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SOMETHING WICKED THIS WAY COMES
Trauma, Dissociation, and Conflict: The Space Where Psychoanalysis, Cognitive Science, and Neuroscience Overlap

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Even in routine analytic work, for what is dissociated to become symbolized and available to conflict resolution, a patient must experience sufficient interpersonal safety to free working memory while activation of unprocessed dissociated experience is taking place. The author proposes that this necessary synthesis of affective security and relational risk depends on what a given patient and analyst do in an unanticipated way that is safe but not *too* safe—an enactment of the relational failures of a patient's past while allowing "safe surprises" in the here-and-now to occur. Remarkable convergence is found between cognitive research (W. Bucci, 2003), neuroscience research (J. E. LeDoux, 2002), and an interpersonal/relational psychoanalytic approach that works at the interface of dissociation and conflict.

As I was making some preliminary notes for this article on trauma, dissociation, and conflict, the attack on the World Trade Center took place. I put the writing aside for a while, and when I came back to it, I realized I had to make a difficult choice. There was no way I could discuss the impact on my mind and my life, of the September 11th attack and the events that followed, without completely changing the focus of the article, which I did not want to do; and to simply allude to it felt like a preposterous trivialization of the horror. So, after much obsessing, I opted to not talk about it directly but to start my article with a memory from my childhood that can perhaps be heard as allegorical.

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When I was a kid, an endless source of fascination was looking out of my bedroom window at our backyard garden to silently observe the mysterious interactions between the animals, birds, trees, bushes, and flowers. But like the Garden of Eden, it received periodic visits from an infamous inhabitant of our neighborhood: a cat, who was referred to by everyone in the vicinity as Adolf (I was a World War II kid). Adolf was an aggressive, predatory, seemingly fearless animal, whose viciousness and mean-temperedness terrorized the other neighborhood cats as well as most of the dogs. I hated this animal totally and, I think, was somewhat afraid of him myself. Adolf would suddenly appear in our garden as if by magic—by magic, because it was a very well fenced-in area and we were never able to discover how he entered. What he seemed to enjoy most was climbing our fruit trees to see whether he could find a nest containing a baby bird or two to feast on. He seemed totally indifferent to the parent birds wildly flapping their wings and shrieking hysterically overhead (*way* overhead, I might add). In the animal world, he was sort of like the neighborhood bully.

One morning, as I was watching the action in the garden, I spotted Adolf. He was climbing stealthily up the trunk of an apple tree, clearly on his way to a nest. As he neared the top branches, two adult birds materialized, seemingly out of nowhere, and began to put on a performance that was nothing short of awesome. They were blue jays, and those birds gave new meaning to the word *tough*. Screaming, they swooped down on Adolf, reversing course inches from his head, precisely at the point beyond which Adolf's claws could not reach. I hadn't seen blue jays in our garden before this moment, nor had I ever seen them in action anywhere else, and, I suspect, neither had Adolf. Adolf and I were both in a state of shock, but for Adolf the shock was horrifyingly personal. Over and over the two jays repeated their dive-bombing until Adolf did what I had never before seen him do or believed he ever could do. He shinnied backward down the tree trunk, falling the final 8 to 10 feet, and began to run. But there was no escape. The two birds pursued him wherever he went, though he was now far from their nest. Neither the ferocity nor the precision of their aerial attacks showed any sign of diminishing, and their abrasive bird-curses became, if anything, even louder. To this day I can recognize a blue jay's call the instant I hear it, and I still love it. The sound has always reminded me of the strangely comforting rasp of a rusty clothesline pulley as the line was being yanked on by my mother. These guys were literally driving Adolf crazy, and I was cheering them on. He could not fight (because they were not reachable); he could not flee (because it was a fenced-in garden, and Adolf apparently had forgotten where his secret passageway was); and he could not hide (because they could find him wherever he was). It was then that I observed (though I didn't know it then) what I now realize was a remarkable example of dissociation as a defense against trauma—what Putnam (1992) has called "the escape when there is no escape" (p. 104). Adolf suddenly lay down right where he was and remained motionless. His body took on a strange, almost flaccid shape, and I began to wonder whether he had died of fright. The blue jays kept up their counterattack for a short while longer and then flew off. As I said, I hated this animal, and I was in no rush to help him if he was still alive. But I stayed at the window, probably somewhat numbed myself at seeing this feline terrorist reduced to mush. Was he dead?

