation to join him in empathic comprehension of their own experience. Updating Kohut, Bacal (1985) spoke of the analyst's "optimal responsiveness"—the flexible ability to be present in any given moment in a way most likely to diminish defensiveness, support more resilient and free self-experience, and help a patient's self-object relationships mature. Clearly, the analyst is present personally for these many moments of thoughtful, responsive meeting; the theoretical focus, however, is on the effects of his or her presence. His or her person can seem to disappear behind the empathy required for treatment. Indeed, interpersonalist critiques of self-psychology jumped on the theme of the disappearing empathic therapist—a counterproductive erasure that is in fact impossible, Bromberg (1989) argued.

Meanwhile, however, theorists such as Stolorow, Brandchaft, and Atwood (1987, 1994) were reshaping self-psychological theory from within by arguing that in human interaction, *inter*subjectivity is never optional. They referred to infant-studies showing that parent-infant interactions are systems of reciprocal mutual influence (Beebe and Lachman, 1988). Young selves are hurt not just by the absence of parental understanding; when their experiences of self-with-other are consistently empty or impinging, their patterns of expectation and response become debilitating negative forces. Maintaining a tie to the Other requires self-organizing principles that distort what the self truly needs (Brandchaft, 1993). Intertwined with self-deficits, these organizing principles create the subjective problems adult patients bring to psychoanalysis; these principles also interact with their analysts' self-organizations to create an intersubjective field of co-transference. In this field, therapist-patient

interactions of attuned emotional understanding rework both unmet need and negative organizing principles (Orange, 1995).

In this intersubjectivist self-psychology, the nature of analytic meeting becomes more complex. The analyst still responds "optimally" to provide a long-overdue safe space for self-growth, and when possible, she repairs breaks in that empathic connection, but she also allows breaks to open into powerful moments of conflictual meeting for herself and her patient. She does so through her willingness to stay emotionally present with the experiences of misrecognition constituted by desires and defenses that come from both sides of the dyadic relationship.

This expansion in quality of meeting expands a therapist's capacity to treat the problem Kohut identified as narcissism and I call chronic shame. Early self-psychologists recognized shame as the underside of narcissism. Morrison (1989) saw shame as faulty self-structure that takes shape when idealizing fails. Broucek (1991) focused on failures of empathic immersion. For Broucek, the origins of shame lie in a child's repeated experience of feeling known not as subject but as object. Objectified, the child feels seen from the outside in, through the parents' evaluations and agendas. Shame takes root as this objectification erodes the child's ability to count on inter-subjective "communion" with the parents.

Self-psychologists have always intended to understand their patients from the inside out. Kohut's key move was from objective to subjective understanding. One of the hallmarks of self-psychological treatment is its counter-shaming way of understanding negative emotions and defenses as laudable self-protections; however, chronic shame is more than the hurt of not being understood; it takes over as destructive patterns of experiencing self-with-other, and this is why it also needs intersubjectivist "meeting." To live within repetitive transference with patients is to live within their experience of relationships as dangerous arenas where power is abused and mistrust rules. It is to seek genuine meeting with them within "worlds of shame" that are constructed by one's own expectations of misrecognition, too.

Orange (2008) maintained that such experiential worlds of shame are transformed only when therapists can sustain radical acceptance of their own and their patient's emotional lives, whatever the pain and damage each suffers. Intersubjectively minded therapists blame no one for the human predicament in which they, too, participate; they seek only to understand what happened and keeps happening to cause the patient or the therapy relationship such trouble. Their relentless interest in the patient's

experience tells patients that they are deeply worthy of respectful regard. They *matter.* Even the most shame-ridden senses of self may be touched by moments of meeting that Orange called *profound recognition*.

Meeting and shame in the interpersonal tradition

Changing how a person's way of *meeting* works from inside *meeting* itself is the essence of the tradition Sullivan (1953) introduced as "interpersonal psychiatry." He believed that curious, reflective interaction with patients about their here-and-now patterns of social interaction could change the me-you patterns of their minds. As interpersonal theory developed, changing the *doing* of relationship remained the reason for interpretation, but with a growing awareness of how unconscious interaction constructs patterns of relationship. Hoffman (1983) explained transference and countertransference as interactive constructions, not distortions, of reality; Mitchell (1997) cast them as the unique ways a patient and therapist have of finding each other.

Within this mutually constructed meeting, therapists experience and express far more than they know or can control. Whereas intersubjectivists attended to the intersubjective field so that their own subjectivity would not compromise optimal response to their patients, interpersonal and relational analysts emphasized therapists' irreducible subjectivity (Renik, 1993)—the constant stream of specific emotions, thoughts, and intentions they bring to therapeutic meeting. Their interactions can't help but communicate personality and self-state, along with subtle unthought reactions to a patient's way of being, and a patient can't help but respond to all of this, too. Such unknown forces aren't a problem as long as therapists work with them; Renik suggested we "surf" these forces instead of trying to control them. What therapists *know* isn't the point—any more than what patients know. The point is to be fully present when meeting patients to help them *do* relationships differently.

Interpersonal/relational thinkers haven't lacked profound empathy for what traumatized patients need to do to keep themselves relationally safe. Bromberg (1989) argued that narcissistic patients need a long period of empathic affirmation to manage anxiety in analysis, but he added that "as adults" they also need to explore the details of their relational lives and to reflect on how they protectively manage the analytic relationship, as they move toward a more interpersonal analysis. Mitchell (1988) talked

about participating in narcissistic patients' gambits to be in grandiose or idealizing forms of relationship with him, accepting that these patterns are the best kind of connection they know, but he also intended to wonder with them—in respectful, well-timed moments—what is lost as well as gained if these forms of relationship remain the only ones possible between them.

Interpersonal/relational analysts have agreed that we short-change our patients if we don't aim to meet them as a full subject. With reference to the creative mutuality between mothers and children, Benjamin (1995) described analysis as a space between subject and subject where each person's self-assertion (and fantasy of destroying the other) is balanced with recognizing the other. In a good hour, this space does not collapse into a relationship in which either therapist or patient is object to the other. Only when a mother (or analyst) is recognized as a subject can a child (or patient) fully experience his own subjectivity in her presence. And this intersubjective meeting requires that she continues to make herself available as a subject to be recognized. Aron (1996) pointed out that when parents are unavailable as subjects, children still try to penetrate to their center; they still need to meet their parents emotional-self-to-self. Likewise, patients try to reach their analyst, and their success is essential to their cure.

Following Benjamin, Aron maintained that intersubjectivity—the capacity for subject-to-subject meeting—is a developmental achievement. Since Sullivan, interpersonalists have also pursued their own developmental vision, positing, for example, that early failures of affirmation produce not a single fragmented self but an experience of different selves in truncated relationship with others: *good-me*, *bad-me*, and *not-me*. Redevelopment through therapy enhances one's authentic *me* in relationship, and the parallel internal change is described not as a more cohesive single self but as new relationships among multiple internal "selves" and newly imagined internal others.

As interpersonal theory merged with object relations theory, it became clearer that psychological problems are caused not by this multiplicity of internalized self-with-other configurations but rather by their dissociation from one another, especially when those dissociated self-other relationships hold within them deep terror, rage, or pain. For Davies and Frawley (1994) and many others, the meeting place of analysis is where the analyst participates in the patient's traumatic self- and object-relational scenarios that, though dissociated, wreak havoc with her or his relational life. These

moments of meeting are fraught with tension; the therapist struggles to move fluidly between each self-other drama without getting locked into any one of them. Healing comes as a patient comes to understand each "self" in its pain and self-protection and is able to move on to more whole, here-and-now relationships with others.

Likewise, Bromberg (1998, 2006, 2011) spoke of analytic meeting as living the patient's unconscious relational fantasies. Enactment allows for a patient to *perceive* different versions of interpersonal reality. New perceptions challenge the truth of old stories. However, health is not the elimination or integration of subnarratives; it's the ability to stand in the spaces between subjective realities without losing oneself or any of them to dissociation.

Dissociation is, for interpersonal/relational psychoanalysis, the main trouble in the unconscious, and it is lived out (enacted) in relationship (Davies, 1996; Stern, 1997, 2010; Bromberg, 1998, 2006). The main treatment question, then, is how therapists perform "presence" in a way that draws absent selves into meaningful relationship. In answer, several themes have emerged. First: Therapists collaborate in making meaning about unthought aspects of what happens in the therapy relationship (Stern, 1997, 2010), meaning that is also a negotiated, paradoxical *doing* (Pizer, 1998). Second: Therapists sustain tension—between enactment and understanding, self-disclosure and non-intrusion, danger and safety (Hoffman, 1998; Aron, 1996; Greenberg, 1986). Third: Therapists use countertransference to create opportunities for meeting, "intimate edges" (Ehrenberg, 1992) where the therapist plays her or his subjectivity cards face-up (Renik, 1999), making space for the patient's fragile subjectivity to emerge. Fourth: by "showing some emotion"—offering intentional connection from a personal, emotional core, holding oneself open to interpersonal surrender and transformation (Maroda, 2002).

Let me share an everyday example of how these different aspects of presence may draw an absent self into relationship. The story: Because of family emergency, I have rescheduled a client's sessions three times in 2 weeks, the first such disruption in 3 years of weekly sessions. On the day my client returns to her normal early morning time, she says she was thinking about not coming. I wonder aloud what's happening between us—making it clear that I truly don't know and would like to figure it out together. In our time together, we have developed a comfortable relationship that includes idealizing, mirroring, and kinship aspects—but

perhaps its safety is also its limit. If my question pushes that limit, any new *doing* will be risky but will also be grounded in mutual trust. Or that's what I hope.

My client is honest. "I feel like for a while you haven't been here, paying attention. Then when I said something about it last session, you said that you're not at your best in the afternoon. But I think that morning or afternoon, you should be here. It's my time."

"You're right," I say. "It was a cheap way to answer you." I want to be honest in return, play with my cards face up. "I think I was feeling guilty about switching things around on you, so I was trying to keep from feeling more guilty. By saying I can't help how I am in the afternoon. Which wasn't about you or your feelings at all." She nods, accepting my words. Something feels unfinished to me, but neither of us has more to say on the subject. She goes on to talk of other things.

Not until the end of the day do I see my part in an even stickier enactment. I realize I had been completely surprised by her protest. It wasn't "like her." What was the meaning of *that* thought?

The next time we meet, I tell her I've been thinking about what's happened between us. "I keep having a thought," I say, "The thought is, 'I've been taking you for granted.'" I have her full attention. "So, for example, you won't get upset if I have to change things; you'll be okay with it." She gives me a bit of a rueful smile. I venture, thinking of her life story as I know it, "I'm thinking this happens to you—has happened to you—a lot." Her eyes fill, and I know there's one more thing I need to say, feeling my own tears rising: "I can see how it would go straight to that place of you're not important to me. That you don't matter to me either."

"Yeah," she says. "I know that one." I just nod, and in our gaze there's something between us that hasn't been there before, something about mattering to each other for real, something that comes by way of our mutual surrender to the emotions moving between us.

Why might this kind of intentional interpersonal presence be especially useful when working with chronic shame? The answer lies in shame's dissociative power. When a parent cannot recognize significant parts of a child's self, the disorganizing pain of not mattering to the other becomes structurally dissociated from the rest of the child's experience. The child's need for loving recognition becomes, in interpersonal/relational theory, a despised, disavowed *not-me*; any reemergence of this need later in life lets loose a flood of shame (Bromberg, 2006, 2011). This shame is a form

of anxiety that strikes with assaultive intensity, threatening psychological annihilation. To survive, the mind continues to dissociate from shame, confining itself to self-stabilizing areas of experience and guarding these safe areas by keeping strict control of self-other interactions (Bromberg, 1998). For my client, for example, it's best not to ever want to matter to somebody. Self-erasure is a habit that makes for safety.

The meeting-space of psychotherapy challenges this safe control, offering the presence of an empathic other with whom a patient can risk interactions that may call up past trauma not yet formulated in narrative memory: the trauma of feeling invisible as a child in the family, for example. To complicate things, while a patient relives past traumas of non-recognition in therapy, the therapist also becomes someone *with whom* the shame of longing to matter becomes, once again, too much to bear.

To preserve the bond with the therapist, the patient dissociates this new need to matter, with its fear, rage, and/or shame, only to enact those feelings in subtle but powerful ways. These enactments elicit corresponding emotions in the therapist that are just as intense and just as dissociated for self-protection. Until the therapist can find a way to be present with what's happening—until mutual recognition can undo mutual shame and dissociation—nothing can change between them, and no new meaning can be made of the events of their relationship (Bromberg, 2006; Stern, 2010).

My client's courage to speak her anger and hurt directly instead of "leaving" in one way or another spared us many hours of mutually dissociated enactment. It let me own a first level of guilt and shame about failing her, and then, on this firmer ground of mutuality, we were able to make contact with the more deeply dissociated interaction between my "taking her for granted" and her "not mattering to me." She had spoken about "not mattering" before, but this *not-me* self had never before been in the room so immediately, so painfully present to both of us.

This being-present that can heal both shame and dissociation requires deep empathy for annihilated *not-me* experience, but it's more than empathy. It's being affectively honest in interactions that are both spontaneous and protective of the patient's affective safety. The therapist must feel, personally, the impact of the patient's *not-me* states and must react to them personally to provide the human context in which these dissociated selves can come alive and be recognized. If the patient is to reflect on the existence of other selves that he or she would like to disown, the analyst must be willing to do likewise with his or her own *not-me* parts

and, as far as possible, Bromberg says, must do so aloud. "Speak—that your patient might see you, in order that his dissociated states of mind may find access to the here and now of the analytic relationship and be lived within it" (Bromberg, 2011, p. 160). I needed to say, "I think I have been taking you for granted."

Mutual dissociated enactments are painful and confusing for both client and therapist, and they don't give way to interpretation. Only a shift in affective relatedness between therapist and client, a nonverbal realization based on shifting affective perception of each other, allows dissociated enactments of shame to dissolve. And only then do a verbal articulation of the process and an expanded self-narrative become possible (Stern, 2010). My client and I felt a shift happen in our gaze, not in our words. We didn't need much story to explain it. However, that moment of meeting opened into a new narrative we're exploring: My client wants to step up and be seen in relationships, and both of us want to be more real and present with each other, even if that means saying things that feel risky.

In the case of profound, dissociated shame, but also in general, the efficacy of psychoanalytic psychotherapy rests on the ability of humans to experience the alive responsiveness of others to the existence of their own mental states. An interpersonal/relational analyst specializes in alive responsiveness; her or his basic "technique" is the ability to navigate useful self-state sharing with her or his patients (Bromberg, 2011). The goal: Where dissociation was, lively subject-with-subject *meeting* will be.

Neurobiology, shame, and empathic/expressive meeting

When Bromberg wrote his book about working with dissociated tsunamis of shame, he invited Allan Schore to write its foreword. There Schore made explicit the connection between interpersonal/relational psychoanalysis and right brain theory (Schore, 2011). Elsewhere, Schore emphasized the mutual resonance between right brain therapy and the self psychological tradition (Schore, 2012). I have borrowed from Schore to define shame in relational/neurobiological terms: *Shame is the experience of one's felt sense of self disintegrating in the presence of a dysregulating other* (DeYoung, 2015b). This definition allows shame to be understood both as an affective state consciously suffered by a self and as an ever-looming affective tsunami that is kept at bay by keeping *not-me* selves out of sight

and out of mind. In treating such shame, the therapist-client interaction—regulating or dysregulating—takes centre stage.

According to Schore, psychological well-being depends on one's capacity for mutual affect regulation, a process made up of myriad moments of meeting between the emotional/relational right brains of dyadic partners. Between parent and infant, this meeting is embodied in a reciprocal flow of changing facial displays, vocal tones, and body energies. Mutual "regulation" sounds like control, but it is actually a spontaneous improvisation of call and response motivated by an innate human need to know and be known in one's affective being. Moments of failed meeting, or dysregulation, are expectable; losing and re-finding the musical beat expands the dance repertoire. However, if severe dysregulation persists, if the infant can find no resonance with her or his affective state, something else happens: distressed hyperarousal and then disconnection. If such moments happen often, a child will make a self-protective habit of dissociating from emotional connection in general, and the development of his or her right brain will suffer. This is the genesis of profound, chronic shame. Shame gains depth and intensity with further experiences of emotional misrecognition, whether inside or outside the family.

Anyone with this relational history expects that emotional contact with others will be dysregulating. If right brain connection carries the threat of shame, it just makes sense to shut down right-brain emotional resonance with self and others and, in compensation, to perfect left-brain performances of self. The outcome of this lifesaving decision can be devastating, however. Even highly rational persons are hurt by emotional isolation. A right brain in pain will make its dissociated distress felt in physical, psychological, and behavioural symptoms. A strong performance of self may barely cover anxious fear of falling into a disavowed, *not-me* self.

In this situation, psychotherapy must begin at the beginning and offer right brain connection in its most basic form: embodied resonance with the client's shifting emotional states. "I see you with my heart and I feel you with my emotions" is right brain being-with and it requires empathic attunement that involves sharing one's own emotional being. Usually, with adult clients, affective states arise as therapist and client co-create emotional/relational narratives of the client's life-experience. As such right-brain connection becomes safer and mutual state-sharing becomes more profound, shamed parts of self will enter the relationship but in interpersonal actions and emotions dissociated from narrative. These

enactments can be welcomed as the only way in which inarticulate shame can speak, the only way, as Schore (2012) noted, that a dissociative client can have an experience of other-with-me *while in the state of not-me*.

Healing is in mutual awareness (not necessarily articulation) of the states being enacted, a shared emotional knowing of what's going on. "Regulation" means this kind of visceral experience of other-with-me. The regulation of enactments, as of all other affective states shared between client and therapist, facilitates the top-down and bottom-up integration of the right brain, linking visceral with emotional with narrative experiences of self.

Most important to my argument: This right-brain way to connect with profound, chronic shame does not privilege either the therapist's empathic attunement or self-disclosure with the client. The two modes of communication coalesce seamlessly in an emotionally expressive and responsive therapist-presence that invites the client into subject-to-subject connection. When I said to my client, "I see how that could go straight to feeling like you don't matter to me," she needed to feel not only my empathy for her pain but my profound sadness to have been part of her not mattering. When she said, "I know that one," I nodded, communicating with my eyes and face that I understood her emotion and could also bear my own emotion within our connectedness. Then she could be there with me; we could be in a moment of meeting together.

Attunement and self-disclosure in mentalizing and in dynamic systemic change

Presence that is simultaneously attuned to the other and expressive of self is also the *sine qua non* of mentalizing. A parent who mentalizes well takes in his or her infant's emotional state and reflects it back to him or her in a way that is based on accurate attunement but is also marked by her or his own subjectivity. The infant has the experience not just of being mirrored but of being emotionally understood by another mind that has its own energies and intentions. Through being "held in mind," children learn that minds exist, their own and others, and they in turn learn to mentalize—to recognize thoughts and emotions in themselves and to imagine the "inside" of others (Fonagy, Gergely, Jurist, & Target, 2002).

The concept of mentalizing has emerged from attachment studies that link secure attachment with parental capacities to hold a child's mind in mind. Mentalizing behaviour is the core of responsive caregiving;

its absence causes relational trauma. Mentalizing theory makes explicit the intersubjective *actions* that turn a parent's empathy for an infant's experience into the shared experience of two minds making emotional meaning; interacting without actively holding an infant's mind in mind *is* the non-recognizing behaviour that leads to shame.

Fonagy and colleagues (Allen, Fonagy, & Bateman, 2008) believed that clients whose childhood relational trauma left them with an insecure working model of attachment need treatment with a mentalizing focus. Therapists do not mentalize *for* such clients; they invite them into a mentalizing process, a shared experience of moving from distress or confusion to "feeling clearly." They respond with interest and acceptance to whatever clients are thinking or feeling in the moment. They bring no prior or expert knowledge to the process, but they do bring transparency about their own understanding as it unfolds. They clarify their intentions, address misunderstandings, and share emotions of their own that belong to the interaction.

Mentalizing interactions, whether parent-child or therapist-client, create the experience of intimate connection between separate thinking/feeling selves. The ability to mentalize allows children to learn to see both sides of a misunderstanding, just as it makes possible mutual dialogue later in life. As Bromberg (2011) pointed out with reference to Fonagy, the development of intersubjectivity depends on whether a person can experience an "other" holding him or her in his or her emotional mind. Safe mentalization includes clients' exploration of their therapists' minds—and finding themselves in the process. Out of this self-with-other process of clarifying emotions, a sense of self emerges, a felt coherence of emotion, thought, and intention, implicitly held in being by another such self.

Therapists keen on mentalizing pay special attention to "mentalizing the transference." Mutual "feeling clearly" about a shared relational experience is an especially potent way to find one's mind in another mind and perhaps to feel self differently when held in mind differently. Such mentalizing can be a process for changing one's implicit procedural knowledge of *how* one can be a self with others. Here mentalization theorists made a direct link to the Boston Change Process Study Group (BCPSG, 2010) and its dynamic-systems understanding of how implicit relational knowing develops and is changed through the interactive meeting of minds.

Like self-psychological intersubjectivists, the Boston Group located the "unconscious" that creates psychological distress or well-being within the unthought principles that organize a person's experience of self-with-

other. Like interpersonal/relational theorists, the Boston Group proposed that this implicit relational knowing "goes live" and can be changed only as it is being enacted with another person. The Boston Group maintained that change in therapy cannot be scripted or even predicted; change emerges out of *qualities* of the therapy relationship that don't simply belong to the "therapeutic alliance," but that can be very precisely specified within the moment-to-moment interactions between client and therapist.

Understanding such change requires seeing the mind as a non-linear, self-organizing system and the therapeutic relationship as a self-organizing system of interaction between two such minds. Each mind brings to the interaction a series of relational moves that each express intention. At this "sloppy" level of micro-process, two minds try to read each other's implicit intentions. Therapist and client feel their way along these unscripted transactions through a process of mutual recognition. When recognition is working well, each feels the fittedness of their mutual responses, and each feels more trust and vitality in the relationship. Through this process, the dyadic system moves to more coherent organizations, though in unpredictable, discontinuous ways. It's within this process that changes in implicit relational knowing happen in small increments and also in the sudden shifts the Boston Group has identified as "moments of meeting."

The Boston Group theorists, like right-brain and mentalizing theorists, have described a therapist who is acutely attuned to the client's state of feeling and intention and who, in almost the same moment, is expressing feeling and intention herself. Within a dyad oriented toward the mutual recognition of relational intentions, such self-disclosure is not optional nor is it a necessary evil; it is a necessary good. When a therapist's empathic, spontaneous self-expression *fits* a client's emerging intention to connect more genuinely, a moment of meeting happens, a "good" powerful enough to change the unconscious.

Conclusion

Analysts aligned both with intersubjectivist self-psychology (e.g., Fosshage, 2009; Hartmann, 2009; Teicholz, 2009) and with an interpersonal/relational perspective (e.g., Bromberg, 2006, 2008, 2011; Stern, 2008, 2010) have integrated neuroscience, mentalizing, and non-linear systems theory into their thinking. As I have argued elsewhere, these newer theories can be seen as emergent properties of "big tent" relational theory, convergent

articulations of its own nonlinear movement toward more coherence (DeYoung, 2015a). At issue here is coherent theory about the necessary simultaneity of empathic attunement and self-disclosing authenticity, especially in work with clients who suffer from chronic shame.

When we move beyond *either/or* to *both/and*, we can discover which *kinds* of empathic/expressive presence fit best for clients who suffer different intensities of shame, hidden by different styles of defense and dissociation. Some clients experience most of the world as "dysregulating other" and live with constant acute disintegration and self-disgust. They need direct right-brain regulation—calming, soothing acceptance—along with our active investment in helping them mentalize. Other clients live quietly with their history of emotional trauma, but depression and anxiety mask intractable self-loathing. They need us to feel with them this unbearable feeling; they need us not to turn away or try to make it better—but also not to give up on them or on facing this shame for what it is. Our clients who are adept at dissociating from their shame need us to engage person to person with whatever parts of self are available to them and to us; our respectful openness with all parts allows hidden, shamed parts slowly to find a voice, in the hope of being known with equal respect and care.

These are but broad strokes of a complex relational approach to treating chronic shame. Each version of shame has a back-story of relational trauma. Each shame-ridden client needs someone who can tolerate empathic immersion in the anguish of shame and the cost of keeping it at bay, and who can also say, "Be with me here; let me know you. I'll be with you for real, too. Let's find our way to a relationship that feels alive and true." In the face of shame, we don't have anything better to offer than a chance at such moments of meeting.

Note

1 The two traditions at issue in this chapter are often designated "relational" and "intersubjective" (e.g., Ringstrom, 2010). For an accurate, inclusive current name for the unifying relational perspective that embraces the interpersonal tradition (as well as object-relations, feminist and social-constructivist themes), I prefer the designation Bromberg (2011) suggests: *interpersonal/relational*. I compare and contrast this current perspective with the *self-psychological/intersubjective*. In my view, the simple term *relational* subsumes both the interpersonal tradition and the self-psychological tradition, both as broadly understood. When speaking

historically, I use the shorter designation, *interpersonalist,* in contrast with *self-psychologist*. Sadly, this chapter cannot not do justice to the complex relationships between interpersonal theory and the various relational themes by which it has been transformed on its way to becoming *interpersonal/relational*.

References

Allen, J. G., Fonagy, P., and Bateman, A. W. (2008), *Mentalizing in clinical practice*. Washington, DC: American Psychiatric Publishing.

Aron, L. (1996), *A meeting of minds: Mutuality in psychoanalysis*. Hillsdale, NJ: Analytic Press.

Bacal, H. A. (1985), Optimal responsiveness and the therapeutic process. In: H. Bacal (ed.), *Optimal Responsiveness: How Therapists Heal Their* Patients, (1998). Northvale, NJ: Jason Aronson, pp. 3–34.

Beebe, B., and Lachmann, F. M. (1988), Mother-infant mutual influence and precursors of psychic structure. In: A. Goldberg (ed,), *Frontiers of Self Psychology*. Hillsdale, NJ: Analytic Press, pp. 3-25.

Benjamin, J. (1995), *Like subjects, love objects: Essays on recognition and sexual difference*. New York: Pantheon.

Boston Change Process Study Group (2010), *Change in psychotherapy: A unifying paradigm*. New York: Norton.

Brandchaft, B. (1993), To free the spirit from its cell. In: A. Goldberg.(ed.), *The Widening Scope of Self Psychology.* Hillsdale, NJ: Analytic Press, pp. 209–230.

Bromberg, P. M. (1989), Interpersonal psychoanalysis and self psychology. In: (eds), *Self Psychology: Comparisons and Contrasts,* Hillsdale, NJ: Analytic Press, pp. 275–291.

Bromberg, P. M. (1998), *Standing in the spaces: Essays on clinical process, trauma, and dissociation*. Hillsdale, NJ: Analytic Press.

Bromberg, P. M. (2006), *Awakening the dreamer: Clinical journeys*. Mahwah, NJ: Analytic Press.

Bromberg, P. M. (2008), "Mentalize This!": Dissociation, enactment, and clinical process. In: E. L. Jurist, A. Slade, and S. Bergner (eds), *Mind to Mind: Infant Research, Neuroscience, and Psychoanalysis.* New York, Other Press, pp. 414–434.

Bromberg, P. M. (2011), *The shadow of the tsunami and the growth of the relational mind*. New York: Routledge.

Broucek, F. (1991), *Shame and the self*. New York: Guilford.

Davies, J. M., and Frawley, M. G. (1994), *Treating the adult survivor of childhood sexual abuse: A psychoanalytic perspective*. New York: Basic Books.

Davies, J. M. (1996), Linking the pre-analytic with the post-classical: Integration, dissociation, and the multiplicity of unconscious processes. *Contemporary Psychoanalysis,* 32: 553–576.

DeYoung, P. A. (2015a), *Relational psychotherapy: A primer*. 2nd ed. New York: Routledge.
DeYoung, P. A. (2015b), *Understanding and treating chronic shame: A relational/neurobiological approach*. New York: Routledge.
Ehrenberg, D. B. (1992), *The intimate edge: Extending the reach of psychoanalytic interaction.* New York: Norton.
Fonagy, P., Gergely, G., Jurist, E. L., and Target, M. (2002), *Affect regulation, mentalization, and the development of the self*. New York: Other Press.
Fosshage, J. L. (2009), Some key features in the evolution of self psychology and psychoanalysis. *Annals of the New York Academy of Sciences,* 1159: 1–18.
Greenberg, J. R. (1986), Theoretical models and the analyst's neutrality. *Contemporary Psychoanalysis,* 22(1): 89–106.
Hartman, H. (2009), Psychoanalytic self psychology and its conceptual development in light of developmental psychology, attachment theory, and neuroscience. *Annals of the New York Academy of Sciences,* 1159: 86–105.
Hoffman, I. Z. (1983), The patient as interpreter of the analyst's experience. *Contemporary Psychoanalysis*, 19: 389–422.
Hoffman, I. Z. (1998), *Ritual and spontaneity in the psychoanalytic process: A dialectical/constructivist view.* Hillsdale, NJ: Analytic Press.
Kohut, H. (1971), *The analysis of the self.* New York: International Universities Press.
Kohut, H. (1984), *How does analysis cure?* Chicago: University of Chicago Press.
Maroda, K. J. (2002), *Seduction, surrender, and transformation: Emotional engagement in the analytic process.* New York: Routledge.
Mitchell, S. A. (1988), *Relational concepts in psychoanalysis: An integration*. Cambridge, MA: Harvard University Press.
Mitchell, S. A. (1997), *Influence and autonomy in psychoanalysis.* Hillsdale, NJ: Analytic Press.
Morrison, A. P. (1989), *Shame, the underside of narcissism.* Hillsdale, NJ: Analytic Press.
Orange, D. M. (1995), *Emotional understanding: Studies in psychoanalytic epistemology.* New York: Guilford.
Orange, D. M. (2008), Whose shame is it anyway? Lifeworlds of humiliation and systems of restoration. *Contemporary Psychoanalysis,* 44: 83–100.
Pizer, S. A. (1998), *Building bridges: The negotiation of paradox in psychoanalysis.* Hillsdale, NJ: Analytic Press.
Renik, O. (1993), Analytic interaction: conceptualizing technique in light of the analyst's irreducible subjectivity. *Psychoanalytic Quarterly*, 62: 553–571.
Renik, O. (1999), Playing one's cards face up in analysis: An approach to the problem of self-disclosure. *Psychoanalytic Quarterly*, 68: 521–539.
Ringstrom, P. (2010), Meeting Mitchell's challenge: A comparison of relational psychoanalysis and intersubjective systems theory. *Psychoanalytic Dialogues,* 20: 196–218
Rogers, C. (1942), *Counseling and psychotherapy.* Boston: Houghton Mifflin.
Rogers, C. (1961), *On becoming a person.* Boston: Houghton Mifflin.

Schore, A. N. (2011), Foreword In: Philip Bromberg, *The shadow of the tsunami and the growth of the relational mind*. New York: Routledge.

Schore, A. N. (2012), *The science of the art of psychotherapy*. New York: Norton.

Stern, D. B. (1997), *Unformulated experience: From dissociation to imagination in psychoanalysis.* Hillsdale, NJ: Analytic Press.

Stern, D. B. (2008), On having to find what you don't know how to look for: Two perspectives on reflection. In *Mind to mind: infant research, neuroscience, and psychoanalysis,* ed. E. L. Jurist, A. Slade, and S. Bergner. New York: Other Press, pp. 398–413.

Stern, D. B. (2010), *Partners in thought: Working with unformulated experience, dissociation, and enactment.* New York: Routledge.

Stolorow, R. D., Brandchaft, B., and Atwood, G. E. (1987), *Psychoanalytic treatment: An intersubjective approach.* Hillsdale, NJ: Analytic Press.

Stolorow, R. D., Atwood, G. E., and Brandchaft, B., eds. (1994), *The intersubjective perspective.* Northvale, NJ: Jason Aronson.

Sullivan, H. S. (1953), *The interpersonal theory of psychiatry.* New York: Norton.

Teicholz, J. G. (2009), A strange convergence: Postmodern theory, infant research, and psychoanalysis. In: R. Frie and D. Orange (eds), *Beyond postmodernism*: *new dimensions in clinical theory and practice*. New York: Routledge, pp. 69–91.

Wolf, E. (1988), *Treating the self: Elements of clinical self psychology.* New York: Guilford.

Chapter 7

The therapist's capacity to tolerate the intolerable

My tears, not his

Martha Stark

How does a therapist come to know her patient's experience and, once known, what does she do with that knowledge? Elsewhere, three modes of therapeutic action have been proposed – each one of which involves a different positioning of the therapist in relation to the patient (Stark 1994a, 1994b, 1999).

Three models of therapeutic action

In Model 1, the interpretive perspective of classical psychoanalysis, the therapist arrives at understanding by *neutral observation* of the patient – and use of her head. In fact, Freud suggests that the therapist should strive to achieve the objectivity of a surgeon and to function as a blank screen onto which the patient can then displace and project, which will be the primary way in which the therapist comes to know the patient's inner workings.

In Model 2, the corrective-provision (or deficiency-compensation) perspective of self psychology and those object relations theories that emphasize the *internal absence of good*, the therapist arrives at understanding by *empathic attunement* to the patient's experience – and use of her heart. As an empathic selfobject, the Model 2 therapist decenters from her own experience, joins alongside the patient, and enters into the patient's experience. But the therapist takes it on only *as if* it were her own because it never actually becomes her own.

In Model 3, the intersubjective perspective of contemporary relational theory and those object relations theories that emphasize the *internal presence of bad*, the therapist arrives at understanding by *authentic engagement* with the patient – and use of her own experience. As an authentic subject, the Model 3 therapist remains very much centered

within her own experience, allows the patient's experience to enter into her, and takes it on *as* her own.

If early-on trauma and abuse experienced by a child at the hands of her parent cannot be adequately processed and integrated into healthy psychic structure (the province of Model 3), then the unmastered experience becomes structuralized in the mind of the developing child as a sense of *internal badness.* The clinical challenge then becomes: Once traumatizing experience has become internally recorded as badness, how can it later be accessed in the treatment and detoxified?

To answer this critically important question, the concept of countertransference comes into play, and the therapist's capacity to tolerate what the patient finds intolerable then becomes the linchpin of the treatment. Whereas in both Model 1 and Model 2 countertransference is thought to be an obstacle to understanding, in Model 3 it will be the therapist's *use of self* that enables her to arrive at an understanding of the patient on the deepest of levels, thereby advancing the therapeutic endeavor.

Unlike Model 2, which pays relatively little attention to the patient's activity in relation to the therapist, Model 3 addresses itself specifically to the force field created by the patient who, under the sway of her repetition compulsion, will be ever busy reenacting with her therapist the same abusive scenarios to which she had been subjected as a child. As with every repetition compulsion, the patient's need to recreate the early-on traumatic failure situation in the therapy relationship has both unhealthy and healthy aspects (Stark 1994a, 1994b, 1999).

Belated mastery

The unhealthy component has to do with the patient's need to have more of same, no matter how pathological, because that is all the patient has ever known. Having something different would create anxiety because it would highlight the fact that things could be, and could therefore have been, different; in essence, having something different would challenge the patient's attachment to the infantile (parental) object. However, the healthy piece of the patient's need to be now failed as she was once failed has to do with her need to achieve belated mastery of the early-on parental failures – the hope being that perhaps this time there will be a different outcome and a better resolution.

More specifically, the patient's activity in relation to the therapist is seen as an enactment, the unconscious intent of which is to engage the therapist

in some fashion – either by doing unto the therapist *the bad* that had been done unto the patient as a child or by drawing the therapist in to doing unto the patient *the bad* that had been done unto the patient as a child. In fact, the patient may know of no other way to get some unmastered piece of her early-on experience understood than by reenacting it in the relationship with her therapist.

A well-conducted psychodynamic psychotherapy will offer the patient an opportunity – albeit a belated one – to gain mastery of unprocessed and unintegrated traumatic experiences that have created psychic scars in the form of a sense of oneself as bad and, by projection, of others as bad. Again, how exactly can that sense of internal badness be accessed – so that it can be processed and integrated into healthy psychic structure?

The obvious answer is that the therapist can gain access to the patient's intrapsychic contents by way of the patient's projective identifications, whereby the patient (as noted above) will reenact her relational traumas in the transference, thereby forcing her therapist to experience aspects of what the patient has not yet been able to process and integrate on her own. Resolution will be achieved once the therapist has been able to step back from her participation in the patient's dramatic reenactments, such that she can bring to bear her own, more evolved capacity to process and integrate. What then gets returned to the patient will be slightly detoxified and therefore more manageable.

Projective identification has two phases (Stark 2015a, 2015b). The induction phase commences once the patient projects onto the therapist some aspect of the patient's experience that had been too toxic for the patient to process and integrate and then exerts pressure on the therapist to accept that projection, thereby inducting the therapist into the patient's enactment.

The resolution phase is ushered in once the therapist steps back from her participation in what has become a mutual enactment and brings to bear her capacity to process and integrate on behalf of a patient who does not know how – such that what is then re-introjected by the patient can be more easily assimilated into healthy psychic structure. And, if all goes well, these cycles of induction and then resolution will happen repeatedly, the net result of which will be gradual detoxification of the patient's internal toxicity. Especially in contemporary relational theory, projective identification is a critically important aspect of the therapeutic action.

Introjective identification

But that is only half of the story. Let us now speak to the rather poorly understood, and almost completely neglected, topic of *introjective identification* – an intriguing construct that has been variously, and confusingly, described in the psychodynamic literature as involving sometimes taking in, and identifying with, some admired aspect of the object (Freud, 1937) and sometimes taking in, and identifying with, the bad object (Klein, 2002). I propose, however, that we use the concept of introjective identification to describe what happens not when the patient initiates the therapeutic action by exerting pressure on the therapist to take on some aspect of the patient's unmastered experience (as happens with projective identification) but rather when the therapist initiates the therapeutic action by entering into the patient's internal world and taking on some aspect of the patient's unmastered experience.

Introjective identification takes place in not only the patient-therapist relationship but the infant-mother relationship. Certainly, a good mother who is attuned to her infant's moment-by-moment experience will use introjective identification as a matter of course. For example, an authentically engaged mother, sensing her infant's distress, will enter into the infant's dysregulated affective state and take it on as her own, lending aspects of her more evolved capacity to a processing and integrating of her child's unmastered – and overwhelming – experience. The mother will do this intuitively and repeatedly, the net result of which will be dilution and modulation of her child's experience of distress – and eventual development of the child's capacity to manage overwhelming affect on her own. As this process continues, the child's need for external regulation of the self will become gradually transformed, over time, into the capacity to be internally self-regulating.

The following vignette, which speaks to the power of introjective identification, describes what happens not when the patient initiates the therapeutic action by exerting interpersonal pressure on the therapist to take on some aspect of the patient's unmastered experience but rather when the therapist initiates the therapeutic action by entering intuitively – and not altogether unconsciously – into the patient's internal world and taking on some aspect of the patient's unmastered experience.

Clinical vignette: Thomas – My tears, not his

I had the privilege and pleasure of working with Thomas for 6 years (from 2000 to 2006), during which time he went from being a dissociated, alienated, lonely, frightened "control freak" to being a wonderfully engaged man living his life in an authentic and heartfelt way.

When first he came my way, Thomas was 29 – a tall, lean, prematurely white-haired, handsome, bespectacled man – a college dropout who had nonetheless managed, by dint of his hard work to become the owner of a fairly successful local restaurant. He presented with an agitated depression, reporting that his personal life had become a total "mess" because of some really "bad choices" that he had made along the way. Thomas said he was desperate and needed my help in figuring out what he should do to straighten out his life.

Thomas was in a painfully empty marriage to Sandra (whom he had known since high school and with whom he had had two children – Jimmy and Dan); he was having a passionate affair with a wonderful woman named Molly (whom he considered his soul mate); he was dating Kathy on the side because he was afraid to commit to Molly; he was still sexually involved from time to time with Sara (an old girl friend) because he could not bring himself to break things off with her; and he was the father of an illegitimate child by Jane (a one-night stand years earlier that had produced a little boy named Kyle, whom Thomas was allowed to see only occasionally). Thomas – who loved music, played guitar, and was himself a songwriter – once said to me, with a slight, self-deprecating twinkle in his eye, "There should be songs written about having four women – but, now that I think about it, who would be interested in such songs?"

Sometimes, when Thomas was feeling especially bad about his "roaming eye," he would "practice not being attracted to other women," but he was never able to sustain his abstinence for long because he was so terrified of being alone. In the meantime, Thomas lived by the rule: "Never get so close that it hurts when they leave."

Thomas was wracked with guilt about everything. He "managed" his complicated life and what he called his "moral badness" and "sinful existence" by engaging in numbers of compulsive rituals and routines, by keeping himself always "at a remove" from too much involvement in any one thing, and by maintaining "rigid robotic-like control" at all times. He was a "clean freak" who took four showers a day, carefully wiped down

the engine in his car every week, and washed the outside of his house three times a year. Disciplined, structured, regimented, controlled – constructs he lived by. He loved symmetry, balance, and organization.

One of Thomas's rituals centered around managing the delicate strings that he experienced as being attached to his back. He knew they were not really there; but, even so, their imagined presence (and their tendency to become entangled) troubled him deeply. Way in advance of his appointment time, Thomas would drive to my office, carefully get out of his car so that the strings would not get tangled, walk up my driveway using the same number of steps every time, come around to the back of my house, and enter the sun porch waiting room. Once inside, however, things would get a little more complicated. He had explained to me that it was easiest for him simply to remain standing quietly at attention inside the sun porch door instead of attempting to sit because, in turning his body to take a seat, he might create an intolerably anxiety-provoking entangling of the strings.

Upon entering my office, he would carefully take a seat, knowing that, at the end of the hour, he would then need to "undo" everything by reversing the sequence of actions that had brought him to that spot. Very carefully, therefore, Thomas would back out of my office, out of my waiting room, down the driveway (the same number of steps down the driveway as steps up the driveway), and into his car, without having messed up the strings. Thomas was a graceful man with a soft elegance, so he was able to manage all of this with such finesse that, unless you watched him closely, you might never notice.

Thomas's goal in life, at that early stage in our treatment, was to keep his "path" as uncomplicated as possible, so that he would be able to avoid the potential for entanglement of his strings – and, thereby, a shortening of his life. He recognized the irony in this – that he, whose life had been immeasurably complicated by virtue of the many "bad choices" he had made in his time, would be now so intent upon simplifying things. However, Thomas, as he described it, was "deathly afraid of dying." Were the strings to become entangled and their length thereby shortened – well, the thought of that was terrifying for Thomas and an all-too-poignant reminder of the finitude of life, the terrifying passage of time, and the inevitable end… He was tormented by thoughts of his own mortality and the knowing that nothing would last forever, nothing was permanent.

Thomas would tell me: "I have always thought that you should not think about things that bother you. You should pretend the problems are

not there. If you need to, you can have 'scheduled unhappiness,' whereby you designate a certain period of time to think about how unhappy you are. But then it is important to move on."

In a desperate attempt to ease his angst, Thomas had been drinking alcoholically for more than 20 years – although, shortly into his treatment, he stopped drinking on a dime when I happened to suggest, as a throwaway comment, that the drinking might be contributing to his agitation and his despair.

Not surprisingly, Thomas, for whom "being in control" was a top priority, wanted always to be in control of our sessions and of what he talked about – which was totally fine with me. And so the "process" between us unfolded gradually, organically, with Thomas always leading the way. In our sessions, he would share details about his life, speaking always in his "reporter mode"; between our sessions, he would often leave me messages on my voice mail in which he would "report in" with details about his week – "It's Thomas, reporting in…" he would always say. Whether in the session or between sessions, never the feelings, simply the facts. Again, all of this was just fine with me. I, meanwhile, was becoming very, very fond of this dear man whose vulnerable, tormented soul was racked with such guilt, sadness, and pain.

Thomas's dad had been a very successful dentist, universally liked and admired – but he was a demanding father with very high standards. He was "very exacting," said Thomas, "good for the teeth but not for the son." His mom, an actuary, was a good woman but with more "head" than "heart." Both parents were often absent – physically and emotionally. Early on in our work, Thomas said very little about them – other than that he had loved them and they had loved him.

There came a time in our work when Thomas began to talk about a dear childhood friend, Bobby, with whom he had been very close. He and Bobby had lived next door to each other for many years and would play together for hours on end – make-believe games in which both would have superhuman powers and no vulnerabilities – and they would live forever.

Thomas had loved Bobby dearly and was devastated when, with neither advance notice nor explanation, Bobby and his family had suddenly left town (when he and Bobby were both nine). They never even had a chance to say "goodbye." Thomas, dissociated but clearly in pain, reported to me that he had never fully recovered from his grief about the loss of Bobby,

that some part of him had died the day he found out that Bobby was, simply, gone. As he recounted the details of their very special relationship and then Bobby's sudden, incomprehensible, and devastating departure, Thomas shed no tears; rather, it was I who began to tear up as Thomas spoke of his heartbreak.

Thomas witnessed my tears but made no mention of them – nor did I. But to the next session he came, bearing a poem that he had written over the course of the week in honor of his deep friendship with Bobby. It was entitled "Sometimes Sad, Forever –"[1]

When you and I were young,
We were forever,
We were in control,
And anything, everything was possible.

Our lives were as one,
Though not really.
I was you,
Though never quite.
Always, simply, wanting to be.

But then you slipped away.
Unscheduled. Forever.
Leaving me behind
With this sadness, this pain, this loneliness
that never lets up. Ever.

My dreams came crashing down around me
through a frightened void
shattered…
splinters lying, like an abandoned jigsaw puzzle
pieces missing – like my life.

I love you, Bobby.
Forever and for always.
But you are gone from me.
Where did you go?
I am lost – and so desperately lonely without you.

Again and again, Thomas would ask rhetorically: "Why would you want to love someone if they're going to leave you, anyway?"

Thomas had been an only child until he was 11, at which time his younger sister had been born. He reported, "I was mean to her because I always thought that she was smarter than I was. She was a weird eater – 5′6″ and 100 pounds. I told her I didn't want her to die on me."

His sister did not die; but, when Thomas was 21, his father did – a horrific death, from cancer of the head of the pancreas.

Thomas reported: "I felt responsible for his death. When I was young, I had been my dad's pride and joy. But, in high school, I began to live irresponsibly, drinking, drugging, lots of sex. I knew I was letting my dad down. I think he had wanted me to be a dentist, just like him. I was good with my hands and probably would have made a good dentist. But, in my late teens, I wasn't caring much about stuff. I was just living on the edge – indulgently, destructively. I got a girl pregnant and then headed off to Europe. I was running away from everything."

Thomas continued: "I didn't tell my dad until some time later. He was devastated and said he never wanted to meet my son (almost 2 by then). That was the only time we ever spoke about Kyle. We never talked about things like that."

Thomas could not forgive himself for having given birth to a child out of wedlock in the first place and then for having burdened his father with the knowledge of it.

Thomas told me: "One day, months later, my dad invited me to have lunch with him. It was surprising because he had never done this before. But we never had that lunch. He suddenly got very sick and was diagnosed with bad cancer. I have always wondered what he would have wanted to talk to me about. In my life, there is Part 1: The time before my dad got sick. Then there is Part 2: The time after my dad got sick."

Later, Thomas reported: "My dad was so disappointed in me. I know I let him down terribly. I think I broke his heart. I wasn't the son he had wanted me to be. He had the cancer, but I think he died from a broken heart."

As was often the case, whenever Thomas would talk (he – ever the reporter) about his pain, his internal turmoil, his racking guilt, his sadness, his heartbreak, his anguish, his loneliness, it was I who would cry. And it happened a lot. Seeing my tears, Thomas would reach for the box of Kleenex beside his chair and hand it to me. I kept the box of Kleenex beside the patient chair and not my own because, with most of my patients,

I myself did not usually need the Kleenex. As I cried, Thomas would sit very still, patiently, gently, tenderly, until I had composed myself and my tears had passed – and then he would continue. Again, we never talked about my tears or what they might mean to him – or to me for that matter! It's just what we did together. He would speak of his heartbreak, and I would cry. And I loved it that he would then offer me that Kleenex.

One particularly poignant moment was when Thomas was telling me about how he would regularly visit his father's gravesite (even those many years later), where he would talk for hours and hours on end, softly, lovingly, apologetically, to his dad about his son Kyle and his regret and his guilt and his shame and all the things he wished he had been able to talk about to his dad "in the living years." Thomas would leave a special bouquet of carefully selected flowers for his dad because he knew how much his dad loved flowers and gardens (an interest they had shared).

As Thomas talked about one of the visits to his father's gravesite, I found myself crying so much – I was sobbing, actually – that Thomas had to stop talking for quite a while. Once my tears began to subside, Thomas asked me, gently, if it was OK for him to continue. I said, "I need another moment, please." So he sweetly waited. Again, Thomas and I never talked about my tears or his lack of them. And that worked for us both.

Thomas loved it when I suggested to him one day that "grieving on your own is very inefficient – but sharing the grief with someone else will make it so much more efficient." Thomas responded, "OK. You know, I had never really understood how you could complete something with someone who was already dead. Once you die, you're dead. Like a rock. But maybe I could, you know, share the grief with you."

Shortly thereafter, Thomas brought me another poem, which he had just written for his dad.

A Song to My Dad

Dad, I'm writing you this letter, pretending you'll get to know its contents
But, when I imagine your eyes, dried like raisins left lonely in their sockets
I feel the futility of it all, writing a letter that you will never read,
another exercise in self-indulgence
Just time wasted.

The last time I wrote to you, when I was 10
or was I in college?
I guess it doesn't really matter.
The mandatory letters, meaningless anyway.

Now as I prepare to let you in
It is too late
Fourteen years or so – too late.

When we were told that you would be dying soon
when I climbed, shaking, the stairs to visit you in the hospital,
my guts retching
I, always so good with words,
shrieking inside "Fuck you, God!!"
And there you lay, rotting,
on the Bullfinch Ward at the Mass. General, a lobby for the almost dead.

