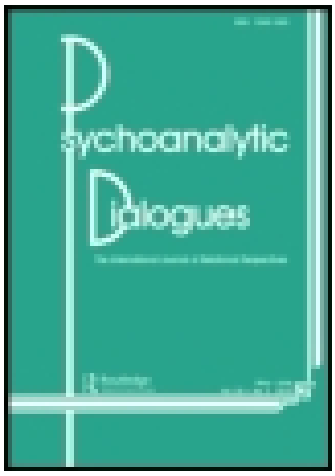

Psychoanalytic Dialogues: The International Journal of Relational Perspectives

Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/hpsd20

The Gorilla Did It: Some Thoughts on Dissociation, the Real, and the Really Real

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Published online: 01 Jul 2008.

To cite this article: Philip M. Bromberg Ph.D. (2001) The Gorilla Did It: Some Thoughts on Dissociation, the Real, and the Really Real, Psychoanalytic Dialogues: The International Journal of Relational Perspectives, 11:3, 385-404, DOI: 10.1080/10481881109348619

To link to this article: http://dx.doi.org/10.1080/10481881109348619

Psychoanalytic Dialogues, 11(3):385–404, 2001

The Gorilla Did It

Some Thoughts on Dissociation, the Real, and the Really Real

Philip M. Bromberg, Ph.D.

This is about a small boy and his "imaginary" friend, who happens to be a gorilla—a friend the boy considers very real indeed. It is also about the fact that no part of the self, including every child's relationship to his own "gorilla," is ever "reasoned" out of existence. It becomes, instead, "not *really* real," because it has had to be relegated to "not really me" in order for the child to preserve his attachment bond with significant others. However, it will continue to make its presence known through being relationally enacted, dissociatively, in ways that eventually become repetitious enough and painful enough to bring the child (now an adult) into our office years later. As analysts, our job at that point becomes one of trying to restore the connection between the little boy and his gorilla in the face of intense pressure by the now "grown-up" patient to keep them apart and to discourage the therapist from trying to bring these old friends back from dissociation into the "really real." The source of therapeutic action that allows this reunion to take place is discussed conceptually and described in clinical vignettes.

I'M GOING TO START WITH A SHAGGY-DOG STORY, EXCEPT THAT THIS ONE is a shaggy-panda story. A panda walks into a bar, sits down on a stool, and orders a tossed salad and a beer. The bartender serves him, and the panda finishes his meal, pulls out a gun, and kills the

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An earlier version of this essay was presented as part of the "Dissociation and Therapeutic Action" panel at the meeting of the Division of Psychoanalysis (Division 39) of the American Psychological Association, New York City, April 18, 1999.

man sitting on the stool next to him. He then gets up and starts to saunter out of the bar. The bartender, recovering from the shock of what he has just witnessed, shouts at the panda, "Hey, where do you think you're going? You can't just come in here, have a meal, shoot someone, and then casually leave!" The panda looks at him with self-righteous indignation and replies, "Hey, man, get off my back! It's no big deal. I'm just doing my thing. I'm a *panda*, for God's sake. Look it up!" And he walks out. The bartender, still in a state of shock, locates a dictionary, looks up *panda,* and, sure enough, it reads: "Panda: A furbearing marsupial—indigenous to Asia. Typically black and white. Eats shoots and leaves."

Now, you might well ask, "What do pandas have to do with gorillas? Is his shaggy-panda story a way to get a laugh before he gets into the subject matter?" Maybe so. On the other hand, one might see the panda's reaction to the bartender as a metaphor for a central aspect of dissociative subjectivity with which we are all familiar—the insularity and concreteness of each self-state as a black-and-white island of "truth" about who one is at a given moment.

The centrally defining hallmark of dissociation is the presence of a concrete state of mind, by which I mean that there is thought without a thinker or, rather, thought without the thinker's being aware of the other as a thinker in his or her own right with whom it might be possible to share or reciprocate ideas. Thus, each self-state insofar as it exists in dissociation from other self-states is necessarily an island of concreteness. "Hey, man, this is who I am. It's no big deal." As we get to meet new and different parts of our patients, often unexpectedly, we are confronted by variations of the panda's reply with little regard for what *we* regard as reality, and find ourselves in the position of the bartender in the story. What I mean will, I hope, become clearer as my point evolves through the clinical material presented here.

In 1981, the San Antonio Museum of Art featured an exhibition on Contemporary American Realism—"Real, Really Real, and Super Real." Perhaps, in another 10 years, we'll use the same title for a conference on Contemporary American Psychoanalysis, as there may not be enough other differences between theories of psychoanalysis worth arguing about. I must confess that I actually like the idea, but, again, you might well ask what this has to do with gorillas. I in fact borrowed the title *The Gorilla Did It* from a wonderful children's book written in 1974 by Barbara Hazen—a book about a little boy, his parents, and a friend who shares the boy's bedroom, a friend who happens to be a gorilla. It's a story about a boy blessed with parents

who, in the face of their own "grown-up truth," are able to be helped by their child to remember how thin the line is between the real and the really real, and who do not force him to surrender his "imaginary" gorilla companion to ensure his continuing place in their hearts.