No! Adolf, as if hit by an electric charge, suddenly sprang upright, fur standing on end, and took off to a far corner of the garden where he lay, shaking, behind a bush. As I look back on this now, I wonder what he was like after that incident. I have no recollection of him in the garden after that time, but I don't really know if that may be more of a wish than a reality. Did he develop a cat version of posttraumatic stress disorder? Maybe his memory loss for the location of his hidden tunnel was the first sign. I was probably too

young to hope he was plagued by flashbacks of blue jays, but that is neither here nor there. The point of this vignette is to make as vivid as I can the power of dissociation when used as a defense. It is a defense unlike any other defense. In human beings, it bypasses cognitive modulating systems and, as LeDoux's (1989, 1994, 1996) research powerfully demonstrates, is clearly anchored in an evolutionary response that is equivalent in survival priority to certain genetically coded response patterns of lower animals to a life-threatening attack by a predator.

The difference between dissociative experience in human beings and dissociative responses in nonhuman animals (including Adolf) is that humans are blessed (sometimes it feels more like cursed) with a self and with self-awareness. The similarity is of course in the role of the Darwinian survival need, but for humans, the highest survival priority is survival as a self. For lower animals it means primarily survival in the face of a potential threat to *biological* life. I think this accounts in large part for the fact that the emotion of fear is usually what is observed in traumatized animals and what is studied when using them as subjects. But for humans, selfhood (its cohesiveness, coherence, and continuity) *is* life, and the need to sustain it when it is in jeopardy obliterates all else. The emotions we find when we look at human trauma certainly include fear, but they are far more complex because they are products not simply of biology but of self-awareness. In our day-to-day work, we are painfully familiar with stories of suicide attempts—sometimes successful—in the face of potential (or actual) situations that are taken in as unbearable assaults on the felt core of what defines "who I am to myself." One might also wonder whether it is the perpetration of such assaults on the selfhood of another that comes closest to the essence of what we are trying to capture when we speak of "evil."

"By the pricking of my thumbs, Something wicked this way comes." This line, the last part of which I appropriated for my title, is cackled by one of the witches in Act IV of Shakespeare's (1606/1942) *Macbeth,* alluding to the unnatural certainty with which she, being a witch, could sense the arrival of impending evil before it got there. In this lady's case, as we know, her tingling thumbs worked perfectly. Macbeth showed up right on cue. But with most other people who attach this same kind of central importance to flawlessly reading the signs that "something wicked this way comes," it frequently speaks to a history of past traumatization—an indication that this individual has devoted a lifetime to vigilantly waiting for the proverbial other shoe to drop, so as to never be caught unprepared when it does hit. It is to these individuals that Emerson (1851/1945) speaks, in his short poem "Borrowing," when he writes:

> Some of the hurts you have cured,
> And the sharpest you still have survived,
> But what torments of grief you endured
> From evils which never arrived!

Indirectly, Emerson is addressing the ironic outcome of *successful* dissociation. As a protection against the repetition of early trauma, the most serious problem for the traumatized adult is the achievement of his own self-cure. The living present and the image of the future serve largely as warnings designed to protect him against trauma that has already occurred. The capacity for imagination is perverted into a way of making sure that the unanticipated quality of the unremembered original event cannot be repeated. By consistently mobilizing for disaster, the person is already prepared for it and his ego is set to master it. The experience is held as a terrifying, but retrospectively falsified, temporal

event. The nature of the fear is real enough, but the mind retains it as a dread of what can happen or is happening rather than as a memory of what *has* happened. The result is that the person, through continual enactment of the affective memory, creates a world of miniature versions of the original situation and lives in that world as a dissociated reality that continues to be substantiated through his ongoing relationships. It is as though he is not to be allowed any peace. Around each corner is potential trauma; peace is simply the calm before the storm, and nothing can convince him otherwise. The "fail-safe" security of his dissociative defense system makes certain of that.