I wonder, if you were to sit here with me,
if I could make you know how much I love you
and how much I miss you – and how sorry I feel.

I wonder, if I screamed it in your face,
As I have so many times at the Linwood Cemetery,
if you could ever know how much I ache for you.

I need you to tell me you love me – in spite of it all
I need you to lie to me if necessary
That would be OK.

Then you could hug me like you used to when I was very small
and not yet a disappointment
and you weren't dead
or like you would have if I had let you
or like we did that time in the garden after we made it so beautiful
and full of life,
or as I should have when you became empty…
your life freshly ripped from its turncoat cocoon
by the bad cancer that would not relent.

You were dead
you were dead too soon
you are dead forever.

It feels very empty in here
I was told that after the mourning period, things would feel better
but my mourning period is lasting forever it seems,
a just punishment.

I have fathered some children you would love
they would love you
they would want to spend some of their lives with you
you could hug them whenever you wanted
I could watch with pride, even as I was feeling envious longing,
hoping no one would notice…

I've done a lot of disappointing since you left
I can't seem to shake it
I can't ever be you
I'm sorry
I didn't mean to kill you.

I love you,

Thomas

One day, Thomas, who had always come on time for every single one of his sessions (in fact, sometimes up to 30 minutes early), Thomas came 5 minutes late and was totally distraught. To complicate matters, he was concerned that, in his haste, the "strings" attached to his back might have become entangled. Time, of course, every single moment, was so very precious to him. Ordinarily, I would not make up the time to a "late" patient – but, with Thomas, I wanted to; and so I told him that I would like to make up those five minutes to him (at the end of our session). Thomas was able to let me know that it meant the world to him, that I would have been willing to do this – and, I believe, it marked one of several watershed moments in the treatment. For reasons never entirely clear to either of us, after I gave him those five minutes back, Thomas found himself becoming

less and less concerned about the strings and their potential entanglement. In fact, he kind of forgot about the strings period – much as a young child, one day, simply lets go of his little blankie.

Over the course of our 6 years together, Thomas turned his life around. As he (and I) grieved the loss of Bobby and, later, the loss of his dad, his heart began to heal – and he became more engaged in life, more invested in life, less afraid, more grounded, less terrified of dying, more present, less frantic about the passage of time, more committed to living right and well and authentically, in the moment and with passion.

Some time before the end of our work together, Thomas had divorced his wife, stopped seeing the other girl friend, and called things off with his sometime lover. Meanwhile, he and Molly were getting very serious and building a beautiful home on a lake (the outside of which Thomas was not planning to wash!).

One month before we terminated, Thomas and Molly invited Kyle to join them and Thomas's two other sons (Jimmy and Dan) for a day at the beach on the lakefront property – all five of them spent a magical day, that was both playful and intimate – which marked a turning point in Thomas's relationship with Kyle. As he told me about that very special day, it was incredibly touching. I knew how incredibly important it was to him. More tears. Mine, of course. Throughout our time together, Thomas had never once shed a tear. But that was fine.

Thomas told me that one of the most comforting things I had ever told him was when I had shared with him the idea that if you were blessed enough to be in a mutually loving relationship with someone who cherished you as much as you cherished her, then inevitably either you would end up losing her (whether to death or to something else) or she would end up losing you. And that's just the way it would go – an excruciatingly painful and sobering reality with which all of us must eventually make our peace. Thomas said that my sharing this "fundamental truth" with him had been both clarifying and tremendously reassuring – it had helped him to feel less frightened and less alone.

Then there came a time when we both knew that it was time to say goodbye. And we were ready for it, sad as it was (for both of us). To one of our last sessions, Thomas brought his guitar and played for me Luther van Dross's heart-wrenching song entitled "Dance with My Father" – about a young boy's longing to be able to dance, just one more time, with his dearly beloved but long-departed father. "I never dreamed that he would

be gone from me/If I could steal one final glance, one final step, one final dance with him/I'd play a song that would never, ever end/'Cause I'd love, love, love/To dance with my father again."

I now share with you what happened in the final moments of our last session. At the very end, when Thomas stood up to leave for the last time (no longer worried at all about any "strings attached"), I – with lots of tissues by my side – reached out my hand to shake his. He immediately reached for my hand – and I then placed my second hand around his. Then he, after only a moment's hesitation, slowly raised his second hand to his face – and, as I followed the movement of his arm, I could see that he was pointing to the tears that were welling up in his eyes and beginning to roll down his cheeks. He smiled sweetly at me through his tears – and I, through my own, smiled back. A very, very special, tender moment that needed nothing more…

Thomas has stayed in touch over the years – and periodically comes in for a "touch-base session." He and Molly ended up going into business together and now run a chain of very successful, high-end restaurants. As Thomas had noted, when first he came to me, he had four women and one restaurant – now he has one woman and four restaurants! We agreed that although you probably wouldn't want to be writing a song about having four women, you could probably write a pretty interesting song about having four restaurants!

Thomas and Molly gave birth to two lovely girls (Christie and Joni), and their beautiful lakefront house is now home to these two daughters and Thomas's three sons. Thomas is supremely happy and tells me that his life is now filled with moments of intense joy. He is aging gracefully. He is no longer afraid. His heart has healed and he has found internal peace. He no longer has the loneliness, no longer feels alienated, no longer dissociates, and is no longer a "reporter." And sometimes he cries – when he feels like it. He still visits his dad's gravesite; but he now feels that he carries his dad inside of him – that, at the end of the day, he did kind of end up being a lot like his dad. Ever humble, Thomas tells me, with quiet, heartfelt gratitude and pleasure, that he knows his dad would be proud of him. And I, personally, am quite sure that Thomas is right about that.

Discussion

With respect to the processing and integrating of unresolved grief, there is an important clinical distinction to be made here between the empathic

attunement of Model 2 (in which the therapist decenters from her own experience, joins alongside the patient, and takes on the patient's experience – but only as if it were her own because it never actually becomes her own) and the authentic engagement of Model 3 (in which the therapist allows the patient's experience to enter into her and takes it on as her own).

In the first instance (of empathic attunement), the therapist will resonate with, and validate, the patient's experience of grief – but it will be the patient who must do the grieving as he, on his own, confronts the painful reality of his devastating heartbreak. Borrowing from Winnicott (1960), the patient will be "alone (with his grief) in the presence of (a caring other)" – but alone he will be.

In the second instance (of authentic engagement), the patient will be not "alone in the presence of another" but "sharing the experience with another" who is willing and able (with shared mind and shared heart) to feel, along with the patient, the pain of the patient's devastating heartbreak – such that the patient's experience of grieving need no longer be such a lonely one.

In my work with Thomas at our intimate edge, I myself (by way of introjective identification) experienced Thomas's incredible pain and shed *his* tears until he himself was eventually able to tolerate the once intolerable pain – and shed *his own* tears.

Conclusion

At the beginning of this chapter, the question had been posed as to how traumatizing experience, internally recorded as badness, could later be accessed in the treatment and modified. The answer had been both projective identification and its counterpart – introjective identification. Both mechanisms involve detoxification of dysfunctional relational dynamics and one's sense of internal badness. However, whereas projective identification involves the patient as initiator of the therapeutic action, introjective identification involves the therapist as initiator of the therapeutic action.

The hypothesis is here being advanced that introjective identification is a powerful relational dynamic that takes place continuously at the intimate edge of authentic engagement between not only infant and parent but also patient and therapist – and most certainly took place in my work with Thomas, especially with respect to his profoundly overwhelming grief and the tears he could not shed.

Note

1 The two poems by Thomas featured in this chapter originally published in *Psychotherapeutic Moments: Putting the Words to Music* (published by the International Psychotherapy Institute, 2015); reprinted with kind permission.

References

Ehrenberg, D. (1992). *The intimate edge: Extending the reach of psychoanalytic interaction*. New York: W. W. Norton & Co.

Freud, S. (1937). Analysis terminable and interminable. *International Journal of Psychoanalysis,* 18:373–405.

Klein, M. (2002). *Envy and gratitude and other works* (1946–1963). New York: The Free Press.

Mitchell, S. (1988). *Relational concepts in psychoanalysis: An integration*. Cambridge, MA: Harvard University Press.

Stark, M. (1994a). *Working with resistance*. Northvale, NJ: Jason Aronson.

Stark, M. (1994b). *A primer on working with resistance*. Northvale, NJ: Jason Aronson.

Stark, M. (1999). *Modes of therapeutic action: Enhancement of knowledge, provision of experience, and engagement in relationship*. Northvale, NJ: Jason Aronson.

Stark, M. (2015a). *The transformative power of optimal stress: From cursing the darkness to lighting a candle*. International Psychotherapy Institute. www.FreePsychotherapyBooks.org .

Stark, M. (2015b). Integrative psychotherapy: Healing the MindBodyMatrix. In: J. Greenblatt, and K. Brogan (eds), *Integrative therapies for depression: Redefining models for assessment, treatment, and prevention*, Boca Raton, FL: CRC Press/Taylor & Francis.

Winnicott, D. W. (1960). The theory of the parent-infant relationship. *International Journal of Psychoanalysis,* 41:585–595.

Chapter 8

Living inside the moment

A view from self psychology

Denise Davis

One year into my own analysis, I remained plagued by a question I had asked my analyst when our work began: "Could this have happened to anyone?" The especially gray Chicago day matched my mood, and I dared to return to this question, choking back tears as I clarified, "But, what I really need to know is…" "Could this have happened to me?" He completed my sentence with this question, resonating implicitly with what I needed to know. In my vivid memory of the moment that followed, he tilts back his head, closes his eyes, and responds slowly and thoughtfully with a specific personal example, detailing exactly how he could have been in the same disastrous situation. Under similar circumstances, he too would have been adrift in the same shame-saturated boat. This experience-near response (Kohut, 1990) liberated me from the burden of shame that I had carried for 18 years and gave me hope that I could move out of the isolation that accompanied it. This "moment of meeting" (Stern, Sander, Nahum, Harrison, Lyons-Ruth, & Morgan, 1998), an indelible moment for me, transformed the contour of the relationship between us and indeed reshaped my relationship to myself, creating an expanded sense of what was possible. Moments of meeting shift the internal and relational landscape so that we find ourselves standing on new terrain.

The Boston Change Process Study Group (BCPSG) recognized moments of meeting, and their precursors, now moments, (Stern et al., 1998) as powerful agents of change. These most memorable moments adhere to patients' memories and psyches long after termination. They buoy us in dark times, illuminate our way when we are lost, and keep us on track when transition threatens to derail us. Moments of meeting are interpersonal touch points that are deeply resonant with selfobject longings. These moments, valuable and enduring, are always "something more" (Stern et al., 1998) but feel like something just right. By studying

microprocesses, BCPSG placed moments of meeting at the epicenter of therapeutic action. I look carefully at BCPSG's breakdown of moments of meeting, discuss the usefulness of self psychology in creating moments of meeting, and challenge some of the properties BCPSG sees as intrinsic to these moments. Clinical illustrations illuminate a self psychological approach to the evolution of moments of meeting.

The power of a moment of meeting

BCPSG asserts that a moment of meeting is "the event that rearranges implicit relational knowing for patient and analyst alike" (Stern et al., 1998. p. 906). In a moment of meeting, the dyad will feel a "sudden qualitative change." Implicit relational knowing (Lyons-Ruth et al., 1998a), the way that we know how to be with another person, shifts initially in the context of the therapeutic dyad and ultimately in the patient's outside world. In a moment of meeting, the participants mutually understand each other's minds with regard to the immediate state of their relationship. Present moments precede now moments or moments of meeting and are the steps in "moving along," the process of "struggling, negotiating, missing and repairing, midcourse correcting, and scaffolding" (Stern et al., 1998, p. 907). Now moments are special present moments, special because of their richer affective texture and the opportunities they provide for creating new ways of being together. They launch both the therapist and the patient decisively and firmly into the present that is alive between them.

According to BCPSG the subjective experience of the now moment is composed of three phases: the "pregnancy phase," marked by a sense that something is about to happen, the "weird phase" that elicits a feeling that something unexpected is about to occur intersubjectively, and the "decision phase," when the therapist elects whether or not to seize the moment and facilitate the intersubjective shift. Moments of meeting are "now moments" that the therapist grasps, seizing the opportunity to propel both patient and therapist toward a novel and shared relational experience. This process establishes and reassembles what the pair will talk about, and it redefines the implicit intersubjective environment for the dyad. It leads to the construction of the goals and the tenor of the experience that the two will share at least in the immediate future.

A moment of meeting is co-created by each person contributing something unique. This new implicit relational knowing ushers in a state

that includes more than what either participant can create independently, resulting in a dyadic expansion of consciousness. (Tronick et al., 1998) From that stage forward, the couple's interactions will take place within this new arena until further expansion of their dimensions of experience invariably prompts additional moments of meeting, deepening and broadening their implicit interpersonal domains. In delineating the elements of now moments and moments of meeting, the BCPSG describes,

> The therapist must use a specific aspect of his or her individuality that carries a personal signature. The two are meeting as persons relatively unhidden by their usual therapeutic roles, for that moment. Also the actions that make up the moment of meeting cannot be routine, habitual, or technical; they must be novel and fashioned to meet the singularity of the moment.
>
> (Stern et al., 1998, p. 913)

Sustained empathic immersion guides moments of meeting

Building on BCPSG's retrospective examination of moments of meeting, I am eager to explore moments of meeting from a prospective vantage point to understand how to facilitate more moments of meeting. If we accept the premise that moments of meeting are the engine of relational change, focused attention on their promotion in the psychotherapeutic relationship is essential. Self psychology's emphasis on empathic immersion as a data-gathering tool (Kohut, 1959) and mutative force (Kohut, 1981) leads robustly to the emergence of moments of meeting. Sustained empathic immersion incorporates an assessment of the patient's developmental phase at the moment within the treatment, with close attunement to the location of the patient's greatest affective engagement. This includes organizing what we hear with an ear toward affectively valenced selfobject longings. Self psychology de-emphasizes codified technique and instead understands that empathic understanding drives technical intervention. A moving illustration from Arnold Goldberg's edited casebook exemplifies a moment of meeting that is an organic outgrowth of sustained empathic immersion with a patient who generally felt depressed and depleted during the weekend separation from his analyst:

> One Monday Mr. E. told me that he had spent a considerable portion of Friday and Saturday frequenting men's rooms. He reported a sense of feeling bizarre. In a desolate voice, he reported having spent the times he was not in men's rooms painting empty chairs in his apartment. Suddenly he shouted, "I demand to know what you are thinking. You think I'm a psychotic, don't you? I replied, "I think you must have been very lonely." There was a pause, and then he burst out crying. When he was able to speak again, he said in a choked voice, "That was the first time anyone ever realized that." He paused again and added, "And I think that includes me." The analyst then explains, Only in being responded to by being understood could he believe himself to be acceptable, valid in his person, and not beyond the pale of humanity. He couldn't tell me about his perversion at first because it meant to him that he was crazy, beyond redemption, until I gave evidence that he could believe that I saw him as a human being and not a curious specimen whose "material of each hour" should be studied.
>
> (Goldberg, 1978, p. 271)

The analyst in this example is "quasi inside" the patient, immersed in the patient's world and exploring from the immersed stance. In Richard Geist's interview with Paul Ornstein, (Geist, 2015) Ornstein clarifies, "By immersing yourself, Kohut meant that you basically live that experience with the patient, but living that experience also means processing it. You formulate and articulate your understanding and offer it to the patient for correction or emendation" (p. 97). The analyst's empathic posture guided him to tune in to both the patient's selfobject longing, to be seen and recognized, and the place of deepest affective engagement: his loneliness. His forward edge interpretation (Tolpin, 2002) that his behaviors served to reduce his loneliness dramatically shifted the patient's sense of himself. Sharing this with the patient promoted a moment of meeting, changing the patient's implicit relational knowing. He can now be with someone else in a new, more intimate way and can also be with himself without disavowing his loneliness.

An attitude of co-creation energizes moments of meeting

BCPSG emphasizes the co-creation of experience inherent in moments of meeting. A self psychological approach lays a foundation for a co-created

experience in a particular way, a way that I think is ideal for moments of meeting to flourish. Guided by dynamic systems theory to inform the nature of the therapeutic process, "sloppiness" is the term BCPSG uses to describe the indeterminacy and variability inherent in therapeutic discourse." (The Boston Change Process Study Group, 2010) "*Sloppiness* encompasses the spontaneous, improvisational, unexpected interpersonal events that *pop up* in interaction and then can be captured to catalyze intersubjective moments of meeting and bring about change" (Boston Change Process Study Group 2010, p. 127). Sloppiness is an important potential source of the spontaneity and creativity at the heart of a vibrant treatment. In a self psychologically informed treatment; what has already been established is the implicit relational understanding that the analyst will attempt to allow the patient to mold the treatment according to her selfobject needs and, where this is not possible, the analyst will openly recognize his failure (empathic failure is always defined from the patient's viewpoint) to do so. In a self psychologically informed therapy, this flows naturally from the state of sustained empathic immersion that lodges us within the patient's internal experience.

With the patient beginning to see her capacity to mold the treatment according to her needs, there is a built-in freedom that opens the dyad to spontaneous, novel, shared experiences. This is a dialogic approach that self psychologists view not as a technique but as a natural outgrowth of the empathic listening mode. This approach, described by Anna and Paul Ornstein as the interpretive mode (Lifson, 1996), is a natural outgrowth of the empathic listening mode. It involves the analyst in an interpretive dialogue with the patient from the beginning of treatment. The therapist puts forth her tentative understanding in a way that tells the patient that it is provisional (e.g., This is what I understand you're saying about your feelings about your wife. Did I get that right?).

From the outset, the self psychologist is letting her patient know that (1) this is a collaborative, co-constructed process; (2) you are listening to and comprehending his narrative in an experience-near way, from inside of his experience; (3) you are engaging in a process of mutual empathy since your sharing of your tentative understanding gives the patient a window into your subjectivity; and (4) this allows the patient, who knows our empathic grasp, to find things in us that he needs (Davis, 2015). This receptivity sets the tone for collaboration, letting the patient know almost immediately that together we will evolve a way of relating to one another that is organically constructed and transformative and that it contains new

elements that are products of the interaction. Volleying back and forth dialogically, not interrogatively, until the patient feels deeply understood, opens pathways to expanded organizing principles.

The process itself shifts implicit relational knowing for many of our patients who have never experienced others as curious about their internal lives. Critically, it gives us access to disavowed selfobject longings and deeply experienced affective states. This open dialogue expresses an attitude of deep attunement and

> sets the tone for what is permissible here in this space: that we come to the process with eagerness and curiosity, that we are full participants and therefore welcome all aspects of our patients, including their questions and curiosities about our thoughts, feelings and personalities and that we are prepared to embark on a co-created relational journey that will in some ways be new for both of us.
>
> (Davis, 2015, p. 72)

Sustained empathic immersion facilitated in part through the interpretive mode leaves the patient feeling known. This promotes fittedness and the recognition process (Sander, 2002) that are at the core of moments of meeting. Feeling known strengthens the patient's self, allowing her the vitalizing experience of including more affective experience in her internal world.

Repair of disruptions promotes moments of meeting

In addition to the transformation of therapeutic relationships through sustained empathic immersion, the disruption-repair sequence frequently leads to now moments or moments of meeting. The repair of ruptures restores the dyad's equilibrium, in turn restoring the patient's hope that the analyst will again understand and respond to selfobject longings.

Kohut (1984) states that when there is an established, maturing selfobject milieu between patient and analyst and the patient retreats to earlier expressions of her selfobject needs, the analyst must acknowledge the patient's retreat and investigate and acknowledge his mistakes and his own impediments to empathic connection and articulate this to the patient. Resolution of disruption and repair in a meaningful, forwarding way can take place only between an already connected pair. Richard Geist (2009, p. 131) describes connectedness as "a consciously or non consciously felt

sense of sharing and participating in another's subjective emotional life while simultaneously experiencing another as participating in one's own subjective life." He adds that connectedness is a process in which "analysts and their patients experience each other as a deeply felt presence in one another's life, as the unarticulated foundation on which self structure is built" (Geist, 2009, p.165). Following that understanding, Geist (2013, p. 275) recognizes that in a connected dyad, the patient experiences the analyst's malfunctioning (during a rupture) "as a malfunctioning part of her self" in the context of their connectedness. Therefore, the therapist's empathy with himself in acknowledging and accepting his own failures expands the patient's capacity to accept her flaws while preserving her self-organization and the potential for robust self-esteem. This resumes the connectedness, as the pair once again experiences each other as healthy parts of their self-organizations. Joined in this healthier way, there is the possibility of exploring new and more flexible ways of being together and within each of them. The patient comes to see that when the analyst is off track, he will always reorient himself to a deepening apprehension of the patient's subjectivity, not only to get back on track but to facilitate the changes that expand and enhance experience (Davis, 2015).

With growing trust and closeness, there is often heightened sensitivity to shifts or chafing within and between each member of the pair and increased hopeful expectation of being understood. This heightened positive expectation potentiates greater vulnerability to slights, but it occurs simultaneously with the accretion of internal structure, so these tensions are tolerable and often a source of aliveness in the treatment. Directional change, inherent in moments of meeting, opens up.

Generally, the rupture and repair sequence becomes a less frequent engine of moments of meeting, supplanted by a positive affectively charged selfobject connection. However, in more traumatized patients, this can be a consuming element of the therapeutic process for a very long time. Sustained empathic immersion and attendance to ruptures allows us to understand our patients more thoroughly so that we respond with greater fittedness, and richer, more frequent and more vibrant moments of meeting unfold.

The therapist's experience of moments of meeting

By privileging sustained empathic immersion as the primary data-gathering tool, a self psychological orientation catalyzes an expansion of the analyst's affective range to resonate affectively with her patients. BCPSG's (Stern et

al., 1998,) analysis of the subjective world of the analyst during moments of meetings assumes the vantage point of the analyst, within the intersubjective context of the dyadic experience but not from the perspective of the analyst within the subjective state of the patient. BCPSG delineates three phases of the now moment: pregnancy, weird, and decision phases. In the "pregnancy phase," there is a "feeling of imminence" as if something is about to happen here (Stern et al., 1998, p. 912). The realization that "one has entered an unknown and unexpected intersubjective space" characterizes the "weird phase." Finally, in the "decision phase," the analyst decides whether or not to run with the moment. BCPSG emphasizes that moments of meeting are characterized by actions that are not "routine, habitual or technical" (Stern et al., 1998, p. 912), and that neither participant hides behind therapeutic roles in that instant.

When we approach these emerging critical moments from a self psychological perspective, the contour of the analyst's subjective experiences changes, and I believe that as a result, their likelihood and frequency increase. BCPSG provides a very beautiful example of a moment of meeting with Molly (Stern et al., 1998, p. 913), a young woman presenting with self-esteem struggles, who throws her analyst off-guard when she wonders aloud if her analyst is looking at her. The analyst struggled with her response; she didn't want to be too seductive, too restrained and distancing, too dominant or too submissive. Resolving her struggle, the analyst responds to Molly, "It kind of feels as if you're trying to pull my eyes to you." The dialogue that follows between them confirms that her words are just right, and a deep sense of "we-ness" unfolds between them. The patient feels hopeful as she recognizes her own self-development toward better self-regulation and mutual empathy. While we all resonate with the analyst's brief internal struggle, I do not see this struggle (which encompasses the pregnant, weird, and decision phases) as a *sine qua non* of the interaction. On the other hand, I would say that during the analyst's moments of internal consternation, she had briefly slipped out of an empathic stance, even though this tumble was never experienced as an empathic failure by the patient because the analyst so artfully recovered and found her way back into the patient's subjective experience.

However, when a consistent attitude of aiming for immersion in the patient's subjective experience prevails, there is greater likelihood of the easy flow of deeply resonant interaction that feels neither stilted nor

contrived. In the event that we do experience the phases that BCPSG describes, we know that we have in fact been pulled out of our empathic stance and must find our way back. Ideally, we return to a place where we have a loose enough grip on our own internal organizing principles to enter our patient's world and spontaneously, freely, and creatively elucidate and guide the moment to recontour the interpersonal landscape between us and ultimately within and for the patient. The deeply immersed empathic stance is a guiding point of reference indicating where we ought to be, so these moments do not feel weird and so that decisions emanate freely and spontaneously. Feeling the weirdness, tells us that we need to recover and pull ourselves back to that point on our analytic compass.

Donnel Stern's concept of relational freedom (Stern, 2013) describes what is needed for implicit relational change. In his paper, he too shares the decision-making process that propels him toward a moment of meeting with his patient, William. Although making use of different language, the case example used by Donnel Stern in his paper, "Relational Freedom and Therapeutic Action," conveys his experience of BCPSG's three phases prior to responding to a patient in a meaningful and useful way, a way that is new and at first uncomfortable for him. The patient's powerful affective response to Stern's affective participation and novel action moves them into new and transformative territory. Stern describes these moments as novel and unbidden and portrays the freedom to experience them as "a deeper-than-conscious willingness to let go and allow the unbidden to come into being" (Stern, 2013, p. 245). He adds that "the more relaxed the (interpersonal) field is, the more the minds of both participants are free to create unbidden experience."

Certainly, relational freedom is necessary to create new implicit experience, but what prepares the soil for relational freedom? When we privilege sustained empathic immersion within a connectedness sensibility over the exploration of the intersection of two subjectivities that heavily weights the therapist's maintenance of his own authentic subjectivity, there is room for more relational freedom, potentially facilitating more relationally altering moments of meeting. I am not suggesting that the analyst squelch her authentic self; this would of course impede her limberness, freedom, and spontaneity. However, when we enter their worlds, our patients roam freely in our subjectivity, allowing them to find the authentic part of us that resonates with what they need to emerge with newer, stronger relational capacities.

Writing about this in a previous paper, I suggested

> once we have entered her world our responses resonate with the patient's sensibility and the dialogue that follows reflects the patient's increased openness and flexibility that in turn expands our own capacity to see new possibilities. Quite possibly, our loosening our own tenacious hold on our own internal organizing principles frees the patient up to relax hers. We are unencumbered by the pregnant phase of anticipation or the weird sense that we are going to do or say something unusual. The decision emanates fluently and organically from within.
>
> (Davis, 2015, p.75)

The selfobject experience is fundamentally an intertwining of two subjectivities. Typically, but not always, the analyst "goes first" by relaxing her internal organizing principles so that she experiences the patient's selfobject longings as her own while still maintaining the capacity to articulate them by de-centering. This enables her to provide the optimal response (Bacal, 1985). When the therapeutic pair experiences one another in this way and the therapist's optimal responses allow the patient to experience herself in new ways—incorporate new internal organizing principles—there is a dyadic expansion of consciousness, and a moment of meeting has occurred.

While BCPSG characterizes moments of meeting as transformative moments, "when the therapist uses a specific aspect of his individuality that carries a personal signature" (Stern et al., 1998, p. 913). The action taken lifts the usual veil of therapeutic roles or when the therapist relinquishes technique for this instance. I would argue, however, that when a connectedness sensibility drives the treatment, the therapist's and that patient's personal signatures are ubiquitous. Both participants are free to be themselves; the unique selves that emerge in the context of this particular pair. The therapist's responses emerge authentically and spontaneously based upon her experience of the patient's subjective world and from the "we-ness" they jointly create.

The idea of hiding behind therapeutic roles or the suggestion that they must step outside of technique to facilitate moments of meeting does not exist in a treatment in which therapist and patient share an interpenetrating experience that is resonant with the patient's selfobject

longings. Rather than beginning with an *a priori* understanding of how we are supposed to be with a patient, we respond flexibly and dynamically, attuned to that particular patient at that very moment. If we emphasize the notion of our authenticity, either of our authentic selves as therapists or as individuals, we remain outside the patient's subjective experience, so that when there is a shift it indeed feels weird. Imagining ourselves into the patient's subjectivity facilitates moments of meeting that may feel "magical, intense, momentous and special, but never weird. Rather than an incredulous sense of 'what just happened?' there would be an air of 'oh, so this is exactly what we have both been waiting for'" (Davis, 2015, p. 76).

Neither therapeutic roles nor technique should mobilize the therapy; when they do, this indicates that we have fallen out of our empathic position and risk either overt disruption or the deadness that typifies treatments devoid of the forward propulsion of moments of meeting. A theory that helps the clinician articulate his experience of the patient's internal subjective world steers the treatment. Technique is a force that comes from the outside and is often exactly what deprives many treatments of a transformative life force. Kohut (1996, p. 366) explained, "technique should follow naturally from one's theoretical orientation of how the mind operates." When our theory roots itself in listening to and feeling with our patients at the most profound levels, a flexible technique that is prescribed for that particular dyad emerges and provides our patients with what they need most.

Many patients describe their most momentous therapeutic experiences as occurring when the therapist lets go of technique. Doesn't this tell us that there is something wrong with the technique? A theory using the empathic listening perspective as its methodology, privileging the immediacy of the intersubjective experience, unburdened by superimposed, experience-distant technique, allows the therapist to be embedded in his patient's world so that there is a freshness and a spontaneity to responses that meet the "singularity of the moment." While the responses will feel neither canned nor tired, they will not necessarily feel unusual, weird, or surprising to either patient or therapist because both will expect the dynamism that emanates from discoveries within a dynamically shifting interpersonal experience. Then, moments of meeting become the organic force strengthening and altering the dyad's implicit relational experience.

Clinical illustration

A mother of three in her forties, Fran was in the process of divorce when we met. From our very first phone contact, she "warned" me that she was "a mess"; leaving our second session, she turned back at the door to ask if she was my "worst patient." I told her that I was glad that she'd come to me, and I was hopeful that I could help her feel like a lot less of a mess. During the first several months of therapy, she wailed to me that her life was bad because she had such bad luck, that it was a waste of time to come and see me, and that her problems would be solved if her parents would give her more money (they already provided an extraordinary amount of financial support).

In a variety of ways, she implored me to be on her side, and I committed myself to always attempting to be on the side of promoting her developing self, letting her guide me as to what that would mean. In our early conversations in which she railed against her parents, looking for my affirmation that they were horribly disappointing and unhelpful, I suggested that there was such a disconnect because although they thought they were giving a lot, they failed to give just what she needed. They gave what made sense from their vantage point but, from her vantage point, what they gave did not help her grow and feel strong, capable, and happy. As a result, she and her parents were always off kilter; this explained why she had kept her distance until her divorce. Now she was dependent on them, subject to getting from them only what they felt she required and repeatedly exposed to their admonitions about her wastefulness or lack of gratitude.

Almost from the moment we began, I was inundated with her panic-ridden, desperate, and despairing proclamation that the best thing I could do for her was to teach her how to kill herself, alternating with moments when she stopped mid-sentence to tell me she loved me or that of all the times she'd been in therapy before, she had not used a therapist in the way that she used me, or that I was "so beautiful" and that she "loved my sense of style." Despite the tumult, she was endearing to me, and I felt confident that over time her sense of entitlement would give way to my sense that she was indeed entitled to something very important that had not come her way.

Entering Fran's subjective world, conveying that I "got it" from inside of her was the only thing that was soothing for her. By speaking to her in

the interpretive mode, our non-threatening dialogue helped her make use of an idealizing selfobject transference in which she saw me as wise, guiding, and soothing. While at times she was in a state of paralysis inhibiting her functioning at work and with her children, if she felt me by her side, she had an impassioned and creative generativity and resourcefulness that motored her successfully in both of these arenas.

Initially, I found her dysregulated state so disorganizing to me that I felt disorganized whenever I was describing her to a colleague, but after awhile, I was able both to experience the utter turmoil, yet decenter enough to serve a calming, regulating function for her, which she slowly began to absorb. As she became more regulated, she conveyed, through several moments of meeting, more precisely what it was that she had needed from her experience with her parents and what she now needed from me.

The first of these was a time I came into my office and found that rather than awaiting me in the waiting room, she was already there. Though I generally find this sort of thing irritating and intrusive, with Fran I did not and simply smiled and asked her, "Did you begin without me?" We both laughed, as we recognized that I appreciated her eagerness, that I was eager to be with her, too, and rather than see the fragment of her that bordered on inappropriateness, I saw the cohesive whole of her that was excited and eager, like a child that had come to play and just couldn't wait. I had no need to assert my typically authentic response of feeling intruded upon since my authentic response to *her* was open and permeable. My immersion in her longing to feel that someone enjoyed her and found her loveable elicited my warm feelings of enjoyment.

On another occasion, Fran cried and moaned on my office floor and appeared desperately inconsolable. I spoke to her, attempting both to match her intensity by underscoring her sense of deprivation and injustice through powerful words and affective resonance, and attempting to contain the flailing about, "temper tantrumy" quality of her gyrations with vocal calmness. She suddenly raised her hands above the back of the chair behind which her body hid, announcing, "Let's have a puppet show!"

Several important things happened here: (1) Fran had the confidence to know that she was free to be her writhing, agitated self with me even if that writhing agitation took place on my floor; (2) Fran felt me with her in her chaos, yet my calming self-regulation facilitated her initiating a new experience, the puppet show; (3) as we flowed together from despair to playful puppet show, we resonated with one another in a quiet hopefulness.

Growing up, if something was bad, it was *only* bad—there was no room for fun, for frivolity, or for an appreciation for what I readily imagined was Fran's spontaneously impish spirit. Instead of the panicky, downward spiraling response of her mother to problems, or the dour, over-burdened, Eeyore-like response of her father, we, with her in the lead, created a small stage on which to play out a different scenario together.

Although we did not discuss this moment of meeting at the time (to have done so would have destroyed the joy, much as her parents did) about 1 year later, she wryly commented, "I bet you don't have a lot of adult patients who do puppet shows." "No, I don't; you're unique!" was my mirroring response, easily cast in the same winking spirit. Since then, the puppet show experience has come up several times, as a point of reference indicating the strength of our partnership and her own emerging capacity to transform darkness into light through play and humor.

Midway through another session in which Fran was somewhat more calmly able to discuss her typically overwhelming interactions with her children, she stopped, looked directly at me, and said "You look amazing today; are you planning to blow your husband tonight or something?" In response to my speechlessness, she said, "Oh, is that the kind of question they teach you not to answer?" In that instant, I saw myself as a school marm, eyeing her with a tight-lipped gaze that shouted, "out of bounds, young lady!" I knew that her comment, simultaneously mirroring and shocking, had disarmed me, and I was putting the brakes on. Rattled by Fran's comment, I slipped out of an empathically immersed state and into a clumsy disavowal of my awareness of myself as part of Fran's self, leaving her unbalanced, alone, and ashamed. Fortunately, I recovered and, welcoming her playful, irreverent spirit, quickly retorted, "Actually, I don't have any particular plans for tonight." I smiled, she laughed, and a nearly failed now moment (Stern et al., 1998) became a moment of meeting in which we both knew that the range of affect that we could include between us and within each of us had just widened.[1]

This was clearly an empathic failure on my part, one that interfered with Fran's idealization and twinship longings. Her crestfallen look and sarcastic comment about me needing to remain silent told me that I had failed to respond to her empathically. My silence expressed some archetypal technical maneuver that I relied on because of my own discomfort; at that moment I was responding to my own internal organizing principles and was distant from her subjective experience and needs. In the words

of BCPSG, I experienced the weirdness before the moment. However, the weirdness was not an intrinsic component leading to the moment of meeting, but rather the weirdness resulted from my failure to resonate with her selfobject longings. The weirdness did not help the moment of meeting come about; instead, until I found my way back, the weirdness nearly derailed the moment altogether.

Though in this case I did not articulate the failure, I did take responsibility for the empathic failure by returning to an empathically immersed stance that she had come to expect from me. Had I not repaired the rupture in that way, given the intertwining of our self-states, my sense of awkward exposure would have permeated her self-state, maintaining and fueling her self-experience as too much of a mess for anyone to handle. My consistent attempts to stay empathically immersed in Fran's world, along with a dialogic approach, allowed her to find what she needed in me to create the growth-enhancing environment that she needed. This facilitated moments of meeting between us in which we implicitly recognized through joint participation that she needed her playful initiatives to be valued, affirmed, and appreciated so that we connected and reconnected on new planes, discovering ways of being together that felt different, enlivening, and hopeful to both of us.

Conclusion

BCPSG attempts to answer the central question of therapeutic action: What do we do that helps patients change and grow? Through microprocess analyses of therapists' hours, they highlight the special moments between patients and therapists as the forces that cause patients to learn new ways of being with others and with themselves in the world. Most experienced clinicians and patients agree. I have asked two additional questions: What can we do to ensure and increase the regularity of these moments, and are these moments special because they are outside conventional technique as BCPSG suggests, or are they natural outcomes of treatments driven by theory rather than technique? A self psychological orientation that emphasizes listening and responding from within the patient's internal world facilitates moments of meeting. With this approach, we remain open to whatever our patients bring us, and we enhance our patients' confidence that we will listen from that perspective, encouraging them to bring us deeper parts of themselves.

Note

1 While not ignoring Fran's sexually tinged references (and perhaps feelings) toward me, I see these as her style of connecting with me that created a spontaneously vibrant tension, and I chose not to comment on that directly. To do so would have merely been shaming and disruptive.

References

Bacal, H. (1985) Optimal responsiveness and the therapeutic process. In: A. Goldberg (ed.), *Progress in Self Psychology*, vol. 1. Hillsdale, NJ: The Analytic Press.

Boston Change Process Study Group (2010) *Change in psychotherapy: A unifying paradigm.* New York: W. W. Norton.

Davis, D. (2015) Moments of meeting: A self psychological approach. *International Journal of Psychoanalytic Self Psychology*, 10, 69–79.

Geist, R. A. (2009) Empathy, connectedness, and the evolution of boundaries in self psychological treatment. *International Journal of Psychoanalytic Self Psychology,* 4, 165–180.

Geist, R. A. (2013) How the empathic process heals: A microprocess perspective. *International Journal of Psychoanalytic Self Psychology,* 8(3), 265–281.

Geist, R. (2015). Conversations with Paul. *International Journal of Psychoanalytic Self Psychology,*10, 91–106.

Goldberg, A. (ed.) (1978) *The psychology of the self: A casebook.* New York, NY: International Universities Press.

Kohut, H. (1959) Introspection, empathy and psychoanalysis. *Journal of the American Psychoanalytic Association*, 7, 459–483.

Kohut, H. (1981) On empathy. In P. Ornstein (ed.), *Selected writings of Heinz Kohut: 1978–1981*. Vol. 4. pp. 525–536. London: Karnac Books Ltd.

Kohut, H. (1984) *How does analysis cure?* (A. Goldberg ed.) Chicago, IL: University of Chicago Press.

Kohut, H. (1990) *The search for the self, vol. 3.* (P. Ornstein, ed.) London: Karnac Books Ltd.

Kohut, H. (1996). Technique, termination, trial internalizations. In P. & M. Tolpin (eds.), *Heinz Kohut: The Chicago Institute Lectures.* pp. 365–379. New York: Routledge.

Lifson, L. E. (1996) *Understanding therapeutic action psychodynamic concepts of cure.* Hillsdale, NJ: The Analytic Press.

Lyons-Ruth, K., Bruschweiler-Stern, N., Harrison, A., Nahum, J., Sander, L. ,Stern, D., et al. (1998a) Implicit relational knowing: Its role in development and psychoanalytic treatment. *Infant Mental Health Journal,* 19(3), 282–289.

Ornstein, A. & Ornstein, P. (1996) Speaking in the interpretive mode and feeling understood. In: L. Lifson (ed.), *Understanding therapeutic action: Psychodynamic concepts of cure*. pp. 103–125. Hillsdale, NJ: Analytic Press.

Sander, L. (2002) Thinking differently: Principles of process in living systems and the specificity of being known. *Psychoanalytic Dialogues*, 12(1), 11–42.

Stern, D. N., Sander, L., Nahum J. Harrison, A. Lyons-Ruth, K. Morgan, A., et al. (1998) Non-interpretive mechanisms in psychoanalytic therapy: The "something more" than interpretation. *International Journal of Psychoanalysis,* 79, 903–921.

Stern, D. B. (2013) Relational freedom and therapeutic action. *Journal of the American Psychoanalytic Association,* 61(2), 227–255

Tolpin, M. (2002) Doing psychoanalysis of normal development: Forward edge transferences. In A. Goldberg (ed.) *Progress in self psychology.* pp. 167–190. Hillsdale, NJ: The Analytic Press.

Tronick, E., Bruschweiler-Stern N. Harrison, A. M., Lyons-Ruth, K. Morgan, A. C., Nahum, J. et al. (1998) Dyadically expanded states of consciousness and the process of therapeutic change. *Infant Mental Health Journal*, 19(3), 290–299.

Chapter 9

Where did that happy ending come from?

Dreaming moments of meeting

Joyce Slochower

This is the story of a treatment that appeared devoid of moments of meeting. In it, my patient Dani and I coexisted more than we connected. Across our time together, she remained implacable, uninterested in—or unaware—of my reactions to her. Our sessions were characterized by stillness rather than movement, by affective flatness more than aliveness. We explicitly "met" only twice: once in a painful enactment and once in a dream. Yet Dani changed dramatically. Why? Querying the therapeutic impact of moments of meeting and of our failure to meet, I focus on the mutative potential inherent in emotional absence.

When I first met Dani, I thought she'd be a really great patient. She seemed thoughtful, self-reflective, open; she wanted analysis and was prepared to do the work, use the couch, look at herself. But then I discovered another face that turned my concern into alarm.

Dani had a new boyfriend. Elated, she spent hours writing him letters, filled our sessions with visions of the relationship they would have, described the wonderful, poetic way he spoke, his gentle warmth and humor. It all sounded great—that is, until Dani mentioned in passing that Michael lived in Japan. Dani's involvement with Michael was not reciprocal, and she had known this from the first. Michael was committed to a Japanese woman and planned to relocate and marry her there. However, Dani assured me that Michael would leave his fiancée for her. Embracing fantasy with manic force, Dani vaporized doubt. Tendrils of delusion seemed to hover at the edges of her plan, impossible to open. How far would she go? I tried mightily but couldn't open the closed space in which she/we dwelled.

Although Dani's life was filled with charged and sometimes eruptive relationships, none of that charge entered the treatment space. In fact, Dani wouldn't/couldn't let us meet. She insistently kept affect and connection

outside the treatment space. In our sessions, she seemed both still and sealed; we mainly coexisted. My attempts to make contact and address Dani's experience of loss, anxiety, desire, or anger from the inside all went nowhere, leaving me feeling both helpless and frustrated. Dani was alternately oblivious to—and disinterested in—my ideas, feelings, concerns about our relationship; I couldn't find a way to deepen or to open things. Nothing ventured and, I thought, nothing lost. All the feelings in this relationship—concern, frustration, irritation, even alarm about Dani's life—were mine, not ours. There was nothing intimate between us, no moments of meeting. Dani remained cut off, perhaps dissociated, and I remained helpless.

How, then, can we understand this: After years of dissociated, frozen stillness, after a treatment characterized by very little engagement (meeting) and a single enactment, Dani changed dramatically. That change first evidenced itself when we met in a dream. The dream, more a marker of change than a moment in itself, heralded a dramatic shift away from misery and delusion toward a steadier, more contented, alive resiliency. Here I query the source and dynamics of this change.

The treatment: Early days

Dani had come to me after the unexpected retirement and subsequent death of her previous analyst, in considerable distress, both anxious and depressed. Although her analyst had done his best to prepare Dani for their ending, his death came as a traumatic shock that left her untethered. However, Dani believed in psychoanalysis and was sure I could help her. And at first, I felt similarly optimistic. Hopeful, energized, I plunged into the work.

The first treatment phase focused on the loss of her former analyst. Dani reviewed and relived the trajectory of that treatment and its abrupt ending. She had only positive things to say about her analyst, whom she seemed to have experienced less as an individual in his own right than as a responsive and empathic object. I sensed that Dani mourned the loss of his holding function more than his actual person. And by the end of the first year of our work, Dani appeared almost to have forgotten him. Reliant on my holding function, pleased to have "a place to talk things over," Dani was neither reactive to me nor willing to explore anything about our relationship.

Dani was similarly disconnected from her trauma history. While the stories she told were searing in content, the pain seemed remote, no longer relevant to her. Hit at age 4 by an oncoming car that veered onto the

sidewalk, Dani suffered multiple fractures and was kept in traction for weeks. There was physical pain, and there was emptiness, vague images of the hospital—big rooms, white walls. Memories of absence—Dani remembered no visitors, no one to offer comfort.

Dani's life seemed without connections or positive emotional encounters. Trauma dominated, evident in what happened and what did not, but my interest and empathy were met with mild dismissiveness. It was an old story, reported from a distance; Dani had been down these roads before and didn't need to revisit them; only the present mattered.

Dani's flatness left me puzzled. Where was her engagement—with her life, her history, and with me? Why was our interaction so *polite*? Why did it feel as if I were carrying her fear and isolation? Or perhaps whiteness *was* the affect, a state of numbness that covered, obliterated the intolerable.

And there was more. Beginning before puberty, Dani and her three sisters came to expect their older brother's bedtime visits, his fondling. Dani remembered pretending to sleep, feeling both dread and pleasure; this was the only physical contact she could rely on.

In light of the repetitive sexual assault to which Dani had been exposed, I found myself more than a bit surprised to learn that sexual trauma did not follow Dani into adulthood. Dani had married in her twenties. She enjoyed sex, felt easy with her body, and described no sexual inhibition or difficulty. Somehow this arena remained protected from both the volatile shape of her emotional experience and her history of sexual abuse. Was it really possible that a childhood replete with sexual abuse had been so thoroughly worked through that it was absent from her adult life (Davies & Frawley, 1994)? Or had Dani dissociated what was unbearable?

It was hard to parse because adulthood introduced Dani to a new set of traumas that both exacerbated and reenacted earlier ones. Indeed, her adult world seemed predictable only in its unpredictability. Relationships ended badly, jobs didn't materialize, projects faltered. A potentially deadly medical diagnosis clouded her thirties. A marriage to a man—a brief taste of pleasure was followed by a freak accident that killed him. Their business failed, leaving her financially and emotionally desolate. Having reestablished herself, a burglary literally cleaned out her house. Even her analyst died young. These adult-onset traumas were assaultive in their own right, not merely repetitions of early ones (Boulanger, 2007). But they also re-evoked earlier trauma, not one après coup (Faimberg, 2005) but many.

Time had been unkind to Dani's physical self as well; a series of minor injuries and progressive arthritis left her limping, interfered with the physical activity she had always enjoyed. Now middle-aged, Dani felt altogether alone in the world, increasingly bitter and hopeless about establishing a satisfying relationship or life.

However, Dani's grief was not as accessible as her sourness. Entering my office with a predictable, irritable sigh, Dani spent nearly every session reviewing and reliving the day's interpersonal slights and physical ailments. Here is a typical exchange:

Dani: I am so depressed; the most awful thing happened yesterday. Janice (an old friend) came over and helped me move all the furniture into the new office—up a flight of stairs with bookcases, desks, books, so much stuff. What a lot of schlepping. I was wiped out, it was too much for me with my back problems, and afterward I just couldn't move. The next day, I needed her to help me organize the books and files. She refused—said that she just couldn't come. Even when I told her that I was exhausted and reminded her that she had promised to help me, she wouldn't. I am really furious. What kind of friend is she! She jumps ship when she decides she's done enough, how incredibly self-centered. Who needs friends like that. It's time I ended this relationship.

J. S: (initially feeling some empathy for Dani's sense of abandonment) She so disappointed you by not coming back, you felt completely abandoned, left.

Dani: Exactly. People cannot be counted on, certainly not Janice.

J. S. And that's what hurts, it wipes out the good feeling you had when she said she'd come on Saturday.

Dani: What good feeling?

J. S. (no longer feeling particularly empathic, but irritated and frustrated): It sort of vaporized, didn't it? I'm remembering the relief you expressed on Friday when she offered to help you.

Dani: I really don't remember saying that.

J. S. (now quite annoyed and actively working to hold onto the idea that Dani had dissociated the dependence associated with getting help from her friend): I'm thinking that it would be really painful to both appreciate the help Janice did give you *and* to feel upset that she didn't come back on Sunday.

Dani: Well of *course* I appreciate what she did. But in the end she failed me and that's what counts: Janice is so self centered that she's not a real friend.

Narcissism as a protection against trauma

Dani couldn't sustain a connection to an empathic other and repetitively returned to a state of collapse. It felt to me as if she alternately blocked and destroyed the possibility of an emotional meeting. On the lookout for injury (Bromberg, 1996), Dani always found it; self-protective bitterness seemed to help her negate the more overwhelming trauma with which she contended. Dani seemed pulled toward what was painful. I thought of Coen's (2003) description of the "thrall of the negative." This was not entirely surprising. After all, there had never been a recognizing witness, neither within the family context nor outside it. Dani had had no experience of maternal care or an overarching stabilizing container. Mother was dead (Green, 1986); the Third seemed to be dead as well (Gerson, 2009).

Dani's extraordinarily thin skin[1] exposed her to traumatic injury at every turn. Ordinary frustrations (for example, dealing with unhelpful service people) evoked both narcissistic fury ("how dare she talk to me that way") and hopeless helplessness ("everything that can go wrong does go wrong"). People owed Dani, and she both carried and enacted a sense of aggrieved expectation, quite unaware of the hostility that lay beneath her bitter reproaches. Repeating the annihilating behavior of her parents and brother, reliving her long hospitalization, Dani negated others, attacked them, and raged against them, desperately hoping to find a different response: one of recognition. While Dani could acknowledge the historical antecedents of these experiences, there was no reflective space within which to work with or separate the two. The past *was* being repeated in the present; there was nothing symbolic about it, nothing dynamic to explore. People simply couldn't be counted on.

I asked Dani whether she ever felt that she couldn't count on me. She paused, puzzled. Why would she be upset with me? I am her analyst, I always listen, I am not self-centered. Despite—or because of—the chronic, bitter misery that dominated Dani's outside relationships—I was not allowed to fail. When I seemed not to understand something, Dani patiently explained herself more fully. When I canceled a session, Dani politely asked to reschedule; if I could not, she nodded understandingly

and said that was fine. And when I wondered aloud about whether she might be bothered by the interruption, she said that she preferred to see me sooner but was comfortable waiting until the following session.