It's a tale that begins with "Just look! There's food all over the floor and grape juice under the radiator. . . . Don't tell *me* a gorilla did all this while you were sound asleep. . . . I want you to go back to bed and think about what happened. And when you've thought it over, I want you to come out and tell me what REALLY happened." The story ends with the boy's coming back out and telling his mom that he and his gorilla cleaned up the mess together, but that the gorilla said he was still hungry. "Can I take him a cookie? And can I have one too?" Mommy, with a look of loving resignation, feeds them both. The little boy, back in his room, looks into his gorilla's mischievously contrite eyes and says, "And he *really* means to be a good gorilla." The reader, kid or adult, closes the book knowing that both the little boy and the gorilla are safe, sound, and well-loved and will grow up enjoying each other's company for a long time.

Let's say the boy had different parents. Not brutal parents, not parents who can't tolerate their own helplessness for even a little while, but just ordinary parents who think that what they are doing is "right" and who continue to insist on their rightness, because they can't modulate the "real" by accessing another part of themselves that knows what it's like to have a gorilla for a friend—in other words, parents for whom their own gorilla has too long ago become "not me." The little boy will then have to give up his gorilla in order to preserve his attachment bond with his parents—a bond that defines his most secure sense of self. But the gorilla won't just disappear. No part of the self ever disappears; it will make its presence known in one way or another that will be experienced as "not me," and sometimes will make its presence known in ways that become painful enough to bring the little boy (often years later) into our office. So, our job at that point becomes one of trying to restore the connection between the little boy and his gorilla in the face of intense pressure by the now "grown-up" patient to keep them apart and to discourage the therapist from trying to bring them back from dissociation into the "really real." How does an analyst do this? In other words, what is the source of therapeutic action? Mitchell (1995) put it this way:

> To understand unconscious processes in one's own mind or that of another is not to expose something that has a tangible

> existence, as one does in lifting a rock and exposing insects beneath. To understand unconscious processes in one's own mind or that of another is to use language in a fashion that actually creates new experience, something that was not there before [p. 8].

In normal mental functioning, a person can simultaneously access a range of discrete self-states that, despite their contrasting and even opposing perspectives on personal reality, are able to engage in internal dialogue. It is this capacity that permits oppositional aspects of self to coexist in consciousness as potentially resolvable intrapsychic conflict by creating what Mitchell called "new experience"—rather than leading to *pathologic* dissociation by threatening to fragment the overarching illusion of cohesive selfhood and existential sense of "going-on-being."

In other words, most individuals are able to bridge the gaps between their multiplicity of discontinuous self-states and are not exiled from the healthy experience of intrapsychic conflict and its potential resolution. I've referred to this "normal dissociative structure of the mind" (Bromberg, 1994) as a set of discrete, more or less overlapping schemata that, taken together, define who one is—each schema being organized around a particular self–other configuration that is held together by a uniquely powerful affective state.

The effect of traumatic experience is is to threaten the illusion of a cohesive self. When the illusion of unity is too dangerous to be maintained, experiential data incompatible with the ongoing self-state are denied simultaneous access to consciousness. The individual cannot hold conflicting ways of seeing himself vis-à-vis his objects within a single experiential state long enough to feel the subjective pull of opposing affects and dissonant self-perceptions as a state of mind that can be taken as an object of self-reflection. Inharmonious contents of the mind (affects, wishes, beliefs, etc.) are not readily accessible to self-observation. The individual tends to experience his immediate subjective experience as truth, and any response to it by an "other" that contains data implying an alternative perspective is experienced as disconfirming, unempathic, and thereby unthinkable. In the words of the novelist George MacDonald (1858):

> Alas, how easily things go wrong!
> A sigh too much, or a kiss too long.
> And there follows a mist and a weeping rain,

And life is never the same again.
Alas, how hardly things go right!
'Tis hard to watch in a summer night.
For the sigh will come, and the kiss will stay,
And the summer night is a winter day [pp. 130–131].

Transition from Dissociation to Capacity for Conflict

In a growth-facilitating treatment, there is an increased ability to surrender the safety afforded by dissociation and a simultaneous increase in the capacity to bear and process internal conflict. A patient becomes more able, mentally, to play with and creatively struggle with experience that before could only be enacted in the interpersonal field. In terms of clinical process, he becomes more able to "speak himself to you" as an intrapsychic process of cognitive self-resymbolization—a pleasurable reconnection of mind to "psyche-soma" (Winnicott, 1949a) that uses the analyst's presence as a trustworthy, nonimpinging object. From the other end of the couch, the analyst, too, starts to feel something subtly different taking place that encompasses both his experience of his patient and of himself. His patient is more able to use the pleasure and security in what Winnicott (1958, p. 34) called the capacity to be alone in the presence of another person—the experience of being alone in the presence of "someone available, someone present, although present without making demands"—and is now doing more and more of the work internally rather than through enactment. Because the patient can relate to his analyst within a more comprehensive experience of selfhood rather than simply use the relationship as a means of *achieving* it, a new demand is now made on the analyst's use of his own subjectivity and on his sense of clinical judgment.