Interestingly, dissociation, in human beings, is fundamentally not a defense but a normal hypnoid capacity of the mind that works in the service of creative adaptation. It is a normal *process* that can become a mental *structure.* As a process, it can become enlisted as a defense against trauma by disconnecting the mind from its capacity to perceive what is too much for selfhood and sometimes sanity to bear. It reduces what is in front of someone's eyes to a narrow band of perceptual reality ("whatever is going on is not happening to *me*"). As a defense against the *recurrence* of trauma, it creates a mental structure that serves as an "early warning system." Its key quality is its ability to retain the adaptational protection afforded by the hypnoid separateness of incompatible self-states, so that each can continue to play its own role, unimpeded by awareness of the others.

It is this early warning system that, regardless of diagnosis, I believe accounts for most of what makes us experience certain patients as "difficult"—patients who cannot "work in the transference"—and is also, I have argued (Bromberg, 1998c), the cornerstone of all personality disorders. For instance, Yoram Yovell (2000) in a recent article, discusses his work with his patient "Tara." "Like Freud's patients," Yovell writes,

> Tara did not want to talk about her history of abuse with me, and only reported it in response to a direct question during our initial consultation. Like Freud's patients, she was terribly ashamed of it, and her memories of it were patchy and disjointed. Whenever the subject would come up in therapy, Tara would feel "numb" and dissociate in my office. She would then often skip the next session. She is unwilling and probably unable to work overtly in the transference at this point in treatment. (p. 179)

It is my belief that a patient's so-called inability or unwillingness to "work in the transference," such as described by Yovell, is directly tied to the person's reliance on dissociation as a means of foreclosing potentially traumatic encounters with the mind of a needed other in the here and now—encounters that could threaten to trigger affective hyperarousal, including shame, without hope of regulating the affect through the relationship itself. It is this vulnerability to affective "triggering" (something found in every patient in certain areas of the personality) that in my view requires that analytic treatment embody a process that facilitates the growth of a patient's confidence in his sense of affective competency as the work progresses. Further, I suggest that this process depends, optimally, not on *avoiding* such encounters but on enabling a patient's here-and-now experience of them to be felt as more and more relationally trustworthy, making it possible for him to rely less and less automatically on dissociation as a proactive early warning system. Thus, as a clinician, I try to be as attuned as possible (often unsuccessfully) to those moments when my patient is experiencing his self-structure as not stable and sturdy enough to encounter the input from my subjectivity without it threatening to destabilize his experience of selfhood and thus increase dissociation to block the potential flooding of both shame and fear. Why both shame and fear?

The reliving with one's therapist of unprocessed traumatic affect from the past, such as fear, is almost always accompanied by a dissociated here-and-now shame experience.

The dissociated shame is triggered by the analyst's inevitable unawareness that his therapeutic "success" in bringing about the reliving is also bringing about, in the relationship with him, a reliving of the hunger for relief and soothing without a way to *directly communicate this hunger.* Why? Because the person whose behavior is creating the distress is also the person most necessary to relieve it, and in the patient's past this was unthinkable. The net result is that the shame of the hunger triggers its own dissociation. I say "directly communicate" because dissociated experience is indeed communicated, but through enactment, where its presence is first felt subsymbolically, to use Bucci's (1997b) concept. So, as with the original trauma, the person from whom the patient hungers for a soothing response (in this case, the therapist) is least likely to be the person to offer it on his own because he is also the person whose behavior (albeit inadvertently) is causing the pain. And in the act of trying to help his patient, the therapist inevitably relives with the patient the experience of placing him in a situation whereby their own relationship has become more affectively complex and dangerous than can be safely contained as internal conflict within a single state of consciousness. As long as the patient's dissociated shame caused by this unaddressed and unprocessed aspect of their enactment *continues* to remain unrecognized in the here and now, his dissociative mental structure remains in place and his increased ability to experience and resolve internal conflict is impeded.