I couldn't contact Dani or experience a sense of connection from her or to her. Trying to imagine my way into Dani's world, trying to find a way to connect with her, I thought about, but couldn't quite feel, a life dominated by abandonment, helplessness, anger. Far more palpable was the narcissism that dominated her responses to current experiences. Dani deserved better, she was *owed*. Unable to make intimate connections with others, she regularly instigated confrontations that resulted in ruptures for which the other was blamed. Listening to her angry complaints and unable to touch her participation in what had happened, I felt alternately numb and irritated, unable to find a point of connection, unable to meet her grief or bitterness. What Bromberg (2009) called islands of narcissism, self-protective enclaves within which Dani could assert her own value and deservingness, blocked the other (and me) and closed off need or a stable sense of going on being.

Reversing trauma with antidotal fantasies

Dani occasionally took that manic flight. Enlivened, smiling broadly, Dani bounced into my office and announced a new plan, a life solution. Once, for example, she decided to become a professional singer. Hiring a coach, she developed a repertoire, contacted recording studios, and borrowed money to make a CD. This wasn't merely an exciting new career possibility; this was a certainty that Dani embraced without an iota of caution. She would succeed; life would change dramatically. On one level, I felt hopeful at this sign of emergent aliveness; on another, it seemed more manic than not, a denial of actuality that I feared would ultimately leave Dani shattered.

Dani's extensive use of fantasy had a long history. As a child, she retreated from abuse by "putting myself into a different place." In a favorite escape fantasy that she dated from age 4, Dani imagined herself "a beautiful actress curtseying on stage as people applauded wildly." Antidotal fantasies were the single solution to a lifetime of non-recognition; they reversed the dead Third (Gerson, 2009) by negating Dani's awareness that she had never been the object of applause, literal or symbolic. Vigorously warding off psychic collapse (Grotstein, 1990), Dani enveloped herself in a non-porous, encapsulated illusion of a rosy future, remaining sanguine,

incurious about her process. Caught between hope and dread, (Mitchell, 1993), I held caution for both of us.

However, while I was both touched and saddened when I thought about this little girl, I couldn't find her in the room. The performative element in Dani's fantasy thinly covered over absent moments of meeting. For that little girl had been neither loved nor hugged; the best that Dani could hope for was admiration from afar.

Absent moments of meeting

Dani certainly did not perform for me: We met neither in the moment nor in her fantasies. Trying to open things, I spoke about *us,* about my sense that we didn't really connect. Dani looked mildly annoyed. She hadn't come to analysis to talk about the transference, and she didn't have time to talk about our relationship. There was too much going on in her life, and she wanted to use her session time to talk about her life, not her analyst. She had lots of decisions to make about how to launch her career, and she wanted to focus on that.

Wanting to open reflective space while respecting her resistance to relational dynamics, I talked with Dani about my sense that she moved between two alternate worlds—one gray and bleak, the other dominated by desire construed as conviction. Wish ("if only I had…") provided no comfort; only certainty ("it *is* going to happen") undid her grim subjective experience. Dani responded with easy recognition. It was true, she always looked for a new possibility and put all her eggs in each basket, but that's because she was basically an optimistic person. It certainly didn't feel that way to me.

Time passed, lessons failed to sufficiently improve her voice and the gigs never materialized. I inferred all this because the topic of career simply vanished, replaced by more urgent relational conflicts. When I inquired, Dani said "Oh, yes, I guess I forgot to tell you, it didn't work out. But I have to talk about something else today that's more important." Having expected to see Dani shattered, I was perplexed by the suddenness with which joy and traumatic disappointment became utterly inaccessible—dissociated, un-mourned, un-bridged (Stern, 2003; Britton 2004; Pizer, 1998).

Entering my office as if surrounded by a pleasant but cool mist, Dani left affective heat at the door. Her politeness flattened things, and I often felt fobbed off, impotent. Was Dani trying to shield us from the emotional storms that dominated her life? Was she evading an invasion of toxic affect

states, by sidestepping both intense idealization and denigration? Did Dani need to avoid the risk of assault, abandonment, or intimacy that seemed always to have accompanied connection? Did she need quiescence more than she needed attachment?

Perhaps, but there was an unfortunate byproduct to this protection: Dani couldn't allow me to function as a recognizing witness or share her experience of trauma. Finding no emotional entrée, more often than not I felt as if I had hit a wall, Dani's wall. And over time, I began to erect my own wall, a wall that protected me from the frustration and helplessness I felt.

Things heat up

Then Dani entered another fantasy space, this time one that involved an other. As I described earlier, this fantasy was of an altogether new life with Michael, her colleague from Tokyo. Embracing Michael as the object of her desire, Dani made plans to relocate there and marry him, blithely obliterating the fact that Michael was otherwise committed. Chilled, I was reminded of the film *Fatal Attraction*; Dani had co-opted Michael into her idea of love. When she showed up in Tokyo, Michael and his fiancée would be blindsided by Dani's intrusion on their life. Dani would steamroll gentle Michael, become defensively imperious, demanding, even menacing. I imagined the destructive scene she would provoke, how Dani would enact, in reverse, the perpetrator-victim scenario that dominated her childhood. And when Michael rejected her, Dani would be shattered, horrifyingly humiliated.

Dani had constructed Michael as the reliable and soothing lover for whom she longed; in the process she annihilated Michael's subjectivity and left herself open to crushing disillusionment. Both aspects of this perpetrator state were utterly disavowed and untouchable. My wall—my self-protective irritation with Dani's self-protective narcissism—rapidly faded as I encountered this worrisome, almost sinister layer. Alarmed, I found myself catapulted into action. Trying to be gentle, holding my breath but not altogether containing my urgency, I confronted Dani with the realities she had sidestepped. And so, I was stunned by her response: "Hmm, you're really worried about me, you think I'll be hurt if I travel all the way to Tokyo and it doesn't work out. That's so kind. But there's no need for worry. Michael doesn't love her, he loves me. When I surprise him in Tokyo he will be thrilled. And even if he's not at first, he'll come around."

Dani hadn't merely minimized the risk of injury and non-recognition, she had obliterated it, creating a narcissistic defense—an alternate world in which she was unconditionally loved and wanted by a perfect other (Rosenfeld, 1971). I tried again, talking about my own sense of helplessness with her, about how hard it was to bring feelings into the room. Dani politely acknowledged and simultaneously ignored my concern, unable/unwilling to think about what might be going on between us or with me, insistently returning to the concrete preoccupations associated with her new life plan. She needed to discuss something else today. She would talk about my concerns another time. I tried until I gave up.

Had Dani recreated with me the traction to which she was subjected at age 4, creating a space devoid of movement, devoid of connection? Did she need to render me as impotent as she had been?

Dani remained immersed in her plan to move to Tokyo for some months. Then, as suddenly as it had appeared, her preoccupation vanished and she returned to the quotidian. Puzzled, I inquired. "Oh yes, well it didn't work out. Anyway, I had the most awful experience with my doctor. I need help from you with that today." Disavowing the crushing blow of Michael's disinterest, Dani closed down interior space. Nothing could be examined, nothing discussed. Internally, I threw up my hands. I thought of Bollas's (1987) description of his response to George, a patient whom he couldn't engage: "Oh, what's the use. The son of a bitch is hopeless. You can't do a thing. Just let him rattle on for the whole goddamn session and don't bother to find a way through to him" (p. 223). I thought I knew just how Bollas felt. Not only was Dani impossible to find, I didn't want to meet her where she was.

An analytic enclave and its rupture

I was stuck with Dani in an enclave that seemed inaccessible to therapeutic process (O'Shaughnesy, 1992). Yet although I felt like a very leaky container for affect, urgency, and anxiety, neither my leaks (my subtle expressions of concern or distress that came through despite my attempt to remain even) nor my periodic eruptions (more intense expressions of concern) seemed to touch Dani. Now both frustrated and anxious, I became a bit concrete, suggesting other ways of handling conflict and implicitly introducing the idea of the other. For example, when Dani encountered a rigid and unresponsive colleague, I tried to reframe things by suggesting that the colleague might have been feeling beleaguered and inadequate

to the task Dani wanted her to take on. I suggested that Dani might get a better response were she to empathize with the colleague's frustration rather than attacking her for her rigidity. And superficially, it worked; Dani began trying to behave better, and relationships calmed down. However, I felt more like a helpful life coach (and critical nag) than a good analyst and worried that I was encouraging the development of false self functioning (Winnicott, 1965) rather than integrated change.

Then actuality intervened to disrupt the enclosed enclave in which we dwelled and forced a painful moment of meeting. On the heels of a planned absence for a conference, I was unexpectedly called to the Midwest by the illness and subsequent death of my daughter-in-law's grandmother, to whom I had become very attached. The week was both distressing and preoccupying. Dani had been up for review at work, and I should have been concerned to find a phone message from her, the first in our 7 years together. Instead, I reacted to her imperious tone with irritation and closed down. Deciding I'd call her later, I altogether "forgot" about it until I returned to New York a full week later.

Dani came into the office, looked at me coolly, and asked why I had not called. She was especially surprised since she never called me. How could I not have realized that something out of the ordinary had happened? There had been a serious, life-threatening event in the family, and she had urgently needed my help.

As I listened to her story, I was filled with alarm for Dani and horror at my failure to respond. Disappearing on Dani like her first analyst, like her parents, I had reenacted a core trauma, negating her pain and our nascent connection. Focused on my own loss, feeling like the one in need of recognition, I had responded to Dani as if she were a demanding, intrusive other/brother.

I wanted to apologize, to make reparation, but I paused, aware of my own urgency, my guilty wish to set things right. On one level, Dani needed me to do what her family never could, to recognize and own my hurtfulness. However, on another, this was *my* need to repair—to reestablish my own professional self-image by demonstrating my capacity to acknowledge my impact. What if my wish to explain myself closed things off and cut off Dani's anger, the first expression of feeling in all our time together? I waited, tried to make room for Dani to say as much as possible about her experience of my failure. Emboldened, she escalated. When a patient calls, the analyst is supposed to call back. It wasn't like me to behave unprofessionally. She wanted an explanation.

Could Dani hear something of my subjectivity? I couldn't parse it, and finally decided to put my dilemma to her: I said that I was willing to explain as much as I could about what happened but was concerned that telling her about my experience would have the effect of silencing her anger at me. While I didn't feel great about not having called her back, I did want her to have room to feel whatever she felt about it. However, Dani did not want me to "act like a shrink." She wanted a real explanation.

For the first time, Dani seemed to want to see (and hear) me. Could we meet? And so I took a chance. There was relief in that decision, but also some anxiety:

JS: It was a real failure on my part not to call you and I'm very sorry I didn't. I also know that in forgetting you like that, I repeated what your parents did when you were small—I left you alone in isolation.

Dani: Exactly. So why did you?

JS: Well, I think there were two parts to my forgetting. One had to do with how caught up I became in my own necessities. Funerals are intense experiences, and this one certainly was. Frankly, I didn't want to think about anything other than what was going on with my family.

Dani: But it's your obligation to put your patients first.

JS: (feeling guilty, "caught" and also a bit self-righteous): I agree with you in part. But there are limits to even that obligation. It's really hard for you to hear that, I know, but this was a time when I put myself first.

Dani: Exactly. You were more involved with yourself than with me.

JS: (probably trying to deflect some of Dani's anger, I returned to the transference): Your parents did that all the time and never acknowledged it; they acted as if you didn't need anything they weren't giving you. And they left you alone too often and for too long. And that's what I did. I feel really bad about that.

Dani: Yeah. They never acknowledged anything. At least you're doing that. And that's a relief.

JS: Well I'm glad it's a relief, but there is another bit that will be more difficult to hear.

Dani: Sighing, okay, tell me.

JS (holding my breath a bit): Dani, you feel so put out, so easily outraged by other people, that it can be hard for you to acknowledge that the other person has a right to have their own needs. When you called me, there was something that felt sort of insistent, pushing, in your voice, and I think I reacted to it. You knew I was away because of a family

emergency, but when you called me that awareness evaporated—I *had* to call you then and that was the only thing that mattered. I minded that a lot.

Dani (crying): If I make room for anyone I get obliterated.

JS: (softening in response to her tears) I know, I know. So the only alternative is to obliterate the other person. I think I felt a bit obliterated by your ignoring the fact that I was at a funeral. And I pushed back.

Dani (after a long pause, sounding much calmer): I never thought about it that way before. It makes sense.

Dani's response felt genuine, heartfelt. Something had loosened a bit in me and in her; for a moment, we touched in emotional space, and things opened up. We played with the negative (Coen, 2003), examined her misery with some humor, were present with each other. This was, I thought, our first moment of meeting.

The analyst's disavowed trauma

In a paper wonderfully entitled "You must remember this," Adrienne Harris (2009) invited us to contemplate the analyst's contribution to impasse. Our own attachment difficulties, failures to mourn (and thus, implicitly, to remember rather than enact), coalesce and combine with our patients' to sculpt the particular analytic freeze we confront. With Davies (2004); Grand (2009); Chefetz (2009); Rosenblum (2009), and others, she reminded us that we analysts are both vulnerable *and* resistant to experiencing shame and victim states.

We analysts have our own reasons for avoiding moments of meeting. At times, we resist identifying with our patients, resist experiencing our own and their dissociative process, resist deepening the connection between us. Our attempts to avoid meeting *ourselves* also pull us away from our patients; we establish a self-protective wall that creates both personal and interpersonal disengagement.

What had I been avoiding and why? I tried to contemplate the intersection of Dani's experience and my own. On many levels, my childhood had been both less traumatic and qualitatively different from Dani's. I had had sane, if neurotic, parents. I had been largely protected from traumatic assault. I had not been the consistent object of attack. My welfare had been attended to.

Or did I over-claim? I too had suffered losses, experienced hurts, some more than a little disruptive. And I had had my own developmental

trauma. Feelings of loss and absence; Dani was not the first person in my life who had seemed impervious to me. There had been trauma in adulthood, too: unexpected shocks that were temporarily derailing. I knew what helplessness and absence felt like, how fantasied connections could soften the pain of the present.

In focusing on Dani's history of severe trauma, I had minimized points of intersection between us and erected my own barriers to moments of connection. Speaking from the distance created by time and analysis, I had been unaware of the degree to which my analytic self, well-integrated and mature, had been hard won. I had repeated the dynamics of non-recognition with Dani, disavowing aspects of my own self-experience and negating the overlap that could have allowed moments of meeting. Suddenly, I was reminded of my parents' occasional remonstrations to "look at the donut and not the hole" in response to moments of insistent childhood crankiness. Dani's chronic complaints didn't merely irritate, I realized, they resonated. Seeing an unpleasant bit of myself in Dani magnified (in my eyes) to a monstrous degree, I had tried to get her to "look at the donut," to find the good in the other, the good in me. In so doing I implicitly shamed her as I had felt shamed. And contributed to our failure to meet.

There is an important literature on the impact of massive trauma and its intergenerational transmission. Sue Grand (2000, 2009) beautifully explored the insidious ways that trauma invades our work and is recapitulated between analyst and patient. It is only in retrospect that I recognize the degree to which Dani and I *together* reenacted aspects of her *and my* traumatic histories. And this interpenetration—of experiences of assaultive intrusiveness on one hand and isolation on the other—were replayed between us. At moments, Dani became my impervious mother, while for her I was the brother whose touch penetrated too deeply, against whom she sealed herself off. And in the end, we had each sealed off the other. Living together in the hospital of Dani's childhood, calm, impersonal, untouched, and untouchable, we erected a space devoid of reflective possibilities because of the traumatic assault that threatened us both. We had colluded to avoid meeting each other emotionally because we were both afraid of what would be evoked as a result. The reversal enacted around my response to Dani's phone call broke into that sealed space and, for a time, softened it. Was this a therapeutic sea change?

Perhaps. For this year, Dani's Christmas gift was personal rather than generic. ("I know you like France, you have that great French poster in

your waiting room, and I thought you'd enjoy this soap I bought there.") A nascent tie now articulated. I was touched by Dani's thoughtfulness—the care and awareness of my personhood that it reflected—and I told her so. Dani was delighted that I appreciated her gift, relieved, perhaps, that she had something good to give. We chatted a bit about France, a shared love, and we laughed together. Dani seemed related, warm, relaxed. While I sensed that her connection to me was not intense, it was there and now was mirrored by my own sense of warmth toward her.

Dani was grounded in life rather than fantasy, and my anxieties about a delusional core faded. Perhaps we had a connection after all. Seeming to confirm this possibility, Dani's relationship with her new boyfriend, Mark, began to deepen in the direction of increasing commitment. This time she seemed to be in love with a "real" other, not with an illusion. She neither stalked nor denigrated Mark and, despite periodic ruptures, the relationship did not implode. Increasingly, Dani reflected on the impact of her own behavior when conflict erupted, rather than throwing up her hands or throwing the other out.

However, while Dani's life continued to improve, our relationship did not. To my dismay, our moment of meeting was not sustained. Dani disengaged from me once again and returned to the cool analytic space that had dominated things between us prior to the enactment. I struggled to hold onto the sense of aliveness that had so briefly infused things. Now aware of my own participation in this dynamic, I tried harder to open it. I talked about my sense of Dani's withdrawal and my puzzlement about it but, once again, Dani sidestepped me politely and sidestepped my questions about her sidestepping. There was nothing going on between us, things were fine, she had more important life issues to discuss. She knew analysts were supposed to address the transference, but she really wished I wouldn't do that today, she had too many other things she needed help with. Frustrated, once again unable to make contact, I reminded myself that despite the absence of the kind of analytic work I longed to do, much had changed in Dani's inner and actual life. It was the analysis, not Dani, that seemed frozen once again.

Meeting in a dream

Months passed, and the memory of our painful moment of meeting did as well. And then, apparently out of nowhere, Dani brought in a dream,

her first "good" one. In it, she and I were together in some kind of social situation. She came up to me, laughing, gave me a hug and then made her way to another room that was filled with people having a good time, leaving me behind.

Happy and connected, Dani had conjured a world with something good in it, something that she could get for herself and could share with me freely. Dani spontaneously and joyfully embraced me and went on to a place of pleasure. Here was a warm, loving emotional meeting—precisely what had been absent in our work.

Did Dani's dream represent the very sort of emotional connection that I had hoped for? Was there more attachment between us than I could feel? Hopeful, relieved, also doubtful, I mused aloud, was Dani beginning to imagine her life in a way that included richness and emotional possibility? She laughed, delighted that I had seen the good in her, had recognized this core change. I asked Dani whether she thought that her dream was telling us that she was getting ready to leave, that there was a party to go to after all. Surprised and touched, Dani wept a bit and then thanked me. I wept too, relieved and pleased to discover her capacity for joy and connection.

Dani's dream heralded a growing capacity to access a vastly different affect state; it embodied possibility, even transformation, and the hope it expressed continued. Now Dani often came into sessions smiling rather than sighing and spoke about her distress without getting flooded by despair or rage.

On one level, then, things were dramatically different but, on another level—the intersubjective—they quickly reverted; Dani returned once again to a buffered enclave. She seemed impervious, sanguine, cordial (i.e., emotionally disengaged) but, in the context of her new sense of pleasure in her own life and her treatment, this seemed like my concern, not Dani's. Ready to try things on her own, Dani decided to set a termination date a year hence.

During our last year, Dani and I talked about her investment in hope and how she might manage a future that did not cooperate with her well-laid plans. She seemed steady, mildly grateful, increasingly sure of her own resilience. And although the date arrived concurrent with a new and serious life crisis, Dani remained comfortable with the idea of ending. After the summer, we met for about a month and then said goodbye. Dani hugged me, much as she had in the dream, and I returned the hug freely and warmly.

It's now about 5 years since we ended our work. Dani lives in my neighborhood, and we run into each other periodically. There is mutual

pleasure in these moments of greeting, a far cry from the dread I used to experience when I bumped into her, saw her bitter, sour expression. Now when I catch a glimpse of her with others, Dani is chatting happily, looking alive and open. She seems able to meet others in a space characterized more by pleasure than bitterness. And I feel more warmth toward her than I had imagined would be possible.

Reflections: Therapeutic success or therapeutic failure?

On one hand, Dani seemed transformed, showed evidence of just the kind of change I hope to find in analytic work. But there is another hand, too. For while the powerful obsessions and manic delusions that drove Dani's experience and behavior faded, they were not unpacked dynamically. Dani's history and her fantasy life, their origins and meanings, were never fully articulated, never explicitly worked through. While there was at least one moment of meeting, the bulk of our work together took place in the absence of emotional connection.

Certainly, the single enactment between us changed things. My failure, itself co-created, seemed to establish an edge that Dani could feel, in contrast to the muted shape and color of the bulk of our work. It introduced dissociated aspects of my own and Dani's experience into relational space and, briefly, we became real to—and with—one another. But it didn't permanently shift the analytic process or Dani's ability to engage with me intersubjectively. I was never able to open the meanings or symbolism of the enactment or help Dani shape a shared historical narrative (Grand, 2000). And there was virtually no work in the transference beyond our exploration of the telephone call and my failure. Dani mostly dwelled within an illusion of goodness—a cousin, perhaps, to the illusion of self-sufficiency that Modell (1975) associated with narcissistic patients. Disavowed traumatic states were neither accessed nor bridged; the interface of past and present was not unpacked.

Perhaps my private confrontation—my meeting with myself—*was* assimilated by Dani. In "re-remembering" what I already knew, I became an active witness to my own life and symbolically, to Dani's. Did my recognition lighten Dani's sense of horror in response to trauma (Rosenblum, 2009) by closing the gap between us?

What happened? Some alternative theories of therapeutic change

I think about therapeutic progress through a lens that privileges the mutative impact of the analytic relationship: its failures, reenactments, and repairs. And by this standard, Dani's analysis was a failure. My more classically inclined colleagues would likely suggest that a transference cure or even behavior modification was at work, that the analysis lacked depth and was highly susceptible to disruption. I suspect that my trauma colleagues would be troubled by the degree to which unformulated affect states, lodged in inaccessible self-states, remained so. They would surmise that my own dissociative processes, together with Dani's erected barriers to the investigatory work that desperately needed to be done. Some of my relational colleagues would pin all the change on the enactment that occurred, arguing that I am minimizing its therapeutic power, the ways it dislodged us both from our frozen states. And to some extent, I agree.

Yet, it seems implausible to me that this single moment of meeting, powerful though it was, represented the only mutative therapeutic agent across nearly a decade of work. Instead, I find myself musing about what *did* happen during those years of stillness—about the mutative power of absence—absent chaos, absent trauma.

Is it possible that absence itself represented a crucial therapeutic "presence," that Dani was able to change only within the context of a sustained experience of detachment within therapeutic borders?

By maintaining a mildly friendly, unruffled connection, Dani gradually metabolized an experience of nontoxic otherness that was cool rather than eruptive. Her insistent refusal to take me on or to take up my attempts to open her experience created a powerful shield against strong affect—hers *and* mine. Was the frozen, sealed enclave in which we dwelled a *necessary* freezing, one that allowed change to take place, unseen and unrecognized?[2]

Ricocheting between mania and bitter despair, Dani used analytic space as more than a haven; it was an enclave. Within it, Dani spared us both from the violent vicissitudes of her emotional life. She retreated from the double dangers of disruption and intensity, thereby preventing the invasion of the traumatic arena into the analytic space. In essence, Dani spared us both moments of meeting because of their traumatic potential. How paradoxical that only in this dissociated emotional space nearly devoid of explicit moments of connection, could things change![3]

As I try to formulate an explanation for the mysteriously happy ending to one of the more difficult treatment experiences I've had, I find myself musing about whether, in our focus on creating emotional connections, helping our patients to remember rather than repeat (Freud, 1914), to access and bridge dissociated self-states, we have overlooked the obverse possibility—namely, that for some traumatized patients, change can take place only within a space that *permits* dissociation and a useful sequestering of traumatic assault. Might the thick buffers created within a sealed but leaky treatment space protect the highly vulnerable, dissociative patient from reentering the realm of traumatic process while offering something new, an other who does not reopen what cannot be borne? Do we need also to theorize the potential dysregulation that moments of meeting embody?

In my experience, traumatic affect states and memories ordinarily infiltrate the treatment space in a gradual way that allows for an increased capacity to access, move between, and ultimately bridge dissociated self-states. However, this didn't happen in Dani's treatment. Instead, the traumatized and delusional experiences that gripped her life seemed to fade from view and lose their hold on her without this kind of active work. It's certainly possible that very small bits of my otherness *were* gradually assimilated even as Dani disavowed what would have been too derailing. However, it also seems possible that Dani moved forward because, despite her inability to engage those self-states, her own self-protective barrier became more porous and less vulnerable to shatter. Perhaps the experience of being held in a non-intrusive space that did not require verbal elaboration was the key therapeutic element between us.

Dani's warmth and gratitude toward me are evident when we run into one another. Recently, she let me know that she is still with Mark, that their business is not doing well but that they are managing. Hope has replaced despair, softness has appeared where imperiousness had been. She has developed an increased capacity for affect regulation, mentalization, and more stable attachments. Dani looks content with life, solid, relaxed. She engages illusions lightly, can hope without foreclosing the possibility of loss, can tolerate the doubleness intrinsic to living with illusion and also with actuality (Slochower, 2006b). If Dani can live with all that, I guess I can live with the mystery of why.

Notes

1 Rosenfeld (1971) described thin- and thick-skinned narcissism as alternative defensive styles, but Bateman (1998) viewed them both as alternating and interpenetrating:

> In "thick-skinned" narcissists, the survival of an idealised self is paramount. The analyst is experienced as someone who wishes to dismantle the patient's self, to effect a cure and to engender dependence. As a result, analytic sessions become dominated by defensiveness, a devaluation of external relationships and a wish to destroy the analyst as an object who can be a source of goodness and personal growth … In contrast, the thin-skinned narcissist is more vulnerable. He is ashamed of himself, feels sensitive to rejection, and persistently judges himself as inferior to others (pp. 14–15).

2 In her rich explication of the dynamics of affective experience, Ruth Stein wrote about two principles of affect functioning that she called *affect articulation* and *affect sparing* (1998, 1999). Affect articulation sharpens emotions and deepens interior exploration, while affect sparing "blocks, suspends, or displaces overflowing or damaging affect" (1998, p. 212) and thus helps the individual to contain and moderate pain. Dani seemed to be unable to engage in affect sparing and so altogether foreclosed the affective realm in the treatment space.

3 Elsewhere I have written about how the analyst's struggle to bracket disjunctive affect states, in concert with the patient's similar process, helps to sustain an illusion of analytic attunement (Slochower, 1996, 2006a). While the illusion that Dani sustained was pale rather than idealized, it intersects with my description of variously shaped holding illusions: Dani chronically smoothed out and minimized the subjective experience of difference between us.

References

Bateman, A. W. (1998). Thick- and thin-skinned organisations and enactment in borderline and narcissistic disorders. *International Journal of Psychoanalysis*, 79: 13–25.

Bollas, C. (1987). *The shadow of the object*. New York: Columbia University Press.

Boulanger, G. (2007). *Wounded by reality*. New York: Routledge.

Britton, R. (2004). Subjectivity, objectivity, and triangular space. *Psychoanalytic Quarterly*, 73: 47–61.

Bromberg, P. (1996). *Standing in the spaces: Essays on clinical process, trauma, and dissociation*. Hillsdale, NJ: The Analytic Press.

Bromberg, P. (2009). Discussion of Robert Grossmark's case of Pamela. *Psychoanalytic Dialogues*, 19: 31–38.

Chefetz, R. A. (2009). Waking the dead therapist. *Psychoanalytic Dialogues*, 19: 393–404.

Coen, S. J. (2003). The thrall of the negative and how to analyze it. *Journal of the American Psychoanalytic Association*, 51: 465–489.

Davies, J. M. (2004). Whose bad objects are we anyway? Repetition and our elusive love affair with evil. *Psychoanalytic Dialogues*, 14: 711–732.
Davies, J., and Frawley, M. G. (1994). *Treating the adult survivors of childhood sexual abuse: A psychoanalytic perspective*. New York: Basic Books.
Faimberg, H. (2005). Après-coup. *International Journal of Psychoanalysis*, 86: 1–6.
Freud, S. (1914). *Remembering, repeating, and working through. Standard Edition,* pp. 147–156.
Gerson, S. (2009). When the third is dead: Memory, mourning, and witnessing in the aftermath of the Holocaust. *International Journal of Psychoanalysis*, 90: 1341–1357.
Grand, S. (2000). *The reproduction of evil*. Hillsdale, NJ: The Analytic Press.
Grand, S. (2009). *The hero in the mirror*. New York: Routledge.
Green, A. (1986). The dead mother. In *On Private Madness*.London: Rebus.
Grotstein, J. S. (1990). Nothingness, meaninglessness, chaos and "the Black Hole" II. *Contemporary Psychoanalysis*, 3: 337–408.
Harris, A. (2009). You must remember this. *Psychoanalytic Dialogues*, 19: 2–21. ·
Laub, D. (1992). Bearing witness: Or the vicissitudes of listening. In: Felman, S. and Laub, D. (eds), *Testimony: Crises of witnessing in literature, psychoanalysis, and history*, pp. 57–74. New York: Routledge.
Mitchell, S. (1993). *Hope and dread in psychoanalysis*. New York: Basic Books.
Modell, A. (1975). A narcissistic defense against affects and the illusion of self sufficiency. *International Journal of Psychoanalysis*, 56: 275–282.
O'Shaughnessy, E. (1992). Enclaves and excursions. *International Journal of Psychoanalysis*, 73: 603–611.
Pizer, S. (1998). *Building bridges: Negotiating paradox in psychoanalysis*. Hillsdale, NJ: The Analytic Press.
Rosenblum, R. (2009). Postponing trauma: The dangers of telling. *International Journal of Psychoanalysis*, 90: 1319–1340.
Rosenfeld, H. (1964). On the psychopathology of narcissism a clinical approach. *International Journal of Psychoanalysis*, 45: 332–337. ·
Rosenfeld, H. (1971). A clinical approach to the psychoanalytic theory of the life and death. *International Journal of Psychoanalysis*, 52: 169–178.
Slochower, J. (1996, 2006a). *Holding and psychoanalysis: A relational perspective*. Hillsdale, NJ: The Analytic Press.
Slochower, J. (2006b). *Psychoanalytic collisions*. Hillsdale, NJ: The Analytic Press.
Stein, R. (1998). The two principles of the functioning of the affects. *American Journal of Psychoanalysis*, 58: 211–230.
Stein, R. (1999). From holding receptacle to interior space—The protection and facilitatation of subjectivity: Commentary on paper by Joyce Slochower. *Psychoanalytic Dialogues*, 9: 811–823.
Stern, D. B. (2003). *Unformulated experience: From dissociation to imagination in psychoanalysis*. New York: Routledge.
Winnicott, D. W. (1965). Ego distortions in terms of true and false self. In *The maturational processes and the facilitating environment*, pp. 140–152. New York: International Universities Press. (Original work published 1960)

Chapter 10

You, me, and us

David Pocock

Some years ago I worked with a woman whose brother had recently died in a road traffic accident. In the first session, she was suddenly overwhelmed with grief and sobbed uncontrollably. Disturbingly (for both of us, I think), I felt entirely unmoved, other than feeling controlled, somewhat irritated, and wishing she would stop. I'm usually quite comfortable with strong expressions of emotion, but there was something about the sudden eruption of feelings that evoked a different response; it was as if I weren't really allowed to be present as myself. Into my mind came the idea of narcissistic crying; that I was being pushed into a response rather than being free to respond spontaneously. At the next session, my un-empathic behaviour came up, and I felt it was important to acknowledge that I had felt unmoved and had been trying to consider what it meant and wondered aloud with her whether I had become a mother who could not take in and respond to her upset self. She considered this carefully and said, rather compliantly – she was that sort of person – that perhaps this was possible but that she really didn't know. She stayed only about 18 months and, while apparently satisfied with some gains that she had made in working through her grief, I felt the work lacked depth and, more specifically for this chapter, lacked a growing sense of 'us'. (I'll try to define what I mean by 'us' later.)

One morning a few years later, after a seminar the night before teaching relational theory to a group of psychoanalytic trainees, I woke with a clear childhood memory – in fact a series of memories – of my mother suddenly bursting into tears when I had done something wrong; often quite trivial things like getting the inside of my Wellington boots wet (there were a lot of streams where I lived) and of me feeling overwhelmed and needing to distance myself. This was not a part of myself I was really familiar with – I couldn't recall it being worked on in personal therapy – but I knew that this was exactly the same feeling I had with that patient, by then long

gone. In the previous night's theory seminar, we had been studying a paper by Anthony Bass (2009) in which he asks this question of a patient: 'Have you sensed something about my preferring not to notice your discomfort?' I think it was this that unlocked my hitherto hidden contribution to that failure to meet my patient; instead, I had fallen back defensively on the theoretical idea of narcissistic crying.

One might think that this failure to be with my patient in that moment comes from my being insufficiently analysed, and there may be some truth in that, depending on how complete one assumes that a training analysis or therapy can ever be. However, I want to suggest a more cultural and institutional problem within the mainstream of psychoanalytic practice that inadvertently supports the difficulty in remaining mindful of the continuous contribution of the self of the therapist to the therapeutic process. At the beginning of a psychoanalytic career – that is during training – the exploration of the self of the therapist (via the training therapy) is separated out from supervision of the work with the training patient. That split persists beyond qualification such that reflection on the therapist's contribution to the process of therapy becomes a mostly private matter (as part of continuing self-analysis), and supervision is largely orientated to understanding a one-way flow: the effect of the patient on the therapist as information about the patient. What easily gets left out in these arrangements is interaction – the meeting between two human beings with conscious and unconscious aspects: whatever emerges from that meeting being a product of moment-to-moment mutual influence. This is the central tenet of the relational tradition.

These institutional structural arrangements of mainstream psychoanalytic practice that split the continuous contribution of the self of the therapist away from the mutuality of the therapy process are supported by some theoretical ideas, which can all too easily slip under the radar to become superego ideals: the therapist as a squeaky-clean container so well analysed than she can receive the patient in an uncontaminated manner, or the therapist as a polished un-cracked mirror that reflects the patient to himself or, further back in time, Freud's recommended stance of benign neutrality. However, for me, the major support for conceptualising this one-way flow of information from patient to therapist came with Paula Heimann's (1950) revision of countertransference as – to quote her – an 'instrument of research into the patient's unconscious' rather than, as I now consider it, the countertransference being the feelings and thoughts that the therapist has about the patient at this moment in the

context of all the interactional mingling of both their subjectivities at both conscious and unconscious levels.

I recently assessed a potential patient: someone rather cut-off emotionally – both her parents having died in their early sixties. Some hours after seeing her, I felt uncharacteristically lonely; I recognised these feelings as mine and belonging to particular periods in my earlier life, and I also noted that there had been a trigger that day of my son phoning his mother but not asking to speak to me, something that normally doesn't bother me but seemed to do so on this occasion. Is this lonely feeling information about the patient or about me? My view now is that it can't be divided up between her and me but is emergent from the complex meeting of our subjectivities and more than the sum of its parts.

I understand that Klein had similar concerns about the one-way flow in Heimann's restatement of countertransference, fearing that this shift might be licence to blame the patient. In fairness to Heimann, she was, as she says in her brief paper, seeking to counter the then prevalent ideal of the emotionally detached analyst, particular for those in training, so anxious about the disturbing aspects of their countertransference that their response was to try to suppress all feeling such that interpretation became a purely cognitive activity. Heimann undoubtedly took a step in the right direction but, in leaving out the effect of the therapist on the patient, the one-way flow – rather than the interactional field – was endorsed.

Falling short of the ideals (a clean container, a shiny mirror, a neutral benevolence) can become a somewhat shameful matter of therapist shortcoming. In contrast, the relational view is of the inevitability – even the necessity – of enactments arising from dissociated and unformulated parts of the self of both patient and therapist, the understanding of which move the work forward. I'll come back to this point.

What is 'us': How is it different from you and me?

I've chosen an everyday term as I hope we might intuitively know the experience of 'us'; even though its precise dimensions are hard to pin down. By 'us', I mean a sense of togetherness, which is made up of shared aspects of you and me in a condition of mutual authentic recognition but a sharing that does not subsume either one of us – It allows you to be you and me to be me. I might have used the term 'the third' as Thomas Ogden (1994) and Jessica Benjamin (2009) do – although each with

different emphases – since I broadly agree with their positions, but that risks confusing their very separate use of the term from the way, for example, Lacan (Bailly, 2009) and Britton (1989) speak of the third. I think there is an important tension to be articulated between those two usages. For Lacan and Britton (again with differing emphases), the third is the oedipal presence of the symbolic father guarding against the dyad of the mother (therapist) and infant (or patient) becoming merged. The child (or patient), in facing the reality that there is someone or something else that the therapist relates to, discovers a space to see himself from the outside, to gain the self-knowledge and knowledge of the other as separate that typifies the maturing individual. In psychoanalytic therapy, theory, the words of one's supervisor, identifications with one's training therapist, or implicit rules of technique all can function as the third. However, this is not without risk: this kind of third can guide us, but it is also something that can be clung to in Benjamin's words 'much as a drowning man will clutch at a straw'. This clinging to Britton's third (the idea of narcissistic crying) was, I think, a factor in the failure to meet my tearful patient.

For Benjamin (2007), the shared third is an intersubjective space: a place where the 'us' can grow. Her 'third' is not a holding onto some external reference point such as theory or technique but in letting go – what Emmanuel Ghent (1990) calls surrendering – allowing aspects of our conscious and unconscious assumptions about the other to be destroyed, negated, or modified to create authentic connection to the other's mind while accepting his separateness and difference. Winnicott (1969) described this repeated process of destruction and recognition in what he thought was his most important paper: *The Use of an Object*. And, of course, I am referring to a two-way process. This third – this 'us' – is not then a place of suffocating merger but one in which each can feel a joy of recognition of the uniqueness of the other having an equivalent but separate centre of self (Benjamin, 1999).

Surrender, as Ghent writes, is not to be confused with submission. Both patient and therapist will at times fall into a power struggle where each feels something is being done to the other, as if the relationship can continue only if someone submits: gives in to the other's truth. This is a zero-sum game … a winner and loser with no third position. Benjamin describes these as 'doer and done-to' dynamics, and this certainly speaks to my experience of power struggles as both patient and therapist. Instead, Stephen Mitchell (2000) offers this delightful illustration of surrender and the intersubjective third:

> When my older daughter was about two or so, I remember my excitement at the prospect of taking walks with her, given her new ambulatory skills and her intense interest in being outdoors. However, I soon found these walks agonizingly slow. My idea of a walk entailed brisk movement along a road or path. Her idea was quite different. The implications of this difference hit me one day when we encountered a fallen tree on the side of the road…the rest of the "walk" was spent exploring the fungal and insect life on, under and around the tree. I remember my sudden realization that these walks would be no fun for me, merely a parental duty, if I held on to my idea of walks. As I was able to give that up and surrender to my daughter's rhythm and focus, a different type of experience opened up to me…If I had simply restrained myself out of duty, I would have experienced the walk as a compliance. But I was able to become my daughter's version of a good companion and to find in that another way for me to be that took on great personal meaning for me.

I used to think it a psychoanalytic virtue to keep still and listen silently without the empathic 'hmms' and 'ahs' and the brief acknowledging comments 'that sounds awful' that allow the patient to feel felt. I also used to think it mattered very much to deliver carefully crafted interpretations with a degree of what I hoped was psychoanalytic authority. I would screw up my courage as if showing myself, the patient, and the psychoanalytic world 'I've got an interpretation, and I'm not afraid to use it'. Now I prefer to offer ideas that arise from my curiosity about what might be happening: to invite both our minds to collaborate. And when the synchrony breaks down, as it always must, I try to ease a tricky new issue out of the complementary realm of you versus me into the shared realm of us and ask this kind of question 'something difficult seems to be happening between us; how we are we to make sense of this? Do you have any thoughts?' And although I offer little factual information about myself (I assume I give myself away nonverbally all the time), I do – if it seems important and likely to help – tell a patient how I feel about him or her.

I don't have any quantitative data to support what I am about to say, but I don't experience negative therapeutic reaction; I don't have patients leave prematurely; on the whole, my patients improve more quickly than I once thought they could; I'm more comfortable with the love that develops; and I enjoy them and the work far more than before. However, I'm in danger

of making this sound too easy, as if it's all about being a good mother, and I need in this final section to attend to the regular breakdowns of 'us' into what Benjamin calls the 'push-me pull-you, doer and done-to dynamics' of you versus me and how to respond to these enactments.

Jean, me, and us

I met with Jean once-weekly for 3 years until her death. She had two chronic illnesses and many associated medical complications that at some point could and would take her life. Her medical condition was complex, requiring her to be seen by a host of different professionals who seemed to all manage a different bit of her and did not communicate well with her or one another. Her digestive system was seriously damaged, and she was fed by tube. There were errors in the composition of her food, resulting in her seriously losing weight to the extent that she found it hard to then fight infections and, during the course of the therapy, she was twice hospitalised in an emergency, coming close to death on both occasions. As well as tube feeding, which took hours, faecal matter also had to be drained off by tube. She was very often in pain.

She was an intelligent woman with a sharp sense of humour and, despite these terrible adversities, was determined to make the best of her remaining life with her adult children, her friends, and her hobbies and interests. I liked her immediately and grew fond of her over time.

Given how close she lived to death, it was perhaps not surprising that there was frequent paranoia with regard to those caring for her, especially senior consultants. When she discovered errors in her treatment and when she was denied an operation, a conviction grew that they only kept her alive for the substantial money these teaching hospitals were paid from local budgets. In an even greater distortion (as it seemed to me), she came for a while to obsessively believe that the medical staff did not consider that she was seriously ill.

She entered therapy with a wholly idealised view of her parents, but this began to break down, and she became more in touch with memory episodes of fearing to upset them by being in any way difficult. She was the youngest child by several years, and her barely spoken anxiety was that her parents had finished with child rearing and that she was a late mistake and unwanted. There seemed to be a double-bind in her experience in which she was required to tell her mother what she felt but that if she truly

did so, she would be too much for her mother and would damage her. This mostly unformulated experience of neglect seemed to be the experiential lens for the transference distortion to the medical staff.

During one phase of her losing weight, I came under great pressure to submit to her view that medical staff were in a conspiracy against her; that they held negative views about her that they were not sharing. I sometimes addressed her paranoia by saying that I could not know any more than she did what else might be in the minds of the professionals but, on this occasion, I went further and said, probably with some uncontained frustration, that given the fragmented nature of her care and the poor communication between departments (which seemed pretty factual), it seemed to me unlikely that as a group they would ever be able to coordinate a conspiracy and that I thought instead that her feeling was fed by prior experiences with her parents. I said I was concerned about this since her assumptions about the professional group might lead her to dismiss the care they could offer. Here I think I was trying to break free of the requirement to submit to her in what Symington (1983) calls an act of freedom, posing a rather irritated counter-view typical of a push-me, pull-you power struggle: her versus me.

At the next session, it seemed clear that I had changed sides in her mind: that *I* had now become someone who had harboured bad thoughts about her that I had kept from her. I was on *their* side, not hers. She told me in her sharp way that she had trusted me but it seemed that I had not heard her. She had strongly considered stopping therapy but thought she should let me know before doing so.

She was cold and controlled. I, however, found myself speechless with anger, and when I did try to talk, I realised I was very somatically affected and not able to speak fluently or think coherently. I felt myself a recipient of her rage, but my main emotionally driven thought was of the many months that I had tried to stay with her suffering. In my rage was an enormous childish sense of injustice that she didn't realise how much I had done. In this turmoil, I now realise, was an identification with my mother's oft-repeated guilt-tripping mantra: 'after all I've done for you'.

With Jean, we were very much in doer and done-to territory, and whatever psychoanalytic wits I could still summon told me to stop talking and just hold on and survive. Anything I said would be in the service of shoving it straight back at her. When the level of arousal had diminished and I was able to think, she told me part anxiously, part triumphantly I felt,

that she could see she had made me very angry. I felt she was expecting me to deny it. I considered interpreting what happened as my receiving *her* rage, but that rang hollow (as it would be a denial of my experience and mystify her accurate recognition of my experience), and I felt what was needed on my part was an authentic response. This felt exposing and less safe – a surrender with no predictable outcome. However, I told her that she was right that I *had* felt very angry with her and that this had been linked to a sense of injustice that she had left out my considerable efforts to stay with her suffering. The mood immediately became calmer, and I was then able to say, quite genuinely, that although I had felt enraged, it was a relief that these strong experiences of failure of care had now come into the room so we could work with them directly.

This episode became something of a turning point in the work, and she often referred back to it. She had never been able to get any authentic response from her parents, and this mystified communication had been reenacted for her in her relationships with medical staff. She was terrified that by making me angry, she would destroy me and at the least I would withdraw, but it was evident to us both that from this point on there was a stronger sense of 'us' – of mutual authentic recognition.

Of course, this same issue needed repeating and working through. For example, some weeks later, toward the end of a session, she asked me if I kept session notes. When I told her that I didn't routinely do this, she expressed concern since she had hoped that I might be able to write something in support of her to other professionals if this was needed. How would I be able to remember things if I didn't keep notes? She then reminded me of an occasion when I had forgotten something she had told me. I said that writing to other professionals was not something I would usually do. She then said that she thought she was making me anxious and she noticed I was gripping my fingers in an unusual way. We were right up against the end of the session, and I needed to finish, and what I said was, 'I think what I am anxious about is that we are a little over time'. After the session, on reflection I realised that she was right, I had been anxious about her request, but I had responded glibly and inauthentically because of being put on the spot. I felt unprotected – as if she were trying to reach right into me – and I had given her a half-truth – that I was anxious but not for the reason that she thought.

At the next session, she told me that had felt very bad all week that she had made this demand on me and assumed that I felt annoyed with her. I

said I was glad she had returned to this moment since in retrospect she had accurately noted something that I had not acknowledged to myself: that her assumption that I would write was making me anxious. I explained that this was taking me out of my comfort zone – since involvement with other people in her world was not part of how I usually worked or was part of private practice generally.

She then gave a list of reasons why she had thought that the assumption of hers that I would routinely keep notes and write letters was reasonable. She had worked in the health service and had written notes and letters to others; Dr J (a psychiatrist she had seen for psychotherapy) had also worked this way. I said that it seemed to me that she was no longer trying to persuade me to write notes and be prepared to write letters but instead was trying to defend herself against an accusation that she had done something wrong in making me anxious. I said that her perception that raising this had discomforted me was accurate, but it didn't follow that there was anything wrong with her doing so; quite the opposite, these moments gave the possibility of some new experience. As before, this recognition from me that she had accurately recognised my anxiety seemed a relief to her and allowed her to accept a little more that my good feelings for her could survive her making me uncomfortable. She then talked further about her mother and elder sister: She felt the message she received from them was 'tell me everything, if you don't then you will do me harm, but if you upset me in any way then you are too much for me'. She could never work out what anyone really felt about her nor risk anything other than a false presentation of self.

Over the time of the work, this sense of mutual recognition – an authentic sense of us – grew through alternate periods of emotionally holding her, combined with work on these doer and done-to moments when the holding necessarily broke down. Her relationship with her children improved, as did their relationship with one another: this had previously been almost nonexistent. She made a warm connection with an estranged and isolated elder brother, introducing him to poetry, which by the end of her life he had come to love.

She found a surgeon whom she trusted who agreed to undertake an operation to restore some possibility of her eating again and of reducing the increasing pain and restrictions on her daily life that were becoming unbearable. She went into the operation with full awareness of the risk of dying, which was thought to be around 50 percent. She put all her affairs

in order, wrote final letters to everyone, gave clear directives about not resuscitating her, and arranged a party for friends and family to take place if she died. As she put it in her black-humoured way, 'I'll either be better or I'll be euthanized'; she was quite clear that both of these options were preferred to what otherwise lay ahead.

Sadly, as I have said, she died. The privacy of the psychotherapy relationship gives limited rituals to process grief after the death of a patient, and writing has helped to memorialise her.

Summary

I've discussed the mutuality of the therapist–patient encounter and the inevitably of ruptures through enactment in that relationship arising from dissociated and therefore unformulated parts of the self of patient or therapist or both, leading to 'doer and done-to' dynamics. I've noted how theoretical ideas – especially Heimann's redefinition of countertransference – have endorsed the one-way flow of information from patient to therapist. I've suggested a tension between the very separate ideas about the 'third' of Lacan and Britton and the 'third' of Benjamin: that we need theory but we also need to know when and how to let go; to allow ourselves to change both in surrendering to authentic recognition of the unique subjectivity of the other and in responding to the call of the other that we too should allow ourselves to be authentically recognised in what Daniel Stern and colleagues call 'moments of meeting' (Stern et al., 1998). 'Us' is what grows through repeated authentic moments of contact with the other and 'us' is what remains when the other has gone.

References

Bailly, L. (2009) *Lacan: A beginners guide.* Oxford: Oneworld Publications.

Bass, A. (2009) An Independent theory of clinical technique viewed through a relational lens: Commentary on a paper by Michael Parsons. *Psychoanalytic Dialogues,* 19, 237–245.

Benjamin, J. (1999) Recognition and destruction: An outline of intersubjectivity. In S. Mitchell & L. Aron (eds) *Relational psychoanalysis: The emergence of a tradition* (pp. 183–200). Hillsdale NJ: The Analytic Press.

Benjamin, J. (2007) *Intersubjectivity, thirdness, and mutual recognition*. A talk given at the Institute for Contemporary Psychoanalysis, Los Angeles, CA. Online at: http://icpla.edu/wp-content/uploads/2013/03/Benjamin-J.-2007-ICP-Presentation-Thirdness-present-send.pdf

Benjamin, J. (2009) A relational psychoanalysis perspective on the necessity of acknowledging failure in order to restore the facilitating and containing features of the intersubjective relationship (the shared third). *International Journal of Psychoanalysis,* 90, 441–450 .