First, because of the patient's greater capacity for internal processing of conflict and the concommitant decrease in enactment, the analyst's experience of the here and now no longer provides as reliable a key to what is going on in his patient. The patient is more self-contained and the analyst suddenly finds himself "a few steps behind," a development that brings with it the analyst's own vulnerability to an unanticipated shift in roles between himself and his patient. The analyst must be able to recognize and accept this unannounced change in the relationship—a shift that is often more of a surprise to the

analyst than to the patient, as illustrated in the first clinical vignette to be presented. All told, as the patient's dread of traumatic "shock" decreases, surprise and spontaneity become more pleasurable and more present in the clinical process.

Second, the analyst must now be able to experience and respect his patient's need for privacy and the patient's new ability to take charge of it on his own, without the analyst conceptualizing as "resistance" his patient's choice to participate less than before in here-and-now exploration of their relationship (including exploration of the role-shift itself). In a now quieter way, the analyst must be as fully engaged with his patient's immediate self-state as he was earlier on, when full engagement embraced vivid here-and-now interaction between subjectivities. If the analyst is more or less comfortably able to move with this silently developing capacity in his patient, the difference during the shift is not that collisions of subjectivity will cease but that, when they do occur, the patient's self-experience, because it is less subject to disorganization by the dreaded return of unprocessed trauma, is less rigidly organized by the single dissociated "truth" of "alas, how easily things go wrong and life is never the same again" (MacDonald, 1858). The experience that life *can* be the same again and that relational ruptures can be repaired (cf. Safran and Muran, 2000) without losing the secure continuity of the attachment on which selfhood depends, begins to be trusted as reliable.

Dissociation and the Therapeutic Action of Psychoanalysis

In this context, analytic technique, notwithstanding the school of thought from which it is derived, is useful only if it isn't held as objectively "correct." Historically, analysts influenced more by British sensibility (e.g., Winnicott, 1949b; Heimann, 1950; Racker, 1953, 1957) or by their work with severe psychopathology (e.g., Sullivan, 1954) have organized their use of countertransference and their use of themselves around the patient's need for safety and have viewed interaction (as well as self-revelation by the analyst) principally in terms of its threat to impinge on a patient's internal reality. The British "Middle School" emphasis, for example, tends to give greatest weight to patients' being particularly vulnerable to the analyst's becoming "dangerous" (Winnicott, 1963) by forcing "not me" concepts into them

for which there is not yet a transitional linkage to their "imaginative" capacity (cf. Rycroft, 1962). At the other end of the continuum are analysts who have emphasized the importance of a more interactive—sometimes systematically so—use of themselves (e.g., Little, 1951; Tauber, 1954; Levenson, 1972, 1983; Ehrenberg, 1992) that centralizes the value of self-revelation of the analyst's own subjective experience within the analytic field. Each of these postures represents a different subjective sensibility that generates its own "technique," giving the analyst an internally valid place to stand during intersubjective negotiation. It is only when an analyst holds his preferred stance as more than simply personal sensibility (i.e., as Technique with a capital T) that he forecloses his ability to function intersubjectively and prevents his patient from using him optimally. The analyst must accept that his stance (no matter what it is) will be continually met by a statement from a different self-state of the patient—"This is not me" and "You are not understanding who I am and what I need."

Why do I hold the analyst's subjective experience to be so critical a factor in the patient's self-growth? My answer, in its most general (and oversimplified) form, is that the reciprocal process of active involvement with the states of mind of "the other" allows a patient's here-and-now perception of self to share consciousness with the experience of incompatible self-narratives that are dissociated but are being held in the mind of an "other." As put by Fonagy and Target (1995):

> Interpretations may remain helpful but their function is certainly no longer limited to the lifting of repression and the addressing of distorted perceptions and beliefs. . . . Their goal is the reactivation of the patient's concern with mental states, in himself and in his object.
>
> We believe that the developmental help offered by the active involvement of the analyst in the mental functioning of the patient, and *the reciprocal process of the patient becoming actively involved in the analyst's mental state*, has the potential to establish this reflection and gradually to allow the patient to do this within his own mind. . . . *The critical step may be the establishment of the patient's sense of identity through the clarification of the patient's perception of the analyst's mental state.* . . . It seems that gradually this can offer a third perspective, opening up a space for thinking between and about the patient and the analyst [pp. 498–499; italics added].

Pathologic dissociation can be said to exist to the degree that the patient cannot simultaneously access other self-states that might modulate the "truth" being held by the self-state that is the "real me" in the moment. In this sense, what I'm calling the "gorilla" is not always a self-state exactly like the particular gorilla in the book; it can be any self-state that has been disconfirmed, invalidated, or traumatically threatened because it is "making a mess" in the eyes of a significant "other" to whom the patient was attached in a primary way that defined his or her sense of continuity as "me." To the degree that self-continuity was compromised by the patient's relationship with *his particular* "gorilla," such a relationship lives out its existence as a "not-me" experience.