What I am saying is that we constantly find ourselves engaging self-states kept apart from one another by dissociation and that a patient's ongoing subjective experience is frequently limited to a quite narrow range, where his mind is often incapable of experiencing intrapsychic conflict, much less processing and resolving it. The communication process between patient and analyst thus embodies what Bucci (1997b) might call a large "subsymbolic" component. It is this component that, from my perspective, is played out interpersonally through dissociated enactments—dissociated in both members of the dyad. Bucci puts it this way:

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

I am proposing that dissociation and conflict are interpenetrating aspects of human mental functioning—a perspective on the mind to which relational analysts such as Davies (1996, 1998), Harris (1996, 1998), Mitchell (1988, 1991, 1993, 2000), Stuart Pizer (1998), Donnel Stern (1997), and others have contributed centrally, each in his or her own way. In this context, let me say a few words about "enactment." What interpersonal–relational analysts call the unconscious communication process of enactment is, from my vantage point, the patient's effort to negotiate unfinished business in those areas of selfhood where, because of one degree or another of traumatic experience, affect regulation was not successful enough to allow further self-development at the level of symbolic processing by thought and language. In this light, a core dimension of the therapeutic process is to increase competency in regulating affective states without triggering the dread of retraumatization. But why is this so difficult to accomplish in treatment? Why don't analysts do it better and more consistently?

Philip Roth (1997) in *American Pastoral* writes, "You go to someone and you think,

'I'll tell him this.' But why? The impulse is that the telling is going to relieve you. And that's why you feel awful—[because] if it's truly tragic and awful, it's not better, it's worse" (p. 82). All too often, Roth is correct, and we all know it. "If it's truly tragic and awful, it's not better, it's worse." What I want to say to him is this: "Even though we still haven't completely gotten it right yet, Mr. Roth, we are definitely working on it, and I think we're making progress."

"If it's truly tragic and awful," the telling is not relieving because what is truly tragic and awful almost always is traumatic. It has a component that has been too overwhelming to be processed cognitively and is held, unprocessed, as negative affective memory (read "nondeclarative" memory or "procedural" memory). *The telling, therefore, is not relieving because the telling creates a reliving.* Traumatic experience, when "retold," is relived, and unless the shame generated by the process of telling itself is recognized and addressed, telling something truly tragic and awful, to use Roth's (1997) phrase, is not better, it's worse, because the part of self holding the shame remains dissociated and the patient feels even more hopeless than before. And yet, if we understand this, why is it still so difficult to find a solution?

> What will it take [for a trauma survivor] . . . to be reassured that the world won't go away, that there are antidotes for emptiness, that the past doesn't always have to swallow the future, that faith and trust are not toxic, lethal impulses, that demons can be undone or even reformed into friends, that the way to fill a home is not with furniture alone? (Rosenbaum, 2002, p. 152)

The problem lies in the fact that the dissociated horror of the past fills the present with affective meaning so powerful that no matter how "obviously" safe a given situation may be to others, a patient's perceptual awareness that *he himself* is safe would require a moment of consciousness that could potentially increase *self-reflective* capacity and thereby decrease reliance on dissociative hypervigilance—an outcome too dangerous to the patient's felt stability of selfhood. Still, why is this problem so hard to solve in treatment?