Britton, R. (1989) The missing link: Parental sexuality in the Oedipus Complex. In: J. Steiner (ed.) *The Oedipus complex today: Clinical implications*. London: Karnac.

Ghent, E. (1990) Masochism as a perversion of surrender. *Contemporary Psychoanalysis,* 26, 108–136

Heimann, P. (1950) On counter-transference. *International Journal of Psychoanalysis,* 31, 81–84.

Mitchell, S. (2000) *Relationality: From attachment to intersubjectivity.* London: Routledge.

Ogden, T. (1989) *The primitive edge of experience*. Northvale, NJ: Aronson; London: Karnac.

Ogden, T. (1994) The analytic third: Working with intersubjective clinical facts. In: S. Mitchell and L. Aron (eds) (1999). *Relational psychoanalysis: The emergence of a tradition* (pp. 459–492). London: The Analytic Press.

Stern, D., Sander, L., Nahum, J., Harrison, A., Lyons-Ruth, K., Morgan, A., Bruschwielerstern, N., & Tronick, E. (1998) Non-interpretive mechanisms in psychoanalytic therapy: The 'something more' than interpretation. *International Journal of Psychoanalysis,* 79, 903–921.

Symington, N. (1983) The analyst's act of freedom as agent of therapeutic change. *International Review of Psychoanalysis*, 10, 283–291.

Winnicott, D. W. (1969) The use of an object. *International Journal of Psychoanalysis,* 50, 711–716.

Chapter 11

Probing for realness and reciprocity in the early years of an analysis[1]

Malcolm Owen Slavin

Introduction

This is the story of the early years of my therapeutic work with my patient, Adam—a young man who, as I came to see it, probed actively to assess my capacity for what I would call *realness, reciprocity, presence*. The meaning of my empathy seemed to depend, in good part, on how Adam saw and read my inner experience of myself and of him and on how I experienced being seen, known, by him. How, in the process of facilitating inner change for him, we both engaged around the same basic set of universal, human, existential issues.

This narrative is based on my notes, my memory, and the shape that the past takes in light of reflection in the present. Adam has read and fully approves of this version of our story … as well as my telling it to all of you. When I asked, he chose to put his experience of our work in a letter that you will find included after my narrative.

Although our relationship is unique, I am aiming to show something a bit wider about what beginning a treatment like this one feels like and means to me. I hope it provides an opportunity for you to read me, Adam, our relationship, and my work from your own perspective. I emphasize our internal and interactive experiences without wrapping them in particular, theoretical languages-—probably best capturing the overarching vantage point from which I work. I hope this leaves you free to encode (or not to) my story in what I believe is a very wide range of possible languages from the relational to the self psychological as well as the more classically psychoanalytic.

Adam

Adam was a young man in his mid-twenties when I first saw him many years ago: A strong, dark, young man—handsome yet somehow blurred by

an air of acute suffering. I sensed his intelligence and that he was caught up, obsessively, viciously it seemed, in painful self-scrutiny and self-accusation. He came to see me in a visibly depressed state, having spent many years stumbling in and out of college: He had completed about 1 year in the last 7. During that time, he had done a fair amount of drugs and a good deal of drinking, unable, it seemed, to harness his obvious intelligence—and what I came to see as his creative potential in many realms.

Adam tells me in our first session about how ugly he feels when he looks in the mirror (and he looks a lot), and about the chronic doubt he feels about the validity of his own motives: "Do I study anything because I am actually interested in it, or because I think it will gain me approval and prestige? Am I capable of love, or do I just get involved with women because I can't live without their attention and admiration? I can really get into sex and then I start to feel like I'm just a pole that she's using to get off. Maybe we're all just using each other."

Near the end of the first hour, I comment to him something like, "You're struggling to know if you can believe anything you feel or see—trying to know what, in God's name, is… real, trying to get a hold on *some thing* that can feel real."

He nods his head a tiny bit and says everything feels like it ends up going down a black hole. There's some silence, and then he suddenly smiles with what feels to me like one of the warmest smiles I have ever seen. "I think my father's been really depressed all his life," he says. "He's a professor. I think I constantly felt scared as a kid because I felt I had to come up with interesting, stimulating things to say to get *any* response from him. In order to get him to pay attention to *anything*, I had to say just the *right* thing, the interesting thing."

Quickly, he adds, "I met with another analyst here in town before I saw you. And I think I'll see you…I guess, if… you're willing."

"Can I ask what your preference is based on?"

"I told the other guy, Dr. X, how I feel I'm ugly. And he asked about it a whole lot in a way that put me off. It was as if he thought…as if he felt he needed to show me that he questioned it… like a way of showing me that *he* really didn't think I was so ugly—but in an incredibly shrinky, indirect way."

"Well," I say, "I'd be glad to see you."

We decide to try out meeting once a week at first. Over the next weeks, I begin to get more of a picture of Adam's past. He is the third child of a family on the West Coast. His sister is 7 years older, and his brother is

5 years older and, in some way, mentally handicapped. Little else is said about them. However, Adam comments pointedly that, "my mother, in contrast to my father, was always doing things for me, driving me places, always enough attention…sort of, in a way… But really I had the sense that she ran around doing that with everyone. She's just that way—a real *(air quotes)* "giver"… to *everyone*. Taking me on her "good deed" runs. Unless she forgot to pick me up. Basically…she can't think of me as anything but completely perfect, loved my independence, my cooking at an early age. They split up right before I went away to college."

"You want to hear what I think?" I say.

"Of course," he says—with bit of a glare.

"You're left," I say, "wondering about whether there is anything worthwhile about you—I mean apart from the stimulating things you can produce for dad or, I guess, with your mom, anything that's really you versus the you…in her head. Nothing starts to seem like you can believe in it, nothing ever holds up—stays real."

Again, he gives the tiniest nod and then a sunny smile breaks itself out of his incredibly tormented, cloudy face. I have an immense feeling of connecting with him. He tells me what he calls a "weird story" about him and his mom when he was a very little kid (a story other people often told him). They are at a family friend's party. Mom is holding him in one of her arms, running around doing things. She stops for a minute, looks up and, in a panic, asks someone, "Where's Adam?"

At around this time, I recall having intense feelings—something like maybe I am the one—the parent type—who can help him. A strong, real father-son feeling that I became able to feel after my own son was born several years earlier. I also remember feeling like a "professor type" father—fearing a bit that, maybe, how Adam feels about *his* father—the performing-for-him stuff—is how my kids might feel about *me*. So I begin to have some thoughts about being able to learn something useful about *me* as a father—maybe getting some emotional perspective on myself in the course of this work.

What it means to me to be understood by you

Soon enough, whenever we'd arrive at framing something that seemed to illuminate a little better why Adam had felt so unable to sense what is "real" about his own abilities (or so horribly blocked in his own achievements),

I would still see flickers of a smile. Yet, now it was a skeptical, even, sometimes, a little bit disdainful smile.

Adam had begun repeatedly to declare something like, "So, you must be gloating in your triumphant understanding of me. Freud, I'm sure, is smiling down on you." Or, just, a sarcastically restrained, "Thank you, Doctor Freud."

"Am I off, somehow, in what I said?" I'd ask, feeling a bit slapped back.

"No," he'd often say, "I don't think you are off much at all today." And I would feel, *simultaneously*, almost treasured for the bit of understanding we achieved *and* completely dismissed. I ask Adam what he is feeling at these moments. He won't say much other than comment, ironically, that,

" If *I* had to guess what *you* are thinking it was that *I* was worried about what *your* real motives are in understanding *me*. Do you actually care about *me*?"

I ask whether what he means is that I *should* be thinking about this because it is incredibly important to his being able to feel a connection to me—like *the* most important thing. He nods when I put this in my words and adds that he feels really envious of my ability to understand things—*and* especially any *pleasure* I get from this.

I think to myself of the phrase that Lew Sander once wrote that captures the complex reciprocity here better than anything I've ever read: "What it means to *me* to be understood by *you* depends upon what it means to *you* to understand *me*" (Sander, 2008, p. 178).

In other words, here,

What it meant to Adam to be understood by me depended upon what it meant to me to understand him.

Drumming and brother

Adam has now increased his sessions to twice a week. However, at some point he pretty much stops talking for what seems to me like many weeks. He'd say a few words about this and that but never really stuck to anything. In response to my questions or observations about what he was feeling, he'd try to say something but then say basically he didn't really know. He'd whistle occasionally. A few times he'd gently throw the tennis ball he carried in his backpack against the wall. It was a bit frustrating. And, increasingly puzzling. Mostly, I remember his drumming on the very large arms of the leather chair in which he was sitting. They were pleasant, rhythmic, jazz-like drum riffs.

After a few weeks of this, I yielded to my mounting impulse simply to drum along with him … drumming on the same wide leather arms on my chair. For a session or two, we drummed together—no talking. Our rhythms interacted, sometimes a bit of call and response, until the session ended.

The next hour, Adam comes in and asks me if he can lie on my "analytic couch." I say, "Sure." He gets on my couch, pulls out a huge packet of photographs from his pocket, and hands them back to me where I am sitting behind him. They are pictures of Adam and his severely developmentally handicapped brother, Luke. They were pictures of them rolling around playing together, holding hands, hugging. Everything in the images brims with the physical. They were recent pictures and some from childhood. I look at the photos while he describes them to me with what seems like great joy.

We drummed together. Adam has begun to talk. Sitting behind him in my chair, I hear his joy but feel an immense sadness. I remember my eyes tearing up, brimming over, for the rest of the hour.

In the following sessions, we return to what I think of as tilted more toward my frame, my verbal realm. Adam tells me immensely more than I have heard before about his brother, Luke, who was both severely developmentally delayed and brain damaged. Luke never really learned to speak. They communicated intensely together with Adam surpassing Luke in speech by age 2. Adam spoke about his joy in their play and the beauty he saw in his brother's nature.

We increase our sessions to three times per week, and I begin to hear a lot more about the one area in which Adam has applied himself and, it turns out, has probably shown immense talent: working with young children who are emotionally troubled, impaired, or from impoverished families. I hear about some jobs and an internship working with troubled kids that he actually completed with great success during the time he was frequently quite depressed, drinking, and dropping in and out of school.

Feeling it together

It is now later that year. It turns out that Adam's father had recently retired from an academic career in which he had never been able to write, publish, and get the promotions he wanted. He lived what seemed to Adam like an obsessively cautious, depressed existence. There were several deeply moving sessions in which we looked at the ways it seemed Adam felt close

to his father in their shared depression, yet wanted—felt he needed—his father's forgiveness so that Adam could feel he deserved to move on with his own life in any of the ways father had not been able to do so for himself. Adam says he can't imagine how such forgiveness could be possible. "My father is *incapable* of understanding me," he says. "Worse, I know *I'd* have to forgive my father *first*."

I say something like it sounds like he feels he somehow needs to be closer, more connected, to his father to free himself from him, but the closeness is already suffocating. He can't imagine how he'd possibly deal with more of it. I feel an awful sense of doom when we talk about this. The painful, trapping feeling of identification with father's weakness and failure is palpable. The undeservingness of striving for more. More than Luke.

"You know what it is," Adam suddenly says, "I'd have to love him more than I do in order to be able to show him how much I hate him…and why. And I have to show him how much I hate him to be able to feel any love for him. He's too vulnerable, and so am I. It's an impossible trap. I can't see a way out."

That session ends. Soon afterward, Adam comes in looking very dejected. Tensely, he says, he wonders what the hell he's doing here in therapy. Whatever it may be that we've understood, he feels caught up, trapped, once again trapped, in a deep bout of depression. It's a sudden rush of sadness and despair, and I tell him I hear how bad he's begun to feel. Then, as the connection strikes me, I suggest to him that, maybe, the awful feeling at this moment has to do with our talking so much in recent hours about what he had called that awful, "impossible trap"—the bind around ever forgiving his father or being forgiven by him

Adam raises his head slowly, stares right at me, and asks, pointedly, "Why are you saying this? Do you feel you need to make me feel hope? Do you need to show me that this therapy can work?"

I feel stunned. I thought I was sharing a tentative understanding with him that might illuminate, even alleviate, a little of his renewed despair. Lots of thoughts rush through my mind about how, earlier on, he had often acknowledged feeling envy and competitiveness with me when he imagined me as "Dr. Freud" who was feeling so proud of his understanding something. I find myself wondering whether increasingly, now, he is feeling he needs to perform brilliantly for me as a patient. In my still stunned state, I have lots of thoughts, but something stops me before I comment aloud on *any* of these thoughts.

Because, suddenly, nothing feels simple, nothing is clear. As we sit together in silence, I have a curious sense that some kind of doors are opening. There seems to be a huge tangle of different strands in me—in my effort to understand and share something about him and his current despair. Yes, one part of it is that I *am* trying to shore him up so that he won't start feeling too much disillusionment with the therapy, as we get even deeper into the hard parts, like those impossible loving/hating feelings about his father and, I assume, some version of them with me. Yes, I realize that I *am* defending the therapy, my therapy, our therapy. I know it will likely hurt Adam in some ways *before*, and *if*—in the longer run—it will ever really, substantially help.

However, I basically keep my mouth shut. It is becoming apparent to me just how much I am sparing myself from that despair. Thankfully, Adam seems quite tolerant and calm enough for the moment—allowing me to let myself stew quietly in the incredible set of different meanings that my initial emotions and apparent intentions seemed to be taking on. I recall a visual image at that moment—an experience of soft, hidden winds from somewhere, winds that are opening door after door in my mind.

Finally I hear myself say, "I think maybe you were seeing something in me before I saw it myself. It feels to me now like maybe you wanted me to be able to be more in touch with *myself* so I could be more with you in your despair about analysis. And that when I was interpreting why you might be getting depressed over feeling trapped by your love/hate tie to your father I think you felt me saying I didn't want to feel any of that despair."

"Yes," he says, "that's exactly what I felt. Was I right?"

"Partly," I say.

And it's the end of the hour. Adam starts to get up, then sits back down and says, "I think I am wondering about whether I can hurt you like my father."

"Kind of feels to me," I say, "like something in you really *wants* to hurt me, a bit like I'm him. Yes, wants me personally to feel hurt—as well as to feel your hurting along *with* you—as long as I can do it, somehow, without being *too* hurt, too much, *by* you." "Yeah," he says. "Sometimes, here though, I don't know what's worse—the idea of hurting you or that other feeling, you know, I always have that there is no damn fucking way I *can* hurt you—*really*.

The unbearable realness-unrealness of analysis

Indeed, what was "*really real*" versus *"seemingly real but also unreal"* about our relationship (including tortuously and tantalizingly real moments like that one) tormented Adam. "Certainly you realize," he says, "that what seems like one word—'therapist'—is actually split in two—it's actually 'the rapist.'" Like your taking such pleasure in making me feel you're actually taking care of me for a couple of hours a week and then each night going home to your family. Me… I'm just one of your 'collective paying children.' And I perform the part so well."

Throughout all of this serious teasing, though, we came to share a clearer and clearer picture of just how much these aspects of our relationship were almost unbearably similar to the super-caring mother who was so busy helping everyone that she forgets her son is in her arms; and to the dad who needed his son to validate and perform for him. Yes, these were clear transference themes imported from the past that gave meaning and perspective to the present.

However—and this was crucial—*only up to a point.* And that point was where Adam would push me to see and step back from this comfortable transference paradigm and make some very interesting qualifications in it.

He might become furious whenever he felt, as he'd say,

"You're starting to hide behind our understanding of my parents' role in all this—which we already fucking know is *huge*."

He meant that, as much as we constantly relived the drama of trying to create something new out of what seemed like the endless, old scenarios of both parents' inability to recognize him for himself, there was, indeed, something else, something quite real that we lived all the time: the fact of *paying* for an hour of our intimacy; of an *ending* to this intimacy someday—an implicit goal of the therapy; of all the "seeming parenting" that we needed to engage in that in many ways could never be the real parental thing.

Something that is designed to imitate and elicit the experience of real parenting but could never actually be it: The realness/unrealness of the analytic relationship was sometimes nearly unbearable. The crucial thing, as I understood it, was that, repeatedly, I would admit to myself and to him that this "analytic business you've got going" was, in significant part, set up for me. If I had been unable to acknowledge to him that these realities were incredibly important—literally, not just *symbolically* important—I

don't think that the huge, "symbolic" realities of the transference repetitions—indeed, the entire transformative potential of understanding the past—would ever have come to take on much real meaning.

In response to what I came to see as Adam's adaptive probing of these meanings, I realized how often I hear (more classically oriented) colleagues interpret the hostility in the patient's powerful skepticism about the realness of the analyst and the therapeutic process as if it were primarily an attempt to undermine the treatment or to resist taking in the therapist's otherness. In contrast, overall, my sense is that the most critical aspect of Adam's angry challenges seemed to lie in their vital function in breaking down my subjective experience, widening my subjective sense of what was real. I did not only "survive" his aggression. Each time, I changed. We changed.

Empathy and hiding the analyst's otherness

When certain efforts to connect with Adam's experience did not feel sufficient, he would sometimes imagine I was *hiding myself* behind a manifestly empathic focus on *his* experience. For instance, when he found himself craving attention and admiration, he would often quickly attack himself as a "selfish phony." I might then refer to something like his longstanding sense of invisibility and un-deservingness in his family. So much better off than his severely disabled brother, no one recognized his needs in a way that might have left him less alone. A presence on the part of his parents, a recognition that might have helped him to build a stronger sense of a deserving self.

You are acting as "attorney for the defense," he'd often reply. For sure, I knew that Adam might experience me as being "too easy" on him. He carried a ruthless prosecutor around inside: one who would dismiss any "attorney for the defense" who would compete with that inner prosecutor's undermining his belief in, or trust of, himself. Yet this simple paradigm would often open, in an almost uncanny way, into something far more deeply mutual. When I gave myself a chance to see it, this understanding of his past—useful and empathic as, indeed, he sometimes, felt it to be—would melt into an entirely different intersubjective engagement.

Meaning, I came to sense his experience of me as both deeply empathic with one part of him and rather unrecognizing of another. At these moments I was, in a sense, like his parents, absent myself. "I think, Adam," I finally said, "it's like you're scrupulously monitoring *me* to see

whether I'm actually struggling to understand *your* own *role* in your life, past and present. A bit like you're trying to hear, once again, the sounds of my going through *my* version of your thing with you: the real weighing of things, the moral tensions, the struggle to know what is real. Trying to see whether I can stand to be with you in the awful, lost, hateful place you're in during these self-attacks. If something is going to help you, it'll only be if, together, we can somehow enable you to create another perspective—to earn and create your own novel way out. It simply can't smell of what you call my 'off the shelf' wish to forgive."

When, over time, Adam finally had fuller access to his own experience, including the words for it, he said, "What's important is that you can hold me *responsible* for my life. Not blame me, but *not* automatically explain things as responses to my past. How I behave with people now. Who I am. There are real issues here, there's *me* here."

What initially felt—to me and to him—like a genuinely empathic mirroring of his suffering and past trauma came to feel like a place for me to hide from opening up myself to the choices, the moral uncertainties, the meaning making, that he had to endure to recognize the potential reality of his own agency. To resist an easy falseness when, sometimes, the only alternative can feel like utter emptiness, a void, the abyss.

"I can't tell you," Adam said one day, "how important it is to me when you let me see that you can in some way see and feel all this in *you*…. That, in your way, you're *in* it. Emotionally, *morally*, in a way, too. "

"I mean," he said, "when *you're able* to move past simply understanding the effect of the childhood shit that happened to me and my continuing reactions to it—which itself sometimes makes me feel even sicker. Even if, of course, in a way, it's incredibly *true*. Because…because," one day he added, a bit cryptically, "we *all* are in it. And you're not evading that."

"You mean?" I said.

"I mean," he said, "that ultimately nothing's real—except what in some way we somehow decide and discover for ourselves is real … what we construct as believable, trustable … the only thing that's certain is… nothing…death. For me, you, all of us."

The ending of the beginning

Although our analysis would go on for many years, there was a time around here—after about 2 years—when it felt like a deep, mutual attachment was

coming into the foreground. It seemed to rest on the foundation of what we created together around the complicated reciprocity involved in adapting to each other. We had discovered, broken down, and revised the continuing tensions, the pulls toward accommodation and over-accommodation of each other. Ultimately, I believe, navigating our conflicting and shared realities had established a bit of the felt realness that Adam craved the day we started.

Yet, as that "ending of the beginning"—as I now think about it—emerged, something else became overridingly present. A pervasive sense of impermanence, an awareness of the pervasiveness of endings, of losses regularly entered the room. It came to permeate many sessions. Without either of us knowing quite for what or why—and with a fullness of emotion rather than simply a sense of melancholy—we seemed to have become more acutely aware of time. We seemed to be grieving.

Once, nearing (and I think signaling) this era, Adam stopped himself at the door and said, "I wonder why the hell I always look back and smile at you when I leave. And why in hell do you smile back at me?" "You have some idea?" I ask. "Do you?" he snaps back quickly. I venture some now-familiar notion like his wanting to make sure that whatever's happened that he hasn't destroyed too much. That we'll be okay until next time.

"No," he says, "it's feeling a little different." "Each hour," he says, "feels sort of like a life. So, each ending of the hour is like dying. And we're sharing that knowledge."

Letter from Adam

Dear Mal,

Mal, this paper is very, very intense for me to read. Seeing me in such pain, hearing my fundamental distrust in others' intentions/motivations, my merciless attacks against me. A long time has passed, but I easily recognize the face "blurred by acute suffering;" and my fury at the world—for positioning me in a way that I couldn't claim anything as me—aside from when I was self-destructing and disappointing others. Equally evocative is seeing me grapple with myself/relationships/life, in new ways, together with you. Reading about how you were taking me in, experiencing me: How you become intertwined with Adam's story.

Yes, Living and Dying Together and Sessions'-end Shared Smiles. This fits nicely as a way to characterize the hope at the end of this period you

describe. Those smiles validated what we were slowly generating together through each Session Life: the relationship through which I was Becoming Me. This was possible, as you write, only after *I sensed* you were able to endure truly being in the not-knowing with me. Without shielding yourself fully from my pain. Without hiding behind empathy (though I needed that, too). And without hiding from yourself. You had to show me that you were open to Becoming You, I suppose.

Of course, I needed you to steadfastly endure across time, too. You tolerated my attacks. And when I would allow it/accept it, I felt your consistent acceptance, affection, seeing me, waiting with me, playing with me, being real.

But, crucially, you acknowledged that you alone set the formal parameters of our relationship. And you eventually acknowledged that my fury and sadness about what I believed to be artificial and potentially limiting boundaries could conceivably be more than just reflections of my relational history or defensiveness. You didn't change the boundaries. But no matter. You came out of, what I sensed to be, a convenient hiding spot.

You know, I remember the arm-chair drumming very clearly. And the day (or days, as I remember it) you joined in. You seem to write that you were, in a way, done waiting. And you gave in to the impulse to join in. It's wild to me that you mark it in this paper as a transitional point. Because I remember how intense your joining was for me. And reading the paper, it rings true that it might truly have been transformational.

When you drummed along, I wanted to ridicule you for how uncomfortable you looked, how vulnerable, yet how pleased with yourself. I wanted to shame you for pandering. I wanted to just stop and stare you down with spite for thinking you were welcome. I was also overwhelmed with affection for you in your drumming enthusiasm. And with enormous respect for your courage at jumping in without invitation. When I think about it now, in the context of your paper, our drumming together strikes me as an explosive, high stakes dance-off to try out having a real relationship, to try out really being alive together. Your bearing and expression made it look like you were taking a big risk. And I can tell you, I felt I had to keep drumming to keep myself both from attacking you and from hugging you.

A last thought, Mal. Yes, I feel pain as I read and revisit my acute suffering. But I also smile wide in recognition of, what I have just this moment identified as, the simultaneous *discovery and creation of self* implicit during this period. Something you didn't emphasize in the paper

but that I recognize unmistakably as I listen to That Me *talking*: I remember painstakingly looking for the right words—frequently attacking myself mercilessly for not finding them fast enough—so carefully trying to put words to feelings and thoughts. You often left me to myself in that grueling work—not presuming to *KNOW or TELL* but rather just *with me* in my aloneness. And when I captured what I was looking for and it felt true, it was largely Me and Mine. I have always known that I found real comfort and hope in the togetherness, or We, of our early work. Now I think just as important to the sense of hope was what happened in my aloneness of those meetings, inseparable, as it may have been, from the particular togetherness we were creating.

Thanks, Mal, for the invitation to share my reactions to your paper. And for writing with such care and affection.

Note

1 A verbatim talk originally given for a Plenary Session, Annual Conference of the International Association for Psychoanalytic Self Psychology, IAPSP, Boston, Massachusetts, USA, October 2016.

References

Sander, L. (2008) Recognition process: Context and experience of being known. In: Sander, L., Amadei, G., and Bianchi, I. (eds.), *Living systems, evolving consciousness and the emerging person: A selection of papers from the life work of Louis Sander.* pp. 168–177. New York: The Analytic Press.

Slavin, M. O., & Kriegman, D. (1998) Why the analyst needs to change: Toward a theory of conflict, negotiation and mutual influence in the therapeutic process. *Psychoanalytic Dialogues, 8* (2), 247–284.

Winnicott, D. W. (1969) The use of an object and relating through identifications, in *Playing and reality.* pp. 101–112. Harmondsworth: Penguin.

Chapter 12

Sleeping/dying

"Now moments" in clinical space

Edie Boxer

I stretch, step in place in a series of small, quick moves, and swing my arms in circles, all in an attempt to force oxygen through my body. I am preparing myself for battle with my opponent who is in the waiting room. Opening the door, I acknowledge his presence, wondering what he will be like today. He nods hello, looks around to make sure he has all his possessions, and trudges down the hall to my office, barely pausing before sitting down on the couch. Without hesitation, he simultaneously begins his monologue while positioning himself in the middle of the sofa. Stuffing a pillow behind his back, he observes me in my chair directly opposite him. I prepare myself to absorb his verbal attacks as he questions my expertise and capability as his therapist:

"I want to talk about what happened last night with Ava, but we never get around to really discussing what is upsetting me. You get caught up in details while I don't even know what you are talking about or why you are focusing on such drivel. You are not helping me at all!"

Here we go again. I can hardly concentrate. I feel so tired all of a sudden. I better figure out how to stay awake; I can pinch my hand. That has worked before, but why is this happening? Suddenly, I hear Lucas proclaim, "You're falling asleep!" I have been caught. "I think I drifted off into thinking about an unsettling email I got just before we met. My supervisor during my analytic training is in hospice care. I'm sorry. I guess the news is affecting me more than I realized." I disappeared for a moment and feel ashamed. "It is shame…which reveals to me the Other's look and myself at the end of that look" (Sartre, 1943/2001, p. 237).

Now, several hours after the session, I become aware of an uneasy, all-too-familiar feeling that I left my patient no space to share what he was thinking. In fact, now I am reconsidering whether my sudden attack of drowsiness was prompted by the sad news. I hadn't even considered what

else might have caused my sleepiness. What did it have to do with my former supervisor? I didn't have her with me. I realize I am more on my own, facing this attacker. I am sure I am withdrawing in the face of feeling assaulted, keeping any awareness of my anger from emerging. There's no space for me, my anger, my words. I feel shut out.

I tell myself that I have failed my patient by disappearing into sleepiness. Feeling inadequate has both historic roots and current meaning (Ogden, 2016). Shame still takes center stage for me. I am not picture-perfect. Viewing myself as incompetent and a failure, I am ensconced in what Morrison (2008) calls the "language of shame." This feeling of imperfection has played a prominent role in my development since the day my mother and I were on the balcony of my maternal grandparents' apartment. I was eight and said to my mother, "You know, I'm not perfect." I don't remember what happened before, that would have led to my declaration of imperfection, but I still remember her telling me she was going to make me as ideal as she could. And then my memory fades. The impact of not being the daughter my mother wanted continues to this day. As a child, I became sad, quiet, and obedient. Not until I was a grown up would I question, aren't little girls supposed to be alive with energy and curiosity and enthusiasm? Why wasn't I acceptable the way I was?

In the midst of this session with Lucas, I am not flawless. I have almost fallen asleep. Perhaps Lucas's disappointment in me is similar to my mother's. I recall my mother's anger flooding the environment, leaving no space for anyone else to display his or her fury—or just to be. Children were definitely disregarded, and my father was quiet and, to a large extent, emotionally and physically absent. If I were indeed angry, I was unaware of it then as I am now with Lucas.

Lucas is often angry and tells me he doesn't want to talk about what happens between us, assigning the responsibility to me to figure out my problems (Aron, 1991). His usual jab: "It's your job to understand your stuff, not mine!" Once again, what can I possibly say? He continues, "I don't know what kind of therapy you are doing. It's not like the other therapists I saw. I walk out of here frustrated with nothing to think about. No problems solved. How long have you been a therapist?" I have no access to my thoughts. We're in a "relational knot," a crisis of disengagement (Pizer, 2003). Each time I open my mouth, he cuts me off: "I don't know what you are talking about! Do you think before you talk?" Suddenly, I know that I am angry. He has no right to talk to me like that! I hate that

he makes me feel inadequate. I think Lucas has no idea what is going on between us, let alone what's happening inside him. He will not let me in. I almost fall asleep, which indicates to me how deadening the therapy is (Ogden, 1997). I'm losing hope as we continue on the edge of a dangerous, even potentially terminal scene.

Feeling overwhelmed and apprehensive, I need to continue to unearth my contribution to this impasse (Renik, 1993, 1996; Aron, 2000; Mitchell, 1998). My mother's style was to withhold herself—her voice—when she was upset and angry with me. Sometimes I was not certain what I had done, but there was no space for me to wonder with her about that. I worked so hard to get her to talk to me. She was silent. If I called "Mother" from the hallway, hoping for a response from her in the nearby room, all I could hear was her enormous sigh accompanied by "Yeah?" I had no one to guide me through my mother's rage. I feel alone without my supervisor and have no one to accompany me through Lucas' rage. And now I have discovered my own.

Alone

As the sessions go on week after week, I am still hesitant to bring up the topic of my almost falling asleep during a session. My early effort at creating a space to discuss what's happening between us failed, as it did with my mother, and prompts an immediate annoyed, repetitive response from Lucas: "I don't know what you are talking about! Do you think before you talk?" Unwilling to process our interaction, this man, who is still positioning himself in front of the couch pillow shoved behind him, expects a great deal from me. As he develops his narrative filled with historical and current relational angst, I am left on my own once again. We couldn't be "partners in thought" (Stern, 2010, p. xiv). He left no room for me.

I wonder how—or whether—I am going to breach this chasm. I cannot imagine initiating a conversation with Lucas that will, as Stern (2004) says, "make sense of what has happened in the past, what is happening now, and how to act upon it" (p. xv). In the co-created clinical impasse with Lucas, I am now threatened with a familiar confrontation with my long-deceased mother. As with Lucas, I had no way to resolve the disconnection. I can understand very little about Lucas's background. His rage seems to be about who wasn't there for him, who didn't understand him, but we can't talk about his fury or his history without his blowing up and shutting

down any possibility of connection or exploration (Hirsch, 2006). Once in reference to his childhood when I said, "Oh, you were insignificant," he seemed to physically settle and was quiet for a few moments only to return to his usual patterns of pushing me away.

During another session, I begin to relax. He is not on the attack. Did I say something to calm him? It must have been when I remarked that in his relationships he has felt insignificant. That's the word to describe the source of some of his torment. It felt like something clicked. I can see it in his eyes and a slight nod of his head. I have hit pay dirt, and that is why he is not barking at me for practically anything I say; then, just a few minutes later, he launches once more into telling me he does not want to complain about a recent painful relationship ending. Yet, he does complain about all he has done for the relationship only to be disappointed and hurt once more. What happened to that meeting place I thought we ventured into when I used an empathic word such as *insignificant*? Maybe my suggesting that I understood his pain frightened him. There is, as usual, no way to discuss what is happening. He cannot allow us to explore his inner world and how it impacts his relationships. All through this impasse, I have been working on my own self-criticism to convince myself I have something to offer him in the midst of his tirades. I find myself more open to my thoughts and feelings. Clearly, this renewed vitality on my part is not apparent to him. And even if it is, Lucas is still on the attack, protecting himself, I speculate, from new possibilities with me and dismissing the impact of his childhood traumas. Terrified, he pushes me away while still coming to session after session, continuously reminding me he is showing up to be, once again, the innocent victim of my inadequacy and imperfection.

Now he begins to talk about terminating and tells me he doesn't know where to go to find yet another therapist. Is he only threatening to leave, or is he really planning his exit? Right after the session, I call a consultant to help me decide whether I am going to help Lucas end our sessions or find a way back into the morass. He begins the next session almost before he sits down with this:

"I don't even know why I am here today. I almost cancelled. Actually, I am done and today is my last session with you. So, we can talk about your thinking I am insignificant like you said the other day. Do you even remember saying that about me?"

"Wait a minute," I respond sharply, "You want to stop?" I instantly know that I feel an overwhelming sense of relief at the prospect of not

being subjected to his verbal assaults three times a week. I don't have to find some referral names for him if he, not I, is the one ending treatment. However, I also feel the loss of the possibility of connecting. Still, I make another try at reaching him, wanting to let him know I am here in the room with him. Suddenly, I hear his abrupt response to my idea about being empathic.

"Empathic? You have got to be kidding. What are you talking about? That is just ridiculous!"

I reply in a stunned voice, "Really? You don't think that trying to empathize exists in this kind of work, in this room?"

With a pause, he barks, "No. I don't even know what you are talking about!"

My internal experience is a mixture of sadness, relief, and an absence of shame and guilt. It seems he cannot comprehend, at the very least, that being empathic is part of forming a relationship, of not being left alone, something he talks about a great deal. Like the impasse, he won't let us explore his feeling lonely. Although I am not as shut down, there still is nowhere to go with him. At the end of the session, I tell him, "I wish you well and that you can find a therapist who can be helpful." "Thank you," I hear him say as he pauses in the doorway. I feel relief and regret that I will not be able to help Lucas change his view that relationships are only damaging and disappointing. We couldn't create "a lived story" for Lucas that is "rewritten by writing over the old" (Stern, 2004, p. 222).

Yet, in our process, I was able to know myself differently. I failed to be perfect in the way Lucas wanted me to be, but I didn't have to be perfect in his way, nor in my mother's. And that was okay. I know I heard him say "Thank you" as he paused in the doorway on his way out. However, I did not understand what he was thanking me for. I also remember my mother, at the end of her life, asking me, "What is to become of me?" I did not know what she meant or how to respond to her. I still don't. In the end, two dyads—Lucas and I, my mother and I—couldn't rework our relationship. Even though I could refind my vitality in my work with Lucas, our relationship couldn't be enlivened. And so it was with my mother. Working on myself during the time Lucas and I met, I could feel very sad instead of angry that my mother and I couldn't break out of the ongoing, historic bind we had always been in.

Sleepiness: "Someday I am going to get out of here"

Thinking about Lucas, my mother, and myself, I am reminded of an earlier patient whom I started to see during my analytic training when I was working with the supervisor who went into hospice. Although Rebecca is a savvy, attractive single woman in her early thirties who came in very depressed and self-critical, she is articulate and eager to work in therapy. In the beginning, I feel a real pressure to sustain her and am anxious because she is my first control case. The therapy begins well enough. I feel a connection with her. There is an easy back and forth, despite her depression and the failure of a previous therapy.

Despite the relative ease of our work over the first few months of treatment, I have trouble keeping my eyes open in several sessions. She casually comments, "Oh, you look sleepy" and may feel guilty about noting my momentary withdrawal that causes a ripple. However, it doesn't become a "now moment" (Stern, 2004), a crisis in the treatment. Instead, our relational moves, including my getting sleepy at times, can be characterized as "moving along," "the everyday dialogue that moves a therapy session forward, at least in time" (Stern, 2004, p. 149; Stern et al., 1998). Within this context, I consider my unusual conduct. Convinced it is due to my getting older, working too much and too intensely, not getting enough sleep the night before, and not having enough air circulating in my consulting room, my sleepiness still puzzles me. Some of the sessions are in the late morning before lunch, not a usual time for me to feel tired.

My supervisor suggests that my patient must also be contributing to my reaction, but she and I do not explore her idea, nor do I explore it with Rebecca. Instead, I feel ineffective and disconnected, at least in those moments when Rebecca talks in a monologue, without giving me space to comment. I want to feel revitalized and connected to her. Rebecca's affect is rather flat, her speech pressured. She sounds angry, increasingly stimulating my own apprehension as I try to determine how to respond. At these times, it gradually becomes apparent to me there is no way to be with her other than to listen. She does not want to explain or explore. The tone of her voice tells me she is unable to step back from her feelings enough to be self-reflective.

Winnicott (1960) teaches us that good-enough maternal care involves environmental and psychological holding. Neither Rebecca nor I received that kind of caretaking. This realization makes the work more bearable

for me. Although unspoken between us, I can know I am not alone in my experience. During a period when Rebecca expresses more acute anguish, it seems impossible to be with her in her hopelessness. She describes such overwhelming despair that I remember my childhood mantra: "Someday, I am going to get out of here." That seems to keep me from joining her in her desolation while allowing me to be fully present and empathic. Indeed, I could have been Rebecca during my bleak times in childhood were it not for my innate expectation that I would and could leave my family. First I had to convince my father I had not only earned my driver's license but also could operate a car by myself. Then even though my parents encouraged my going away to a university about 3 hours' drive from home, I struggled to leave home, and yet I did establish myself in the world.

Now I can stay with Rebecca's pain because I remind myself that I did leave home. Then she begins to describe various disturbing scenarios with her family without losing herself, and can be more reflective. Early in treatment, her life begins to expand beyond her debilitating depression. She describes enjoying time with friends. She is able to glimpse that this therapy might work for her. Usually the feeling is only momentary. Underneath, she believes she is not entitled to most anything in her life, including healthy relationships. Things just don't work, including previous therapies. She calls these beliefs "her protection" borne out by "her experience." As she talks, I feel more anxious. I want her to have a different experience than she had as a child.

Could we find out where these beliefs came from? I always feel better and less anxious if I can understand the answers to my questions, if I can say, "Oh, that's why. I understand. Now I can go on." However, in these sessions with Rebecca, I fail to remember that others might not experience the same relief as I do. Without considering her perspective, I start to ask one question after the other. At this point in my analytic career, I desperately want to tease out a linear history that will explain her despair and potentially, hopefully, alleviate the anxieties we each have.

In what seems like an instant, she appears to physically withdraw; her body retreats into the couch while she has a vacant look in her eyes. It's as if she's almost shrinking. She grows silent while I try harder, feel more anxious, and begin to have a hard time articulating what I want to say. At the same time, I feel progressively disconnected from her and myself. The feeling is so intense that, thankfully, I can't help paying attention to it and stop my interrogation. I feel bad, like a perpetrator, and tell

Rebecca I can see from her affect that I'm not getting something she is trying to communicate. Perhaps, I say, she is questioning the value of this analysis. Maybe she is trying to say, "Why bother?" As I comment on our process, I wonder whether she is feeling abandoned by me, and she agrees. Abandoned is a good and familiar word to both of us. For her, it represents being left with her mother's overwhelming, unacknowledged anxiety.

Even though we are at the end of the session, I tell her that it is important that we discuss what just happened when I abandoned her. She tells me she also feels criticized/shamed by my questions. That is, she feels I am really saying she is doing therapy wrong and wonders how others do it. Unlike the experiences with Lucas and my mother, Rebecca and I are attempting to find new ways to be with each other that are different from the relational patterns established in both of our families.

When I abandon Rebecca with my questions, I create a potential crisis that could derail the treatment, what Stern (2004) calls a "now moment" (p. 245). Rebecca and I could resolve our conflict, leading to more understanding and connection, a "moment of meeting" (p. 244).

Rebecca tells me that her other therapists didn't explore their disruptions. No, not at all. What stories I heard! They told her she is the problem and would not take any responsibility for what happened. My questioning of her comes out of my anxiety, which must have triggered her memory of being caught in her mother's anxiety. Taking care of the other's feelings is a familiar task. Confronted with both of us, Rebecca withdraws into herself, exhausted, blaming herself for her failure to appease her mothers and feeling disappointed mostly in herself. When I feel disconnected from her, I get sleepy and feel the familiar draw of a deadening, but essential, relationship with my mother.

Now, we agree, we can pay attention to our journey to discover what happens between us. Rebecca and I have become a good match. In this moment, we each came through old patterns to find something new. Co-creating this moment of meeting (Stern, 2004) with Rebecca opens the space for me to think more deeply about my childhood and how it influences my work as an analyst (Kuchuck, 2013).

Memories

I remember my maternal grandmother as being both physically and emotionally distant. She was a rather small woman who presented as

austere, while my grandfather's smile and playful nature emerged from time to time. It isn't that I witnessed or experienced my grandmother's limiting style of parenting. Rather, I sensed that my mother's allusions to her mother being much more of a restraining parental figure meant that we were lucky there wasn't more to cope with. My mother had her own traumas but, unlike me, she did not have the curiosity or desire to learn how to be an emotionally reliable presence for her children.

Another scene appears to me when I recall myself as a very young child, holding onto my mother's hand as she talked on the telephone. I did not want to let go of her or to the hoped-for warm, comforting feeling that might accompany our touching, but although my mother was holding my hand, she was preoccupied with her call; we were not looking at each other. I yearned for nurturance and a comforting connection. And so, my mantra, "Someday I am going to get out of here," took on more importance. I lived in a familial environment where my mother's unforgiving expectations, along with my father's passive acceptance of her rules and regulations, meant that we often were told "Children are to be seen and not heard."

When my brother and I were young, our parents spelled words to each other in an attempt to keep us from understanding them. We were present for the discussion, but they must have believed we could not comprehend what they were saying. As we got older and could figure out the words my parents did not want us to know, my mother spoke some Yiddish to my father. This was only one of many examples of how my only sibling and I did not feel respected and acknowledged. Each of us, however, took different paths to separation, with very different outcomes. Unlike my brother, who continued to live a rage-filled life, ultimately ending with his early death at fifty-four, I was able to thrive as I launched myself in college, marriage, parenthood, and my career as a social worker and psychoanalyst.

In another memory, I am 10 years old asking my mother whether I can use the baby clothes I notice in a closet to dress my doll. I hear her tell me "No" from another room.

I ask her a few questions, all the time not in sight of her. "Whose baby clothes are they?"

She replies, "My first baby, a boy, but he died."

At the same distance, the conversation continues with more of my questions:

"How old was he?"

"Five days."
"What was wrong with him?"
"His heart."
"Where is he buried?"
"In the cemetery."

That was the first and last time we talked about her first baby. What did I do with that information when I was 10 years old other than asking my brother if he knew? It was only as an adult in analysis that I wondered what it was like for my parents to lose their first-born child. How did it affect my brother, their second child? There is no one to hear these questions or answer them, because my parents and brother are long deceased.

Finding the box containing the baby clothes represents an aborted exchange with my mother. This time, it was about her traumatic loss, which I stumbled across in my childhood enthusiasm to play with my baby doll. Never am I able to capture her attention to deal with all that I do not know or understand. My mother could not be with her grief, so she was unable to help both of us manage that which felt unmanageable—profound sorrow. If she were able to embrace moments like this between us, I believe our relationship could have had the potential to grow. I would not have felt so alone and unheard. It makes me sad that my mother and I never had such a moment of meeting. I never had one with my brother, either. I felt I could have had that kind of connection with my father, but he died before I could develop an adult relationship with him.

Disconnection-death

Both Lucas and my mother kept me at a distance. Behind my mother's unavailability was the trauma of the death of her first child that was not discussed, even, I imagine, with my father. This child's death was a haunting presence in my family's life, a deadening legacy, certainly for my mother. Lucas refuses to be vulnerable with me, hides behind his rage, exerts control, and keeps me at a distance, just as my mother did. In almost falling asleep with Lucas, I am thrown into the underworld of death and dying.

In a session with my analyst well before I met Lucas, he notes that I often speak of death and wonder what could have happened in my childhood to explain this. At that moment, I remember that conversation I had with my mother about the doll's clothes. Aside from a faint memory, I had not recalled that conversation in many decades. "No wonder you

thought about death," my analyst says. "You lived in a home filled with death. You and your brother were replacement children she had to control so she wouldn't suffer further. And you had to be perfect." Lucas needed me to be perfect, too, so he wouldn't suffer, although he didn't believe for a minute that I could be even good enough. I could accept my own imperfections even though there was no opportunity for repair with him, or with my mother, as there was with Rebecca.

I can only wonder how my parents survived that loss and felt overwhelming sadness for years. Tragically, my brother's first child, a boy, died in the birth canal, his umbilical cord wrapped around his neck. This time my parents lost their first grandchild, but once again there was no discussion in the family. When I was pregnant with my first child, a boy, I told my doctor I was terrified the same thing could happen to me. Seemingly incapable of being empathic, he dismissed my fear and closed down any discussion. My association of disconnection with death comes from my family history. I imagine my experience of feeling sleepy with Lucas is not only a response to how deadening our session was but a response to how he distanced himself, which evocatively pulled me into that underworld my mother lived in. Only a few days ago in a session with a relatively new patient, I am very aware I could fall asleep as he is talking nonstop, but this time I catch myself. I can step back and reflect on what is happening to me. I don't have to fall into that familiar place with my mother, her loss, and the specter of death.

References

Aron, L. (1991). The patient's experience of the analyst's subjectivity. *Psychoanalytic Dialogues*, *1*(1), 29–51.

Aron, L. (2000). Self-reflexivity and the therapeutic action of psychoanalysis. *Psychoanalytic Psychology*, *17*(4), 667–689.

Hirsch, I. (2006). Commentary: Psychoanalysis as a personal relationship. *Psychoanalytic Perspectives*, *3*(2), 7–15.

Kuchuck, S. (Ed.) (2013). *Clinical implications of the psychoanalyst's life experience: When the personal becomes professional*. New York: Routledge.

Mitchell, S.A. (1998). The emergence of features of the analyst's life. *Psychoanalytic Dialogues*, *8*(2), 187–194.

Morrison, A.P. (2008). The analyst's shame. *Contemporary Psychoanalysis*, *44*(1), 65–82.

Ogden, T.H. (1997). *Reverie and interpretation: Seeing something human*. Northvale, NJ: Jason Aaronson.

Ogden, T.H. (2016). *Reclaiming unlived life: Experiences in psychoanalysis*. New York: Routledge.

Pizer, B. (2003). When the crunch is a (k)not: A crimp in relational dialogue. *Psychoanalytic Dialogues*, *13*(2), 171–192.

Renik, O. (1993). Analytic interaction: Conceptualizing technique in light of the analyst's irreducible subjectivity. *Psychoanalytic Quarterly*, *62*(4), 553–571.

Renik, O. (1996). The analyst's self-discovery. *Psychoanalytic Inquiry*, *16*(3), 390–400.

Renik, O. (1997). Conscious and unconscious use of the self. *Psychoanalytic Inquiry*, *17*(1), 5–12.

Sartre, J. P. (2001). *Being and nothingness: An essay in phenomenological ontology* (trans. H. Barnes). New York: Citadel Press. (Original work published 1943).

Stern, D.B. (2010). *Partners in thought: Working with unformulated experience, dissociation, and enactment*. New York: Routledge.

Stern, D. N. (2004). *The present moment in psychotherapy and everyday life*. New York: W. W. Norton and Company.

Stern, D.N., Sander, L.W., Nahum, J.P., Harrison, A.M., Lyons-Ruth, K., Morgan, A.C et al. (1998). Non-interpretive mechanisms in psychoanalytic therapy: The "something more" than interpretation. *The International Journal of Psychoanalysis*, *79*(5), 903–921.

Winnicott, D.W. (1960). The theory of the parent-infant relationship. In: D. W. Winnicott (ed.), *Maturational processes and the facilitating environment* (pp. 37–55). New York: International Universities Press.

Chapter 13

Mutual discoveries emerging from secrets, lies, deceptions, and truths

Linda G. Beeler

In this chapter, I examine the process of a psychoanalytic treatment in which the analysand challenged me to question my identity as an analyst and organize a new one. My struggle with evolving beliefs in ego psychology and classical one-person psychoanalytic theory paralleled my patient's struggle to integrate disparate aspects of his identity. I elucidate several enactments that contributed to my growth and to my patient's growth, enlarging my ability to encompass relational and more contemporary perspectives in my work. The co-construction of the interactive process of the analytic dyad shifted the treatment and fostered therapeutic change in the patient.

This chapter illuminates how my response to my patient's rigidity uncovered my own rigidity, thereby gradually enabling me to become more flexible. Intrigued by creativity, spontaneity, and moments of freedom, I have navigated new terrain by shifting my theoretical orientation from a classical Freudian position to a contemporary psychoanalytic perspective incorporating relational theory (Mitchell, 1988), self-psychology (Kohut, 1984), systems models (Beebe, Jaffe, & Lachmann, 1992), and intersubjectivity (Atwood & Stolorow, 1984).

Early theorists who diverged from Freud's classical thinking were Ferenczi, Klein, Bion, Fairbarn, Guntrip, and Winnicott. They contributed to the development of object relations theory, with its emphasis on the role of the interaction between analysand and analyst. Ferenczi (1988) believed that analysis was a mutual encounter: that the analyst was not an authority but instead a co-participant who shares his countertransference with the patient. Melanie Klein, who provided "the crucial bridge between Freud and modern British object relations theories," theorized that the "infant was wired for human interaction" (Mitchell & Black, 1995, p. 113). Bion (1967) broadened Klein's thinking related to projective identification, theorizing

that there are two unconscious minds in the room, the analyst's and the patient's. According to Fairbairn (1952), the libido is object-seeking, not pleasure-seeking. Specifically, Winnicott (1960, p.39) proposed, "there is no such thing as an infant—only the infant-mother unit." This dramatic statement was significant in the development of the two-person system and the evolution of relational thinking. Stated in another way, regarding the analytic relationship, "there is no such thing as either the patient or the analyst only the patient-analyst unit" (Binder, 2006, p.163).