In an interesting *New York Times* article, "On Having the Grace to Grow Old, Gracefully or Not,"[1] Jefferson (1999) wrote that according to F. Scott Fitzgerald, "the test of a first-rate intelligence was the ability to hold two opposing ideas in your head at the same time and maintain the ability to keep functioning." Although Fitzgerald wasn't much interested in what factors might *impair* this ability, his observation was pretty astute as it applies to the effect of pathologic dissociation on mental functioning. Someone who cannot, as Fitzgerald put it, "maintain the ability to keep functioning" while holding two opposing ideas in his head at the same time constricts the use of his mental capacity in a manner that can not only come across as a defect in intelligence but is also interpersonally confounding to those with whom the person is engaged in relationships.

Independent of theoretical persuasion, almost every seriously held theory of therapeutic action holds that the creation of an authentic analytic experience depends on whether the analytic situation is able to facilitate and support a sufficient level of transferential intensity to sustain enactments and nourish their analysis. Both classically and postclassically, this is brought about through a treatment structure that permits the continuity of the ongoing *process* to become the most powerful organizing experience in the patient's internal world so that, regardless of the specific "real life" issues with which a patient enters treatment, there is an increasing shift toward the patient's experience of his own mind as an object of attention. This is why clinical psychoanalysis, regardless of the theory on which it is based, invariably has some "frame" that organizes and structures what an analyst does

[1] I thank Fran Scheff for calling this article to my attention.

while being an analyst. The analytic stance deemed most appropriate to make maximum use of the relationship as the most powerful medium of therapeutic action—that is, to support an optimal level of transferential intensity—is thus linked directly to how a particular theory conceptualizes and implements its "frame." But to make matters even more complicated, most of us know from our own clinical work that, within any single theoretical approach, the meaning of "useful analytic behavior" also varies from patient to patient in the work of any one analyst. This is not to say that the concept of a source of therapeutic action should be retired, but rather that any definition that attempts to specify the source relationally, in *abstract* terms, is bound to collide with the reality that its intrinsic nature is tied to the uniqueness of each given analytic dyad and thus to the unpredictability of the moment-to-moment context that gives it shape. Consider, for instance, the following example.

Helen

Helen, a patient in her mid-30s, had a history of severe trauma that had led to a reliance on dissociation so long-standing that she was unable to experience herself with a past that felt like hers, a present that she breathed life into, or a future that she could imagine. To ensure that the protective function of her dissociative solution remained reliable, she had defined the scope of her existence in a manner so limiting that she allowed herself almost no interchange with the outside world other than her work. When not in her office, she secluded herself in her small apartment, saw few friends, had virtually no social life, and was sexually inactive. When I first met her, she could barely contain her unprocessed rage at knowing that she was somehow shortchanged as a human being but not knowing who to blame or whether she even had the right to do so. "Was I just born this way —different from everyone else—or could I have been a whole person if only . . .?" Ironically, she was herself a therapist—a therapist endowed with an extraordinary gift for healing others despite her own pain, which never went away. Being a therapist, she was aware that I wrote, and she made a point to read my work as it appeared in print. I was never quite sure of what she did with what she read, because the impact of experiencing me as part of "the world out there" was held in different domains of reality by different parts of her self, and I was privy only to those parts that were least likely to threaten

the fragility of the attachment that she felt was always in danger of being irreparably broken. In this respect, her image of me called to mind the words of Kathryn Harrison's (1997) protagonist in *The Kiss*: "I cannot remember a time that I was not aware of my mother's fragility. It's part of what has convinced me of her surpassing worth, the way only the best teacups break easily" (p. 50).

After about five years of work, we had reached a point at which she was able to hold in conscious awareness the existence of her own dissociative processes and was able to reflect on what function they served. Not surprisingly, she also began to share with me aspects of herself that were now safer to allow into our relationship, including her growing ability to make self-reflective use of some of my writings in a way that was dramatically different from her storing them away as a protection against discovering their existence unexpectedly and being helpless to prevent their assault on her mind.

On this particular day, she arrived for her session filled with undisguised enthusiasm—a state that caught me completely unprepared, as I had not been part of it before. I blurted out both my surprise and delight, but witheld my confusion, hoping she wouldn't see it. She responded, however, with a mischievous smile, and said that for a change it was me who had to deal with being shocked, and that it made her feel strong to have read my writing without feeling she was doing something bad either to me or to herself. "In fact," she went on, "I'm enjoying the disturbed look on your face; there's something about it that makes me feel closer to you." She then reported having just read my latest paper, thinking about it, and experiencing an exciting insight about herself—as she put it, "without help from *anyone*." As I began to reply, I found myself aware of speaking from a strange state of mind in which I felt more like her patient than her therapist—a state that, uncannily, was as physical as it was mental. I was clearly not "myself"—at least not any of the selves I was accustomed to being when I was with her. Oddly, I wasn't anxious about the shift in our roles, and was even aware of feeling "held" by her self-confident recognition of what was taking place. In retrospect, I'm pretty sure that this was a part of why I hadn't been anxious—*it felt good*. Is this, I wondered, what she is like in her own office? If so, small wonder her patients get better. As I allowed myself to more and more "go with" my "unboundaried" feeling of intimacy, I could sense that my own sponaneity was being matched by a new level of spontaneity in her and that we were in fact experiencing aspects of each other's selves with an immediacy that had not before been

possible. When reflecting later on how much I had enjoyed the moment, I recalled a remark made by Haley (1993) about Carl Whitaker, whom Haley reported as having once said that "he most enjoyed a treatment session when he could say afterwards, 'I never did that before'" (p. 15).