According to Kihlstrom (1987), "the key to consciousness is *self-reference*" (as cited in LeDoux, 1989, p. 281), and in order for what is dissociated to become symbolized in conscious awareness, "a link must be made between the mental representation of the event and a mental representation of the *self* as the agent or experiencer. These episodic representations . . . reside in short-term or working memory" (p. 281), and the question is, What makes it so difficult to link, in working memory, the dissociated reliving of something "truly tragic and awful" with a mental representation of the self as the agent or experiencer? There are many different vantage points from which answers might be offered, but an especially interesting one is suggested by neuroscience research, most notably the work of Joseph LeDoux (1989, 1994, 1995, 1996, 2002). When considered in conjunction with Bucci's cognitive research (Bucci, 1997a, 1997b, 2001, 2003) and my own clinical writing (Bromberg, 1994/1998a, 1996/1998b, 1998c, 1999, 2000a, 2000b), LeDoux's findings provide at the brain level an additional source of data, one that strikingly parallels Bucci's and my own observations and concepts and points to a remarkable convergence between cognitive and neuroscience research data and an interpersonal–relational psychoanalytic approach that works at the interface of dissociation, conflict, and self-state communication.

LeDoux (2002), in neurobiological terms, shows that the enigma of brain processes is related to the enigma underlying multiplicity of self. Because the human self is a multiple configuration of states as well as a functional unit (Bromberg, 1996/1998b), the more intense the unsymbolized affect is, the more powerful are the dissociative forces that are

preventing the linking of the isolated islands of selfhood, and the harder it is for episodic or "working" memory to represent the perceptual nature of the external stimulus or to access long-term memories. Consider in this light what LeDoux, a neuroscientist, has to say about the multiplicity of self:

> Though [the self] is a unit, it is not unitary. . . . The fact that all aspects of the self are not usually manifest simultaneously, and that their different aspects can even be contradictory, may seem to present a complex problem. However, this simply means that different components of the self reflect the operation of different brain systems, which can be but are not always in sync. While explicit memory is mediated by a single system, there are a variety of different brain systems that store memory implicitly, allowing for many aspects of the self to coexist. As William James (1890) said, "Neither threats nor pleadings can move a man unless they touch some one of his potential or actual selves." Or as the painter Paul Klee (1957) expressed it, the self is a "dramatic ensemble." (LeDoux, 2002, p. 31)

LeDoux's research points toward the fact that there are parallel, but functionally dissimilar, information-processing modes in the brain. The first, mediated by the brainstem and the limbic system, primarily the amygdala and hippocampus, is responsible for nonverbal encoding of emotion; the second, mediated by the neocortex, is in charge of verbal and representational symbolization of experience. How to get them to collaborate when they don't want to is the neuroscience version of the clinical question asked above: Why is it so difficult to link the dissociated reliving of something "truly tragic and awful" with a mental representation of the self as the agent or experiencer?

Ledoux (1996) describes what takes place in the brain more or less as follows: The amygdala assesses the emotional significance of incoming information, which it then passes on to areas in the brainstem that regulate the autonomic and hormonal systems. It then transmits this information to the hippocampus, whose function it is to integrate it with previously existing information and with cortical input. Under ordinary conditions of amygdalic arousal, the event is then processed by the hippocampus, which transforms the experience into a thinkable event by first "filing" it (van der Kolk, 1987) within cognitive schema to which it is linked. If all goes well, cortical symbolization increases, and a traumatic situation can more easily be distinguished perceptually from one that may contain certain similarities but is otherwise relatively benign (such as a stressful moment in therapy). But, as we know, all does *not* always go well.