Human relationships rather than biological drives are central to relational theory and are at the foreground of human development within a therapeutic context as well as in life. Therapeutic change takes place within the analytic relationship. As formulated by Greenberg and Mitchell (1983), relational ideas bridged the individual and the social, internal objects and external, and interpersonal relations.

This chapter charts the clinical journey of Jay. It sets forth his history as it unfolded during the course of treatment. Throughout the psychoanalytic process, there were moments of surprise and the pleasure of discovery. As Bromberg (2000) reminds us, "The gateway to our most pleasurable moments of intimacy with our patients, [is] sometimes a Pandora's box we wished at that moment had remained shut, but [which] … contribut[es] life-force to clinical psychoanalysis without which our work would be as creative as painting by numbers" (p. 6).

As I traveled with this young man on his journey of recovery, his hope, dread, and determination gave me inspiration for my own journey. There were several heightened affective moments between us that expanded my authentic engagement and spontaneity. Jay's astounding transformation illustrated how the analytic dyad is indeed an ongoing system of interactive influence (Beebe & Lachmann, 1988; Lichtenberg, Lachmann, & Fosshage, 1992) between patient and analyst, influencing each other within the analytic encounter.

Unfolding of the drama and initial conceptualizations

A strapping, tall, muscular man of 35, Jay walked into my office for the first time, flooded with anxiety. His tension permeated the room. He was sweating and pacing, in the midst of having a full-blown panic attack. Prompted by his agitation as he appeared to be on the verge of fleeing, I felt my own distress and apprehension. I did not retreat into a traditional

stance but, instead, perhaps to reduce my tension as well as his, offered him a glass of water, which he accepted. I experienced in that moment what Hoffman (1998, p. 235) identified as a critical "tension between spontaneous responsiveness and adherence to psychoanalytic ritual."

The giving of water could be seen as an act of humanity and kindness. However, within the model of traditional theory, the giving of the water would be considered a parameter to further the psychoanalytic work. Had I adhered to the classical model, I would have resumed an analytic stance, by verbally facilitating ongoing associations and analyzing the defenses and the resistances. I recognized that my analytic style was shifting from being a neutral, passive observer to an expressive, active analyst.

Had I not offered the water, my inactivity would have been the equivalent of shutting the door on him. I pondered the effect that the giving and taking of water had on both of us. I focused on the transference-countertransference configurations and the moment-to-moment interaction between us. I started to think that this interchange between us was at the core of how we were to work together.

In our first meeting, Jay spoke of being paralyzed, frightened, and incapable of walking to the supermarket or using public transportation. Imprinted in his mind were two ideas: his mother's terrorizing, sadistic behavior toward him and his mystifying inner narratives and tormented ruminations about his father's identity. He was preoccupied with negative thoughts related to his brutalizing mother, the search for the truth about his own identity and that of his biological father, and his striving to be free of the traumatic memories of his past.

Ubiquity of enactments

Our sessions gave rise to complex enactments. Together, we played out a set of dual fears and wishes that we each feared and wished for in our lives. The first encounter between us had already evoked images for Jay of the hated internal object of his mother. His biggest fear was being beaten by her and being humiliated by her angry unpredictable outbursts. I understood that his panicky feelings were related to an intense early maternal transference of his fear of being trapped by his abusive mother and of being terrified of the emotions engendered by her. I recall the dialectic tension within me as I was challenged to be the nurturing, attuned mother, experienced as different from the assaultive, rejecting mother.

When I offered Jay the glass of water, I experienced myself as nurturing toward him (unlike his mother, who required him to nurture her). The giving and taking of the water and the interaction between us had a self-regulating and comforting effect on him. He revealed that he frequently served tea to his mother to calm her down.

Upon giving him the glass of water to relieve his state of panic, my own countertransference leaped out like a ghost from my past. I was suddenly aware that Jay's anxiety reminded me of my mother's tension. I recalled having attended to my mother when I was 12, when she had a severe migraine headache. My mother fainted, and I responded with a sense of urgency. Was I feeling too strong a sense of urgency with my patient? Was I unconsciously afraid that he, too, would faint? Earlier in time for me, it was a life-and-death situation. My burden was to revive her. Within minutes, she regained consciousness. I muted my panic by offering her a cup of tea. Although she accepted the tea, she barely acknowledged that I provided it to her. I felt dismissed.

As Jay accepted my offer of water, he reported experiencing me as being like himself. To me, this translated into being the nurturing, soothing self-object to him that he had been to his mother. He and I had engaged in a mutual (complementary) enactment: a repetition of my giving my mother tea as she recovered from her fainting spell and of his functioning as a self-object with his mother by providing tea to her to calm her violent outbursts. This interaction between us demonstrated a mutual vulnerability that foreshadowed the future treatment.

I became his fantasized mother to whom he did not have to offer the breast of nourishment but from whom he could receive nourishment, and he became my fantasized distressed mother with whom I could connect and who could generously accept. We co-enacted together the most feared-for and most wished-for parts of our experiences. "[I]n order to find the patient, we must look for him within ourselves,…we find ourselves in the patient as well (Bass, 2001)."[1] Jody Davies (2004) refers to transformative moments in the therapeutic exchange during which the analyst encounters his or her own vulnerability by penetrating the patient's hidden selves.

Unknown identity

Early in the therapy, Jay told me of a dramatic event that impacted his entire life. When he was 19, he had attended the funeral of a former

boyfriend of his mother whom he had always referred to as his "Uncle Murray." While at the funeral, he overheard someone referring to him as "Uncle Murray's" son. He recalled experiencing himself in a stone-like state of disassociation. He further elaborated that as a child, he did not know his biological father, who he understood had abandoned his mother early in her pregnancy.

Jay remembered that he had confronted his mother and his half-sister, Mary, after the funeral and questioned them whether "Uncle Murray" was his biological father. His mother just shrugged without affirming or denying the validity of the information. His half-sister, who is 10 years his senior, refused to provide any information about his paternity.

As this young man expanded on the circumstances of his childhood, he described how his happiest memories were visiting his "Uncle Murray." He was a kind man who gave him the cherished gift of a ham radio that profoundly changed his life. When Jay was with "Uncle Murray," he felt relieved of the insanities of being with his mother. The ham radio was his connection to the outside world.

In many of the analytic sessions, Jay was preoccupied with trying to understand why "Uncle Murray" would keep the knowledge of his paternity a secret. As the patient ruminated about his "uncle," I found myself sitting at the edge of my chair in horror and disbelief. It was unimaginable to me that he had not communicated with his "uncle" about whether he was his biological father or was not. He could not ask his mother for fear she would beat him. He lived in the privacy of his isolated mind and hid parts of himself to survive.

Rage in the analytic space

In the early stages of analysis, the patient's affect was restricted and his manner robotic. Over time, however, his presence in the room became stronger, characterized by intelligent and eloquent speech. It was no surprise to learn that he worked as a sports announcer. In the transference and countertransference matrix, I wondered whether the trumpet in his voice would keep me at bay or whether I could penetrate the sound barrier between us. I felt anxious and worried that I would be overwhelmed and paralyzed by his intensity.

He talked in bellowing tones of his hatred toward his mother who was a single parent. Jay's tension-filled voice escalated with disdain as he railed

about his mother's irrationality, in contrast to his earlier subdued affect. It was like a volcano that erupted in the room. He had vivid memories of being beaten; under the constant threat of her assaultive behavior and, at the same time, dependent on her for survival, he learned early in life to contain his affect and avoid confrontation.

In my countertransference, I experienced the patient as being like his mother, enacting her rage, and felt like a trapped little child. I wondered whether he might be trying to destroy me. At times, I found myself disassociating from his pain. I was aware of the tension within me as I struggled both to listen to his hateful feelings toward his mother and to stay attuned to his despair and hopelessness. I did not want to shut him out as his mother had and as he had his mother. When I regulated my own inner state by moving away from his despair, Jay's heightened affect and metaphoric language pulled me back in. He described himself as a "caged animal," a "time bomb ready to go off," and a "prisoner waiting for his life sentence to be over."

I emerged from feeling cornered and overpowered by Jay's anger and felt less afraid of him and freer to interpret that he was a victim and wanted revenge against his mother. In response, he fantasized that his happiest day would be when he could "dance on her grave." I interpreted that the internal voices of his mother in his head would then be dead. He replied, "Yes, the demons would be gone."

Davies (2004) wrote, "to feel sane, I must recognize the very significant other is insane…." (p. 720). As Jay spoke of eliminating the demons in his head and destroying his mother, his struggle was to preserve his sanity and develop a firmer self-definition and identity. Simultaneously, I found myself feeling overpowered by his voice. I became aware of my own destabilizing feelings in his presence and the need to avoid being destroyed by his venom.

I did not restrain myself as I would have in a classical framework. I said, "I am shut out by your powerful anger!" He responded, "I feel powerful and found my voice that I locked away as a child!" At this moment, I noticed a shift in Jay's tone and expressions of rage. He became freer and less constricted by the rage toward his mother. He shouted and pleaded, "I want to know who my father is!" Together, we reconstructed his unconscious fantasy of his "killer-mother" who he imagined had destroyed his father and his own identity.

Model scenes

We reconstructed model scenes (Lachmann & Lichtenberg, 1992) that depicted early memories of Jay's retreating into his room to protect himself from his mother's assaultive behavior. One model scene was a poster of a pilot and a 747 airplane. The poster depicted the patient's fantasy of a bridge to the outside world and his means of escape. Another model scene centered around the cherished gift of the ham radio. As he revisited the memory of receiving the ham radio, we were mutually engaged. He reflected on having avidly spoken with others using the radio and having practiced being a radio announcer. We came to understand that the radio was a personification of the "uncle" and the "far away" father. My recognition of his passion transformed his state for the moment, supporting his sense of freedom and the attainability of what he loved and had locked away for many years.

He hoped to become free of being held hostage by his mother. He had fantasies of being reunited with his father. He idealized him and imagined his father would protect him from his disturbed mother. I interpreted his need for his father to be his savior. His search for his idealized father was his lifeline, enabling him to differentiate himself from the insanity of his mother.

Jay stated that it was terrifying for him to associate himself with the "hateful psychotic" tendencies of his mother. I told him in an emphatic tone that he wasn't "crazy" like his mother. I attempted to help him differentiate and hold onto the boundaries of his own self as distinct from his mother.

A pivotal moment

In his third year of analysis, a pivotal moment occurred after the patient returned from a vacation in Italy. He brought me a gift: a magnetized etching of the country of Italy. He wanted me to have a keepsake and hold onto it as a representation of him that would be with me even when he was not actually in my presence. By internalizing my image and holding onto it as he traveled, he had been able to sustain a feeling of safety. When I attached the magnet to the metal radiator in my office where he could see it, the moment was a transforming one in which Jay said he experienced me as holding onto him magnetically and consistently in my mind, just as he was attempting to hold me consistently in his mind. His ability to "mentalize" (Fonagy, 1991, p. 639) our relationship was an important

piece of progress for Jay. His contempt for his mother had impeded his capacity to mentalize her and others.

As I placed the magnet on the radiator, I recalled my son's recent school assignment in which he had described his family as being like a radiator: his father was the structure, his younger brother was the rattle and noise, and I was the heat and warmth. I experienced our interaction as symbolic of my radiating heat and warmth. The magnet symbolized that Jay and I would stick together like a mother and a baby. Our relationship was represented by a metallic magnet with its uninterrupted holding power, in contrast to his wooden mother who repelled him by her stiffness, rage, and unresponsiveness.

I mulled over who I was in the transference. Was I the lost or "far away" father? I wondered whether Jay was afraid that I was going to abandon him as had his father. After all, this young man had experienced the profound absence of his father. To him, all relationships were unpredictable, secretive, lost, and broken. I interpreted to him that the magnet was symbolic of being held by me and the continuity of our relationship. He stated that he was terrified of losing the connection with me and being "forgotten." I told him, "I could not forget you and I will always remember you!"

In the past, I would have worked with a patient who had given me a gift by reluctantly accepting the gift and interpreting the meaning of the magnet through putting it under an analytic microscope. In this case, I had disregarded the internal voices of my classical training not to gratify the patient and had instead responded directly to his anxiety by prominently displaying the magnet on the radiator where he could see it. I understood the gift as a sign of his trust and appreciation of our work together and his newfound capacity to give and love.

Moments of surprise and perturbation of the system

Although Jay and I reexamined his mother's abusive and violent behavior toward him from many different perspectives, he did not fathom the depths of her emotional disturbance. He complained bitterly about his contempt for his mother because she hid the truth about his biological father. He frequently shouted, "I lived out this charade and feel humiliated." He discussed his shame of living with these deceptions and lies. He wanted to discover the "truth." There was a rising level of tension in the relationship between us. I experienced myself feeling that we were at a crossroads. I thought the patient was making progress. He was now able to talk about

his rage toward his mother, which he had previously suppressed. However, he railed against me, expressing his fury and irritation. He asserted, "I am frustrated because I am not getting enough." "I want more answers!" "You are doing nothing to relieve my distress and tormenting shame." I surprised myself by stating, "We will have to deal with the uncertainties. I don't have all the answers, and we will have to explore them together."

I struggled to overcome the rupture between us and convey the mutuality in our relationship. There was an implicit understanding that Jay was discovering my inner struggles and my vulnerability. I welcomed his anger toward me since this was new in our interaction and the first time we tangled. After he described his feelings of emptiness and despair, it became evident that he could not hold onto his therapeutic gains. I mulled over the meaning of his feelings of deprivation and frustration toward me in the transference, which were similar to his experience with his mother. I thought to myself, did he experience me as putting on a charade? Was I holding something back from him? I reflected on whether the analysand thought I was harboring a secret from him. I wondered whether he held a secret and was putting on a charade with me.

In the very next hour, Jay expressed his feelings of shame about not knowing the identity of his father. He quickly shifted his affective state by exploring his meaningful relationship with his half-sister, Mary. He described her as functioning as a surrogate mother. It was poignant as Jay acknowledged to me that Mary was the gatekeeper to the secret of his identity. It was a revelation as he explored his relationship with her from a different vantage point. He revealed for the very first time that Mary never lived with him and was raised by a foster family. A Family Court had ruled against his mother and placed his sister in foster care. Jay had memories of his wish that Mary would return home and be his protector—a wish that didn't come true. I was shocked that he was left unprotected at the hands of his abusive mother and commented in a forceful voice that his mother was considered "unfit" to care for Mary. In the past, I would have chosen a more delicate word, such as "troubled," rather than "unfit," but my intense emotions of anger and outrage came pouring out of me. Jay screamed, "My mother is the scum of the earth. My mother is a monster. I lived in hell and was raised by a Tasmanian devil." He imitated a devil by twisting his head around.

The "now moment" when I stated that his mother was "unfit" was one of the more important and significant affective engagements between us. I addressed the "truth" of his disavowal of his mother's severe mental

illness. Jay exclaimed, "You are changing!" I smiled and asked him, "How do you experience me as changing?" He assertively stated, "You are being more straightforward and no-nonsense with me." I said, "I have no secrets and I am being candid with you." I experienced my own subjectivity with this interaction as being affectively engaged, spontaneous and, therefore, more authentic. At this point in treatment, I felt this young man was reworking old feelings and conclusions and discovering and expanding new ones about himself, his mother, his half-sister, and myself.

According to Stern (1998),

> a "now moment" is seen as an emergent property of a complex dynamic system (intersubjective field). The emergent moment challenges or threatens the stability of the ongoing initial state. It announces the disturbance in the system. When a "now moment" emerges, the therapist and patient are surprised, in a sense of being taken off guard because the exact form and instant of appearance of the moment was not predictable (pp. 301–305)

Immediately after the session during which the illuminating "now moment" occurred, Jay reported a recurrent dream that had haunted him since his "Uncle Murray's" funeral:

> I was walking in the street and saw "Uncle Murray." I reached out to him but I could not touch him. I tried to call to him but words would not come out. "Uncle Murray" did not see me or respond to me in any way. The weather was foggy, and he was in the distance. I was going to ask him if he was my father He kept walking and did not acknowledge me.

Jay's associations to the dream reflected an intense state of anxiety. He felt that his anxiety was related to not knowing whether he was "Uncle Murray's" son. He was disturbed by "Uncle Murray's" lack of responsiveness to him and interpreted it to mean that "Uncle Murray" was not acknowledging him as his son. The distance and the fog symbolized the ambiguity of his relationship to "Uncle Murray." And "Uncle Murray's elusiveness was related to Jay's struggle to understand the meaning of the mysterious announcement at "Uncle Murray's" funeral. I addressed the transference and inquired whether the dream could also reflect Jay's

feeling that I was too "distant" from him. He stated "yes!" and that he "still wanted more 'answers' from me."

Although the dream was recurrent, it was only after the "now moment" that the patient was fortified to express his emotional turmoil to his sister. He no longer had to hide from the truth. Jay experienced a sense of his own agency and was less paralyzed. He unleashed his rage by demanding that his sister reveal the identity of his biological father. Previously, he had needed to suppress his frustration and aggression toward his sister for fear of being abandoned by her. He felt validated by the pivotal emerging moment and his ability to strongly assert that he wasn't "getting enough" from me. He realized the "truth" of the court decision that had ruled against his mother's having custody of his sister. He had been paralyzed out of fear of being out of control like his mother. He discovered new pathways to express his anger and his needs, which had been previously inaccessible. His sister confessed to Jay that his biological father was not "Uncle Murray," and that she had known the name of his father all along. His father was a young man, about 20 years old when he abandoned his mother during her pregnancy.

The search

He immediately located his father, who acknowledged his paternity. Jay insisted that his father take a DNA test because he wanted the truth. The test conclusively confirmed his paternity. His father welcomed him into his family. His father's embracing him turned out to be good fortune, better than he had ever anticipated. It affirmed to Jay that he was not forgotten. His father has offered Jay a renewed sense of himself that encompasses love, sanity, and stability. Interestingly enough, the patient had never experienced himself as being rejected by his absent, silent father. Instead, he had experienced his father as rejecting and walking out on his mother prior to his birth. He was not angry and needed to preserve him as a good object, for now.

After Jay's fourth year of analysis and the discovery of the identity of his father, he pursued his childhood dream of becoming a pilot. He walked into my office wearing his pilot's cap and his wings on his shirt! I stated, "Never in my wildest dreams did I imagine that you would soar above the earth, become a pilot, and overcome your debilitating anxiety." Triumphantly he replied, "You taught me to fly and pursue my childhood

dream!" I exclaimed, "You have certainly spread your wings." We both laughed in a playful manner. This was a heightened affective moment between us and a metaphor for his newfound sense of self.

Transformation and conclusion

Jay's progress and growth in treatment has encouraged him to develop the capacity to move out of his insulated, solitary world. He used me as an object to express his hatred, and anger toward the internalized object of his mother, who had failed him. Throughout the course of treatment, he discharged and released the intense feelings and fantasies that had gripped him in his traumatic experience with his mother. As this young man worked through his states of overwhelming rage, hopelessness, isolation, and terror, he gradually expressed awareness of using me as a container to hold his anguish and fears. He said to me, "You were here holding me with all my terror and I didn't have to be left alone." I replied, "You felt safe with me, and it would have been horrifying to be alone."

Because I demonstrated the capacity to hold his pain deep inside me, he was able to tolerate these unbearable affects and different self-states. He felt held, recognized, and accepted. He was able to mentalize the other, firm up his sense of self, and form a meaningful connection with me and then with others.

Over the course of our work together, we came to understand that for Jay to survive his terrorizing mother, he had had to disclaim and submerge parts of himself from himself, his mother, and the world. He was helped to reclaim his hidden identity, integrate his different self-states, and add new dimensions to his sense of self. Through the transformation of his newfound identity, the powerful voice of his internalized mother steadily weakened, and healthier constructive inner dialogues took its place. Finding his biological father consolidated his newfound identity, reaffirmed his sanity, and provided him with the experience of being "remembered."

In retrospect, the analytic process with Jay has been a liberating experience for me as well. I was psychoanalytically trained in an era when classical techniques and ego psychology were mainstream. However, as I have become more exposed to contemporary theorists and post-modern thinking, I am no longer constrained by analytic rules of abstinence. My shifting clinical sensibilities have become infused with relational thinking. I am inspired to trust myself to be more affectively engaged and to allow

my humanness and my inner struggles to enter the analytic relationship. At this integrated stage of my professional life, I am free to bring into the analytic room the playful and adventuresome self that I had previously left at home. Had I kept my "neutrality," it would not have been neutral but restrictive, retraumatizing, and like a straitjacket for both of us. Like Jay, I have reintegrated my spontaneity, broadened my identity as an analyst, and incorporated remembered parts of myself.

It is my hope that this chapter has provided an increased appreciation of how the psychoanalytic encounter can transform the analysand and the analyst. Intrapsychically and relationally, it was a journey that touched both of our lives.

Note

1 Karen Starr, PsyD, quotes this passage from Tony Bass as the discussant regarding this chapter on the panel "Where Truth Lies" at the IARPP conference, Legacy of Stephen Mitchell in March 2012.

References

Atwood, G., & Stolorow, R. (1984). *Structures of subjectivity*. Hillsdale, NJ: The Analytic Press.

Bass, A. (2001). It takes one to know one; whose unconscious is it anyway? *Psychoanalytic Dialogues*, 11, 683–702.

Beebe, B., Jaffe, J., & Lachmann, F. (1992). A dyadic systems view of communication. In: N. Skolnick & S. Warshaw (eds.), *Relational perspectives in psychoanalysis,* pp. 61–81, Hillsdale, NJ: The Analytic Press.

Beebe, B., & Lachmann, F. (1988). The contribution of mother-infant influence to the origins of self and object representations. *Psychoanalytic Psychology*, 5(4), 305–337.

Binder, P. (2006). Searching for the enriching sense of otherness: The psychoanalytic psychotherapist as a meaning-bearing other. *International Forum of Psychoanalysis,* 15, 162–168.

Bion, W. R. (1967). *Second thoughts selected papers on psychoanalysis.* London: Karnac Books.

Bromberg, P. (2000). Potholes on the royal road: Or is it an abyss? Presented at a full meeting of the Toronto Institute of Contemporary Psychoanalysis.

Davies, J. M. (2004). Whose bad objects are we anyway? Repetition and our elusive love affair with evil. *Psychoanalytic Dialogues*, 14, 711–732.

Fairbairn. W. R. D. (1952) *An object-relations theory of the personality.* New York: Basic Books.

Ferenczi, S. (1988). *The clinical diary of Sandor Ferenczi*. (J. Dupont. Ed.), Cambridge, MA: Harvard University Press.

Fonagy, P. (1991). Thinking about thinking: Some clinical and theoretical considerations in the treatment of the borderline patient. *International Journal of Psychoanaly*sis, 72, 639–656.

Greenberg, J., & Mitchell, S. (1983). *Object relations in psychoanalytic theory*. Cambridge, MA: Harvard University Press.

Hoffman, I. (1998). *Ritual and spontaneity in the psychoanalysis process.* Hillsdale, NJ: The Analytic Press.

Kohut, H. (1984). *How does analysis cure*? (A. Goldberg & P. Stepansky eds.), Chicago, IL: University Of Chicago Press.

Lachmann, F., & Beebe, B. (1992). Representational and selfobject transferences: A developmental perspective. In: A. Goldberg (ed.), *New therapeutic visions: Progress in self psychology*, pp. 8, 3–15, Hillsdale, NJ: The Analytic Press.

Lachmann, F., & Lichtenberg, J. (1992). Model scenes: Implications for psychoanalytic treatment. *Journal of the American Psychoanalytical Association,* 40, 117–137.

Lichtenberg, J., Lachmann, F., & Fosshage, J. (1992). *Self and motivational systems: Toward theory of psychoanalytic technique*. Hillsdale, NJ: The Analytic Press.

Mitchell, S. (1988). *Relational concepts in psychoanalysis: An integration*. Cambridge, MA: Harvard University Press.

Mitchell, S., & Black, M. (1995). *Freud and beyond.* New York: Basic Books.

Stern, D. (1998). The process of therapeutic change involving implicit knowledge: Some implications of developmental observations for adult psychotherapy. *Infant Mental Health Journal*, 19, 304–305.

Winnicott, D. W. (1960). The theory of the parent-infant relationship. In: D. W. Winnicott, *The maturational processes and the facilitating environment,* pp. 37–55, New York: International Universities Press, 1965.

Chapter 14

Retirement from psychotherapy practice

A mutually generative rite of passage

Elizabeth McKamy

> "Sara," I said, "I have something to share with you." Her posture straightened.
> "The time has come for me to retire. A big decision, but I want to conclude my work while I'm still able to do so well. So everyone benefits as best she can from the experience."
> "You're not sick, or moving away?"
> "No, I'm not sick or moving away."
> "So when are you kicking me out?"
> "I'll stop seeing patients the end of September. In six months."
> "So…" Sara calculated, "we have 24 sessions left …Wow!"

"Wow, I thought to myself. The decision to retire my practice is rolling out." Caught in an irrevocable thrust toward terminating with dozens of patients, many of whom I'd worked with for years, I felt much as I do when my seatbelt is tightened, the door of the plane has closed, and the gateway folds into its lock at the terminal.

Like many, I prefer to deny age-related vulnerabilities and my eventual mortality. It's hard enough to acknowledge getting on in years, but so much harder to own the fact that there's a finish line to treasured careers and to the relationships with the people who make them possible. How does a psychotherapist process such issues? When aging and ending our careers are spoken of among psychotherapists, it's often with hesitation, apology, even guilt, adding to the difficulties of making the decision (Eissler, 1975; Novick, 1997; Power, 2016).

Timing

I've come to believe that psychotherapists should conclude clinical responsibilities before limitations of age short-change the potential for full

mutual participation with patients. Older therapists, presumably prepared financially have, in my opinion, an ethical responsibility to bring their work to a close before age-related limitations deprive patients of the option to articulate work accomplished, validate meaning of the shared relationship, and acknowledge unresolved issues to work on elsewhere, if indicated.

To do so requires a therapist's attention to detail, plus energy and sufficient health to convey that terminations, while at times fraught and uncomfortable, are normal occurrences for us all. Relatively healthy older therapists who elect to retire unencumbered by disabling distractions are able to weather the challenges that are part and parcel of ending any mutually valued relationship so that each participant can move on knowing she has satisfactorily bidden the other farewell (McKamy, 2015).

When I decided to retire after 45 years, there was scant reference in the literature regarding how others had negotiated the transition. The *choice* to stop seeing patients when still functioning well is different from terminations necessitated by relocation (Sherby, 2004), professional impairment (Gabbard & Myers, 2008), pregnancy (Lementani, 1981), illness (Morrison, 1990), or death (Pizer, 1997). It's certainly different from patient-initiated termination (Freud, 1917; Balint, 1950; Novick, 1997; Novick and Novick, 2006). Retirement, for most a normal *rite of passage,* tends to be underrated among psychotherapists.

Well-seasoned clinicians love what they do and are good at what they do. The reluctance to end a gratifying career that benefits oneself and others in so many ways is understandable. There is fear that camaraderie among members of the professional community will be lost, one's professional identity forgotten. Some older therapists fret that time will hang heavy on their hands.

While I certainly experienced many such worries, the more compelling motive was to conclude clinical responsibilities while I had agency to guide patients through the process and to assist good transfers. I also wanted freedom to pursue other things while I had time and health on my side.

Getting ready

I had concerns about how to inform patients, even though I suspected my advancing age had been in plain sight for some time. I doubted patients would be blindsided by my announcement and recalled that some had already asked whether I had plans to retire. Viewing my career as something

that had always had an end point was helpful. Coming to terms with that obvious fact helped to clarify where I stood and, ultimately, eased things when I informed patients of my decision.

Furthermore, it was energizing to admit my own needs and set realistic goals even as I bent every effort to consider those in my care. The process of doing so seemed consistent with established concepts of generativity and legacy in late life (McKamy, 2015; Erickson, 1963).

As I approached retirement, I reminded myself that a therapist actually has few secrets from her patients. Throughout my career, patients would surprise me with their implicit knowing of pregnancies, before they were manifest, periods of depression during personal trials, incidental episodes of distraction, or burnout I had thought unnoticeable.

It was reassuring to recall that events that occur outside the office that are *correctly inferred* between a therapist and her patient enhance vantage points for each party and strengthen the sense of connection long after particular moments of meeting have passed (Freud, 1937; Karlen-Lyons, 1999; Holmes, 2010).

Knowing that there are intimations of the end of any treatment from its beginning is a supportive concept, as is that retirement from a beloved career is a natural step (Freud, 1937; McKamy, 2015). The context of seeing retirement as a *rite of passage* offered opportunities for mutual mourning and healing, for patients and for me, too, in some measure, from traumatic and non-participatory losses of the past.

The playing field shifts

When a therapist initiates time-specific closure with all her patients, it sets in motion a deviation from customary analytically informed models of treatment. To declare a "last day" imposes multiple *forced terminations* (McKamy, 2015; Power, 2016). My patients did not have say-so about when our work would end other than to choose to depart before I did. I was keenly aware, imposing my deadline upon patients, that the spacious horizon of psychoanalytically informed psychotherapy would contract.

At the announcement, treatment with each patient became more akin to strength-based short-term psychotherapy. The immediate, ever-present reality of parting became central. While psychodynamically informed work patients and I had done up to that point underlay everything, an accelerated experiential dynamic psychotherapy model made the most of

unique relational time-limited spaces (Fosha, 2004). Focus on the reality before us, with recognition of patients' larger treatment issues, blended well with accumulated knowledge from past insights and allowed treatments to deepen even as they were coming to an end.

"You've said very little today," I commented to John, a 20-year-old student who usually had much to say in his weekly sessions. "You've been rather quiet since you mentioned the date you have after this appointment."

As I waited for John's response I found myself unusually curious about his evening plans.

Was this a new girlfriend? Where were they going? To a new restaurant I'd not yet visited? I imagined its menu …..

"What am I supposed to talk about?" John asked. "It's hard to know what to say with only a couple of months left."

A silence, which allowed analyzing my reverie. I said, "Maybe, with just a couple of months left, it feels like we're here but almost somewhere else as well."

"Well, yeah," he said. "I have no idea what you're going to do after you stop seeing me." He laughed. "Are you going to tell me what you'll do Thursday evenings after you retire?"

We laughed together. Then I told him that my plans weren't clear. "This experience of leaving a job I love is where my thoughts are right now."

John began to talk about the unknowns of both our futures. Where would I be in the months and years ahead? Where might he be after graduation from college? What would a new therapist be like? Would I remember him as time passed? How would he know how I was doing?

A developmental perspective

A psychotherapist's retirement is one of many developmental chapters that occur, often significantly, alongside patients' therapy journeys. When we navigated training and internships, patients were affected. When we transferred from one caseload to another or relocated from one setting or type of clientele to another, treatments were impacted. It's the rare therapist who hasn't had to let clients go and begin again with others. Usually our expertise and confidence are enhanced by such disruptions, and patients do navigate endings successfully; many survivors of terminations become

our patients and integrate previous connections and gains effectively (McKamy, 1976).

When I announced my retirement, I was confident that losses and interrupted journeys could generate positive growth. My task was to convey, without unnecessary burden, that I, too, would grieve saying goodbye but felt sure we would all emerge intact from the experience.

Still, there are patients who do not tolerate charged information or stimuli of intense attachment well. For such patients, I knew my news would evoke great anxiety. Overwhelming feelings might well override those patients' abilities to self-regulate (Fonagy, 2009).

Gretchen, had accrued a cluster of diagnostic monikers for decades, including major depression, schizophrenia, and borderline personality disorder. Beneficiary of a trust, she lived alone, putting in hours of labor at a veterinary clinic where she had volunteered for years.

"How will I manage without having you to talk to?" she cried. "Why did I ever trust you? I'm never seeing another one of you shrinks!" she shouted as she slammed the office door.

Several days later, having processed concerns that I had handled the session poorly—and familiar frustration that Gretchen's unhappiness continued to manifest in destructive behaviors—I phoned her.

"It's hard dealing with my retirement," I offered. "Would you be willing for us to sit down so we can talk together about this? Doing so would mean a lot to me," I added.

Gretchen returned and eventually connected her "wild" anger to impotent rage at a lifetime of feeling controlled by others' unbridled wills.

"Everyone else can do as they want. When I try to do what I want, I'm always in the wrong."

While envy at my freedoms was obvious, in her final sessions we revisited childhood traumas under the care of alcoholic narcissistic parents. As Gretchen articulated comforts she'd experienced with me over the years and acknowledged insights gained in our work together, she agreed to transfer to a new psychotherapist.

"Not too old, but not too young," she instructed.

In Gretchen's case and in those of other less functional patients, it was particularly helpful to review histories, strengths, and vulnerabilities. Likewise, it proved especially important to maintain customary boundaries with my more disturbed patients while attending to unusually distressing enactments, such as precipitous cutoffs and threats of self-harm. Staying

on my toes and voicing concerns about the possibility of self-destructive behaviors minimized acting-out among patients who were less able to put words to the impact of my imminent departure.

The retirement decision

There had been wake-up calls that patients noted age creeping up on me. On occasion, I ran late, double-booked, or forgot an appointment. I failed to pay attention a time or two. Such lapses, I suspected, were not necessarily related to counter-transference. Some patients took note of those slips. As I got into my late sixties, some joked about my smart phone struggles or word-finding lapses. I noted solicitous understanding of small but noticeable hitches in my ways of doing things.

Patients pick up on what may or may not symbolize age-related changes. The proverbial dying potted plant comes to mind, a psychotherapist's tendency to take more notes, repeat herself, or talk more during sessions. Older patients readily assumed I knew about bum knees and bunions. Younger ones said I reminded them of grandma. Like it or not, I'd been promoted to the senior league.

"The timing of your vacation was pretty awful," 30-year-old Sara, complained a year before my retirement plans began to jell. "My parents sold our lake house. Right out from under me! Never talked about it. Just up and said it's too much hassle. Said they're tired of the responsibility. And what am I supposed to do? Like nothing." She rolled on, indignation at parents and me sharp on her tongue.

"There they were—acting like I don't count. Like who cares what Sara thinks?" Long pause. "And there you are off on some cruise probably! You guys," she said, "Just go ahead and forget about Sara! Next thing I know," she added, studying me, "you'll decide to take to the road. That's what my dad calls everything since he retired. You all get to decide what you want to do."

Sara's comments about a retirement I had just begun to consider was a distant early warning that my aging was a leitmotif woven into my work with all my patients. Sara's hurt and anger that her parents had decided to sell the vacation home without giving Sara, in her opinion, fair warning signaled that even if aware of my age, most patients would be profoundly unsettled at my decision to step down.

Ambivalence

Presumably all senior psychotherapists love what they do and know the people and the work will be missed tremendously when they stop. For me, there was guilt, too, as I was still reasonably active and engaged at 69. Did I have a *right* to leave my patients?

After all, Freud set the gold standard by maintaining his practice through multiple surgeries for throat and esophageal cancers. Bearing chronic pain, he worked until just a few weeks before his death (Gay, 1988). Furthermore, members of our profession, as well as patients, tend to idealize psychotherapists and regard us as not subject, in the same way as other people, to the mind's and body's vulnerabilities (Pinsky, 2002).

Like many psychoanalytically trained psychotherapists, I tend to be excessively conscientious, indelibly altruistic, and rather driven. What would it be like to depart from what I was trained, if not wired, to do when I was still doing it fairly well? What personal issues would get stirred up?

Michael, a 55-year-old businessman, volunteered to go to Haiti for an extended stay after the earthquake. Adopted at birth, he always felt "different" among his conservative, extended community of relatives and friends. He didn't resemble them particularly and had interests and talents that set him apart.

"Can't figure out why I'm so uneasy about the decision to go to Haiti." Michael said as he plied his fingers through a thatch of grey hair. "This is crazy…. Agreeing to stay there for weeks? Maybe longer? Why would I dream of turning over the business to a partner when we're finally up and running?"

As we analyzed his concerns, it became clear Michael's anxiety was rooted in anxiety about abandoning others and upending his comfortable, if static, way of life. As themes of traumatic loss, separation, and individuation unfolded, Michael gained ease with the give-and-take of some of those issues. Simultaneously, his associations exposed my conflicts about letting others down. I didn't like thinking of myself as someone who would desert people I cared about.

Besides wanting freedom to do other things, and aware that older psychotherapists sometimes stay the course too long, I doubted that continuing clinical practice to the outer limits of my capabilities would be helpful to patients. Even with contingency plans in place, should my

practice end abruptly, it didn't seem responsible to extend my career and risk leaving patients stranded. Far worse, I thought, would be to inflict protracted troubles of my own upon them, such as dementia, long absences due to illness, or obvious pain.

There are few guidelines for how to prepare to close this business or what others are to do if a colleague's practice ends precipitously (Leupker, 2012). What a burden it is when colleagues, family, or patients must intervene if a psychotherapist ceases to function adequately. While there are some ethical imperatives that support interventions by colleagues in these situations, I knew I didn't want them called into play for me (Gabbard, 2008; Leupker, 2012).

To overstay one's career, to camouflage diminishments, to deny one's mortality, or to minimize the impact of one's frailties on one's patients fails to potentiate patients' recovery from their ongoing problems. It also denies them a frame of reference to navigate their own limitations, preferences, and future losses. In contrast, immeasurable gain is possible when an older therapist clearly states that the time has come to move on (Novick and Novick, 2006; Salberg, 2010; McKamy, 2015).

Moments of meeting

In the lead-up to retirement, my interest peaked regarding how older people dealt with wrapping up careers. Some gained energy when they left their jobs. Others didn't fare so well.

"How did your father take to retirement?" I asked Andrew, a 70-year-old banker who sought therapy for anxiety and insomnia, ruminating "day and night" his decision to retire.

"Everything fell apart when Dad retired," Andrew mused. "Mom hated having him around all day. She had her way of doing things – including rum. Much rum," he added with a mirthless laugh. "I don't think Dad knew what the hell she was up to 'til he gave up work. Work kept him away most of the time actually."

Andrew paused. "How was Dad after he quit work? Ha! He was miserable. Within a year – to the day almost – he keeled over. Massive heart attack, and you know what we had on our hands with my mother after that," Andrew reminded.

I recalled some of the retirement lore I had accumulated. Tales of recent retirees stricken with cancer and coronaries. Co-workers forgetting former

colleagues, family upheavals…"Andrew," I said at his next session. Your dad's retirement was traumatic for him and for you as well."

"Yah, you know that already," Andrew irritably dismissed my comment. "I've got enough crap to worry about today. I've pulled something in my leg. Overdid time trials last night. The damn race is next weekend." He detailed more about his hamstring and the senior marathon he hoped to run. "I was awake half last night," he added "and, of course, ended up thinking about everything that will probably go wrong when I leave my job. Hell, I can't even get to a race without screwing up my leg."

"Do you think your parents worried enough, talked and planned adequately for your dad's retirement?"

"Hell, they never planned for anything together. Hardly saw each other most of my life." A long silence followed. "Carol says I over-worry about retirement. Do you think I'm trying to cover my own bases and piling on the ones my folks seemed to overlook as well? I'm going in circles."

Images of myself as a small child taking on adult worries about how my parents handled, or failed to handle, a troubled younger sibling, came to mind.

"Assuming our parents neglected responsibilities or failed to protect us or others from harm puts a lot of pressure on similar issues that come up when we're adults," I said. "Disappointment and trauma that arose from your folks' failure to address your mother's drinking and prepare realistically for retirement may well amplify your apprehension about retiring." After a pause, I asked, "In what ways have you and Carol prepared differently from your parents for retirement?"

Andrew's voice lifted, lightened. "We have money saved. The house is ship-shape."

He went on to speak with pleasure about his wife. "Carol's a rock. We do okay. You know we do," he added, as if my history of witness further fixed his confidence. He reviewed how he and his wife took care of their health. "Always have," he added, "except for this bum leg … but I think it'll be okay by the weekend."

As I thought about Andrew's broadened perspective on the impact of his father's retirement, I noted my tendency to over-function in situations that trigger familiar anxiety, situations that involve vulnerable others, for instance.

A lifelong concern for my emotionally disabled sister, particularly my inability to alleviate her unpredictable and never-ending troubles, inevitably escalates my reaction to people who struggle with like burdens; people

who no one, for that matter, has seemed able to help or heal. Andrew's issues stirred me to reprise what I'd learned in my psychoanalysis and helped prepare me for the highly personal challenges the termination phase of my career would likely present.

Leave-taking versus abandonment

Michael, the businessman who volunteered his construction skills in Haiti for an extended project, arrived at his session just before departure, quite agitated. "I have no idea how I can get on that plane Saturday," he said. "I'm going nuts with everything I have to do… in fact this whole trip is totally nuts. Look at me… I'm a mess." We sat quietly.

"I really want to do this," he said. "You know how much I want to do this."

"How might it feel if you don't go?" I asked.

"Terrible," he said. "This is really important to me. For all the reasons we both know." "But…" he added, "It's just taking leave. I'm not dumping anyone or trying to hurt anyone. Or destroy the business," he added with a smile.

"Taking one's leave is different from abandoning or deserting, isn't it?" I said to Michael and repeated silently to myself with a feeling of immense relief.

I was reminded that patients often seek treatment because they feel stuck, in unsatisfying or harmful relationships, in dead end jobs, in troubles beyond their control, or in afflictions or financial conundrums that truly seem to defy resolution.

Psychotherapy is geared to help people to make sense of conflict and ambivalence and become free from unhealthy habits or attachments without recrimination. Patients' core strength and progress often are measured by their ability to get free from unrealistic expectations of self or others in a timely and gracious manner. Deadlines often prompt people to make hard choices, to get unstuck.

"In the unconscious every one of us is convinced of his immortality" (Freud, 1918, p. 291). It is easy to act as if we (and our careers) will go on forever. We psychotherapists function in a surround that demands little physical exertion. Our job responsibilities enhance our sense of vitality and importance. It's not unusual to feel at the top of our game in late career. Many social needs are met and sustained by what we do. All of that makes it hard to confront the finish line.

Letting go

I assume any psychotherapist wants to leave patients in a manner that validates work accomplished and the importance of the unique shared relationship. Given a choice, why not work through goodbye in the company of the truly caring other who has experienced the relationship with you?

Psychotherapists try to help patients neutralize symptoms and anxieties that are attributions of past separation traumas. We know that many of our patients have, in their pasts, been shamed by loss and humiliated by unilateral, abrupt, or wordless desertions (McKamy, 2015). A mutual participatory termination experience can significantly mend such wounds.

Most of my patients immediately asked, "How much time do we have left?" Focus on the calendar offered a concrete place to perch as the destabilizing implications of retirement settled in.

"Now is that the end of September or the beginning of October you're leaving?" "Can I come in more frequently between now and the time you retire? I can free up Mondays." "I'm on vacation two weeks in July can I make those up in August before you stop?" "When did you say your last day will be?"

Stating an exact closing date and holding firm felt strange, if not dictatorial, although doing so modeled living within one's decisions, and doing so allowed my patients to move past trying to negotiate the frame so they could explore their related concerns and associations.

Andrew, the bank president, was notably disturbed when I announced my decision."You must be sick. Maybe your husband is. I bet something's wrong that you're just not telling me." In actuarial fashion, he demanded an accounting from me. "If you're sick I need to know," he said. "If it's your husband or someone in your family we can work out a plan," he added.

I told him I had no pressing health issues…"except getting older." Andrew persisted in taking stock. "You had that cough – at least that's what you called it – it went on for months last year. Then that long vacation… probably not a vacation…. You didn't look too great when you got back now that I think of it." He went on.

"It sounds like you think I'm withholding something from you… that there's more to the story than, simply, the time has come for me to retire," I said gently, without accusation.

"Well, yes, I guess so," Andrew responded. "It doesn't add up…. "But," he added, "I guess it does. Sort of." He looked me over. "I mean… I kind of hoped you'd be here a long time… Like forever?" And then he began to cry.

I was surprised by how difficult it was to hold back my tears at that moment but knew letting them flow would override his response, making things more about me. I was struck with how stressful it was as well, one after another, to work through farewells with a caseload of patients. I felt my vulnerability. The enormity of the task I had undertaken. My age. A lot.

"This is difficult," I said. "The idea of not working together anymore is hard.

"My father," he said. "My father died just like that. He was there for breakfast and gone an hour later."

Andrew's statement brought to mind my father's death hours before I could reach his bedside from across the country. I recalled my frustration waiting for the plane to take off, the traffic-clogged drive from the airport to my parents' home where he had, in fact, already passed away. The mix of despair and anger about not getting there in time. It had been years since I'd thought about details of that endless day and its enormously disappointing conclusion.

"You didn't have a chance to get to goodbye with your father, did you?" I said. There was a long pause. "I think there's a difference in what people call "saying goodbye" and being able to have time to arrive together at goodbye." Extended pause. "You and I have worked together a long time. We'll both need time to remember what we've accomplished and think about how to carry that forward. That's something you didn't get to do with your father – to take the measure of your relationship together."

Like Andrew, many patients questioned my health or possible family demands. Some prodded boundaries, calling me at home, overstaying sessions, or "forgetting" something and returning for it. I listened and gave reassurance when appropriate. Interpretive interventions ameliorated most inclinations I had to bend the rules. Patients said they wished I would stay but understood my reasons and right to go. A few took the end into their own hands and set an earlier date for termination. Everything regarding my practice required uncompromised focus and energy in the months of termination.

"So," Sara said at one of her last appointments. "That book shelf where you keep those stupid paperweights goes, too?" Her face contorted in its effort to withhold tears, maintain anger. "This fuckin sucks … just sucks," she barked, putting her fists to her eyes. "I've held this pillow for 12 years," she accused as she elbowed where it rested on her lap. "Obviously it goes, too," she sobbed, shoving it aside as if in momentarily relinquishing its

comfort she could relinquish me and the acquired attachments that had become a part of "us." We had analyzed the various meanings of that old pillow many times over 12 years.

Sara's eyes tearfully scanned the room. With her references to the shelf of paperweights, her pillow, the literal meeting place of our relationship, my throat ached.

Having considered so much in anticipation of letting patients go, I hadn't thought much about loss of territory, or patients' attachments to objects, the nuances of color and sound, the sensuous meld of sensation that existed in the setting where psychotherapy had occurred for them and me over the years.

Near the end of Sara's last session, I asked if she had further thoughts about her pillow.

"I'll miss it," she said. "It's sort of the pillow, and really just about here… having spent so much time here. With you," she added.

"I'm going to miss being here with you too, Sara," I said. "This office holds so many memories for both of us."

While it occurred to me to give her the pillow in parting, it didn't seem necessary. We both understood what it represented, and we both knew that no *thing* could stand in for the unique experience and relationship we had formed together.

Leftovers

I still miss my cozy office and suspect my former patients do as well. It was a wonderful place to be: quiet, gently framed by a window facing the woods beyond. I certainly missed my patients in the months after I closed my practice but noticed something else as well. Released from being present for multiple others in ways that had been intense and unremitting for decades, I discovered gaps, important occasions I had not been fully present in for myself. On the unmarked canvas before me, bits I had not completely attended to earlier in life resurfaced and took form.

There was leftover mourning that, despite pain endured, and good intentions had gotten shortchanged, as the emphasis was on trying to make sense of other people's lives. When Gretchen, the lone older woman loaded with diagnostic monikers, came to mind, details of my chronically ill sister's life resurfaced with attendant frustration and sadness. Thoughts

of Sara's attachment to her family's home and articles in my office brought up memories of places and things that had been important to me over a lifetime. Andrew's story, Michael's, and others' too, floated lightly but persistently on the margins of my retirement. Joys and sorrows from nooks and crannies of 70 years bubbled to the surface, illuminated by various recollections of former patients.

Attending to others tends to bring out our best and most orderly selves. It empowers us and enhances our sense of connection in a personal and public world that often seems overwhelming. Constant listening to others actually *contains* therapists in many ways and serves defensive functions as well.

We develop habits of suppression and handily deny our own needs. We postpone making sense of our difficulties and are inclined to give short shrift to personal pleasures and joys. I found that as I progressed from the foyer to the interior of retirement, I became reacquainted with myself.

Magic years

For the first extended time since early childhood, days and hours returned to play with as I chose to appoint them when I stopped working. I discovered that 50-minute hours had shaped me in ways that took effort to shake off. It took a while to ease into long lunches with friends, writing into the night without worry about energy for appointments the next day, taking off on a whim for a day or a week.

In clinical practice, free hours allow much-needed breaks, though therapists fret if there are too many of them. In practice, hours represent income and security, recognition, and success. In retirement, one relinquishes that relationship with time. It's not as important to make each hour count or be significant. There's room for play.

The practice of psychotherapy holds us in ways that are remarkable among most workers. There aren't promotions. While we teach and supervise, changes seldom occur in what we actually do, how we do it, or even where we do it. There is always the desk, couch, or chairs, and while that represents security, which maximizes our commitment to being steadfast, it can leave us adrift when we imagine ourselves in comparatively formless post-career days. By the same token, absence of defining lines allows for vibrant, unexpected pleasures and satisfactions.

Conclusion

Recently someone asked what I was up to in my free time and seemed surprised that exploring the dynamics of retirement was still of interest to me. "Maybe you're not 'closed for business' after all," he quipped.

In a way, I think my friend hit the nail on the head. Just as I came to understand that there are profession-specific responsibilities and resources that are called into play in the service of closing a clinical practice well, I have discovered that the intense relational work, which was the joy and requirement of the job for decades, indeed left an indelible imprint on me long after the last patient was seen.

Moments of meeting, compounded for years with patients such as Sara and Gretchen, Michael and Andrew, are melodies that refrain over the base notes of my life journey. As I, like other psychotherapists, listened patiently over decades – an interesting word in this context – I was constantly stirred, stimulated, and affected..

When clinical hours ceased, there was a sound of silence. Different, I presume, from that experienced in other professions. Bound by ethical imperatives of confidentiality, psychotherapists cannot talk about moments of meeting with former patients. We must continue to guard against recalling aloud the very moments that highlighted our skills or the interpersonal connections that impacted our lives.