The paper that Helen had read was "Playing with Boundaries" (Bromberg, 1999), an essay that included a personal vignette illustrating the normal ability of the human mind (in this case, my own) to go beyond the usual boundaries that define what we experience as "reality" and to hold multiple states of consciousness simultaneously if existing conditions are facilitating. The reported incident in the paper, which I called my "adventure of the oval room," took place during a hot August vacation in Rome. Rather than summarize the incident, let me simply quote from the paper:

> It is mid-afternoon. The art world, mercifully, has finally shut its doors, not to open them again for three hours. Back in my hotel room. Blessed relief. Lying on the bed, windows opened wide, the oval room filled with a breeze. From where? Definitely not from where I had just been! It did not exist out there, only in here, in my oval room. Let me tell you about this room. Being oval, it lacked corners, and lacking corners, it created for me an unusual physical state of being—a feeling of being part of a spaciousness that went beyond the actual size of the room. It evoked an almost "heady" sense of being held in limitless space, and imparted a bodily and psychological sense of wholeness and well-being. The personality of the room was not defined by the usual hard-edged physical boundaries that say "this is as far as you can go." My oval room was different, somehow; it gave no sense of being an "other" with its own requirements as to how far I could exist in any direction. I was in it and "of it" at one time. Being a corner room, it provided separate vistas through the windows, but because there was an unexpected absence of corners *in* the room, looking out of a window was also different from anything I have ever experienced. The room had three windows, each looking out upon a different view of the city, but because no window was located on a boundaried wall, when I looked through any one window I could feel the uncanny presence of the other vistas even if I could not visually "see" them. Though each piece of the "world out there" had its own boundaries, my personal space was not defined simply by these external

limitations. I felt at one with the oval sweep of the room that held me, and the outside felt as much created by my internal reality as by city planning. Unconstrained by normal barriers, I could "play" with boundaries and with reality [pp. 61–62].

"When I read it," Helen said excitedly,

I felt like I was in it myself. I knew what you were talking about because I could feel it. And I wasn't even scared. I could even feel that circles are *better* than squares. Corners stop you, so they're safe. If you can't go around the corner, you can't be hit by the flood of bad stuff that is waiting there to get you, so you have to start all over again each time there's a corner. It's like beginning life over and over a thousand times a day. But now I'm realizing that this is why I can't live my life. The corners stop me as though each moment is another ending. It protects me from the bad stuff that might be around the corner, but each time I start over I also lose what came before, so everything I do is for nothing.

But my real insight isn't just that; it's that I now understand why I'm always making pronouncements to you about how I'm going to be different—but never act on them. It's a way that, when I'm with *you,* I can get past the corner but still be me—the me that's safe. While I'm with you in a session, what's around the corner is safe because you're there; so I make a pronouncement about how I'm going to be different tomorrow because today isn't tomorrow. But then when tomorrow comes, I'm all by myself, and I can't remember ever feeling safe because the corners are really still there."

The Dizziness of Intersubjectivity

Attempting to talk about what happened during this session in terms of therapeutic action leads me to repeat my belief that its definition is tied to the uniqueness of each given analytic dyad and thus to the experience of unpredictability and surprise inherent in the moment-to-moment context that gives it shape. Why surprise? Reik (1936) suggested that there is no "royal road" to the unconscious, and, if there were, it would be discovered most vividly not in dreams, as Freud (1900, p. 608) suggested, but rather in the dizzying experience of

surprise, in that surprise allows an analyst to find something new that will then create its own technique. Translating Reik's insight into postclassical language, one might say that the road to the patient's unconscious is created nonlinearly by cumulative surprises, through the analyst's own unconscious participation in its construction while he thinks he is simply observing it. In this regard, Jessica Benjamin, in her 1995 book "Like Subjects, Love Objects," makes the valuable and interesting point that

> intersubjectivity refers to the capacity of the mind to directly register the responses of the other. It is affected by whether the other recognizes what we have done and is likewise charged with recognizing the other's acts. Whatever breakdowns in recognition occur, as they inevitably do, the primary intersubjective condition . . . is that of experiencing the dizziness *together* [p. 183].