Regarding retirement from clinical practice as a normal *rite of passage,* one of many change agents in inter-relational chapters in therapists' and patients' lives, allowed me to offer a well-grounded opportunity for me and my patients to bring to a close our mutually valued relationships as only we could do together. Having chosen to retire when still healthy allowed grief, history, and affirmations to be shared.

Because so many experiences in my psychotherapy career touched and shaped me deeply, the business of reflection and growth continues. Because affective attributes of the therapeutic work were worked through between me and my patients, I feel assured that they too continue to reflect and grow.

References

Balint, M. (1950). On the termination of analysis. *International Journal of Psychoanalysis*, 31, 196–199.

Eissler, K. R. (1975). On possible effects of aging on the practice of psychoanalysis: An essay. *Journal of the Philadelphia Advancement of Psychoanalysis,* 2, 138–152.

Erikson, E. H. (1963). *Childhood and society*. New York: Norton.

Fonagy, P. (2009). When analysts need to retire. In: Wallock, B., Curtis, R., & Bohm, L. (eds), *Taboo or not taboo? Forbidden thoughts, forbidden acts in psychoanalysis and psychotherapy*, London: Karnac.

Fosha, D. (2004). Nothing that feels bad is ever the last step. *Clinical Psychology and Psychotherapy*, 11, 30–43.

Freud, S. (1915). Thoughts for the times in war and death. In *Collected works standard edition*, 14, 289–300. London: Hogarth Press.

Freud, S. (1917). Mourning and melancholia. In: E. Jones (ed.), *Collected papers* (pp. 152–170). New York: Basic Books.

Freud, S. (1918). *Reflections on war and death: Our attitude towards death*. Frankfurt, Germany: Lang.

Freud, S. (1937). Analysis terminable and interminable. *Interntaional Journal of Psychoanalysis,* 18, 373–405.

Gabbard, G. O. (2008). What is a "good enough" termination? *Journal of the American Psychoanalytic Association*, 57(3), 575–594.

Gabbard,G. O., & Myers, M. F. (2008). *The physician as patient: A clinical handbook for mental health professionals.* Arlington, VA: American Psychiatric Publishing.

Gay, P. (1988). *Freud: A life for our time*. New York: WW Norton.

Holmes, J. (2010). Termination in psychoanalytic psychotherapy: An attachment perspective. In Salberg, J. (ed.), *Good enough endings: Breaks, interruptions and terminations from contemporary relational perspectives* (pp. 63–82). New York: Routledge.

Karlen-Lyons, R. (1999). The two-person unconscious: Intersubjective dialogue, enactive representation and the emergence of new forms of relational organization. In: Aron, L., & Harris, A. (eds), *Relational psychoanalysis*, vol.11, Hillsdale, NJ: Analytic Press.

Katsavkakis, K. A., Gabbard, G. O., & Athey, G. I. Jr. (2004). Profiles of impaired health professionals. *Bulletin of the Menninger Clinic*, Winter, 68(1), 60–72.

Leupker, E. T. (2012). *Record keeping in psychotherapy and counseling: Confidentiality in the professional relationship*. 2nd ed. New York: Routledge.

Limentani, A. (1982). On the "unexpected" termination of psychoanalytic therapy. *Psychoanalytic Inquiry*, 2(3), 419–440.

McKamy, E. H. (1976). Social work with the wealthy. *Social Case Work*, 57(4), 254–258.

McKamy, E. H. (2015). Closed for business: Reflections on a psychoanalytic psychotherapist's voluntary retirement. *Contemporary Psychoanalysis*, 51(4), 727–746.

Morrison, A. (1990). Doing psychotherapy while living with a life-threatening illness: Self disclosure and other ramifications. *Psychoanalytic Dialogues*, 7, 225–241.

Nields, J. (2013). When the frame shifts: A multilayered perspective on illness in the therapist. In: Adelman, A. J., & Malawista, K. (eds), *The therapist in mourning: From the faraway nearby* (pp. 137–157). New York: Columbia University Press.

Novick, J. (1997). Termination conceivable and inconceivable. *Psychoanalytic Psychology*, 14, 145–162.

Novick, J., & Novick, K. K. (2006). *Good goodbyes: Knowing how to end in psychotherapy and psychoanalysis*. Lanham, MD: Rowman & Littlefield.

Pinsky, E. (2002). Mortal gifts: A two part essay on the therapist's mortality. *Journal of the American Academy of Psychoanalysis*, 30(30), 173–204.

Pizer, B. (1997). When the analyst is ill: Dimensions of self-disclosure. *Psychoanalytic Quarterly*, 56, 450–469.

Power, A. (2016). *Forced endings in psychotherapy and psychoanalysis*. London: Routledge.

Salberg, J. (ed.) (2010). *Good enough endings: Breaks, interruptions and terminations from contemporary relational perspectives*. New York and London: Routledge.

Sherby, L. (2004). Forced termination when pain is shared. *Contemporary Psychoanalysis*, 40(1), 68–90.

Part IV

Alternative relational modalities



Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

Chapter 15

Something more than "'something more' than interpretation"

Accelerated experiential dynamic psychotherapy (AEDP) works the experiential edge of transformational experience to transform the internal working model

Diana Fosha

In 1998, commenting on the ground-breaking "'something more' than interpretation" articles from the Process of Change Study group (see Lyons-Ruth et al., 1998; Stern et al., 1998a, 1998b; Tronick, 1998), Peter Fonagy wrote:

> Finally, there is the question of implication for technique. Here I feel much more needs to be done…. In reading the superb case reports … I was struck and re-assured by the absence of dramatic technical innovation … This is a reassuring picture, for a classical therapist, that is. It must however be an illusion. If the ideas proposed by the group have substance, it is inconceivable that the exact same technical priorities that were drawn up on the basis of traditional object relations theory would serve equally well this completely new set of ideas. I think we should not shy away from technical innovation.
>
> (1998, p. 351)

Peter Fonagy, I could kiss you.

He had also said a bit earlier,

> The challenge is that one suspects that any of the phenomena referred to cannot be readily quantified without the use of tape-recorded or videotaped psychotherapy sessions, transcribed and rated … It is up to the authors to identify reliable markers of change in procedural knowledge and explore changes in these in relation to "moments of meeting."
>
> (Fonagy, 1998, p. 351)

This chapter is about how *something more* than "'something more' than interpretation" is needed to reliably change people's relational patterns, if those changes are to effect internal working model transformations. Taking on Fonagy's challenge to identify "reliable markers of change in procedural knowledge" in relation to moments of meeting that would inform new techniques, I describe some experiential techniques that aim for discontinuous change (Fosha, 2006) and are guided, moment to moment, by phenomenological markers of the transformational process (Fosha, 2009a, 2009c). I do so from the vantage point of Accelerated Experiential Dynamic Psychotherapy (AEDP), a healing-oriented, attachment-based, affectively focused mind/body treatment (Fosha, 2000, 2013b; Fosha, Paivio, Gleiser, & Ford, 2009; Gleiser, Ford, & Fosha, 2008; Russell, 2015) that puts positive neuroplasticity (Hanson, 2009) into clinical action (Yeung & Fosha, 2015). In AEDP, therapy sessions are videotaped as a rule, and teaching and supervision are conducted from videotape (Prenn & Fosha, 2016).

In Part 1 of this chapter, I discuss AEDP, its technical and phenomenological contributions, focusing on how to make the most of the transformational potential of 'moments of meeting' and thus reliably transform *now moments* into *wow moments*.[1] I also suggest an expanded conceptualization of "moments of meeting" that goes beyond the intersubjective relational realm to include all change-for-the-better moments. Using Sander's work (1995, 2002) and building on previous work on the role of recognition in transformational change (Fosha, 2009a, 2013a), I propose that *moments of meeting* be defined as all moments that evoke a "click of recognition" and a resulting state shift (Fosha 2009a). Thus conceived, the "meeting" can indeed be relational (i.e., between self and other), but it can also be between self and self, or between experience and representation, or between self and process. This would allow us to consider the important role of moments of meeting not only in relational change, but also in changes in emotion processing, affect regulation, and somatic experience, to just name a few.

Part 2 focuses on *metatherapeutic processing*, AEDP's contribution to a systematic methodology for working with transformational experiences. In metatherapeutic processing, each new "moment of meeting," once experientially processed, itself becomes a platform for launching another round of experiential work with transformational experience.

Part 3 is devoted to a close, moment-to-moment analysis of some vignettes from a videotaped AEDP session. The case illustrates how a series of moments of meeting become woven together to effect a

transformation in the patient's internal working model. A lot of this comes to fruition in one session, session 12, which is reported on in detail. I conclude, first, with some reflections on the need to effect change both at the level of experience (the "'something more' than interpretation") and at the level of representation (the *something more* than "'something more' than interpretation"), and, second, with some musings on the creative potential of engaging the dialectic between "sloppiness" and systematic experiential work.

Part 1: On AEDP

AEDP is a healing-oriented transformational treatment model that aims to undo aloneness to transform emotional suffering and set in motion resilience and transformational processes of flourishing. AEDP heals trauma by championing the innate healing capacity of neuroplasticity in a safe, attached therapeutic relationship. Through the moment-to-moment in-depth processing of difficult emotional and relational experiences, patients are helped to recover their sense of core self and experience increased resilience and renewed zest for life. AEDP has roots in many disciplines including interpersonal neurobiology, attachment theory and developmental research on dyadic processes, emotion theory and affective neuroscience, existential and somatic approaches to treating trauma, and transformational studies. Its change-based metapsychology and experiential transformational methodology reflect an organic integration of these many sources and experience with two decades of AEDP practice by a growing number of practitioners world-wide.

Four factors allow AEDP to be a transformational therapy: (1) a healing-oriented metapsychology (i.e., a theory of therapy rooted in naturally occurring change mechanisms), as expressed in the construct of *transformance,* conceptualized as the innate and wired-in motivational tendency toward healing and self-righting that pulses within us (Fosha, 2008); (2) an embodied, affirmative, relationally reparative therapeutic stance aimed at "undoing the patient's aloneness in the face of overwhelming emotions" (Fosha, 2003, p. 245); (3) an experiential methodology for processing to completion the somatic states and deep affects associated with attachment trauma and emotional suffering to help transform them into adaptive resources for secure connection, resilience, and well-being; and (4) a transformational methodology

called *metatherapeutic processing,* through which systematic work with transformational experiences organically leads to further rounds of transformation and upward spirals of energy and vitality that culminate in highly integrative, expanded, new self and dyadic states.

AEDP is relentlessly experiential in its technique. It uses experiential work with relational experience to co-create safety and transform relational experience (Fosha, 2009b; Lamagna, 2011; Lipton & Fosha, 2011; Pando-Mars, 2016; Prenn, 2011), and uses a four-state phenomenology of the transformational process which, moment-to-moment, guides the work (Fosha, 2009a, 2017; Russell, 2015). AEDP's transformational phenomenology differentiates between (1) defense-dominated states and (2) states where there is embodied somatic access to adaptive affective change processes and where transformational processes can take hold. Since AEDP understands psychopathology to result from the individual's unwilled and unwanted aloneness in the face of overwhelming emotional experience, the AEDP therapist strives to engage the patient from the get-go so that, together, they can co-create a safe dyadic environment in which, through dyadic affect regulation, challenging emotional experiences—both negative and positive—can be accessed, worked through, and processed to completion (Fosha, 2000, 2005).

AEDP's transformational practices blossom because they are rooted in a positive, embodied, attachment-informed and intersubjectively engaged therapeutic relationship that seeks to replicate "secure attachment, limbic resonance, mammalian care giving, and early development" (Loizzo, 2017, p. 188). Grounded firmly in an understanding of the bidirectional relationship between neurobiology on one hand and attachment and intersubjectivity on the other (Bowlby, 1988; Lyons-Ruth, 2006; Porges, 2009), AEDP offers a brain-based, relationally rooted, and affectively affirming dyadic therapeutic stance.

The stance of AEDP is intentionally positive (Lipton & Fosha, 2011). In a clear-cut departure from neutrality and, taking a page from security-engendering mothers, the AEDP therapist's stance is characterized by active emotional engagement, embodied dyadic mindfulness (Fosha, 2013b), a strong "being with" (Pando-Mars, 2016), and affirmative advocacy on behalf of patients and their deep knowing (Fosha, 2005, 2013a). Though not articulated in this language, that way of engaging therapeutically is *de facto* designed to make moments of meeting more likely.

AEDP both seeks to make happen, and is organized around, *moments of change*. These moments-of-change-for-the-better, or healing moments, or transformational moments—all terms I use interchangeably—are manifestations of positive neuroplasticity (Hanson, 2009) in clinical action. *Moments of meeting* (Buber, 1955; Buber & Friedman ,1988; Sander, 1995; Stern et al., 1998b), as defined by the Process of Change Study Group (Stern et al., 1998a), are one kind of positive change moment that AEDP privileges and works with: They are highly valued in and of themselves for their transformative power (Lipton & Fosha, 2011), and are also understood as the relational prerequisites for effecting transformational changes (Fosha, 2000). However, there are many other positive transformational moments that, in AEDP, are also deemed important: for instance, moments of change involving categorical emotion, moments of healing, moments of core self "this is me" experience, moments of change involving a body shift, change moments in the management of neural energy, and finally, moments of truth, to name some, though by no means all.

Honoring the centrality of Buber's fundamentally dialogic work to the matters at hand, Beatrice Beebe (1998) reminds us of Sander's earlier application of Buber's *moments of meeting* concept to dyadic process: "In a 'moment of meeting,'" two states of consciousness are "matched," in the sense that "the way one would 'know' oneself would be matched by the way one was 'known' by an other" (Sander, 1995, p. 589). Sander notes the similarity with Winnicott's description of the "sacred moment" in the "squiggle game": a moment of shared awareness such that "the child becomes aware that another is aware of what the child is aware of within" (Sander, 1995, p. 590). "A match between how one knows oneself and how one is known facilitates developing agency and identity" (Beebe, 1998, p. 335).[2]

Based on Sander's work on recognition processes (1995, 2002) and prior work on the crucial role of recognition processes in transformational work (Fosha, 2009a, 2013a, 2013b; Gleiser, 2013; Lamagna, 2011), I suggest that the concept of "moments of meeting" be enlarged to go beyond the relational intersubjective realm, to fold into it all different types of change-for-the-better or transformational moments. Quantum change happens when a "moment of fittedness" (Sander, 2002, p. 19) or a "click of recognition" (Fosha, 2009a) takes place, resulting in a state shift involving a reorganization of experience leading to increased coherence and expansion of both self and dyadic states of consciousness (Fosha, 2009a, 2009c, 2013a).

This is what I wrote in an earlier paper:[3] "My usage of recognition includes but goes beyond the relational experience of being known: It refers to all experiences which occur when there is a 'click' between something inside and something outside, however 'inside' and 'outside' are subjectively defined… The recognition process occurs in experiential therapy when the moments of fittedness occur between the individual and some process in a dyadically co-constructed environment of safety. Recognition is always 'dyadic' in that it involves two things fitting together, but it is not necessarily relational or interpersonal: The fit can be between self and other, but it can also be between self and self, or self and process, or self and experience. The 'click' occurs between what is felt as 'me' and 'not me,' in a way that allows what was felt as 'not me' to eventually become integrated into 'me'" (Fosha, 2009a, p. 179).

A feature of these transformational moments is that they are invariably accompanied by positive affect, positive in the sense that they feel "right" and "carry intense fulfillment" (Beebe, 1998, p. 336) to the person who is experiencing them; as such, they acquire a motivational thrust of their own (Fosha, 2009a, 2013b; Ghent, 1990, 2002; Tronick, 1998, 2009, 2011b), shaping further growth and development. A string of such moments of fittedness has the individual engaged in a transformational process. The flow of energy and vitality is enhanced, new phenomena and actions emerge, and the experience of what emerges thus becomes further motivating, a source of agency, direction, and self-initiative.

I propose that *moments of meeting* be defined as all moments that evoke a "click of recognition," with a resulting state shift (Fosha, 2009a) and subsequent reorganization of experience. This would allow us to consider the important role of moments of meeting not only in relational change but in changes in emotion processing, somatic experience, and self-states.

However, in AEDP, the occurrence of the now redefined moments of meeting is not the culmination of the transformational process, for what is often an endpoint in other treatment modalities is the starting point of a new round of exploration in AEDP: Enter AEDP's *metatherapeutic processing*, where transformational experiences are experientially processed as assiduously as traumatizing experiences, and the *transformational affects* (i.e., the positive affects that accompany transformational experiences) are attended to as carefully as the negative affects of trauma.

Part 2: Metatherapeutic processing and the transformational affects

Metatherapeutic processing, or *metaprocessing*, is a systematic methodology for working with transformational experiences and their associated *transformational affects* (i.e., the positive "'fulfilling" affects associated with them). Extensively written about (Fosha, 2009a, 2009c, 2013b; Fosha & Yeung, 2006; Russell, 2015; Russell & Fosha, 2008), metaprocessing has also been the subject of empirical interest and investigation (Iwakabe & Conceicao, 2015). In AEDP, transformation is not only a desired goal or process to be entrained, it is an *experience* to be harnessed. We have discovered something very cool; experientially processing the *experience* of transformation is itself transformational, begetting further transformation. The practice of metatherapeutic processing involves experientially investigating what is healing *about* healing, in the context of a healing relationship.

Five *metatherapeutic processes,* each with its respective *transformational affect,* have been identified to date: (1) the process of *mastery* evokes the *mastery affects*, the "I did it!" feelings of joy, pride, and confidence that emerge when fear and shame are undone; (2) the process of *mourning-the-self,* accompanied by the transformational affect of *emotional pain*, involves painful but liberating grief and empathy for one's self and one's losses; (3) the process of *traversing the crisis of healing change* evokes the *tremulous affects*, fear/excitement, startle/surprise, curiosity/interest, even positive vulnerability, maintained with the support of the therapeutic relationship; (4) the process of *the affirming recognition of the self and of its transformation* evokes the *healing affects*, gratitude, and tenderness toward the other and feeling moved, touched, or emotional within oneself; and (5) finally, the process of *taking in the new understanding* evokes the *realization affects*, the "*yes*" and "*wow"* of wonder, awe, amazement, the genuine *wow moment* associated with the grasping of the magnitude of changes taking place.

Metaprocessing involves a dialectical bouncing back and forth between right brain–mediated, somatically based experience and left brain–mediated experience-near reflection, promoting a prefrontal cortex-based integration. In response to each moment of meeting, whether big or small, the therapist experientially explores the emergent positive experience and asks, "*What's that like*?" Then, upon the emergence of each new

experience that arises in response to that inquiry, the therapist follows that up by asking, "*And what's that like*?" This is a recursive process in which each round's reflection on an experience of change-for-the better yields a new experience, which then, in turn, becomes the focus of the next round of experiential exploration and reflection. In this way, new experience begets new experience as each moment of meeting, once experientially explored and reflected on, becomes the platform for the next round of exploration. And with the reorganization, new forms of agency, initiative, "adaptive action tendencies" of adaptive emotional experiences (Frijda, 1986) emerge. Progressive rounds of metatherapeutic processing lead to a nonlinear, non*finite transformational spiral,* an ever-emergent upward movement (Frederickson, 2009) which fuels the system with more and more energy and vitality (Fosha, 2009a, 2009c; Tronick, 2009), bringing in more coherence, greater expansion of states of consciousness and, of course, emergent experiences of agency, initiative, connection, closeness, intimacy, trust, and well-being.

In the session I present below, we have an illustration of what happens when moments of meeting are enlarged by metatherapeutic processing. As we are able to track the transformational process moment-to-moment, we can see how positive neuroplasticity is put into action; as if with time-lapse photography, we get to witness the transformation of the internal working model in the making.

Part 3: The session

Halle is a 30-something woman who comes to therapy seeking help for her pervasive anxiety. Attractive, bright, well-educated, and well-spoken, nonetheless she has just hobbled along, with little engaging her professionally and having had very few relationships, none great and none lasting more than a few months. Halle yearned for closeness, connection, relationship, and eventually marriage, family, and children. Yet her fears proved larger and more powerful than her yearnings. At the start of treatment, Halle's avoidant defenses and defensive self-reliance were striking; in light of them, her feeling stuck both professionally and personally made sense.

AEDP's aim is to co-create enough safety so that defenses can start to be relinquished sufficiently to allow somatically based access to affective experience. In the eleven sessions preceding the session I present below,

affirming, validating, yet relentless work with the patient's avoidant defenses had more or less accomplished that. A major breakthrough in the fourth session resulted in a quantum increase in Halle's willingness to trust me as her therapist and allowed her to surrender—though not without trepidation—to the experiential work of AEDP.

Session 11, the session directly preceding the session to be presented, was another noteworthy session. It started with a moment of awkwardness, not quite a *now moment* or, if a *now moment*, then a very small one. We rapidly repaired and re-coordinated and soon found ourselves sharing a moment of delight. The experiential metaprocessing of the shared delight led to a lengthy *moment of meeting*, a long, deep, largely nonverbal period of mutual gazing, which extended over the remaining 15 to 20 minutes of the session; That gaze might have gone on longer had the session's end not been upon us. Such intense uninterrupted gazing is more the currency of the realm with young babies and their mothers, or lovers; it is certainly highly unusual, almost unprecedented, between adults not romantically involved (Stern, 2003, personal communication). Yet there it was.

As a result of the work with defenses and the intense affective experiences of the preceding eleven sessions, Halle's lifelong avoidant defenses no longer ruled, replaced instead by unfamiliar yearnings and affective states. There is a way in which session 11, the gaze session, is an example of the power of the "something more than interpretation" to effect a quantum shift. However, the experiential exploration that we are about to witness in session 12 (see below) reveals that, despite significant procedural changes, Halle's internal working model has not been updated, resulting in both tension and distress.

The session begins with Halle's announcement of the theme "new and underdeveloped." Uncannily apt: The old has left, and what is in its stead, i.e., the new, is indeed new and underdeveloped. We are in the realm of the *tremulous affects* associated with "traversing the crisis of healing change," i.e., the crisis that sometimes develops when the desired, yet also feared, transformation happens quickly (Fosha, 2006, 2009a).

Emergent experience: New and underdeveloped

Pt: (long pause) … I've been feeling lately like I'm …. at sort of a point in my life, or just right now what I am aware of is feeling very… sort of… new and underdeveloped. And I've noticed that I am just trying to let that

be okay and sort of not hide it… or present it in a different way when I am talking with friends …… I'll try to give an example ….

We pick up the session a few minutes later.

Further unfolding: Vulnerability and mourning-the-self

Pt: Now I'm having this feeling of sort of … a little tension, I don't know what it is

Th: About the interaction with Zina?

Pt: Yes. It's hard for me to leave that kind of interaction unresolved. I tend to want some kind of closure that affirms …. you know, that affirms me, validates what I've been doing and that it's okay.

Th: Stay with this tension… which you feel where? [experiential focus privileging somatic experience over content]

Pt: In my chest…. Mmmm….. (long pause) … …… [shift of topic: the focus on the body refocuses patient and accesses deeper material] I guess I am thinking of….. ….. (long pause) … …… For the past six months now, I have been taking a singing class … and I used to sing when I was younger and I have fantasies that this is something I should have pursued or I wanted to pursue when I was younger… (*soft tentative shy quality as she is speaking*) and…

Th: (*very soft gentle voice*) What's the feeling that's coming up?

Pt: I think….. that I feel very vulnerable in revealing that (*close to tears*) [click]

Th: (*warm, gentle tone*) Stay with me with that, with what's emerging

Pt: (*tears in her voice*) It makes me very sad to acknowledge that I have such undeveloped and unformed sort of desires and impulses that at this age are sort of…. It's embarrassing to me to be in my thirties and not have … I have like a semblance of a "career" (*air quotes*) but it's not something I feel strongly about (*fighting off stronger crying*) … and …. I am sort of desperate for something right…

Until this moment, the patient never mentioned her singing classes. On the face of it, the content seems innocuous (i.e., a once-a-week class to pursue a hobby). Yet, the vulnerability associated with sharing it reveals its closeness to self. It is indeed a precious relational development, to reveal and share with the therapist something so very close to self. Just this side of shame, tremulous vulnerability is a marker of emergence; something new is coming forth.

"Undeveloped" and "unformed desires and impulses" (Halle's own words) and pain and embarrassment about a self not yet declared: The new material takes Halle even closer to the edge of her window of tolerance. And yet, she continues to come forward; remarkably, she does not pull back. The experience of mourning-the-self is followed by a profound, adaptive if inchoate declaration: "I am desperate for something right." This is such a *cri de coeur*: It is her nascent transformance motivation peeking through. We want to make the most of the precious opportunity that we've been granted.

Stay with it, and stay with me is a key intervention that captures AEDP's ethos. *Stay with it* by itself—with *it* referencing the emergent experience—could very well be the motto of any experiential therapy. However, "stay with it *and stay with me*" is quintessential AEDP; it seeks to root the upcoming experiential exploration solidly within the therapeutic bond, making explicit that the patient is not alone. In the call and response of attuned dyadic interaction, responding to the therapist's encouragement, the patient reveals something so vulnerable, in response to which the therapist offers support and issues the call for further—though explicitly accompanied— unfolding: "Stay with me with that, with what's emerging." The patient responds and reveals more. Unfolding on!

A little later in the session.

Exploring the patient's response to the therapist's affirming recognition

Pt: I have kind of a wide range of interests… they all feed some…creativity or something in me that I haven't figured out how to manifest or explore….
Th: Yes… That is something that has roots deep within your self
Pt: Yes (*head nod, strong assent, clear declarative tone*) [click of recognition]
Th: How do you feel when I say that?… What comes up? [metaprocessing the patient's experience of the therapist's recognition].

A moment of meeting. The therapist recognizes something about the patient, and the patient strongly endorses it. We are close to self. Sacred self. Creativity. Something.

Until very recently, Halle has strongly relied on avoidance and defensive self-reliance, having an internal working model where she is alone and the

Other is inadequate and not up to the task (i.e., mom). Now we want her to not only benefit from the *experience* of recognition (i.e., the experience of feeling seen and understood); we want her to *know* that she has been seen and understood, that she is not alone, and that her experience is unfolding as a result of what she and I are doing *together.* As Dan Stern (2004) says: "A moment of meeting kicks the intersubjective to another level." Metaprocessing the patient's affective response to the therapist's recognition does just that: It kicks the intersubjective to another level.

Walking the new walk, yet talking the old talk (nice problem to have)

Pt: (*tears—gaze up*) It's hard for me to acknowledge anything that's deep within myself –(*head nods*)… that is a very difficult… concept (*exhale*) [moment of meeting: truth].

A very important declaration. Patients with avoidant states of mind have an affect phobia about their own internal experience. They are afraid of being overwhelmed by it, and/or they are afraid of being revealed as inadequate to cope with it (Pando-Mars, 2016). Halle's saying "It's hard for me to acknowledge anything that's deep within myself" expresses that avoidant phobia of experience.

There is a paradox though: Through this profound communication about her wish to avoid her internal experience, she is sharing something deep about herself with me. In the next set of interventions, the therapist addresses these issues directly and with kindness. *A la* AEDP, we are making the implicit explicit and the explicit experiential, but we are also seeking to make the procedural (i.e., the new procedural) representational.

Th: And yet, it also touches you in some way when I say it … I want to hear more about why it is so hard for you to acknowledge and affirm within yourself something that has deep roots… [addressing fear of emotional experience]
Pt: (*deep sigh, gaze up*)
Th: …. but there is also something about my recognizing it that brings these tears [naming relational experience]
Pt: (*head nod, sigh*)… Yes (*declarative, emphatic)* [click of recognition]. If you are acknowledging it or seeing it, then… or referring to it as something that must exist, then maybe it does [exist] (*head nod*)

Th: (*gentle tone*) So what's the feeling that goes with that? …. That maybe it does [exist]?

Pt: (*sighs, long pause*) I feel … touched (*gaze up, makes motion with hands together, one hand nested within the other*), and… afraid (*questioning tone*), and very vulnerable (*declarative tone*)…. (*head nod*) [moment of meeting: right brain experience meets left brain language, with a resulting state shift]

Bringing language to unformed experience is anxiety-regulating. When Halle declares "I feel touched, and afraid, and vulnerable," instead of such vulnerable exposure increasing her anxiety, her putting her experience into words has the opposite effect: as her unformed experience acquires "shape," she gets calmer. Dyadic affect regulation through the co-construction of meaning is organizing, and it leads to a state shift. This moment of meeting becomes a platform for launching a new round of experiential work to deepen and consolidate the change:

Th: Can we stay with that? (*gentle, empathic tone*) [inviting further experiential exploration]

Pt: (*head nod, gives assent*) [important green light]

Th: … touched, and afraid, and vulnerable… (*therapist matching patient head nods, in resonance*)…

Pt: (*head nods, a couple of deep sighs*)

Th: 'Cuz I had such a feeling… I had the feeling of your being touched, even before you said that you were vulnerable… On one side, there is the sadness about finding yourself at this point in your life with things still not developed… But there is another side to this vulnerability that has to do with your feeling touched by my recognition, feeling touched by my affirmation (*patient nodding*)…. that there is something touching… and I take "touching" to be positive… and touching (*smiles and touches her hands together*)… but also scary and vulnerable making [naming and affirming relational experience, and the emotions associated with it].

Pt: (*head nod, sigh, another deeper exhale*) [nonverbal click of recognition]

Th: Just stay with it, with what's coming up… with what it feels like.

Pt: It feels like…. (*sigh*).. ummmm (*sigh*)… I feel a little calmer now… [state shift]

The crisis of transformation: The clash between the old and the new, and then, the transformational moment

Th: Right now something about my recognition and articulation and being touched by something deep within you is evoking such strong feelings…. Stay with it [encouraging experiential exploration]

The therapist's encouragement to "stay with it" conveys to the patient that the therapist feels it is safe and okay to keep going and that she has faith in both the patient and the process. As we know from the visual cliff/social referencing experiments (Sorce, Emde, Campos, & Klinnert, 1985), the attachment figure's state of mind has a huge impact on whether the baby crawls across the Plexiglas covering the visual cliff. If mom communicates fear, the baby doesn't move; on the other hand, if the mother is smiling, her ease beckons the baby, and the baby crawls across. My "stay with it" beckons Halle to keep exploring. She does, and we are into the next round.

Pt: Yeah, I feel like… I don't want to know what it is.…
Th: "It" being…?
Pt: … Whatever it is that is deep inside me… or… frustrating me or there that can't come out or I can't find some expression for… Even though I know that that is … I don't want it to be real because it seems so hard to deal with … and I don't even know what I am talking about (*incipient tears*).

The vagueness of the patient's language is not a tactical defense. We are in the realm of unformed experience, being languaged for the first time: not top-down abstract language but rather bottom-up experience-near language. When the transformation comes about quickly and right brain experience gallops ahead of left brain representation, it is quite disorganizing and anxiety-provoking (Fosha, 2006), especially for patients with avoidant and dissociative defenses who are used to feeling in top-down control (Lanius et al., 2001, 2004). Which is why Halle is so distressed when she says, "I don't even know what I am talking about." It is now important to bring in the left brain, so that we can bring right brain and left brain, experience and reflection, together.

Th: The part of you that doesn't want to know…. why doesn't it want to know? Why does it want to keep it hidden, under a lid, walled up? [empathic invitation to defense elaboration]

Pt: (*deep tears*) Whatever it is, is too much… it's too much to deal with.
Th: (*empathic tone*) I wanted to add "alone"…. Too much to deal with alone…
Pt: Yes… because I can't see how I would be anything but alone. (*deep exhaling sighs):*[state shift: Affect and verbalization come together] (*sighs, head nods, calmer, settles*) [moment of meeting of affect and meaning, i.e., "click of recognition"; state shift]

The patient in essence articulates the limits of her old internal working model: Because she has always felt alone, she cannot imagine not being alone and cannot imagine being accompanied and supported, even though it is happening in actuality. And not just in therapy: also with good friends who, as stories make clear, really care about her. Our task now is to get the representations of her internal working model to catch up with the reparative experiences that she is already actually having. Little-step-by-little-step (Fosha, 2000, pp. 150–151) the quantum leap makes.

Th: So would this part of you feel a little bit less despairing… less overwhelmed… if you let me be with you…(*the patient nods her head*), if you don't do it alone?
Pt: (*head nod*)
Th: Tears come up. (*very tender tone*) [mirroring]
Pt: Maybe… But I don't know … I feel like you can't help me *(distressed tone)*

In essence, I ask Halle whether she would be willing to do what we are in fact doing. Her first response, nonverbal, is to nod in assent. For a moment, she considers it—"maybe"—but then, the old internal working model reasserts itself: "I feel like you can't help me." In the previous exchange, we dealt with the representation of Self in the old internal working model (i.e., "I can't imagine being anything but alone"). Now we are dealing with the representation of the Other in the old internal working model (i.e., an Other who can't help). I meet that terrifying experience with empathy, anchored solidly by feeling our actual connection and deepening work..

Th: Let's stay with that. [affirmation and encouragement to keep feeling]
Pt: (*sigh*) (*gets distressed again*)
Th: … cuz that's an awful and scary feeling. [and then, the empathy]

Pt: (*head nod*) Yeah, I feel like I can't be helped by someone (*big exhale—so something shifts here*)… I think because I don't really know… I can't imagine what that's like. (*she sighs; calms upon the integrated articulation of what she is feeling*) [moment of meeting: experience finds language]

Th: (*deep tone, slow kind inviting voic*e) What do you mean? What do you mean?

Pt: (*deep sighs*)

Th: Deep sigh … deep sigh (mirroring, articulation and reflection)

Pt: (*deep sighs*) I don't know what it's like to be open and … with that scariest part of me, and share that with someone else. [moment of meeting of experience and meaning; "click of recognition"]

Th: Uh-huh.

Pt: And… feel helped or… like it's being shared… And I don't want to share it… because then I think that I would feel that I would be too dependent on whoever I am sharing it with… almost like I would lose my self. (*head nods*) [important articulation of yet another fear]

Th: That's the fear….

Pt: (*big deep breath, settles, nods*) [moment of meeting of experience and meaning; "click of recognition"; moment of intersubjective meeting and feeling understood]

WOW!!! This is the precise moment of transformation. We are equidistantly poised between the old internal working model that no longer applies and the new internal working model that's not yet been represented. Russell identifies this phenomenon as the *self in transition* (Russell, 2015).

One of the joys of transformational work, and possibly one of my favorite interventions, is to show patients that that which they are most afraid to do, they are already doing. In a play by Molière, a character says: "What do you know? These forty years, I have been speaking prose without knowing it" (1670, p. 200). She doesn't yet know it, but Halle needs to find out that she is already speaking prose.

Th: It feels soooooo good to me that you can share this with me… and share this fear.

Pt: (*head nods*)

Th: I mean, it's a fear about not sharing but you're sharing so much with me right now.

Pt: (*head nod*)… I feel much calmer. [state shift] [moment of truth, moment of meeting]

In an affectively resonant, personally engaged way, the therapist now begins to make the implicit explicit about what's been procedurally going on. While empathizing with the patient's fears, the therapist names the intimacy and closeness that has been there nonstop and enacted since the beginning of the session. Halle nods, feels much calmer, and does not disagree.

Having done such a huge piece of therapeutic work, the next step is to metaprocess it. We pick up the action a little later in the session.

Metatherapeutic processing

Th: How do you feel with me? Or what is your experience of me? [making the explicit experiential]

Pt: I feel like you're with me and that I was able to… I feel like the things that I was saying were kind of… just coming out automatically, without thinking… like I don't have a real knowledge of… [right brain processing, procedural experience] and I felt like I was able to say those things and share them with you because you were recognizing them… and me. [click of recognition]

The new internal working model makes its first appearance, and it is impressive. Self-Other connection is represented, "I feel like you're with me; the Other (i.e., the therapist) is represented as being able to help and the Self as actually being helped: "I was able to say those things and share them with you because you were recognizing… them and me." This is, indeed, a *wow moment.* The metaprocessing continues, seeking to deepen the experience now possible as a result of the newly articulated integration:

Th: … What does *that* feel like? (*deep sigh*)… cuz I keep hearing and matching (*corrects self, laughs*) … I keep hearing and feeling these deep sighs, cuz I'm also hearing myself sighing. (*sighs*)

Pt: It feels less scary and…. soothing …? (*tentative tone*)…

Th: Uh-huh.

Pt: But I also feel like …. I'm feeling like I was able to see in your recognition that there is something within me that I can't articulate or I am not aware of, consciously, that needs and wants to come to the surface.

Th: Uh-huh.
Pt: .. and … that … I may be able to let it come to the surface… with you ….. …..(*sigh)* [clear statement of dyadic affect regulation initiated by the patient] although I don't know….
Th: Wow!! (*matching head nods, matching smiles*)… WOW!!!!!! That feels big.

Another *wow moment.* With the transformation of the internal model comes the transformation of emotion regulation and emotion-processing capacity. With dyadic regulation in place and with ongoing integration of right brain experience and left brain reflection, the previously overwhelming emotions can now be engaged with. Halle spontaneously articulates that "something inside" needs and wants to come to the surface and volunteers that, together with me, she might be able to allow it to come to the surface.

Alongside these remarkable declarations, a bit of resistance/anxiety in the form of "although I don't know" also comes up. There is a clinical choice here, between keeping on going with the new, or shifting to address the return of doubt. I choose to continue to lean into the transformation, continuing to privilege the positive, the new, and the emergent. And the patient goes with me. The emergent qualities that come online next are pretty awesome: faith, motivation and trust!!

Pt: Yeah, I had this feeling that I really believe in what we're doing… – which has been a process for me to come to—and I also have a fear that (*big release of breath and tension*) ….(*starts again*) I feel like there is a something, and then I have a fear that there is not. Or that I won't be able to bring to the surface whatever this….
Th: Well, you don't have to do it by yourself…. You don't have to do it by yourself.
Pt: (*head nod, moved*) (*big pause more head nods, deep exhales)*

The resistance has been patiently waiting in the wings, but its time has come. It comes forth in the form of "the backlash of criticism," which now gets addressed.

Pt: But I did have that…. I think it goes right along with me trying to value what we're doing here and feeling that backlash criticism of "you're supposed to be doing your job and here you are, doing this whatever thing"….

Th: *(laughing)* "This whatever thing"…. That's good… I like "this whatever thing"… it's definitely a dropping down from hyperverbal … I mean I hear the dismissiveness in the part of you that dismisses it, but … that very rational, linear, critical part of you doesn't have a language for what we're doing.

Pt: Right. … Yes. That is true. … [moment of meeting, click of recognition, truth](*long pause*)

Addressing the resistance while affirming the transformation allows the next round of transformational experience to come forth. What follows next is very beautiful. It is tremulous, it is new, and it is emergent.

The new internal working model manifested: The rise of integrated self, relational, and emotional experience

Pt: And …. Yes. And I was thinking that (*sigh)* … when I am experiencing these new feelings and thoughts with you, there is something uh…. (*halting language again*) (*first she makes a big round gesture with her hands and then the words come)* I feel like a child…. or like a baby…. And… that sort of focus and sort of (*again makes round gesture with her hands, like shaping a sphere)*…. I think I am recognizing it as… sort of integrating my feelings and my real emotion with what comes out of my mouth and… ya, mainly what comes out of my mouth… (*head nod, sigh*).

Pt: …And … it's hard for me to hear what comes out of my mouth…. And I'm not used to it… [tremulous affects] and the scary part is … (*long pause*) to me, (*makes round gesture with her hands, like shaping a sphere)* what I feel and say here is so totally different than what I allow myself to feel and say in the world where I am whoever I think I am, (*nervous laugh*) that I feel like I would have to be totally different… (*tears)* and that's scary.

Th: It is scary… It is scary… [empathy] which says to me that you're being so brave… [affirmation]

Pt: (*another burst of healing affects; sigh; head nod*)

Th: And that you're really feeling it, and that it's very real, and very new…. And that we're really launched on this journey… and that *WE* are launched on this journey….

Pt: … (*nods… smiles*)

Left and right brain, the procedural and the representational, are finding one another. The integrative result of the metaprocessed and thus represented transformation is a coherent and cohesive narrative of her emergent experience taking place in real time, in the here-and-now. It takes into account her experience: of herself, of me, of us, and of her emotions, present and emergent. Motivation and deep valuing are emergent properties. The areas of unformed experience are acquiring language, and then some. Halle offers her musing on emergence and transformation, in relation to another, with herself in relation to me: "When I am experiencing these new feelings and thoughts *with you*, there is something I am recognizing as … sort of integrating my feelings and my real emotion with what comes out of my mouth…."

With the *felt* experience of transformation, of course, there is a new round of experience and, with it, a new fear. Transformation is transformative. As such, when it arrives, especially when it is big and arrives quickly, it is scary: Established identity is threatened. We've seen this throughout this entire session, and here it is again, now much more coherently stated. Which leads the therapist to validate, empathize with, and affirm Halle's courage, without in any way minimizing the enormity and scary nature of the undertaking. The saving grace is that we're doing it together.

In fitting fashion, the session ends with *relational affects* (Fosha, 2000) expressed in "we" language (Emde, 1988), "we" representing the fundamental transformation of the avoidant person's isolation and aloneness. Halle's defensive self-reliance is giving way to an emergent willingness to trust and rely on the Other to be there and help. I end the case presentation with a quote from Robert Emde:

"[A] sense of "we" involves a profound shift of self-perspective—a shift to an active experiencing of shared reality with another" (1988, p. 36–37).

Discussion and conclusion

The session we have just shared in is one of those gifts that allows us to witness some phenomena almost directly—here that phenomenon is the transformational process—seeing it unfold, truly moment-to-moment, as if in slow motion. Transcribed from videotape and microanalyzed, the session allowed us to see how it goes when experiential work is used in tandem with experience-near representational work, all in the context of an affirmative,

dyadically engaged, healing-oriented therapeutic relationship, guided moment to moment by a well-delineated transformational phenomenology. The session also illustrated how the methodology of metatherapeutic processing can systematically turbocharge the transformational process, extending, deepening, consolidating, and expanding its reach. Through metatherapeutic processing, moment of meeting upon moment of meeting, one after another—each a result of the transformation of the one preceding it and each the agent of transformation of the one coming after it—until at the end of the session, we have not only procedural transformation but representational transformation, the new internal working model appearing to have caught up to what the patient and therapist had been up to.

One last thing before we say goodbye, and it has to do with *something more than messiness*: A key point of the work of the Process of Change Study Group is that the change process is of necessity sloppy and messy, with key moments, whether the challenging "now moments" or the restorative "moments of meeting," as serendipitous moments of coherence and thus opportunity in a fundamentally chaotic process. Far be it for me to argue against messiness, for indeed, messy is so much of what therapy is. And indeed, the work of the Process of Change Study Group illuminates something profound about spontaneous serendipitous moments with huge transformational potential, taking us out of the realm of the privileging of the interpretive and into the realm of privileging authentic interaction, a very salutary and much appreciated shift.

However, it is also important to not believe messiness to be the only non-interpretive change mechanism. A lot of work has been done in experiential and emotion focused therapies, of which AEDP is one (e.g., Fosha, Gendlin, Greenberg, Levine, Ogden, Schwartz, & Shapiro), to illuminate transformational processes and develop systematic methodologies to bring them about, which shows us that we need not be at the mercy of serendipity for transformational change to take place. Buttressed by the recent explosion of understanding in brain science, affective neuroscience, interpersonal neurobiology and the science of neuroplasticity (see Fosha, Siegel, & Solomon, 2009), these experiential and emotion-focused approaches have made huge strides to develop techniques that reliably effect change, including quantum discontinuous transformational change, and do so in ways that are systematic and, thus, teachable and learnable.

It may be that the 'now moment → moment of meeting' sequence, which indeed is about a relational crisis that requires the Other of the therapist

to show up for the Self of the patient unique to the dyad and unique to the moment, requires something authentic, personal and specific, creative, messy, and not by the book. However, transformation need not only be forged from the crisis of relational hurt and disappointment. Quantum change can also be forged from work with adaptive change processes that are intrinsically transformational (Fosha, 2002, 2013b): over and over in the case presentation we witnessed another sequence: crisis moment → moment of meeting (expanded definition) → *wow moment* of transformation.

The work in this chapter showcased a therapeutic approach that makes moments of meeting more likely without needing to rely on the disruption of the now moments and the do-or-die need for repair they engender. The micro-crises of the transformational process suffice to provide the impetus for the self's experience needing to be met, be it by other or by process, by experience or by reflection. In that way, every moment of genuine coming forth is a micro-now moment, so to speak, needing to be met in a genuine fashion, not disallowing that authentic responding can be informed by solid and systematic technique. Artists and athletes *par excellence* show us how strong technique, far from interfering with the creative process, supports artistry, authenticity, and inspiration.

In this chapteer, taking to heart Fonagy's (1998) witty, gracious, yet to-the-point challenge, I tried to show how serendipity and experiential systematic experiential work can come together, especially in metatherapeutic processing, to systematically process spontaneous moments of meeting, where more begets more and upward spirals can keep bringing in energy, vitality, and coherence for the task of transformation.

Notes

1 My thanks to Shari Steinberg for the felicitous coining of *wow moments*.
2 However, how one knows oneself is the dependent variable, so to speak (i.e., that which changes as a result of these recognition experiences). Often, the one doing the recognition recognizes something in us before we (consciously) know it in ourselves.
3 N.B. For our purposes, "fit," "click," and "dyadic" can be considered as synonymous with "meeting."

References

Beebe, B. (1998). Procedural theory of therapeutic action: Commentary on the symposium, "Interventions that effect change psychotherapy." *Infant Mental Health Journal*, 19 (3), pp. 333–340.

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. New York: Basic Books.

Buber, M. (1955). The life of dialogue. In: M. S. Friedman (ed.), *Martin Buber: The life of dialogue*, pp. 86–91. Chicago, IL: The University of Chicago Press.

Buber, M., & Friedman, M. S. (1988). *The knowledge of man: Selected essays*. Atlantic Highlands, NJ: Humanities Press International.

Emde, R. N. (1988). Development terminable and interminable. *International Journal of Psychoanalysis*, 69, 23–42.

Fonagy, P. (1998). Moments of change in psychoanalytic theory: Discussion of a new theory of psychic change. *Infant Mental Health Journal*, *19 (3)*, 348–353.

Fosha, D. (2000). *The transforming power of affect: A model for accelerated change*. New York: Basic Books.

Fosha, D. (2002). The activation of affective change processes in AEDP (Accelerated Experiential-Dynamic Psychotherapy). In: J. J. Magnavita (ed.). *Comprehensive handbook of psychotherapy*. *Vol. 1: Psychodynamic and object relations psychotherapies*, pp. 309–344. New York: John Wiley & Sons.

Fosha, D. (2003). Dyadic regulation and experiential work with emotion and relatedness in trauma and disordered attachment. In: M. F. Solomon & D. J. Siegel (eds.), *Healing trauma: Attachment, trauma, the brain and the mind*, pp. 221–281. New York: Norton.

Fosha, D. (2005). Emotion, true self, true other, core state: Toward a clinical theory of affective change process. *Psychoanalytic Review*, 92 (4), 513–552.

Fosha, D. (2006). Quantum transformation in trauma and treatment: Traversing the crisis of healing change. *Journal of Clinical Psychology/In Session*, 62 (5), 569–583.

Fosha, D. (2008). Transformance, recognition of self by self, and effective action. In: K. J. Schneider (ed.), *Existential-integrative psychotherapy: Guideposts to the core of practice*, pp. 290–320. New York: Routledge.

Fosha D. (2009a). Emotion and recognition at work: Energy, vitality, pleasure, truth, desire & the emergent phenomenology of transformational experience. In: D. Fosha, D. J. Siegel, & M. F. Solomon (eds.), *The healing power of emotion: Affective neuroscience, development, clinical practic*e, pp. 172–203. New York: Norton.

Fosha, D. (2009b). Healing attachment trauma with attachment (…and then some!). In: M. Kerman (ed.), *Clinical pearls of wisdom: 21 leading therapists offer their key insights,* pp. 43–56. New York: Norton.

Fosha, D. (2009c). Positive affects and the transformation of suffering into flourishing. In: W. C. Bushell, E. L. Olivo, & N. D. Theise (eds.), *Longevity, regeneration, and optimal health: Integrating Eastern and Western*

perspectives, pp. 252–261. New York: Annals of the New York Academy of Sciences.

Fosha, D. (2013a). Speculations on emergence: Working the edge of transformational experience and neuroplasticity. *International Neuropsychotherapy Magazine*, 1 (1), 120–121. (Also in *The Neuropsychotherapist*, Issue I, www.theneuropsychotherapist.com.)

Fosha, D. (2013b). A heaven in a wild flower: Self, dissociation, and treatment in the context of the neurobiological core self. *Psychoanalytic Inquiry*, 33, 496–523.

Fosha, D. (2013c). Turbocharging the affects of healing and redressing the evolutionary tilt. In: D. J. Siegel & Marion F. Solomon (eds). *Healing moments in psychotherapy*. Ch. 8, pp. 129–168. New York: Norton.

Fosha, D. (2017). How to be a transformational therapist: AEDP harnesses innate healing affects to re-wire experience and accelerate transformation. In: J. Loizzo, M. Neale & E. Wolf (eds). *Advances in contemplative psychotherapy: Accelerating healing and transformation*. Chapter 14, pp. 204–219. New York: Norton.

Fosha, D., Paivio, S. C., Gleiser, K. & Ford, J. (2009). Experiential and emotion-focused therapy. In: C. Courtois & J. D. Ford (eds.), *Complex traumatic stress disorders: An evidence-based clinician's guide*. Ch. 14, pp. 286–311. New York: Guilford Press.

Fosha, D., Siegel, J., & Solomon, M. F. (eds.) (2009). *The healing power of emotion: Affective neuroscience, development, clinical practice*. New York: Norton.

Fosha, D., & Yeung, D. (2006). AEDP exemplifies the seamless integration of emotional transformation and dyadic relatedness at work. In: G. Stricker & J. Gold (eds.), *A casebook of integrative psychotherapy* (pp. 165–184). Washington DC: APA Press.

Fredrickson, B. L. (2009). *Positivity: Groundbreaking research reveals how to embrace the hidden strength of positive emotions, overcome negativity, and thrive*. New York: Random House.

Frijda, N. (1986). *The emotions*. Cambridge, UK: Cambridge University Press.

Ghent, E., (1990/1999), Masochism, submission, surrender: Masochism as a perversion of surrender. In: S. A. Mitchell and L. Aron (eds.), *Relational psychoanalysis: The emergence of a tradition* (pp. 211–242). Hillsdale, NJ: The Analytic Press.

Ghent, E. (2002). Wish, need, drive: Motive in light of dynamic systems theory and Edelman's selectionist theory. *Psychoanalytic Dialogues*, 12 (5), 763–808.

Gleiser, K. (2013). Seeing the invisible: The role of recognition in healing from neglect and deprivation. *Transformance*: *The AEDP Journal*, 3. www.transformancejournal.com

Gleiser, K., Ford, J. D., & Fosha, D. (2008). Exposure and experiential therapies for complex posttraumatic stress disorder. *Psychotherapy: Theory, research, practice, training*, 45 (3), 340–360.

Hanson, R. (2009). *Buddha's brain: The practical neuroscience of happiness, love, and wisdom*. Oakland, CA: New Harbinger.

Iwakabe, S. and Conceicao, N. (2015). Metatherapeutic processing as a change-based therapeutic immediacy task: Building an initial process model using a modified task-analytic research strategy. *Journal of Psychotherapy Integration*, 26 (3), 230–247.

Lamagna, J. (2011). Of the self, by the self, and for the self: An intra-relational perspective on intra-psychic attunement and psychological change. *Journal of Psychotherapy Integration*, 21 (3), 280–307.

Lanius, R. A., Williamson, P. C., Densmore, M., et al. (2001). Neural correlates of traumatic memories in posttraumatic stress disorder: A functional MRI investigation. *American Journal of Psychiatry*, 158, 1920–1922.

Lanius, R. A., Williamson, P. C., Densmore, M., Boksman, K., Neufeld, R. W., Gati, J. S., & Menon, R. S. (2004). The nature of traumatic memories: A 4-TfMRI functional connectivity analysis. *American Journal of Psychiatry*, 161 (1), 1–9.

Lipton, B., & Fosha, D. (2011). Attachment as a transformative process in AEDP: Operationalizing the intersection of attachment theory and affective neuroscience. *Journal of Psychotherapy Integration*, 21 (3), 253–279.

Loizzo, J. (2017). Embodied practice, the smart vagus, and the mind-brain-body integration. In J. Loizzo, M. Neale & E. Wolf (Eds). *Advances in contemplative psychotherapy: Accelerating healing and transformation*. Chapter 13, pp. 185–203. New York: Norton.

Lyons-Ruth, K. (2006). The interface between attachment and intersubjectivity: Perspective from the longitudinal study of disorganized attachment. *Psychoanalytic Inquiry, 26 (4),* 595–616.

Lyons-Ruth, K., Bruschweiler-Stern, N., Harrison, A. M., Morgan, A. C., Nahum, J. P., Stern, D. N., & Tronick, E. Z. (1996) Implicit relational knowing: Its role in development and psychoanalytic treatment. *Infant Mental Health Journal, 19 (3),* 282–289.

Molière. (1670). The bourgeois gentilhomme. In *Moliere*, vol. 1. Trans Katharine Prescott Wormeley. Boston, MA: Roberts Brothers, 1894.

Pando-Mars, K. (2016). Tailoring AEDP interventions to attachment style. *Transformance: The AEDP Journal, 4 (2),* www.transformancejournal.com

Porges, S. W. (2009). Reciprocal influences between body and brain in the perception and expression of affect: A polyvagal perspective. In: D. Fosha, D. J. Siegel, & M. F. Solomon (eds.), *The healing power of emotion: Affective neuroscience, development, clinical practic*e, Ch. 2. New York: Norton.

Prenn, N. (2011). Mind the gap: AEDP interventions translating attachment theory into clinical practice. *Journal of Psychotherapy Integration*, 21 (3), 308–329.

Prenn, N. & Fosha, D. (2016). *Supervision essentials for Accelerated Experiential Dynamic Psychotherapy*. Washington DC: APA Press.

Russell, E. M. (2015). *Restoring resilience: Discovering your clients' capacity for healing.* New York: Norton.

Russell, E., & Fosha, D. (2008). Transformational affects and core state in AEDP: The emergence and consolidation of joy, hope, gratitude and confidence in the (solid goodness of the) self. *Journal of Psychotherapy Integration*. 18 (2), 167–190.

Sander, L. W. (1995). Identity and the experience of specificity in the process of recognition. *Psychoanalytic Dialogues*, 5, 579–594.

Sander, L. W. (2002). Thinking differently: Principles in process in living systems and the specificity of being known. *Psychoanalytic Dialogues, 12 (1),* 11–42.

Sorce, J. F., Emde, R. N., Campos, J., & Klinnert, M. D. (1985). Maternal emotional signaling: Its effect on the visual cliff behavior of 1-year-olds. *Developmental Psychology*, 21 (1), 195–200.

Stern, D. N. (2004). A grain of sand: Moments of meeting in psychotherapy. From Lecture Notes by Leah Lucas. Trinity College, University of Toronto http://prstoronto.com/article-moments-of-meeting-in-psychotherapy.html

Stern, D. N., Brunschweiler-Stern, N., Harrison, A. M., Lyons-Ruth, K., Morgan, A. C., Nahum, J. P., Sander, L. W., &Tronick, E. Z. (1998a). The process of therapeutic change involving implicit knowledge: Implications of developmental observations for adult psychotherapy. *Infant Mental Health Journal*, 19 (3), 300–308.

Stern, D. N., Sander L. W., Harrison, A. M., Lyons-Ruth, K., Morgan, A. C., Brunschweiler-Stern, N., & Tronick, E. Z. (1998b). Non-interpretive mechanisms in psychoanalytic therapy. The "something more" than interpretation. The Process of Change Study Group. *International Journal of Psychoanalysis*, 79 (5), 903–21.

Tronick, E. Z. (1998). Dyadically expanded states of consciousness and the process of therapeutic change. *Infant Mental Health Journal*, 19 (3), 290–299.

Tronick, E. Z. (2009). Multilevel meaning making and dyadic expansion of consciousness theory: The emotional and polymorphic polysemic flow of meaning. In: D. Fosha, D. J. Siegel, & M. F. Solomon (eds.), *The healing power of emotion: Affective neuroscience, development, clinical practic*e (pp. 86–111). New York: Norton.

Tronick, E. Z. (2011a). Infants' meaning making .and the development of mental health problems. *American Psychologist*, 66 (2), 107–119.

Tronick, E. Z. (2011b). The psychobiology of pleasure: Meaning making, open systems, and pleasure. In P. Cooper Davis & L. Cooper Davis (eds). *Enacting pleasure: Artists and scholars respond to Carol Gilligan's new map of love,* pp. 13–21. Chicago, IL: University of Chicago Press Books.

Yeung, D., & Fosha, D. (2015). Accelerated experiential dynamic psychotherapy. In *The Sage Encyclopedia of Theory in Counseling and Psychotherapy*. New York: Sage Publications.

Chapter 16

Mindfulness, intimacy and presence

Moments of meeting in psychotherapy

Susan Lord

"I'm just tuning in. Getting here." Mara is sitting across from me. Her shoes off, she is cross-legged on the loveseat. She looks sleepy-eyed and vulnerable as she moves her gaze from the patterns in the oriental carpet between us to my face. Her face is open, and there is a moment of contact. I can feel my anxiety rise as our eyes meet and we exchange warm smiles. There is an energy between us, a thickness in the room, and a feeling of pure connection. Love. This has happened before with Mara as we have worked together over the years. And I always think, "Okay, don't blow it. Stay here. Be present. Get out of the way. Let it happen. Breathe."

Mara has a history of childhood sexual abuse perpetrated by her father. Much of our work together has to do with her difficulties in metabolizing feelings and tolerating intimacy of any kind. It seems of critical importance that I meet her in the moments in which she is able to connect. These are moments that can help her to heal and expand her relational capacities. And so I become anxious about their importance, as does she, which can alter the energies in the room and create situations that are fraught with misunderstanding. This is at the center of our work together. These moments of pure connection, of shared love, and our negotiation of the enactments they engender are, I believe, what will offer reparative work for Mara.

These particular moments of meeting are difficult to come by, as Mara is often closed off to them for many reasons. She talks about the longing she feels to have more of these experiences of mutual connection. She says that she doesn't know how they happen; they feel good to her, and she believes that they are not in her control. She wants me to be able to "make them happen," as though I am somehow in charge of these "magical" occurrences. She also speaks of the fears that go along with these moments. She says that she is afraid I will influence her in ways that she does not want to be influenced; she experiences herself as vulnerable and easily

changed by others. Relationships have always been filled with danger for her. Not only is she a survivor of childhood sexual abuse, she ended a prior analysis to have a romantic relationship with her analyst, and the relationship ended badly, spiraling her into a regression and contributing to her increased difficulties in trusting anyone. She says that she sometimes experiences me turning into her harsh and critical father—my nose grows longer and my features become "pointed and ugly." Sometimes she tells me that I dismiss her as, at the end of each session, I stand, turn my back to her, and walk away from her. I point out that there is a wall behind my chair and say that perhaps she is having a reaction to our interactions.

Mara recognizes her defensiveness around the possibility of connection, and she has sought treatment to work on her difficulties with intimacy. In her marriage of 20 years, she has been unable to tolerate much connection of any kind. She says that she and her husband are "good friends" who share a companionable existence, but there is a distance between them that she is ambivalent about. Sexual contact feels frightening and dangerous to her, and she dissociates during the rare times that they are able to have sex. He "likes to play games," dressing up and taking on different identities, and she often feels that she is an object in these encounters. She becomes "young and frozen" and says that she can barely tolerate the games and often dissociates. She says that he hurts her, though he doesn't mean to, as she is so closed to him. In private moments, she whips herself with a belt to arouse herself.

In our work together, I am careful to try to assume a collaborative position so as to minimize the "power over" dynamic of therapist as expert as much as possible. This is nearly impossible, though my relational approach, in which I position myself to enter into mutual interactions as an authentic and vulnerable subject with clients, along with our use of mindfulness practices, does seem to help.

The Meditative Dialogue process that we engage in together at the beginning of each session helps to position us to develop what I have called "sacred space" in between us (Lord, 2010). This is a co-created safe space in the middle of the room that is imbued with spiritual energies. It becomes an alchemical crucible ready to hold and metabolize whatever may come in our work together. I think of it as a relational space, a container for the fire that we tend together as we cultivate the energies that arise in the space between us. We use these energies to achieve an intersubjective relationship through which forms of intimacy can be experienced and examined.

This chapter offers an exploration of the use of mindfulness practices as a vehicle that therapist and client can use to position themselves in ways that help to facilitate mutuality, presence, and availability to the processes of therapy. I present some theoretical background on mindfulness and relational analysis, offer a case to illustrate the use of mindfulness practices in psychotherapy, and present the idea of a fourth space of subjectivity, an "intersubjective fourth" (Lord, 2010) that offers a relationship with the numinous, or the spiritual, in psychotherapy as a prism through which the work of engaging in an intimate relationship can be accomplished.

Relational psychoanalysis

Over the past 30 years, psychoanalysis has moved from a fixed positivist one-person model to a dynamic and enlivened, collaborative, and mutual two- (or more-) person relational model of interaction (Boston Change Process Study Group, 2010; Greenberg & Mitchell, 1983; Mitchell, 1988, 2003; Stern, 2004; Stern et al., 1998; Stolorow & Atwood, 1992). We have moved from a blank-screen position of relative neutrality to a more vulnerable and open position of being more transparent and known. We are interested in the systems of whole persons intersubjectively relating to whole persons, rather than working from a distance as subject and object. As part of this movement to embrace the whole person, we have embraced our clients' humanity as well as our own.

One of the major innovations in contemporary psychoanalysis lies in the interactive sphere of consideration of use of self in the positioning of both analyst and patient. This encompasses kinesthetic energies and somatic experiences, as well as the mind, the psyche, and spiritual aspects of both participants in the intersubjective interaction. As a clinical social worker who has received training in psychodynamic psychotherapy, family systems therapy, Jungian analysis, social constructionism, and mindfulness practices, I position myself to offer a relational psychotherapy that is anchored in mindfulness practices.

Mindfulness and psychotherapy

Mindfulness is said to be a state of being cultivated through a meditation or a contemplation practice that encourages presence, openness, compassionate acceptance, witnessing, and nonjudgment (Bishop et al., 2004). According

to Kabat-Zinn, "mindfulness is the awareness that emerges through paying attention on purpose, in the present moment, and non-judgmentally to the unfolding of experience moment to moment" (2003, p. 145). Germer defined mindfulness as "moment-by-moment awareness" (2005, p. 6). Mindfulness includes curiosity and a depth of listening that is important in any therapeutic interaction.

Over the last 20 years or so, mindfulness practices have become increasingly integrated into psychotherapy and have been empirically found to be helpful with emotion regulation, the development of empathy and compassion, reducing symptoms of anxiety and depression, increasing positive emotions, and improving relationship satisfaction, among other things (Baer, 2003; Davis & Hayes, 2011; Linehan, 1993; Rubin, 1996; Simpson et al., 2007; Skogrand et al., 2007; Styron, 2005; Surrey, 2005; Williams et al., 2007). While many therapists themselves practice mindfulness and encourage their clients to practice mindfulness, not many engage in the practices of mindfulness during sessions together. Surrey, in her chapter "Relational Psychotherapy, Relational Mindfulness" (2005), described her process of "co-meditating" with her patients:

> While the therapist's focus remains on the experience of the patient, both patient and therapist are engaging in a collaborative process of mutual attentiveness and mindfulness in and through relational joining. . . . Because both therapist and patient are called on to be present to the best of their abilities (to themselves, to the other, and to the movement of the relationship into and out of connection), the therapy process is deepened and enlarged. It begins to show a quality of growth consistent with the broader goals of mindfulness. . . . These moments of deep connection go beyond the nature of relationship as customarily described in object relations, relational or intersubjective psychology literature.
>
> (pp. 94–95)

The use of mindfulness and meditation practices in psychotherapy serves to cultivate and intensify the spiritual energy that develops in the sacred space between therapist and client, a space in which alchemy can occur (Rowan, 2001). This helps to focus and enhance both the therapist's and the client's use of self and their ability to be authentically present to themselves and to each other, increasing their ability to take risks in their relational work.

With those who are open to this practice, we begin each session with a 10-minute meditation, a method that we use to promote focus and facilitate presence in preparation for the Meditative Dialogue process. We follow these specific guidelines (Lord, 2007):

1 Focus on the breath, on body sensations, and on the space in the middle of the room.
2 Reflect, contemplate, pause.
3 Listen deeply.
4 Allow speech to arise from silence.
5 Experience the space.
6 Notice assumptions.
7 Notice reactions and judgments.
8 Give the process full attention.
9 Say only what really wants/needs to be said.

This shared practice helps to ground us, bringing us to the present moment, while moving our energies and heating up our interaction in ways that encourage relational intimacy and an openness to whatever may arise in the therapeutic space. Through this process, we become open to the present moment and are able to engage in ways that might otherwise take more time or be impossible to attain. We develop the capacity to "just be" (Winnicott, 1971) and to be alone in the presence of an other (Winnicott, 1958). We facilitate powerful moments of meeting between us, moments that can be surprising and sometimes frightening in their intensity of connection.

In these moments, Mara will often retreat to her position of feeling shame and self-loathing, "I feel like I'm too much. Unlovable. Like no one can handle all of me." And so it becomes of critical importance that I meet her, love her, and "handle" her. We work together to remain open and curious about her life and her ways of being. The acronym COAL, coined by Dan Siegel (2007) to denote "curiosity, openness, acceptance and love" (p. 7) is one that we have found useful in our work together. Mara will often tell me "It must be important–I'm not getting it," when she is going through what she calls "chemistry-changing moments." These are moments in which she experiences an alteration in her internal world as she risks intimacy with me. She often will appear confused in these moments and describes them as moments in which she "loses her bearings."

Through meditating together and engaging in the Meditative Dialogue process, the therapeutic relationship that develops is, at the same time, one of the most intensely real and unreal relationships in which client and therapist may ever participate. The fact that it is a relationship out of time and space and that it harnesses the energies of the space in between renders it a powerful vehicle for risking emotions and engaging more intensively.

Intimacy and love in its many permutations

Mitchell, in his posthumously published 2002 book *Can Love Last?* wrote about the importance of risk-taking, and the tensions between autonomy and connection that are inevitable components of intimacy. In *Relational Concepts in Psychoanalysis,* he said that in order to work relationally, the therapist must be prepared to take risks in the service of connecting with the patient in real, humane and authentic ways (1988). These include loving and hating in the therapeutic interaction. In his 2003 book *Relationality,* he spoke of the importance of loving and hating "with abandon" (p. 133) in the analytic relationship. He clarified that these feelings of love and hate, which show up on both sides of the intersubjective engagement, have their own distinctive qualities:

> What makes it possible to love and hate with abandon is involvement with an other who has feelings in return, sometimes even love and hate, but who is working to employ the feelings on both sides of the relationship in the service of analytic work—constructive, insightful growth and development
>
> (p. 133)

Bernstein has said that some of the confusion about the importance of love in the psychoanalytic literature has to do with "a failure to distinguish between the feeling of love and the act of love" (2001, p. 253). There are so many kinds of love, and many, if not all of them, may show up in the therapeutic relationship. Love appears in many forms and under many names in the analytic literature: transference, countertransference, holding, empathy, compassion, unconditional positive regard, containment.

In his 1906 letter to Jung, Freud wrote, "Psychoanalysis is, in essence, a cure through love" (p. 12). Although Freud was writing about transference love, Ferenczi is said to have interpreted Freud's words to also mean "the

analyst's loving feelings and attitudes toward the patient" (Kuchuck, 2015, pp. 224–225). Kuchuck also wrote about Ferenczi's "language of tenderness and passion" in the analytic interaction (p. 225).

More recently, with the increasing numbers of relational analysts, more has been written about love in the therapeutic relationship (Bernstein, 2001; Bodenheimer, 2011; Bridges, 2005; Celenza, 2007; Davies, 1994, 1998; Ellman, 2007; Hirsch, 1994; Kuchuck, 2012, 2015; Meyer, 2000; Mitchell, 1988, 2000, 2002; Rentoul, 2010; Sander, 2002; Schamess, 1999; Seikkula & Trimble, 2005; Vida, 2002; Young-Eisendrath, 2007). Young-Eisendrath (2007) wrote about a "therapeutic love" in which,

> The two discover together the goodness of their relationship. They feel the strength and courage in holding a mental space or openness in the midst of desires, pressures, conflicts, attacks, and hatred. Within this kind of therapeutic love, the analytic partners keep the faith that their endeavors, no matter how difficult, will eventually lead to greater freedom for at least one of them, and more profoundly for both
>
> (p. 234)

Bridges (2005) has written about the intense affect and "bounded intimacy" that inevitably enters the treatment room in relational psychoanalysis. She spoke of the "L word" (p. 77) and the importance of carefully working to name love as a relational state that "expands and elaborates the dense layers of the self and other experience and feelings" (p. 77) in the therapeutic relationship. Seikkula and Trimble (2005) spoke of their open dialogue group process as "an embodiment of love."

What is important in these therapeutic moments of intense connection is that they remain boundaried and contained. For Mara and for me, it is particularly important that there be no confusion about the limits of our relationship. As time has gone on we have both become more comfortable with the intense moments of meeting, the surprising human moments in which there are "chemistry-changing" impacts.

Recently, Mara brought in a dream that she had had, in which she was at a party at my house, and there were many people present whom she didn't know. She wondered whether they were also clients. She said that when she came in, I gave her a big hug and "wouldn't let go." We talked about the wish and the fear that she had about my holding her and not letting go, and she said that she felt held by me and was clear that I would

never really hug her, nor would I "let her go into outer space." She said that she felt that the dream signified that she was "becoming an adult" in her abilities to risk and tolerate intimacy with me, and that she was aware of an increasing feeling of competence in her relationship with me, which she said was "spilling out" into her marriage and into her relationships with others.

For my part, I am pleased with Mara's dream and with her increasing sense of competence. At the same time, I am aware of the complexities of our relationship and of my need for her. As Slavin and Kriegman have written,

> …our own investment in the analytic frame is, itself, a very complex human commitment, tied to some of our own needs, to our professional identity and beliefs, as well as to our attachment, empathy, understanding—growing intimacy with—a particular patient. We must allow the multiple, sometimes contradictory, strands in our commitment to be challenged and *partially disassembled*…. The analytic process comes to tap the power of an ancient evolved human imperative—the yearning for genuine reciprocity.
>
> (2012, p. 118)

I do feel love for Mara; it is a love that comes of a mutual collaboration and a shared humanness and vulnerability as we have cultivated sacred space and worked together, developing an intimacy and connectedness through facing life's challenges over a period of years. Our therapeutic relationship is especially significant in that she came to me as my sister was dying of breast cancer. Two years into our work together, Mara told me that her sister had been diagnosed with ovarian cancer. Her cancer was on a very rapid trajectory, and she died 3 months later. My sister died in August, hers died in October of that same year. Mara knew that my sister had died, as I had taken some time away from my practice to metabolize things and to mourn. That her sister died 2 months later sealed us into a profound connection that felt sisterly, "familiar."

Over the years of our work together, Mara has remembered the date of my sister's death each year as she has prepared for the anniversary of hers. We connect around our shared sense of loss, around the poignancy of what might have been, and around a commitment to live our lives authentically and to seek enlivenment and presence because of what has been lost.

Radical presence

The concept of presence is important in relational psychoanalysis and in the cultivation of more moments of meeting. Both therapist and client become invested in authenticity and open presence as they engage in the work of taking the necessary risks for growth and healing. Showing up and being present, what McNamee (2015) has called "radical presence," is key to cultivating the change processes that are promoted through moments of meeting. And when radical presence is there, the crackling energies can often lead to moments of love.

Cooper (2011) wrote of a practice in which he applied the Zen concept of "total exertion" to describe an "attentional stance" assumed by patient and analyst, "As an active process, the opportunity for total exertion occurs in each and every moment. In this regard, every ordinary moment, every ordinary activity becomes special, sacred, and profound in its ordinariness and simplicity" (p. 596).

Ted Jacobs spoke of an empathic attunement that went further than that described by others and was developed through a process of moving beyond careful and attentive listening and beyond being able to imagine oneself into another's experience. He said that to be able to be empathic with an other, one had to embrace the chaos and complexity of not knowing what would arise in the interaction, along with an openness to "creations on the part of the analyst" (2013, p. 166). These included the analyst's own unbounded reveries, fantasies, memories, intuitions, daydreams, and dreams. He spoke of a co-created process between therapist and client in which a conduit was opened between the two through which both conscious and unconscious communications could flow. This required a certain state of mind, and an *evocative* form of listening through which there was an experiential understanding of what was being communicated. This kind of listening called forth openness and curiosity on the part of both therapist and client, and a sense of wonder as to what would be communicated verbally and nonverbally, consciously and unconsciously.

Rogers (1957) identified six conditions that needed to be in place for therapeutic change to occur: (1) psychological contact; (2) a client experiencing a state of incongruence (feeling vulnerable or anxious); (3) therapist congruence or genuineness; (4) therapist unconditional positive regard; (5) therapist empathic understanding; and (6) communication of the therapist's unconditional positive regard and empathy to the client. He spoke of the state of consciousness that he strove to attain in his listening stance:

> I find that when I am the closest to my inner, intuitive self – when perhaps I am in touch with the unknown in me—when perhaps I am in a slightly altered state of consciousness in the relationship, then whatever I do seems to be fully healing. Then simply my presence is releasing and helpful. At those moments, it seems that my inner spirit has reached out and touched the inner spirit of the other. Our relationship transcends itself, and has become part of something larger. Profound growth and healing and energy are present
>
> (1987, p. 50)

"Radical presence," "total exertion," "evocative listening," and a "slightly altered state of consciousness in the relationship" are all different aspects of working to position ourselves for the development of moments of intense connection and the meeting of therapist and client in surprising and simple ways that become part of something larger that is transformative.

An intersubjective fourth

This "something larger" is a concept I have described elsewhere (Lord, 2010) as an "intersubjective fourth," which is not a product of subject and object, object and subject, subject and subject (Benjamin, 2004) but rather the client's and the therapist's co-created relationship with the numinous, or the energies of the divine. Stern et al. (1998) have called this the "something more" in the therapeutic interaction.

Jung spoke of the importance of attracting the numinous through the processes of psychotherapy, "The main interest of my work is not concerned with the treatment of neurosis but rather with the approach to the numinous. But the fact is that the approach to the numinous is the real therapy and inasmuch as you attain to the numinous experiences you are released from the curse of pathology" (1973, p. 377). This relationship with the numinous, or a spiritual form of love, can offer safety and healing to those for whom relationships have been difficult, and may serve as a vehicle toward other forms of love. Bion also spoke of the numinous, and the "faith that there is an ultimate reality and truth – the unknown unknowable, 'formless infinite'" (1970, p. 30).

The co-creation of a relationship with the numinous through mindfulness practices helps to develop the sacred space within which Mara and I are

able to risk radical presence and intimacy in our therapeutic relationship. It offers an energy that moves things along and sustains us in the work that we engage in together with vulnerability, courage, and love.

Conclusions

Mindfulness practices are wonderful tools that help to position client and therapist in ways that invite radical presence and risk-taking abilities both during the therapeutic hour and in life. They offer a vehicle through which to connect with the energies of the numinous, and can bring us to more authenticity, openness, and transformative moments of meeting with each other. While outside of the traditional frame of analysis, they can seamlessly fit into the modern relational analytic repertoire, heating up and intensifying the interaction and bringing us to new and exciting levels of intimacy and connection.

Mara was a meditator long before she came to me, and easily became acclimated to the Meditative Dialogue process. She came to me because she knew that I practiced in this way, and she says that she finds it helpful, not only for settling into the session and deepening her awareness, but that she finds the energy that we co-create and share to be healing. As she has been able to experience loving feelings in her relationship with me, she has been more able to invest energy into her relationship with her husband. She says that she is less ambivalent, and that she wants to move closer and have a more intimate relationship with him. She has voiced her concerns about his "game-playing" during sex and has told him that she would like to be able to have him be more present with her so that she can meet him more intimately and not dissociate when they are making love. "Before I was totally not in my body and couldn't be there and couldn't explain it. Now I find that I am able to go beyond a hard stuck place to a soft more connected place where I can tune in to myself."

As we move along in our work together, it will be important to hold space not only for loving feelings but for the feelings that will arise in both of us as Mara negotiates optimal distance and closeness and as she eventually separates from me: anxiety, fear, grief, and loss. Ironically, some of these feelings might be, for Mara, more easily articulated and metabolized than they will be for me. Love is difficult for her; saying goodbye is difficult for me. As with any relationship, I know that I will grow and learn from the particular idiosyncratic interactions of my relationship with Mara. One

of the gifts of being therapist is the opportunity to hone one's internal structures and capacities through the interactions of so many relationships.

Meditation is, of course, not for everyone (Farias & Wikholm, 2015). For those who are not comfortable with meditation, perhaps due to psychotic illness or trauma histories and difficulty in trusting, we use other mindfulness practices such as breath work, awareness, and relaxation techniques in session. I find that the Meditative Dialogue process does tend to speed up change processes for those who can tolerate it, as we are able to more quickly come to a deepening of dialogue and an increased tolerance for intimacy.

Recently, Mara was remembering the difficulties she experienced with the process of meditating in session with me in the beginning. She talked about the anxieties she experienced when closing her eyes in the presence of another, and about her racing thoughts and difficulty breathing. She has come to a place of feeling pleasure that she describes as "almost sexual" when she meditates with me now, and this makes her feel uncomfortable as she continues to struggle with her feelings and with the sensations of inhabiting her body. Much of the practice of mindfulness has to do with developing exquisite awareness of self and other and of the energies of the space in between. Her defenses of dissociation and numbing are no longer necessary, as Mara has developed an ability and openness to become authentically known in a humanly interconnected person-to-person relationship.

References

Baer, R. (2003). Mindfulness training as a clinical intervention: A conceptual and empirical review. *Clinical Psychology: Science and Practice, 10,* 125–143.

Benjamin, J. (2004). Beyond doer and done to: An intersubjective view of thirdness. *Psychoanalytic Quarterly, 73*, 5–46.

Bernstein, A. (2001). Beyond countertransference: The love that cures. *Modern Psychoanalysis*, *26*(2), 249–255.

Bion, W. (1970). *Attention and interpretation*. London: Tavistock.

Bishop, S. R., Lau, M., Shapiro, S., Carlson, L., Anderson, N. D., Carmody, J., & Devins, G. (2004). Mindfulness: A proposed operational definition. *Clinical Psychology: Science And Practice, 11,* 230–241.

Bodenheimer, D. (2011). An examination of the historical and current perceptions of love in the psychotherapeutic dyad. *Clinical Social Work Journal, 39*(1), 39–49.

Boston Change Process Study Group. (2010) *Change in psychotherapy: A unifying paradigm*. New York: Norton.

Bridges, N. (2005). *Moving beyond the comfort zone in psychotherapy.* New York: Jason Aronson.

Celenza, A. (2007). Analytic love and power: Responsiveness and responsibility. *Psychoanalytic Inquiry, 27*(3), 287–301.

Cooper, P. C. (2011). Total exertion: Zen, psychoanalysis, life. *Journal of Religion and Health, 50*(3), 592–601.

Davies, J. M. (1994). Love in the afternoon: A relational reconsideration of desire and dread in the countertransference. *Psychoanalytic Dialogues, 4*, 153–170.

Davies, J. M. (1998). Between the disclosure and foreclosure of erotic transference countertransference: Can psychoanalysis find a place for adult sexuality? *Psychoanalytic Dialogues, 8*, 747–766.

Davis, D., & Hayes, J. (2011). What are the benefits of mindfulness? A practice review of psychotherapy-related research. *Psychotherapy, 48*, 198–208.

Ellman, S. (2007). Analytic trust and transference: Love, healing ruptures and facilitating repairs. *Psychoanalytic Inquiry, 27*(3), 246–263.

Farias, M., & Wilkholm, C. (2015). *The Buddha pill: Can meditation change you?* London: Watkins Publishing.

Ferenczi, S. (1933). The confusion of tongues between adults and children: The language of tenderness and passion. In: M. Balint (ed), *Final contributions to the problems and methods of psychoanalysis, vol. 3.*, 1980, (pp. 156–167), New York: Brunner/Mazel.

Freud, S. (1906). Letter from Sigmund Freud to C. G. Jung, December 6, 1906. *The Freud/Jung letters: The correspondence between Sigmund Freud and C. J. Jung*, (pp. 11–13), New York: Penguin.

Germer, C. K. (2005). Mindfulness: What is it? What does it matter? In:C. K. Germer, R. D. Siegel, & P. R. Fulton (eds.), *Mindfulness and psychotherapy* (pp. 3–27). New York: Guilford.

Greenberg, J. R., & Mitchell, S. A. (1983). *Object relations in psychoanalytic theory*, Cambridge, MA: Harvard University Press.

Hirsch, I. (1994). Countertransference love and theoretical model. *Psychoanalytic Dialogues, 4,* 171–192.

Jacobs, T. J. (2013). *The possible profession.* New York: Routledge.

Jung, C. G. (1973). Letter to Mr. Martin, August 20, 1945. In: G. Adler & A. Jaffee (eds.), *C. G. Jung letters* (1: 1906–1950, pp. 376–377). Princeton, NJ: Princeton University Press.

Kabat-Zinn, J. (2003) Mindfulness-based interventions in context: Past, present, and future. *Clinical Psychology: Science and Practice, 10*(2), 144–156.

Kuchuck, S. (2015). On the therapeutic action of love and desire. In :A. Harris & S. Kuchuck, (eds.), *The legacy of Sandor Ferenczi: From ghost to ancestor* (pp. 223–234), New York: Routledge.

Kuchuck, S. (2012). Please (don't) want me: The therapeutic action of male sexual desire in the treatment of heterosexual men. *Contemporary Psychoanalysis*, *48*, 544–562

Linehan, M. (1993). *Cognitive behavioral treatment of borderline personality disorder.* New York: Guilford.
Lord, S. (2007). Meditative dialogue: A tool for engaging students in collaborative learning processes. *Journal of Family Therapy, 29,* 334–337.
Lord, S. (2010). Meditative Dialogue: Cultivating sacred space in psychotherapy—An intersubjective fourth? *Smith College Studies in Social Work, 80*(2), 269–285.
McNamee, S. (2015). Radical presence: Alternatives to the therapeutic state. *European Journal of Psychotherapy, 17*(4), 373–383.
Meyer, W. (2000). The psychoanalytic social worker/the social work psychoanalyst: What shall be our message? *Clinical Social Work Journal*, *28*(4), 355–367.
Mitchell, S. A. (1988) *Relational concepts in psychoanalysis: An integration*. Cambridge, MA: Harvard University Press.
Mitchell, S. A. (2000). *Relationality: From attachment to intersubjectivity*. New York: Routledge.
Mitchell, S. (2002). *Can love last?* New York: W. W. Norton.
Mitchell, S. (2003). *Relationality: From attachment to intersubjectivity.* New York: Routledge.
Rentoul, R. (2010). *Ferenczi's language of tenderness.* New York: Jason Aronson.
Rogers, C. (1957). *Active listening.* Chicago: University of Chicago Press.
Rogers, C. (1987). Interview with Carl Rogers on the use of self in therapy. In M. Baldwin & V. Satir (Eds.), *The use of self in therapy* (pp. 45–52). Binghampton, NY: Haworth Press.
Rowan, J. (2001). Therapy as an alchemical process. *International Journal of Psychotherapy, 6*(3), 273–288.
Rubin, J. B. (1996). *Psychotherapy and Buddhism*. New York: Plenum Press.
Sander, L. (2002). Thinking differently: Principles of the process in living systems and the specificity of being known. *Psychoanalytic Dialogues, 12*(1), 11–42.
Schamess, J. (1999). Therapeutic love in the countertransference. *Clinical Social Work Journal*, *27*(1), 9–26.
Searles, H. F. (1959). Oedipal love in the countertransference. *International Journal of Psychoanalysis, 40,* 180–190.
Seikkula, J., & Trimble, D. (2005). Healing elements of therapeutic conversation: Dialogue as an embodiment of love. *Family Process, 44*, 461–475.
Siegel, D. (2007). *The mindful brain: Reflection and attunement in the cultivation of well-being*. New York: W. W. Norton.
Simpson, T., Kaysen, D., Bowen, S., MacPherson, L., Chawla, N., Blume, A., et al. (2007). PTSD symptoms, substance use, and Vipassana Meditation among incarnated individuals. *Journal of Traumatic Stress, 20*, 239–249.
Skogrand, L., Singh, A., Allgood, S., DeFrain, J., DeFrain, N., & Jones, J. (2007). The process of transcending a traumatic childhood. *Contemporary Family Therapy: An International Journal, 29*, 253–270.
Slavin, M. O., & Kriegman, D. (2012). Why the analyst needs to change: Toward a theory of conflict, negotiation, and mutual influence in the therapeutic process.

In: L. Aron & A. Harris (eds.), *Relational psychoanalysis, vol. 2: Innovation and expansion.* (pp. 75– 120). New York: Routledge.

Sorenson, R. (2004). *Minding spirituality*. New York: The Analytic Press.

Stern, D.N. (2004). *The present moment in psychotherapy and everyday life*. New York: Norton.

Stern, D. N., Sander, L.W., Nahum, J. P., Harrison, A. M., Lyons-Ruth, K., Morgan, A. C., Bruschweiler-Stern, N., & Tronick, E. Z. (1998). Non-interpretive mechanisms in psychoanalytic therapy: The 'something more' than interpretation. *International Journal of Psychoanalysis, 79*, 903–921.

Stolorow, R., & Atwood, G. (1992). *Contexts of being. The intersubjective foundations of psychological life*. Hillsdale, NJ: Analytic Press.

Styron, C. W. (2005). Positve psychology: Awakening to the fullness of life. In: C. K. Germer, R. D. Siegel, & P. R. Fulton (eds.), *Mindfulness and psychotherapy* (pp. 262–282). New York: Guilford Press.

Surrey, J. L. (2005). Relational psychotherapy, relational mindfulness. In: C. K. Germer, R. D. Siegel, & P. R. Fulton (eds.), *Mindfulness and psychotherapy* (pp. 91–110). New York: Guilford Press.

Vida, J. E. (2002). The role of love in the therapeutic action of psychoanalysis. *American Imago, 59,* 435–445.

Williams, M., Teasdale, J., Segal, J., & Zinn, J. K. (2007). *The mindful way through depression: Freeing yourself from chronic unhappiness*. New York: Guilford Press.

Winnicott, D. W. (1958). The capacity to be alone. *International Journal of Psychoanalysis*, *19*, 415–420.

Winnicott, D. W. (1971). *Playing and reality*. London: Routledge.

Young-Eisendrath, P. (2007). Learning about love through the therapeutic action of psychoanalysis. *Psychoanalytic Inquiry, 27*(3), 310–325.

Chapter 17

Finding each other in a crowded room

Internal family systems and group psychotherapy

Annie Weiss

The goal of group psychotherapy has been succinctly and aptly described as developing "the ability to love oneself and to allow oneself to be loved" (Yalom and Leszcz, 2008, p. 383). This chapter illustrates how the Internal Family Systems (IFS) model helps members in interpersonal group therapy to achieve this goal by facilitating deeply authentic healing "moments of meeting": between group members, between group member and therapist, and between the "parts" of the group members' and the therapist's intrapsychic systems. Such "moments of meeting" involve the explicit and implicit, affective sense of feeling known and seen in the here and now (Stern, 2004; Boston Change Process Study Group, 2010).

The Internal Family Systems model (Schwartz, 1997) helps the therapist and group members to navigate challenging group dynamics, and to bring their authentic selves into meaningful contact, rooted in the present moment, with curiosity and compassion. *In vivo* group interactions evoke members' habitual feelings, reactions, interactions, and defenses that shape their internal sense of self and often constrict interpersonal relationships. The competing demands and complex interactions among multiple members in a therapy group evoke intense reactions for the group leader as well. Buffeted about by these necessary reenactments, the group leader must identify, metabolize and utilize her own reactions that will be inevitably triggered in order to remain openhearted and curious enough to help group members to do the same within themselves and with each other.

Clinical example: Unblending and speaking for parts in group

In a new group, after a period of silence, Robin speaks: "I'm pretty nervous. I don't like talking about myself." More silence.

Sarah: "I don't know why my therapist thinks telling strangers my problems would help me."

Mary: "I don't mind talking" and describes in detail frustrations with her devaluing boss. Several group members ask Mary questions about her job and offer suggestions about how to deal with her boss.

After several minutes, Adam, looking annoyed, asks me: "What's your plan to make sure everyone gets equal time?" Bill sits silently, fidgeting.

First, I notice my own reactions. A part of me perks up in response to the group's discussion of "dealing with the boss" and wonders about their reactions to me. I notice my body tighten and lean forward, a sure sign of the part of me that gets impatient when members ask a lot of questions and give advice. This is a signal to me to slow down and check my physical state to see whether my heart, literally, feels open. As I do this, my impatient and eager reactions relax. This gives me space to see the bigger picture and sense how each member's reaction may connect to feelings of anxiety about the new situation. I notice I have an anxious part, too, which propels my eagerness and impatience. This gives me internal space to choose how to proceed, to bring group members into connection with one another in the here and now, and to help them start to notice and speak for different parts of themselves.

The internal family systems model

Parts

A basic principle of the IFS model is that the mind consists of an inner system of discreet subpersonalities or "parts" (Schwartz, 1997). A multiplicity of parts is considered to be normal, nonpathological, and universal; everyone has an internal array of feelings, beliefs, impulses, adaptive strategies, and coping mechanisms. "Parts" manifest in myriad ways including physical sensation, thoughts, memories, feelings, and habitual reactions. These parts form a complex internal system: some parts help us to manage everyday life, some carry emotional pain, and some protect us from pain, with more or less adaptability or flexibility.

According to the IFS, there are no "bad" parts; *all* parts hold something valuable for the system in their non-extreme role. In response to trauma or relational misattunement, some parts get hidden or "exiled" while others get forced into extreme and potentially maladaptive protective roles in

an attempt to balance or manage the system. No matter how distancing, seemingly self-defeating or apparently destructive a reaction or behavior may be, all parts are understood as having a positive intention for the person. Even "resistance" is understood as the manifestation of a part's concerns.

Unblending

The IFS therapist implicitly and explicitly helps clients to notice "parts" as entities that are separate from the essential core "Self"; this is known as "unblending" (Schwartz, 1997). Unblending bypasses intellectualized defenses and interpretations. Instead clients establish a relationship with various parts to sense and understand a part's feelings, fears, beliefs, and intentions at a deep, implicit level. By identifying a part as separate, often locating it in or around the body, and asking the client how he or she feels *toward* it, the therapist facilitates an attuned, affective dialogue between the client and her or his parts. These internal "moments of meeting" within a client's own internal system allow parts to feel seen, known, and accepted, and to relax, develop, and heal.

In group therapy, unblending frees members to accept and normalize aspects of themselves they might otherwise disown—such as selfishness, neediness, greed, sadism, or lust. It is relatively easy to join with other group members who also, inevitably, have similar parts. Unblending parts from the Self almost invariably has the immediate effect of reducing reactivity, projection, shame, and defensiveness. This allows space for curiosity, compassion, connection, and exploration.

Self

Another essential principle of IFS is that everyone, no matter how traumatized or compromised, has a "Self" which can be understood as a core of calm, wisdom, compassion, and healing (Schwartz, 1997). Some people describe a spiritual dimension to this, whereas others describe a state of mindfulness, centeredness, or acceptance. As parts unblend, one's essential Self emerges as a resource for the internal system, creating a virtuous healing cycle. Interpersonally, these internal shifts reduce the need for reactive defenses and judgments. In group therapy, this catalyzes authentic, vulnerable, and compassionate connection within and between members of the group and the therapist.

Theorists including Freud, Klein, Kohut, Winnicott, Greenberg and Mitchell, Bollas, Bromberg, and others have described multiple internalized objects, internal structures, or self-states. IFS integrates the idea of multiple self-states with systems theory, addressing the roles and interactions of parts and defining clear protocols to "unblend" parts from the individual's core "Self" to restore balance and health to the system (Schwartz, 1997). A full description of the protocols for a client to work "inside" with parts to fully understand, unburden, and eventually heal and transform them is described in *Introduction to the Internal Family Systems Model* (Schwartz, 2001).

Clinical example: Unblending, Part 2

After noticing and unblending my anxious part, I ask: "I wonder whether Robin wasn't speaking for others' concerns right now—about saying hello, getting help, being valued, and maybe about whether the boss in here will take care of you." There is nodding, then silence. My impatient part gets noisy.

Therapist: "It makes sense, doesn't it, that worried parts show up now as you are all meeting new people?" Group members nod but remain silent.

Bill: "I feel embarrassed that at my age I still feel shy meeting new people."

Mary: "I think I might talk too much when I meet people."

Therapist: "Anxious feelings show up in different ways. We want to make space to get to know all of these parts, which is hard if we shame or judge them."

Adam: "What are you talking about?"

Therapist: "Can it be okay for that anxiety or shyness just to be here? And that you are right there with it?" Several group members nod.

Bill looks at the floor: "I don't see how."

Therapist: "It might help that part if you look around to see who is here with you." Bill looks at me questioningly. I gesture to the other members. He looks around the room and sees warm eyes looking back. This provides his shy part with a new, reality-based experience in the present rather than perpetuating historic beliefs and patterns.

Robin: "I feel nervous too, but like I should just make myself talk."

Therapist: "So Bill's shy part has company here?" Members nod. "Maybe we can make room for both—that some parts want to speak up and be

seen, even while other parts have good reasons to hang back?" Every member nods, more connected and relaxed.

In this early stage of group, I want to help group members to move into authentic meeting within themselves, with me, and between one another. First, I check inside to get a sense of my own internal system and unblend from my own parts—including anxiety—to intervene with open-hearted curiosity. I invite group members into contact with one another by finding and valuing parts with similar concerns rather than by allowing defenses to calcify and create distance. Parts that problem-solve, interrogate, withdraw, silence, and otherwise protect them begin to relax.

As group members see and appreciate the similar concerns that might underlie disparate, sometimes conflictual or alienating behaviors, they begin to feel safe enough to participate and to connect with one another. While it is a reasonable stance for a psychodynamic therapist to wait and let the group react, various members would likely get ignored, interviewed, pressured, or become the object of projections. Someone such as Bill, for example, might burrow further into recalcitrance or attempt to force himself to participate. Or eventually he might start to feel more comfortable speaking up, hopefully getting positive feedback from the group as he does so. This would all potentially have great value. However, in this model, once Bill's parts that do and do not want to talk have been acknowledged and validated, he and others immediately begin to learn about their internal systems and shared concerns.

Rather than being pushed into silence by his anxious part or muscling past it, Bill can explore its perspective, concerns, and impact in a safe and non-shaming way. He quickly becomes a useful spokesperson for the entire group as others acknowledge and appreciate the manifestation of anxious parts, such as Adam's annoyance, Mary's chattiness, or others' problem solving or caretaking. As group members speak on behalf of their parts, I notice myself relax, too. I trust the process, I feel enlivened by the recognition and connection that starts to develop between members and excited about what will unfold.

Unblending: The therapist

Relational analysts have long been interested in how to make use of the feelings and behaviors that are mutually elicited between therapist and

client, traditionally understood as "transference and countertransference" (Mitchell, 1988; Renik, 1993). IFS introduces strategies to access and interact with my own parts as they emerge in the intersubjective field. To bring authentic, open-hearted curiosity to clients' well-honed defensive systems, I work within my own internal system to unblend from reactive parts. Undoubtedly, whatever parts led me to become a therapist in the first place carry their own agendas. These parts can be caring, knowledgeable, and often helpful. At times, they can also interfere with being truly present, available, and compassionate. I have parts that can be intellectualized, opinionated, and judgmental and other parts that want to avoid pain.

Often, subtle physical sensations are the first indication that a part is activated, even while it is outside of conscious awareness. Maintaining awareness of my physical experiences throughout group helps me to notice parts of my own system that are reactive, anxious, annoyed, or otherwise interfere with compassionate curiosity. I have learned that I am no longer Self-led, for example, when I am leaning forward in my chair waiting to interrupt someone, when my hands are gripping my armrests as conflict brews, or when I want to deliver a clever interpretation. When I notice that I have become blended with a part, I ask it to unblend and give me some room to be more fully present, Self-led, and curious in response to group members' parts.

It is particularly challenging to bring open-hearted curiosity to all parts in group because of multiple allegiances, anxiety about the impact of one member's part on another or about the impact on the stability or safety of the entire group. I have to work harder in group to harness my own Self-energy to appreciate skillful protectors in group and to avoid unintentionally colluding with avoidance, scapegoating behavior, or other reactive, rigid, polarized protective parts. I might make a mental note to explore a part later, I might say aloud that I am asking a part to step back, or I might explicitly discuss activated parts in group. This helps to create an authentic relational space within which group members can access deeply held memories and feelings and heal burdened parts.

Clinical example: Welcoming defenses—Moments of meeting between client and therapist

Janet came to group to work on aggressive behavior toward her spouse and coworkers. She revealed little about herself, deflected questions,

but challenged and analyzed others. I found myself annoyed with her, impatient for her to reveal her vulnerabilities and get the help I believed the group could offer. I found myself intervening from a position of impatience and irritation, challenging her and wanting group members to challenge her, too.

Slowing down to turn my attention inward, I noticed a part of me felt thwarted by Janet and wanted to reestablish control. I sensed that a part was judging her and wanted group members to confront her. I felt curious about all this activity within my own system, knowing I needed to connect internally and unblend my own triggered parts before I could be open, and helpful, to Janet.

As Janet deflected the group's questions, I asked: "What part of you doesn't want you to talk about the concerns that brought you here?" Displaying a flash of anger, Janet said: "The part that doesn't want to do what you want me to!"

Therapist: "Can you tell me more of that part's concerns?"
Janet: "You expect me to do things a certain way. I don't have to perform for anyone!"

Janet's part that resists expectations was highly and accurately attuned to the part of me that was, in fact, expecting something from her. This revelation elicited my compassion and interest, which helped my irritated and impatient parts let go of the need to make Janet reveal something, and said sincerely: "Wow, that part is working so hard to protect your integrity."

Janet softened somewhat: "I guess."
Therapist: "I think it was onto something. I realize a part of me did have expectations of you."
Janet looked at me, surprised.
Therapist: "Maybe we could both appreciate that hard-working, vigilant part of you."
Janet: "If I didn't do what I was supposed to do, my mother would explode. I thought she'd kill me."
Therapist: "So this part that resists expectations is life-saving for you." Janet visibly relaxed. She described her mother's overbearing demands and hysterical reactions.

Then Janet's demeanor shifted as another part emerged. She looked at the floor and said flatly: "I've been a jerk in here. You are angry at me."

I checked inside myself and did not feel any trace of anger left. I asked Janet to conduct a "reality check": "I'm not aware of feeling any anger, but can you ask that part to check me out and see what it senses?"

Janet looked up, appraising me. I held her gaze, feeling full of love. I had the sense that Janet was truly seeing me and taking me in for the first time. Only then could she experience me as a real person interested in her authentic experience. Her protective system appeared to relax, and she identified a part that wanted to please me, a part that rebelled against me, and a part that feared angry retaliation. I asked her to acknowledge each part. She began to discuss the difficulties in her marriage and work, including behaviors about which she carried deep shame. Other group members spontaneously expressed appreciation for Janet's vulnerability and candor and shared similar reactions and feelings.