The power of this session with Helen, I argue, was in fact located within the dizziness experience to which Benjamin referred—an experience Helen and I each had, in different ways, as we made contact through self-states that permitted a temporary suspension of our familiar "corners." In this same context, Benjamin (1995) drew on the work of the French philosopher Bataille[2] (1962), who pictured death as the ultimate reference point for the loss of boundaries between self and other. "Bataille's picture (1962, pp. 12–13)," Benjamin stated, "is paradoxical: individual islands separated by a sea of death—representing the ultimate oneness—which the isolates must cross to meet one another" (pp. 181–182). In Bataille's words, "Death opens the way to the denial of our individual lives" (p. 24). This then led Bataille to ask the penetrating question, the answer to which I believe determines how far a patient and analyst are ultimately able to go together: "Without doing violence to our inner selves, are we able to bear a negation that carries us to the farthest bounds of possibility?" (p. 25). How long can we hold the "dizziness" of intersubjectivity under stressful interpersonal conditions without having to dissociate some part of ourselves—what Benjamin (1995, p. 185) called "the

[2] I acknowledge my debt to Karol Marshall, who first pointed me in the direction of Bataille's writing, and whose two essays (1996, 1998) elucidating Bataille's philosophy have informed my awareness that that "the unthinkable is always at war with coherence, identity, thought, and theory" (Marshall, 1998, p. 7).

breakdown into complementarity of doer and done to"—so that other parts of our selves may live and so that, in the words of the poet Szymborska (1983, p. 116), "*non omnis moriar*, I shall not wholly die." What Bataille (1962, pp. 12–13) offered is no easy solution, but it does describe for me what feels most real in my own clinical experience. Bataille said, "I cannot refer to this gulf which separates us without feeling that this is not the whole truth of the matter. It is a deep gulf, and I do not see how it can be done away with. Nonetheless, we can experience its dizziness together. It can hypnotize us" (quoted by Benjamin, 1995, p. 182). I would say that this comes pretty close to the heady, hypnotic pleasure I felt in surrendering my fixed role as therapist, in suddenly experiencing a moment of intersubjective contact that had been foreclosed, in crossing a gulf that, as Bataille put it, "the isolates must cross to meet one another."

Reality, Affect Regulation, and Shame

How does this take place? What does it mean to say that the analyst "works" with dissociation? If the experiential self—the boy and his gorilla—is indeed dissociated, where is it located that you are not only "observing" it but are often speaking to it? My own answer is that the world of internal objects is as observable as that of real people, as long as the field of observation is defined as intersubjective rather than as simply interactive, and the analyst does not choose to avoid being pulled into the enactment of what is unsayable in words but exists as felt meaning. If the analyst does not avoid this, then the "observable" data are coming from the interface between the analyst's own shifting self-states and those of his patient. As an analyst, if you allow yourself to enter and participate in this field, you come to know the boy and his gorilla through what you are feeling, what you are thinking, and what you are doing, as long as you do not try either to mask or to minimize your *own* gorilla's part in its creation or try unilaterally to deliver meaning as if it were objective truth. A new kind of reality, a reality *both* "shadow" and "substance" (Bromberg, 1993), can then begin to take shape—a reality in which previously incompatible domains of self begin to coexist.

I don't take for granted the presence of intrapsychic conflict or even a patient's capacity to experience it, much less to reflect on it. Even for so-called good analytic patients, I believe that working in the

transference is a matter of the degree to which a patient is able to access aspects of self-experience that have been dissociated. For patients in whom the effect of trauma on the organization of psychic structure has been most pervasive, the reflective ability to work in the here and now is least likely to be there at the beginning. These patients tend to use each session to process the nonprocessible experience from prior sessions. That is, each session is a kind of commentary (through derivatives, dreams, and enactments) on the preceding session or sessions. The analysis often proceeds that way for a long period of time, with the analyst's job being to try to enable the processing to be safer and safer so that the patient's tolerance for potential flooding of affect goes up—that is, the threshhold for autonomic hyperarousal increases—so the patient can increasingly process, in the moment the full complexity of the transferential experience, in all its vivid "here-and-nowness," with less and less need for dissociative processes.

Muller (1996) wrote about a patient who self-mutilated by scratching into her wrist "the gang name of a biker boyfriend, oriented so that the name faced the viewer as if it were a tag claiming ownership of her body and its pleasures, an identity tag for her self as the object of someone else's desire" (p. 85). I argue that sadomasochistic relationships are, in general, a perfect example of dissociative self-definition. When a person is behaving either masochistically or sadistically with regard to an "other," the event often feels to the person, in the moment, as if it had a life of its own, because some aspect of the person's self is watching the event and experiencing it as if at a movie. The feeling is:

> I could stop it if I wanted to—I don't have to do this—he [the "other"] is right about how he is seeing me now, and I could acknowledge it if I chose to, but I can't or won't. If I did, it wouldn't be me. I would betray who I "am." If I were to think about what I am doing and reflect consciously on the other's reality of me, I would lose myself and have to become a different person.

Because trauma cannot be narratively represented in memory, traumatic experience is unsymbolized by language and therefore cannot be spoken "about" as material. Attempts to do so invoke a reliving of it as part of the "telling," which for the patient also involves the activation of intense shame that is typically dissociated to preserve

the bond with the analyst. One of the most difficult aspects of the clinical process, it makes the most demands on the relationship; the analyst is frequently unable to recognize the patient's high level of negative affect and shame because it is dissociated. The reason that seemingly "repeated" enactments are struggled with over and over again in the therapy is because areas of trauma are activated in the here and now, and the analyst is over and over pulled into the same enactment to the degree he is not attending sufficiently to the arousal of shame. The patient hears anything else the analyst is saying as though he is really meaning, "The pain you are experiencing now is no big deal; it is just from the past; what you feel now isn't really happening now," translated by the patient into, "You'll get over it; *I'm* not causing it." Even if the analyst is not feeling any of those things initially, the odds are that, sooner or later, he will be. If the analyst does not respond with genuine personal concern to the patient's pain at that moment, the patient will almost always experience his or her own pain as toxic to the analyst.

Nathanson's (1992) description of this therapeutic dilemma is worth considering here:

> When affect is piled on affect, one magnifying the other continuously, all in the context of a social or interpersonal situation forbidding surcease or solace relevant to the affects really involved, the resulting affect density can be unbearable [p. 424].
>
> Central to treatment is the understanding that the patient, stuck alone in the shame experience, is unable to return to normal interpersonal interaction unaided [p. 324].
>
> Therapeutic passivity—the decision to remain silent in the face of a humiliated, withdrawn patient—will always magnify shame because it confirms the patient's affect-driven belief that isolation is justified [p. 325].

This is Nathanson's way of describing the conditions leading to a dissociative solution to trauma, the "unbearable" quality of which is what we see in traumatized patients with symptoms such as "feeling like my head is going to explode from inside." It also speaks to patients who "disappear" during a session when what is being discussed touches unprocessed early trauma. They enact an interpersonal (therapist–patient) situation that mirrors the original event in which it was impossibile to manage the pain within the relationship (by fight, flight,

or negotiation), *before* the pain became unbearable and *before* they could no longer imagine (in Nathanson's words) "surcease or solace."

I'm going to end with a brief clinical vignette that I think will make this last point come more alive and that perhaps will also make clearer why I feel an inseparability between the therapeutic action of psychoanalysis and working with dissociation as a relational phenomenon. I've chosen this vignette precisely because the patient was not "classically" dissociative—that is, dissociation did not signal itself through dramatic symptoms but rather through the kind of characterologic patterns of relatedness with which we are all familiar.

James

James, an actor, was successful, highly intelligent, witty, and chronically depressed as far back as he could remember. He was also a man of great warmth, and I, as almost everyone in his life, was very fond of him even though in some ineffable way I wasn't sure I really knew him. He had been in analysis with me for about four years and had grown significantly during this time in both his personal and professional lives. As he was nearing the end of treatment—a seemingly mutual decision—he was telling me about a check he had unexpectedly received from his professional organization, which, besides having other functions, monitors films on television and makes sure that the performers whose movies are shown get paid each time they appear. As I was listening to James's story, I found myself toying with the fantasy of how great it would be if, every time he had a positive life experience to which our work together had contributed, his inner world would be monitored by this organization, and he would then automatically think about me. I wouldn't be exactly getting "residuals" on my successful interventions—but something not too far from that! Although this fantasy seemed humorous to me, even at that moment I could feel it connecting with something about him that wasn't funny, but I didn't know what it was. Yes, I was going to miss him when he terminated, but this felt like more than that—it had something to do with a need to stay alive in his mind after he was gone. So, I shared the fantasy with him and asked if he had any feelings or thoughts of his own that might relate to it. Haltingly, and with a degree of shame I had not seen in him before, he began to cry. He revealed that the need I just described feeling in myself was one he had lived with all his life—a need that was still there and that he had been too ashamed

to admit to anyone, including me. It could never change anyway, he said—it is simply a piece of childish irrationality, a wish to be so important that he could not be forgotten. Yes, we had talked about one level of it—his seemingly unquenchable need for fame and recognition—but he was always too afraid to reveal that part of himself that cried in bed at night because no one knew how alone and scared he was, and he was sure that no one would believe it if they did know, and, even if someone knew, he or she could never *really* know what it was like because he was so successful. He allowed that he was feeling more and more empty and cut-off as termination was approaching, but he said he believed that this was just a natural reaction to ending and he never would have said anything if I hadn't revealed my fantasy. He said that he told me about the residual check so that I would feel good about how much I had helped him be successful and so that, when he left, I would have good feelings about him. I allowed that I did feel good about how I had helped him be successful but said that my personal reaction to the story was more complex than just feeling good. I also felt something that I wasn't used to feeling—something that had been James's constant companion. I told him I felt that, when he left, I would somehow disappear because I would disappear from his mind forever, and I felt a need to keep that from happening by a fantasy in which he would be forced to think about me—like his own wish to be so important that he could not be forgotten. I said that it was as if, at that moment, I could feel in myself a bereft part of him that had never been able to speak in here, and perhaps this was the only way I could ever really hear that voice—by knowing, at least in a small way, what it personally felt like to look strong but to feel that I would disappear as soon as someone else didn't need me anymore. Needless to say, the "termination" phase continued longer than either of us anticipated, and it led to places that neither of us could have imagined before that session. James's gorilla had joined us in the room, more and more "really real" to James because James's gorilla at last became "really real" to *me and to my own gorilla.*

REFERENCES

Bataille, G. (1962), *Death and Sensuality*. New York: Walker.