IFS and interpersonal group therapy: speaking for parts

Group therapy is particularly powerful and effective because of the opportunity it provides to elicit, explore, and heal the burdens of interpersonal relationships. Group relationships and dynamics catalyze reactive parts and habitual responses, reenacting a family-like social structure of live, compelling moments that vibrate with the immediacy of "now" and the echoes of "then." Protective parts and the vulnerabilities that they protect emerge spontaneously and vividly in real time to enact intense, familiar dramas.

For example, vying for attention with other group members elicits competition and envy reminiscent of early sibling dynamics. Conflict and longing emerge, as do strategies to avoid them. The reactions that group members have to one another and to the leader illuminate characteristic, unconscious patterns of interaction. The most potent group interventions involve illuminating these here-and-now triggers and interactions, providing repeated opportunities to unblend from reactive parts to work through, repair, and practice alternative, more flexible responses.

Unblended parts can be understood, described, and engaged in a dialogue. When clients speak "for" the part, describing its concerns, feelings, beliefs, and agendas, rather than just reacting (speaking "from"

the part), this helps interpersonal communication in two important ways. First, when parts unblend and relax their hold, defensive reactions soften so we can get to the heart of the matter much more quickly. Second, when someone speaks for a part, she or he can actually be heard, and the person listening is much more likely to respond with interest, caring, and identification.

For example, in a therapy group, one member is angry that another is late. Speaking *from* this part, she might attack, criticize, or judge, likely eliciting anger, defensiveness, or shame from the latecomer but rarely eliciting understanding or connection. However, when the member speaks *for* this part, such as, "a part of me is angry that you are late" she can discover and describe the feelings and beliefs that part carries. Rather than reacting as if those feelings and thoughts were true, all-encompassing, or inevitable, members have room to explore the experience of a part without having to vilify themselves or others. The group member with an angry part has space and curiosity to understand the feelings or concerns underneath it; the latecomer can hear those concerns and respond to them, rather than to the angry part that protects them.

Acknowledging a part is far less threatening and, therefore, does not require strong defenses. It is also less threatening for other group members to subgroup around shared parts that aren't all-encompassing. Even group members who could not tolerate seeing themselves *as angry people*, for example, can acknowledge that they at times *have angry parts*. Unblending and speaking for parts expedites authentic self-expression and whole-hearted connection between group members who in fact experience some version or aspect of the same things. Historical defensive patterns that cause interpersonal difficulties are less likely to be marshaled and reified, allowing access to authentic feelings and moments of meeting between members (Stern, 2004).

Clinical example: Conflict and group agreements—Rick

Rick refused to pay for a group session held on a snowy night. He lives farther away than others and deemed it unsafe to drive. He called to tell me I should cancel the group, then blasted me with an angry email about my decision to hold the group, stating that he would not pay.

When we next met, Karen referred to Rick's absence.

Rick (angrily): "The roads were awful; there was no way I was coming here."
Karen: "Actually the driving was okay by the time group started."
Rick: "Not where I live." A dispute about the safety of the roads ensued.
Therapist: "You let me know you had a part that was really mad at me for holding group, so mad you said you wouldn't pay me."
Dan: "That's not fair, you know the agreement."
Rick: "You care more about money than my safety!" Other group members reacted angrily to him, defending my decision to hold the group and challenging his refusal to keep the fee agreement. Some mentioned times they paid for missed sessions, some defended the rules.
Rick: "This is ridiculous! You care more about the rules than whether I live or die on the highway! I've had it with this group."

I felt anger welling up in me. The part of me that likes to be in charge wanted to insist that Rick follow the rules. I had the impulse to jump in and challenge him directly. A part of me enjoyed seeing other group members challenge him and defend me.

I got curious, and I noticed quieter voices in my head: "*Am* I greedy? *Are* my rules fair?" Despite my urge to jump into the fray, I took a breath, inviting these parts to "unblend." I became aware of a more vulnerable part of me that was feeling devalued and diminished by Rick and I sensed it was being induced by a similar part of Rick. With this awareness, I began to feel connected to him, rather than angry. Parts that wanted to manage or blame Rick made way for curiosity about what he was protecting. This gave me room to consider how to help other members re-own their disavowed parts.

As things in the room got increasingly polarized, I said, "I'm hearing that a lot of you have angry parts. I think each one is showing up to protect something deeply important." Immediately the energy in the room shifted.

Therapist: "I wonder whether Rick could be speaking for anyone else with a part that might not want to pay for a missed session."
Dan: "I think the group is worth it and you deserve to be paid."
Karen: "I didn't like paying for group when I was really sick last month."
Therapist: "Rick isn't the only one who has parts that don't like paying for missed sessions, even if a part also understands why I have that policy?"

Karen: "No one likes paying for nothing."
Therapist: "Is Rick the only one with a part who wonders if I care more about the money?"
Dan: "It's not like you're a lawyer!"
Sarah: "Maybe I wonder sometimes. But Rick shouldn't speak to you like that."
Karen: "I'm kind of glad he did. Like impressed. I could never do that." Others appreciated having space to speak for parts that might question my policies or even greed.
Therapist: "Rick, I wonder how it is to hear that others have parts that don't want to pay, or don't like the rules, or question my motives."
Rick: "Better than everyone yelling at me." He smiles.
Therapist: "Are you curious how a part convinced you that you were totally uncared for?"
Rick: "People always take advantage."
Therapist: "I had a part that got angry too, because it didn't want *me* to be taken advantage of either." Rick made eye contact with me for the first time that evening. I continued: "It's so important in our relationship that we both feel valued."
Rick: "That would be new for me."

Once his angry, protective, defiant parts felt affirmed and valued by the group, Rick had space to notice and take in the care for him (mine and the group's) that contradicted the beliefs of his worried part. This opened up what IFS would call a "trailhead" or a path to help Rick to connect his reactions in the moment to emotionally intense experiences in his history.

In this example, helping group members to speak for parts mitigated projective identification, scapegoating, and shame. Without IFS, Rick may have gotten vilified as the aberrant group member. Instead, others could talk about parts of themselves that resented paying. Some, me included, were able to speak for parts that wanted to be valued and treated fairly. Some appreciated seeing the part that challenged me, and several appreciated that he opened the door for parts that may not want to play by the rules.

Clinical example: Conflict Part 2—Lydia

Lydia often felt overwhelmed and frightened and was highly reactive to Kara, who joined group to work on her temper. Kara tried to engage Lydia and got frustrated by her silence:

Kara: "I hate it when you withdraw. Just say what you're thinking."
Lydia, looking down: "I can't. I don't feel safe with you."

After several more attempts, Kara leaned toward Lydia with menacing posture and flashing eyes: "It's not like I'm a monster or something! I can't stand it when you act like that."
Lydia suddenly stood up, shaking. "I have to get out of here!"
Kara: "You can't just leave!" This only served to rigidify Lydia's protectors and she responded: "Oh, yes I can!"

I felt the impulse to tell Lydia to sit down, driven by a chorus of parts: one that wanted to maintain control, one that worried about Lydia, even a very young part of me that can feel abandoned. I quieted those parts enough to ask Lydia to put her feelings into words rather than acting them out by leaving, but she shook her head and grabbed her coat.

Managing to sound calmer than I felt, I said, "Lydia, you are in charge of whether you leave. Before you do, could you just take a moment to speak for the part that says you have no choice but to get out of here?"
Lydia: "I have to protect myself."
Therapist: "This part feels you are in danger."
Lydia: "Yes."
Therapist: "Can you let that part know you get that? And that I get it, too?" I sensed a subtle shift in Lydia's body.
Therapist: "What's that part afraid will happen if it doesn't get you out of here?"
Lydia: "There's no one to protect me."
Therapist: "This part doesn't know there is anyone here to protect you?"
Lydia looked at me, calmer. "It doesn't know about you. Or anyone else in here. That's weird."
Therapist: "Does that part know about you, the adult you are now?"
Lydia shook her head.
Therapist: "Will this scared part look around and see who is here with you?"
Lydia looked around, met the kind eyes of the other group members, sat down, and crumbled into tears.
Lydia: "I get what's happening. This is now, this isn't then."

I felt deeply connected with Lydia, and I felt the group's compassion for her as well. I asked if she could take in what she was seeing, and she nodded.

Therapist: "I'm wondering whether anyone else has a part that was scared or sometimes wants to get out of here?"

David: "Kara's anger can be really scary."

Iris: "I wanted to get the heck out of here, too."

Susan: "I checked out mentally when the tension started."

Kara: "I have a part that hates my anger, too, and if I could get the hell away from it, I would. Maybe it's trying to keep *me* safe. But I don't want to hurt you." At this point, Lydia held Kara's gaze. Then, weeping, she described a new memory of being abused by her mother.

Appreciating the shared concerns of different parts had many beneficial effects beyond keeping Lydia in the room. If I had insisted that she stay, she would have either rebelled or acquiesced, rather than address her parts' concerns and needs. Had she left the group, she would not have had the opportunity for the corrective emotional experience that helped to heal the part that feels endangered and unprotected. Instead, Lydia learned that she is not alone, which in itself is an antidote to the terror and fear of annihilation she experienced as a child. This connection also mitigated the shame she might feel in getting overwhelmed or wanting to flee. Understanding her reactions as protective parts helped others to identify with Lydia, rather than projecting their disavowed feelings and scapegoating her. Even Kara could acknowledge and speak for a scared part, joining with Lydia rather than remaining polarized with her. Over time, Kara and Lydia became intimate allies in the service of supporting and healing the parts that reacted to each other.

Keeping the agreement to speak *for,* rather than *from,* parts supports all the other group agreements and boundaries. From a curious, non-pathologizing and more flexible perspective, members can explore parts that want to come late or skip group, that don't want to pay, that want to quit, that want to socialize, and all the other parts that "act out." Being aware of these reactive parts helps people to stay *in* relationship—both within themselves and with others—even in the face of intense affect, conflict, or boundary transgressions. This normalizing stance melts defenses and engenders insight, flexibility, connection, and repair, which are capacities that are vital to healthy relationships of all kinds.

IFS, relational theory, and the self-led therapist

Originally, the IFS model, developed by a structural family therapist, was not considered particularly "relational" because the primary healing relationship was understood to be between the client's own Self and his or her own internal system. IFS posits that each person, no matter how compromised, has the resources for healing and transformation within his or her Self, and the therapist's role is to guide and facilitate this internal healing relationship. In practice, however, the IFS therapist of course first has to create the necessary safe, affect-regulating relationship articulated by attachment and relational therapists (Greenberg & Mitchell, 1983) *within which* the client's system feels safe enough to allow experiential work without shutdown or backlash.

Therapist and client are in it together, each with parts that can be met and explored in authentic moments of meeting. In her research examining how analytically trained therapists use IFS, Michelle Schlief stated: "Self-led therapists experience an increased ability to feel and express curiosity, compassion, and respect toward their clients, and their clients show an increased ability to handle therapeutic challenges and to gain access to their own Self" (2014, p. 17). When IFS therapists can become aware of and unblend from their own parts, they can "access information from their parts, including emotional reactions and thoughts, weigh that information, and then judiciously decide if and how to act on that information" (Schlief, 2014, p. 83). The therapist may choose to speak for these parts with the client, so together they can understand what is being mutually evoked and created.

Therapist and client develop a mutual sense of knowing and being seen, which creates both the safe container for the client's internal work and the here-and-now context for relational repair. This is consistent with the beliefs of relational psychoanalysts that authentic, intersubjective contact between therapist and client is the primary source of therapeutic action (Boston Change Process Study Group, 2010; Bromberg, 1996; DeYoung, 2015; Greenberg & Mitchell, 1983). According to Mitchell, "the intrapsychic and the interpersonal are perpetually interpenetrating realms that continually fold back into each other" (1993, p. 143). IFS enables both therapist and client to be more fully aware of the parts that are activated within each realm and to unblend from and work with parts that block authentic relating.

Conclusion

IFS supports an explicitly non-pathologizing stance of appreciation and healing of parts that might block the implicit, felt sense of being seen and known. The IFS processes of "unblending" and "speaking for parts" reduce defensiveness and reactivity for both therapists and clients, enabling deep intrapsychic and interpersonal connection. For the therapist, this might include unblending from parts that drive certain agendas for the client, protective parts that need to be seen as smart or useful, or "figuring out" parts that insulate from painful memories, feelings, and longings.

Unblending and speaking for parts in group facilitates powerful moments of meeting between: (1) the therapist's Self and his parts, (2) the client's Self and his parts, (3) the client and the therapist, and (4) group members. The therapist and group members come into contact freer of transference distortions, intellectualization, and other self-protective parts that might otherwise block authentic connection and discovery. Unblending helps group members to be and feel "seen" both by themselves and by other group members without the interference of habitual beliefs and preconceptions. This diminishes pathogenic patterns of relating, mitigates projection and scapegoating, and catalyzes a healing interactive cycle, creating safety for group members to explore and ultimately heal their most vulnerable and wounded parts.

Rather than trying to find one another through the haze of defenses and projections, IFS helps group members to unblend from wounded and protective parts to find one another, vividly, in the moment, to explore the interplay between their internal systems. In this safe relational space, clients can access unbearable feelings and memories to not only understand but to repair and heal internal conflicts, pathogenic beliefs, and self-limiting interpersonal patterns rooted in history. As the relationship between Self and parts develops, group members have the often unfamiliar experience of seeing themselves as whole and worthy of love.

References

Boston Change Process Study Group (2010). *Change in psychotherapy: A unifying paradigm*. New York: Norton.

Bresler, J., & Starr, K. E. (2015). *Relational psychoanalysis and psychotherapy integration: An evolving synergy.* New York: Routledge.

Bromberg, P. M. (1996). Standing in the spaces: The multiplicity of self and the psychoanalytic relationship. *Contemporary Psychoanalysis*, *32*, 509–535.
DeYoung, P. A. (2015). *Relational psychotherapy: A primer.* (2nd ed.). New York: Routledge.
Greenberg, J. R., & Mitchell, S. A. (1983). *Object relations in psychoanalytic theory*. Cambridge, MA: Harvard University Press.
Mitchell, S. A. (1988). *Relational concepts in psychoanalysis: An integration*. Cambridge, MA: Harvard University Press.
Mitchell, S. A. (1993). *Hope and dread in psychoanalysis*. New York: Basic Books.
Renik, O. (1993). Analytic interaction: conceptualizing technique in light of the analyst's irreducible subjectivity. *Psychoanalytic Quarterly*, *62*, 553–571.
Schlief, M. L. (2014). *Adaptation of the internal family systems model among analytically-trained therapists.* (Doctoral dissertation). Retrieved from ProQuest Dissertations and Theses. (Accession Order No. AAI 3644242).
Schwartz, R. (1997). *Internal family systems therapy.* New York: Guilford Press.
Schwartz, R. (2001). *Introduction to the internal family systems model*. Oak Park, IL: Trailheads Publications.
Stern, D. (2004). *The present moment in psychotherapy and everyday life.* New York: W. W. Norton & Company.
Yalom, I., & Leszcz, M. (2008). *The theory and practice of group psychotherapy.* (5th ed.). New York: Basic Books.

Afterword

Hazel Ipp

This suite of chapters organized around "moments of meeting" offers a rich array of clinical and theoretical perspectives from a diverse group of authors who come to their understanding of moments that matter and why they do through the lenses of their own particular perspectives and experiences, often shaped by the seemingly pivotal moments themselves. Indeed, this is as it should be. We find our ways to our theories and our clinical moments of meaning through our own histories and the theories we are exposed to or gravitate toward. What binds us is our common goal to transform our patients' experiences so they can feel more fully vital and engaged, more able to make choices and assume agency beyond their traumatic pasts and compromised presents.

What happens in each particular dyad described in this volume varies according to the dyad and what is brought to bear at any given moment. Change occurs nonlinearly in myriad ways. What we focus on depends on our perspective and how this is experienced clinically with any particular patient.

Coursing through these papers is the perspective that something shifts affectively and experientially in the space between and within each member of the dyad at certain key junctures that lifts the process beyond the prosaic. These junctures are often preceded by periods of impasse or struggle that appear to be mired in inexplicable ways. And, indeed, while these are organized around moments of meeting, mutative moments, transcendent moments, electric moments, moments of grace, uncanny moments, or seemingly in not readily apparent charged moments of communion, as variously described in this suite of chapters, what is clear is that something heretofore inaccessible to consciousness is rendered more available. These moments come unbidden. They cannot be anticipated, summoned up, or occur through volition or technique. However, they, like the therapeutic

endeavor itself, do require a level of openness and mindfulness (Lord, this volume) on the part of the analyst so as to optimize the "courting of surprise" (Bromberg, 2006; Stern, 2015)—a key factor that tends to elicit significant moments of interplay and the heightened charge of felt communion and new experience that accompanies them.

So what happens when unformulated or dissociated material emerges in the moments described? To what extent does the affective experience become subsequently symbolized in language that advances the understanding and recognition communicated through the affective experience? Clearly, as we see in this volume, different clinicians tackle these moments differently. Some are content to let the affective shift speak for itself as the work continues. Some are more intent on moving the affective experience forward into a deepening understanding through processing what has happened through language: feeling with knowing, with recognition.

Affective dialogue is an experience that includes but often transcends language. It is one that is registered most richly and deeply in its felt state, a state that often defies words but one that may seek words to anchor it, validate it, and establish a touchstone for future reference. It is akin to the experience of listening to music, of viewing art, of reading good poetry where the power of something seemingly contained, circumscribed, is carried forward by the spirit of so much more. Stuart Pizer (1998) captures this beautifully in his description of art as a conveyor of paradox, holding the simple and the complex simultaneously, serving as a focus for the mind while containing more than can be comprehended.

While there are different currents among analytic thinkers and clinicians that may emphasize the implicit versus the explicit aspects of mutative therapeutic change, there is an increasing tendency to view these as essentially interconnected and integral to one another rather than as distinct or bifurcated modes of engagement. As Lew Aron (2012) writes,

> We contend that all show involves tell, and all tell involves show. Words and actions, remembering and repeating, association and enactment are all transformations of each other. They all contain and rely upon one another, and should be thought of dialectically rather than dichotomously.

So it is that we need our words, and our words need our affects, and they need to bump up against one another as we seek to locate greater meaning

and resonance in our communications, less constrained by formulaic or hollow utterances, "dead narratives" (Stern, 2015), or unregulated intense affects that struggle to find purchase.

These hot moments frequently seem to stand apart, even transcending language in the moment. Certain moments are, as Slavin and Rahmini describe (this volume), indeed "momentous." They appear to ignite the process, to deepen the experience, to highlight previously unformulated material, and to advance greater mutual recognition. Focusing on those junctures that involve a choice point for the therapist, Slavin and Rahmini write, "…something momentous can and does happen in a fraction, or moment of time, in the choices analysts make in what they say or don't say to their patients."

At the same time, we might argue that these seemingly pivotal moments are markers that represent the culmination of many micro-moments of matching, mismatching, struggle, rupture, and repair along the way as analyst and patient keep striving to move their process forward, working to deepen their engagement and felt understanding and sense of dyadic consciousness.

As I have written elsewhere, therapeutic action is always a felt experience:

> It is recognized affectively though the process of unpacking the enactments between analyst and patient that then permits the experience of something novel and unanticipated in the present to be verbally symbolized and understood. It is the place where we feel emotional space opening. It is where we achieve a felt and mutual sense of deeper recognition of different aspects of self and other. It is the space that heralds intersubjectivity, where our awareness of mutual influence and impact deepens in terms of our shared experience and finding each other within it. It is the place where more complex empathy resides and from where it rises
>
> (Ipp, 2016, p. 12)

Many of the chapters included here demonstrate repeatedly the inevitability of the mutual if not asymmetrical influence and impact of the clinical process on both analyst and patient as they struggle to find each other and themselves in those moments of mismatching and repair that optimally culminate in an advanced felt understanding of aspects of self and other, previously occluded from conscious awareness.

A striking note in this compendium is the Jungian contributions that highlight Jung's prescient awareness of the analyst's necessary involvement both consciously and unconsciously. Cambray (this volume), citing Jung, writes:

> …the relation between doctor and patient remains a personal one within the interpersonal framework of professional treatment. By no device can the treatment be anything but the product of mutual influence… For two personalities to meet is like mixing two different chemical substances; if there is any combination at all, both are transformed. In any effective psychological treatment the doctor is bound to influence the patient; but this influence can only take place if the patient has a reciprocal influence on the doctor. You can exert no influence if you are not susceptible to influence
>
> (1929/1966)

In so many ways, this is an important foreshadowing of much of the relational literature that succeeded these writings of Jung and where the emphasis on mutual influence, intersubjectivity, and dyadic consciousness became central. Where the notion of the analyst's inevitable and abiding subjectivity is not only essentially intertwined in the process, it will itself be impacted in enduring ways. Indeed, it is in this interplay of subjectivities, in the coming together, in the collisions, in the finding, losing, and re-finding, where we witness the deepest therapeutic work occurring and where transformations for both members of the analytic couple are most likely to be generated.

Malcolm Slavin and Dan Kriegman address these dimensions of mutual influence, inevitable conflict, and negotiated resolutions compellingly in their seminal 1998 paper. And, indeed, many of the chapters in this volume demonstrate clinically these moments that rise beyond the prosaic and always, no matter what the author's theoretical persuasion, demonstrate the conscious and unconscious interplay between analyst and patient in terms of their respective psychic histories and intersubjective space. And, in doing so, they confirm the notion of change and growth as bidirectional.

Contemporary analytic work compels clinicians to delve within themselves, as they struggle to transcend blind spots, aspects of their selves that had been previously dissociated and occluded and that have become manifest in ways that seem to obstruct the dyadic process. As Levine

(2016, p. 572) citing Baringer (2008) emphasizes, "…neither member of the couple can be understood without the other." And with this sharpened sense of awareness, we are increasingly aware of the mutual vulnerability that permeates our clinical work when we are truly immersed and open to the "reverberations across manifold relational realms" (Levine, 2016, p. 572). Tolerating our own vulnerability as clinicians is our perpetual challenge, but tolerate it we must if we are indeed intent on moving toward transforming our patients lives in meaningful ways.

Embedded in the transcendent moments that many of the authors describe, those powerful and momentous moments so poignantly described through this volume, moments that heighten awareness and that are felt dyadically, are the abiding threads of mutual influence and mutual vulnerability of both patient and therapist as both are impacted, and move toward, nonlinearly of course, greater conscious awareness, and recognition of what was previously less accessible or seemingly inaccessible. Each author has contributed in his or her own way toward deepening our understanding of mutual influence and experience deepening our understanding of mutual influence and experience that in turn renders greater purpose and meaning to the relentless struggles we go through that in turn renders greater purpose and meaning to the relentless struggles we go through internally and with our patients as we strive together for greater vitality and communion.

References

Aron, L. (2012). *The current state of relational psychoanalysis: Polarization, thirds, pluralism, eclecticism and integration.* Paper presented at the 33rd Annual Spring Meeting of Division 30. Boston, MA.

Bromberg, P. (2006). *Awakening the dreamer: Clinical journeys.* Hillsdale, NJ: The Analytic Press.

Ipp, H. (2016). Interweaving the symbolic and nonsymbolic in therapeutic action: Discussion of Gianni Nebbiosi's "the smell of paper." *Psychoanalytic Dialogues, 26* (1), 10–16.

Levine, L. (2016). Mutual vulnerability: Intimacy, psychic collisions, and the shards of trauma. *Psychoanalytic Dialogues, 26* (5), 571–579.

Pizer, S. A. (1998). *Building bridges: The negotiation of paradox in psychoanalysis.* Hillsdale, NJ: The Analytic Press.

Slavin, M. O., & Kriegman, D. (1998). Why the analyst needs to change: Towards a theory of conflict, negotiation, and mutual influence in the therapeutic process. *Psychoanalytic Dialogues, 8* (2), 247–284.

Stern, D. B. (2015). *Relational freedom: Emergent properties of the interpersonal field.* New York. Routledge.

Index

abandonment 56, 92, 94, 181, 183, 185, 229, 254, 257, 319; mutual discoveries 238, 241, 244; states of grace 102, 106
abuse 48, 57–8, 241, 320; early 146; emotional 55; physical 55; sexual 52–5, 57, 180, 293–4
Accelerated Experiential Dynamic Psychotherapy (AEDP) 267–88
acceptance 139, 141, 220, 230, 295, 297, 310; radical 130
acts of freedom 204
adaptive action tendencies 274
aesthetic vertex 86–90
aesthetics 84–96; conflict 92; containment 89; deficit 93
affect 16, 84, 95, 136, 163, 178, 184, 227, 229, 239, 320; AEDP 268, 283, 286; affective directions 21; affective moments 4, 235; safety 135; states 194; tremulous 273, 275
affect regulation 85, 195, 321; dyadic 270, 279; mutual 137
agency 47, 53, 218, 244, 249, 271–2, 274, 324
aggression 217, 244, 313
Ainsworth, M. D. S. 20; Strange Situation paradigm 29
alcohol 151, 153, 210, 213, 252
alienation 158, 312
aliveness 116
aloneness 221, 269–70, 286
Als, H. 20
Ambady, N. 30
ambivalence 254–5, 303
analytic attitude 106–8
analytic dyad 84, 90, 96, 234–5
analytic enclave 186–9
analytic relationship *see* therapeutic relationship
Andrews, H. 30
anger 103, 183, 205, 217, 220, 259, 315–19; mutual discoveries 236, 238–9, 241, 244–5; now moments 223–4, 226–7
anxiety 4, 58, 91–2, 103, 146, 179, 205–6, 235, 243–4; AEDP 274, 279–80; group psychotherapy 309, 311–12; mindfulness 293, 296, 303; now moments 228–9; retirement 254–5, 258; shame 132, 135, 141
apology 248
Appelbaum, S. A. 85
Aron, L. 3–5, 132, 325
art 85, 87, 93
assimilation 147, 193, 195
asymmetry 68, 326
attachment 19, 28–33, 38, 138–40, 218, 252, 268–9; disorganized 30–2; insecure 25, 34; misattunement 309; patterns 85; resistant 25
attunement 138–40, 167, 314
Atwood, G. E. 129
authenticity 67, 107, 110–14, 200–1, 205–7, 287–8, 312; identification 145, 148–9, 157, 159; mindfulness 294, 296, 298, 300–1; retirement 235, 243; self-psychology 169–71, 173; shame 126, 132, 141
avoidance 277–8, 313
awareness 105, 110, 296
Aziz, R. 70

Bacal, H. A. 129
Bahrick, L. 34
Baranger, M. 73
Baranger, W. 73
Bass, A. 199
Bateson, G. 3
beauty 89, 96

Beebe, B. 13–39, 72, 112, 271
Beeler, L. G. 234–46
Bell, R. Q. 14
Bender, M. 25
Benjamin, J. 132, 200, 203, 207
Bennett, S. 23
Berger, P. L. 3
Bergman, A. 36
bidirectionality 15, 33, 69; influence 23, 327; model 14–15, 22; regulation 13, 22
Bigelow, A. 35
binocular vision 3
Bion, W. R. 86–91, 95, 100, 107, 115, 234, 302
Birch, H. 18
Blatt, S. 20, 22
Bleuler, E. 69
Bollas, C. 92, 94, 100, 115, 117, 120, 186
borderline personality disorder 252
Boston Change Process Study Group (BCPSG) 4, 110–12, 116, 126, 139–40, 267, 271, 287; moments of complexity 67–8, 70–1, 73; self-psychology 161–5, 167–70, 175
boundaries 116, 252, 259, 320
Bowlby, J. 21
Boxer, E. 222–32
Brandchaft, B. 129, 183
Brazelton, T. B. 20
Bridges, N. 299
Britton, R. 201, 207
Bromberg, P. 90, 129, 131, 133, 136, 139, 189, 310
Brooks, J. 20
Broucek, F. 130
Bruschweiler-Stern, N. 4
Buber, M. 271
Buck, K. 30
Budd, M. 84
Buss, L. 35

Cambray, J. 67–81, 100, 102, 115–16
Carpenter, G. 20
Carter, L. 71–2, 105, 107, 115
change processes 1, 3, 271
chase and dodge 23–5
Chefetz, R. A. 189
China 70, 76
Civitarese, G. 96
co-construction/creation 4, 78, 131, 137, 229, 272, 294, 302; moments of meeting 164–6
COAL 297
Coen, S. J. 182
coexisting 178–9
Cohen, J. 30
Cohen, P. 30, 35–6, 38
Cohn, J. 15
coincidence model 72
collaboration 14, 22, 27–30, 34–6, 108, 133, 165, 202, 294–6, 300
Colman, W. 100–2, 106, 108, 115
comfort zones 2
communication 25, 203–4, 229, 278, 301, 316, 325–6; implicit 113; nonverbal 13–14, 16, 30, 35–6, 136, 275, 281, 301; unconscious 90
compassion 107, 295–6, 298, 308, 310, 313–14, 320–1
confidence 173, 175, 251, 256, 273
connection 178, 194–5, 225–6, 250, 294, 299, 317, 320, 322; connectedness 77, 89, 116, 138, 166–7, 169–70, 300; disconnection 117, 127, 137, 172, 179, 224, 227–9, 231–2; emotional 137, 192–3, 195; mutual 293
containment 89, 91–2, 116, 182, 186, 199, 239, 245, 261, 321; mindfulness 294, 298–9
contingency: interactive 34; self-contingency 33–4
Cooper, P. C. 301
countertransference *see* transference
cross-modality 21, 32–3
Crown, C. 27
Crowther, C. 71, 100–20
Cureton, R. 90

data 29–30, 163, 202
Davies, J. M. 52–3, 132, 189, 237, 239
Davis, D. 161–76
defenses 106, 128, 130, 236, 261, 274–5, 277, 280, 313, 320; defensiveness 129, 185, 199, 220, 286, 294, 310, 313, 316, 322
deintegration-reintegration model 108
delusion 179, 190
denial 47
depression 14, 32, 112, 141, 149, 179, 181, 213–14, 252, 296
depth psychology 74
Descartes, R. 115
despair 55, 91–2, 103, 114, 151, 172–3, 194–5, 214–15, 228, 259, 281; mutual discoveries 239, 242
detoxification 147

development 46–7, 49–50, 72–3, 85, 132, 163, 251–3, 272; clinical 45; developmental events 47; emotional 15; microanalysis/infant research 13–14, 18, 20, 22, 24, 39; theory 45
developmental psychology 15
DeYoung, P. A. 125–41
dialectic 3, 268; dialectical tension 84, 236
dialogue 27, 166–7, 173, 227, 271; affective 325; meditative 294, 297–8, 303–4; open 299; rhythms 27–8
Dimen, M. 95
disability 217, 256
disavowal 137, 174, 186, 193, 317
disruption 57, 78–9, 112, 171, 194, 229, 251, 288; microanalysis 25, 35, 38; repair 112, 166–7
dissociation 132–3, 135–8, 151, 158, 194–5, 238–9, 294, 303, 325
distance 244
doer and done-to 201, 203–4, 207
double-bind 203
dreams 69, 73–4, 94, 104, 108, 115, 178–9, 191–3, 300–1
Driesch, H. 69
drugs 153, 210
dyads 73, 78, 110, 165, 288, 324; dyadic consciousness hypothesis 111, 271, 326–7; dyadic environment 270; dyadic expansion 71, 100, 163, 170; dyadic experience 168; dyadic interaction 277; dyadic recognition 272; dyadic relationships 130; dyadic transformations 67–8, 171, 286
dynamic systems theory 34, 112, 138–40, 165, 243

ecological perspective 74, 76, 78
element of surprise 89, 102–6
embarrassment 277
embodied experience 90
embodiment 137
Emde, R. 286
emergent phenomena 71
emergent theory 115
empathy 129, 131, 138, 164–5, 171, 174–5, 198, 217–18, 286; attunement 126, 137–8, 141, 145, 158–9, 301; immersion 126, 128, 130, 141, 163, 165–7, 169; mindfulness 296, 301; now moments 226, 228, 232
enactment 51, 53, 126, 133–6, 138, 140, 146–7, 178–9, 193, 200, 236–7; reenactments 147, 180, 187, 190, 194, 205, 308, 315
engagement 145, 159, 179–80, 245, 318, 324–5; disengagement 24, 31, 189, 223; emotional 270
Enlightenment 48
envy 118–19
ethics 49, 76, 249
ethology 19
Eureka moments 71, 102–5, 108, 111, 117, 119
experiential work 130, 204, 250; AEDP 267–88
exploitation 50
exploration 225

face-to-face interaction 13–14, 21, 24, 26–7, 32, 34, 37
Fagan, J. 20
fantasy 104, 185, 190, 245; antidotal 183–4; relational 133; sexual 94
fantasy thinking 114
Fantz, R. 20
fathers 91, 151, 154, 213–15, 221, 238, 241, 244, 255–6, 259, 293–4
fear 149–50, 157–8, 180, 232, 293, 299, 303; AEDP 273–4, 280, 286; group psychotherapy 310, 318, 320; mutual discoveries 236–9, 245
Feldstein, S. 26–7, 30
Ferenczi, S. 48, 53–4, 234, 298
fittedness 166; moment of 271
Flaskas, C. 2
flourishing 269
Fogel, A. 33
Fonagy, P. 139, 267–8, 288
Fordham, M. 102, 108
forgiveness 153, 214, 218, 230
Fosha, D. 267–88
Frawley, M. G. 132
Freeman, S. 39, 115
Freud, S. 46–9, 61, 76, 234, 254, 298, 310
Friedman, D. D. 36

gazing 275
Geist, R. 163, 166–7
generativity 250
Germer, C. K. 296
Gerstman, L. 28
Ghent, E. 201
globalization 3
Glover, N. 84
Goldberg, A. 163

good enough mothering 27, 227
Grand, S. 189–90
gratitude 107, 118–19, 192, 195
Gray, K. 32
Greenberg, J. 235, 310
grief 151, 154, 158–9, 181, 198, 207, 231, 300
Grinberg, L. 86
group psychotherapy 308–22
guilt 134–5, 149, 151, 153–4, 204, 226–7, 248, 254

Hagman, G. 85
Hahn-Burke, S. 39
Haith, M. 20
Hane, A. 35
Harris, A. 2, 189
Harrison, A. 4, 35
healing 133, 138, 268, 271, 275, 308, 310, 313, 320–2
Heimann, P. 199–200
helplessness 190
heuristics 46
Hoffman, I. Z. 131
Hogenson, G. 71–2, 74, 103, 115–16
Hoven, C. 35
humanism 3
humour 113, 174, 203, 207

Igleheart, H. 28
immersion 163
implicit experience 169, 172
implicit relational knowing *see* relational knowing
improvisation 89–90
individuation 110, 254
infants 4, 13, 89, 92; autistic phase 20; capacities 21; competent 14; International Conference of Infant Studies (ICIS) 19; research 13–16, 19–23, 27, 33, 67, 72, 106, 108, 129 *see also* mothers
information sharing 3, 80
insomnia 255
interactional field 200
interactive model 15, 21
interactive regulation 19, 29, 33–5
Internal Family Systems (IFS) model 308–22
internal working models 268–9, 274–5, 277, 281–3, 285–7
internet 80; psychotherapy 76–9
interpersonal tradition 131–6, 140
interpersonal world 47
interpretation 106, 128, 131, 136, 200, 202, 310, 313; aesthetics 88, 90, 93, 95; forward edge 164; something more 67, 110, 267–8, 302
interpretive mode 165, 173
intersubjectivity 107, 116, 145, 168, 192–3, 234, 278, 294, 321, 327; engagement 298; fourth 295, 302–3; relational psychotherapy 126, 128–30, 132, 139–40; Third, the 201–2
intimacy 5, 235, 293–4, 297–300; bounded 299
intrapsychic experience 71
introjective identification 148, 159
Ipp, H. 324–8

Jacobs, T. 301
Jacobson, E. 21
Jaffe, J. 16, 25–7, 29–30, 34, 36
Jaffe-Feldstein model 37
James, W. 69, 73
Jasnow, M. 27
jazz 89–90
Jung, C. G. 68–75, 79–80, 85, 88, 100–1, 104, 110, 112, 114, 117–20, 298, 302, 327

Kabat-Zinn, J. 296
Kaitz, M. 36
Kalsched, D. 119
Kaplan, R. 105
Kavenna, J. 108
Keane, M. 91
Kessen, W. 20
Klein, M. 107, 109, 119, 200, 234, 310
Knox, J. 115
Kohut, H. 5, 21, 128, 132, 138, 163, 166, 171, 310
Kozlowski, B. 20
Kriegman, D. 51, 300, 327
Kuchuck, S. 298

Lacan, J. 201, 207
Lachmann, F. 21–3, 26, 38, 72, 112
Lange, A. 36
Langs, R. 73
language 13, 279–80 *see also* communication
laughter 113–14, 173–4, 191–2, 245, 251, 255
law 76
Lee, C. 89

Lee, S. 30
Levine, L. 327
Lewis, M. 14, 20
liberation psychoanalysis 48–9
Likierman, M. 92–4
literature 113–14
lived experience 137
local level 111
Loewald, H. 47
loneliness 158, 163
longitudinal studies 29
Lord, S. 293–304
love 48–9, 153, 157, 185, 244, 298–300, 302–3, 315, 322; love/hate 215; therapeutic 299; transference 48
Luckmann, T. 3
Lyne, J. 32
Lyons-Ruth, K. 4

McKamy, E. 248–62
McNamee, S. 301
Mahler, M. 20–1
Main, M. 20
Main, R. 70
mania 183, 194
Mansfield, V. 74
Margolis, A. 34
Markese, S. 28, 30, 36
masochism 55
mastery 147; unmastered experience 146–8
mathematical analysis 25
meaning 84, 325
meaning-making 72, 133
medication 57
Meditative Dialogue 294, 297–8, 303–4
Meltzer, D. 92
Menke, C. 84
mental health 109
mentalizing 138–40
Meredith-Owen, W. 100, 118–19
Messinger, D. 34
meta-analysis 30
metaphor 2, 78, 85–6, 89, 108–9, 239, 244–5; sexual 108
metapsychology 269
metatherapeutic processing 268–9, 272–4, 278, 283–7
methodology 269, 287
microanalysis 4, 14; mother-infant treatment 35; video 13, 16, 18–19, 23–6, 29–30, 33, 35–8, 67
microinteraction 20
microprocesses 162
migration 91
mindfulness 270, 294–8, 302, 304, 310, 325
Miranda, S. 20
mirroring 174
Mitchell, S. A. 2, 5, 131–2, 201, 310
Mitrani, J. 89, 92
model scenes 240
Modell, A. 193
moment of fittedness 271
moments of change 271
moments of freedom 234
moments of meeting 1, 4, 161–3, 189–91, 207, 229, 250, 308, 310, 324; absent 184–5; AEDP 268, 270–1, 275, 278–9, 287–8; disruption/repair 166–7; living inside the moment 161–5, 168–71, 173, 175; mindfulness 293, 297, 299, 301, 303; moments of complexity (MoC) 72–4, 76–9; non-local aspects 67–80; retirement 255–7; shame 125–41; states of grace 100, 110–14; therapist's experience 167–71
moments of surprise 241–4
moments of truth 45–51, 60–1; foliage 54–9; perverse scenarios 52–4
Money-Kyrle, R. 100, 118–19
Moore, M. S. 27
Morrison, A. P. 130, 223
Moskowitz, S. 36
mothers 89, 91–2, 190, 203–4, 221–32, 252, 280, 314, 320; environmental 89; mother-infant communication 13–15, 21, 27, 37, 239; mother-infant interaction 19, 28, 30, 91, 148; mother-infant reciprocity 15; mother-infant treatment 35; mutual discovery 236–41, 245
mourning 31, 179, 189, 250, 260; self 276–7
Murphy, L. B. 14
mutuality 2, 5, 107, 112, 132, 207, 218, 241, 249, 300; influence 21, 50, 129, 326–8; regulation 13–15, 21, 136
Myers, M. 35

Nahum, A. 4
narcissism 128–30, 132, 193, 252; crying 198–9; protective 182–3, 185
narrative 133, 165, 209, 286; dead 326
neuroplasticity 268–9, 271
neuroscience 50, 90, 136–8; affective 287
neutrality 50, 295
non-locality 72–6, 80

novelty 29
now moments 1, 116, 174, 243–4, 275, 287; clinical space 222–32
numinous 101, 105, 120, 295, 302–3

object relations 19, 234
object representations 21–2, 26
object-seeking 235
objectivity 3
observation 3
Oedipus 201
Ogden, T. 88, 95, 116, 200
optimal midrange model 27–8
Orange, D. M. 130
Ornstein, A. 165
Ornstein, P. 163, 165
Oster, H. 20
Other, the 129, 217–18, 222, 278, 281, 287, 326

pain 277, 313
Panajin, A. 87
paradigm shift 2–3
paradox 133, 194, 278, 325
parental influence 14
parents *see* fathers; mothers
pattern matching 21
patterns 22; movement 26
Pauli, W. 69, 74
perverse scenarios 52–4
Pfaff, D. 35
phase changes 71
phenomenology 268, 270, 287
philosophy 70
physics 69, 73
Piaget, J. 15, 20
Pizer, S. 325
Pocock, D. 198–207
polycentricity 76
positivism 48, 295
post-modernism 245
power relations 201, 294
predictability 34
predictive systems 26
present moments 1, 113
procedural knowledge 268
projection 53, 310, 312, 322
projective identification 147, 159, 234
psyche 75–6, 80, 88, 161; ecological perspective 74–6
psychic collapse 183
psychic integrity 48–9, 53, 60–1
psychic organization 22
psychic reality 78
psychodynamic psychotherapy 1, 73, 147–8, 312
psychoid 67, 69–70
psychological disturbance 85
psychological fields 116
psychological space 77
psychopathology 32
psychosis 56, 72
psychotherapy 1, 4, 21

qualitative change 67

radical presence 301–3
Rahmani, M. 45–61, 326
reactivity 89, 179, 310
realness 209–21; realness-unrealness 216–17
receptiveness 116
reciprocity 209–21
recognition 94, 102, 118, 127, 166, 200, 271–2, 278, 325; misrecognition 130; mutual 135, 140, 205–6, 326; nonrecognition 190; profound 131; self 106
reenactments 147, 180, 187, 190, 194, 205, 308, 315
regression 294
regulation 137–8, 148, 168, 173; dysregulation 137, 141, 173; mutual 13–15, 21, 136
Reiswig, R. 36
relatedness 26
relational domain 68, 96, 119, 165, 235, 251, 268; grace 110–12
relational experience 50, 139
relational freedom 169
relational intimacy 297
relational knowing 108, 140; implicit 111, 139–40, 162, 164, 166, 167
relational patterns 268
relational psychoanalysis 4–5, 79–80, 209, 295–6, 298–9, 301, 303, 321; history 125–41; mindfulness 295, 298–9, 301, 303; moments of truth 45, 49; theory 2–3, 140, 198, 234; tradition 5, 199
relationality 84–5, 90, 95
religion 87, 95, 109–10, 119
Remez, A. 36
Renik, O. 50, 61, 131
repair 112, 320, 326
research 13, 27, 79, 90, 112, 269, 321; complexity 74; empirical 20; infant 13–16, 19–23, 27, 33, 67, 72, 106, 108, 129

resistance 189, 284
responsiveness 136
retirement 179, 213, 248–62
reverie 88–9, 91, 107, 116–17, 251, 301
rhizomes 74–5
rhythms 25–6, 38; dialogue 27–8
rigidity 234
risk factors 14
risk-taking 298, 303
Rogers, C. 126, 301
Rosenblum, L. 14, 189
Rosenthal, R. 30
rupture 103, 175, 186–9, 241; and repair 167
Russell, E. M. 281
Ryle, J. 110

safe spaces 130, 294, 302
safety 94, 135, 272, 274, 321
Salpatek, P. 20
Sander, L. 4, 33, 212, 268, 271
Sandler, P. S. 89
schizophrenia 252
Schlief, M. L. 321
Schmidt, M. 71
Schonbar, R. 18
Schore, A. 136, 138
science 76, 87, 95, 114; paradigms 74
Scmidt, M. 100–20
seduction theory 46
Seikkula, J. 299
self 21, 132, 199, 201, 236, 245, 277, 288, 296, 326; core 269; experiences of 117–18; group therapy 310–11, 313, 321–2; mutual discoveries 236, 245; reflection 84, 178, 227; representations 22, 26; self-assertion 132; self-deficit 128; self-disclosure 54, 138–41; self-erasure 135; self-functioning 187; self-growth 130; self-knowledge 31, 34; self-loathing 141, 297; self-object relations 129, 161, 163–7, 170, 173, 237; self-organization 103, 129, 167; self-other interactions 132–3, 135, 283; self-predictability 15; self-protection 128, 189, 228, 313–16, 319; self-regulation 22, 29, 33–5, 148, 168, 173, 237, 252; self-reliance 277; self-scrutiny 210; self-state 131, 175, 195, 310; self-structure 130, 167; self-sufficiency 193; self-with-other 125, 127, 129–30, 132, 139–40; states of grace 100, 106, 110; in transition 282
self-harm 252
self-led therapy 321
self-psychology 128–30, 136, 139–40, 209, 234; living inside the moment 161–75
semantics 90
September 11th attacks 36
sexuality 54, 56–8, 92, 153, 210, 294, 303; erotic desire 52–3; fantasy 94; libido 235; metaphor 108
shame 125–41, 161, 189, 222, 229, 258, 276, 297, 310, 312; language 223
shared experience 165, 286
shared philosophy 2
Sharff, J. S. 77
Siegel, D. 297
Simard, S. 75
Slavin, J. H. 45–61, 300, 326
Slavin, M. O. 51, 209–21, 327
Slochower, J. 178–96
sloppiness 111, 140, 165, 269, 287
Smith, H. T. 14
somatic experience, change last few 204, 268, 272–4, 295
somatic states 76, 268–70
Sor, D. 86
Sossin, K. M. 36
speech 26–7, 91, 95, 227, 238–9
Spiegelman, J. M. 74
spirit 70
Spitz, R. 21
spontaneity 165, 234, 287
Stark, M. 145–59
Starr, K. 3
state-sharing 137
states of grace 71, 100–8, 113–20; relational aspects 110–12; roots 108–10
statistics 30
stay with it, and stay with me 277, 279–80
Stechler, G. 20
Steele, H. 28
Steele, M. 28
Stern, D. 4, 13, 15–16, 18–20, 23–6, 28, 100, 110, 169, 207, 224, 229, 243, 278, 302
Sterne, L. 113
still-face experiment 29, 31
Stolorow, R. D. 129
Stone, L. J. 14
strangers 28–9
structure 116
subject-to-subject interaction 5, 128, 132, 136, 138, 162
subjectivity 3, 5, 85, 87, 129, 168–9, 171–2, 185, 187, 200, 272, 295, 327
submission 168, 201

suicide 172
Sullivan, H. S. 49, 131–2
superego 101, 199
supervision 268
surrender 201
swarm logic 76
symbolism 101, 104, 119, 216–17; alchemical 69
Symington, N. 88, 204
synchronistic phenomena 70, 72–3, 79, 102–4
systems theory 234, 310; dynamic systems perspective 34, 243
Szasz, T. S. 47, 60

Tabak de Bianchedi, E. 87
technique 48, 50, 61, 88, 110, 136, 201, 245; AEDP 267–8, 270, 287–8; self-psychology 163, 165, 170–1, 175
temporality 71; coherence 34; patterns 25–6
tension 133, 236, 241, 320
termination 161, 192, 249, 251, 257–9; forced 250
theory 20–1, 61, 111, 116, 175, 199, 201, 207, 236, 245, 324; development 45; evolution 2–3
therapeutic action 68, 71–2, 79, 145, 147–8, 159, 162, 175, 321, 326
therapeutic change 68, 194–5, 234, 241, 245, 301, 324–5
therapeutic dyad 162
therapeutic relationship 67, 147–8, 191, 194, 207, 222–32, 259–60; AEDP 269, 276–7, 287; mindfulness 298–9, 303; moments of truth 46, 51; mutual discoveries 234–5, 240, 246; self-psychology 163, 166; shame 129–30, 136, 140
therapeutic roles 170
Third, the 200, 207; analytic 74, 76, 78, 117; dead 182–3; intersubjective 201–2; shared 201
thought 90
thrall of the negative 182
time-series analysis 15, 28
timing 25, 27
togetherness 200–1
Tortora, S. 36
training 13, 268
transcendent function 71, 101, 104, 116
transcendent moments 324, 328
transference 47, 51, 69, 111, 139, 217, 241, 243, 298; co-transference 129; countertransference 4–5, 68, 73, 131, 133, 146, 199–200, 236, 238–9, 313
transformational work 268–72, 285–8, 310, 324, 328; crisis 280–3
transparency 5–6, 126, 139, 295
trauma 31, 47–8, 167, 179–80, 190, 193, 195; AEDP 269, 272; core 187; early 146, 252; protective narcisssism 182–3; relational 139; retirement 254–6; reversing 183–4; separation 258; shame 132, 135, 141
Trimble, D. 299
Tronick, E. 4, 15, 19, 29, 71, 73, 100, 111
true self 49, 115
trust 275, 284
truth 115

UK 22
unblending 308, 310–13, 316, 322
unconditional positive regard 126, 301
unconscious 112, 133, 139–40, 146, 199–200, 234, 257, 327; communication 90; moments of complexity 68–9, 73, 75–6, 78; moments of truth 50, 58; primary repressed 115
understanding 211–12
unthought known 100–1, 105, 115, 117–19
us 200–7
USA 22, 91

victimhood 189
videotaping 13, 16, 18–19, 23–6, 29–30, 33, 35–8, 67, 268
violence 237–9, 241
vocal exchanges 22; turn taking 29
vulnerability 189, 220, 237, 241, 300, 303, 315, 317, 328; AEDP 276–7, 279; mutual 328; tremulous 276

weight loss 57, 204
Weiss, A. 308–22
Welch, M. 35
well-being 136
Wener, H. 20
Werner, H. 15
Western thought 70
Williams, M. H. 88
Winborn, M. 84–96
Winnicott, D. 21, 27, 49, 89, 115, 159, 201, 227, 235, 271, 310
wow moments 268, 273, 283–4, 288

Young-Eisendrath, P. 299

Zen 301
Zinkin, L. 106