Benjamin, J. (1995), *Like Subjects, Love Objects: Essays on Recognition and Sexual Difference*. New Haven, CT: Yale University Press.

Bromberg, P. M. (1993), Shadow and substance: A relational perspective on clinical process. In: *Standing in the Spaces: Essays on Clinical Process, Trauma and Dissociation*. Hillsdale, NJ: The Analytic Press, 1998, pp. 165–187.

——— (1994), "Speak! that I may see you": Some reflections on dissociation, reality, and psychoanalytic listening. In: *Standing in the Spaces: Essays on Clinical Process, Trauma and Dissociation*. Hillsdale, NJ: The Analytic Press, 1998, pp. 241–266.

——— (1999), Playing with boundaries. *Contemp. Psychoanal.,* 35:54–66.

Ehrenberg, D. B. (1992), *The Intimate Edge*. New York: Norton.

Fonagy, P. & Target, M. (1995), Understanding the violent patient: The use of the body and the role of the father. *Internat. J. Psycho-Anal.,* 76:487–501.

Freud, S. (1900), The interpretation of dreams. *Standard Edition,* 4 & 5. London: Hogarth Press, 1953.

Haley, J. (1993), *Jay Haley on Milton H. Erickson*. New York: Brunner/Mazel.

Harrison, K. (1997), *The Kiss*. New York: Random House.

Hazen, B. S. (1974), *The Gorilla Did It*. Hartford, CT: Atheneum.

Heimann, P. (1950), On countertransference. *Internat. J. Psycho-Anal.,* 31:81–84.

Jefferson, M. (1999), On having the grace to grow old, gracefully or not. *New York Times,* August 23.

Levenson, E. A. (1972), *The Fallacy of Understanding*. New York: Basic Books.

——— (1983), *The Ambiguity of Change*. New York: Basic Books.

Little, M. (1951), Countertransference and the patient's response to it. *Internat. J. Psycho-Anal.,* 32:32–40.

MacDonald, G. (1858), *Phantastes*. Grand Rapids, MI: Eeerdmans, 1981.

Marshall, K. (1996), Termination of an "infinite conversation": Post-structuralist literary figures, Greene, Blanchot and Bataille aid reflections on the last day of an analysis. Paper presented December, Northwest Center for Psychoanalysis, Seattle Washington.

——— (1998), Desire and/or Self: Reflections on "T*he Many Faces of Eros*" by Joyce McDougall. Paper presented November, International Federation of Psychoanalytic Education, New York City.

Mitchell, S. (1995), Response to Charles Brenner. Paper presented November, Columbia Association for Psychoanalytic Medicine, New York City.

Muller, J. P. (1996), *Beyond the Psychoanalytic Dyad*. New York: Routledge.

Nathanson, D. L. (1992), *Shame and Pride: Affect, Sex, and the Birth of the Self*. New York: Norton.

Racker, H. (1953), The countertransference neurosis. *Internat. J. Psycho-Anal.*, 34:313–324.

——— (1957), The meanings and uses of countertransference. *Psychoanal. Quart.*, 26:303–357.

Reik, T. (1936), *Surprise and the Psycho-Analyst*. London: Kegan Paul, Trench, Trubner & Co.

Rycroft, C. (1962), Beyond the reality principle. In: *Imagination and Reality*. London: Maresfield Library, 1968, pp. 102–113.

Safran, J. D. & Muran, J. C. (2000), *Negotiating the Therapeutic Alliance: A Relational Treatment Guide*. New York: Guilford.

Sullivan, H. S. (1954), *The Psychiatric Interview*. New York: Norton.

Szymborska, W. (1983), Autotomy. In: *Postwar Polish Poetry,* 3rd ed., ed. & trans. C. Milosz. Berkeley: University of California Press, 1983, pp. 115–116.

Tauber, E. S. (1954), Exploring the therapeutic use of countertransference data. *Psychiat*ry, 17:331–336.

Winnicott, D. W. (1949a), Mind and its relation to the psyche-soma. In: *Collected Papers: Through Paediatrics to Psycho-Analysis*. London: Tavistock, 1958, pp. 243–254.

——— (1949b), Hate in the countertransference. *Internat. J. Psycho-Anal.*, 30: 69–74.

——— (1958), The capacity to be alone. In: *The Maturational Processes and the Facilitating Environment*. New York: International Universities Press, 1965, pp. 29–36.

——— (1963), Communicating and not communicating leading to a study of certain opposites. In: *The Maturational Processes and the Facilitating Environment*. New York: International Universities Press, 1965, pp. 179–192.

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