High levels of stimulation from the amygdala, such as from emotional experiences that are "truly tragic and awful," interfere with hippocampal functioning. Traumatic experience, in other words, bypasses the hippocampus and is stored either somatically or as visual images that can return as physical symptoms or as flashbacks without cognitive meaning. *This is why, in neurobiological terms, very high levels of affect in a therapy session may prevent a here-and-now cognitive evaluation of the ongoing experience, and thus prevent the therapeutic process from linking the dissociated reliving of something "truly tragic and awful" with a mental representation of the self as the agent or experiencer.* In therapy, just as in real life, "feelings of fear come about when . . . working memory becomes occupied with the fact that the amygdala is active. Then we have some of the ingredients that turn an experience into a fearful experience" (LeDoux, 1999, p. 45). When this occurs in treatment (and it occurs inevitably), the sensory imprints of experience that are stored in affective memory continue to remain isolated images and body sensations that feel cut off from the rest of self. Because the hippocampus is not playing its necessary role in helping to categorize the incoming information, these elements of affective and somatic experience continue to lead an unintegrated existence, and when the

patient leaves the session, as Roth (1997) so poignantly described, "it's not better, it's worse."

Van der Kolk (1995) puts it that "physiological arousal in general can trigger trauma-related memories. Conversely, trauma-related memories precipitate generalized physiological arousal" (p. 45). This feedback loop creates a chronic readiness for trauma in which "the strength of the memories appear to be so deeply engraved that Pitman and Orr (1990) have called it the 'black hole' . . . [which] attracts all associations to it and saps current life of its significance" (van der Kolk, 1995, p. 45). Van der Kolk (1995) states further that "decreased inhibitory control may occur under a variety of circumstances: under the influence of drugs and alcohol, during sleep (as in nightmares), with aging, and after strong reminders of the traumatic past" (p. 49)—as during the process of psychotherapy itself. Both LeDoux and van der Kolk describe what is a likely physiological substrate for what I have portrayed in my own writing as the patient's readiness to find disaster around every corner (Bromberg, 1994/1998a, p. 260)—a backup system in the hippocampus that functions as what van der Kolk calls a "smoke detector," which, at the brain level, seems to account for the state of hypervigilant anticipation of trauma. It may help us to understand, biologically, why such individuals so easily manifest autonomic hyperarousal of affect in response to anything that can remotely be associated with the original traumatic experiences, and why certain patients' negative affect is more readily "triggered" by a therapist's misattunement.

Neurochemical evidence seems to indicate that the hormonal neurotransmitter serotonin plays the largest role in regulating the sensitivity of what I call the early warning system (and what van der Kolk terms the "smoke detector"). Early trauma creates a decrease in the serotonin level, which then interferes with the subsequent ability to modulate arousal and so produces hypersensitivity ("exaggerated" emotional reactivity) to seemingly mild stimuli. Such individuals, under pressure, often react as if they were being traumatized all over again by the therapy, leading to increased dissociative activity within the therapeutic relationship itself. Neurochemically, if the serotonin level is able to be increased, a patient will develop a higher threshold for "smoke" and be less likely to be triggered when there is no fire. Conversely, if *through the therapeutic relationship* the threshold for affective triggering is increasingly elevated, the patient will be more "able to achieve distance from the emotional impact of incoming stimuli and to use cognition [better]" (van der Kolk, 1995, p. 51), and one would expect that the serotonin level should also show corresponding elevation. Do I think this can be done through psychoanalytic psychotherapy? Yes I do.

As LeDoux (1999) emphasizes, when the amygdala is providing working memory with the affective input of fear—the emotional component of that which is "truly tragic and awful"—it does so implicitly, which is to say unconsciously. However, the dissociative process that keeps the affect unconscious is above all else a process that has a life of its own—a relational life that is interpersonal as well as intrapsychic, and is played out between patient and analyst in the dyadic dissociative phenomenon that we term *enactment.*

While the analyst is working, and absorbed cognitively, he begins to vaguely feel something a bit "off," something inside himself that is not yet connected by him to the patient's dissociated affect. He gets more and more uncomfortable without recognizing the source, and his own discomfort draws him, at least for a time, into a dissociative process of his own that shuts down the potential for an intersubjective connection in the moment. Eventually, if the analyst is sufficiently attuned to his own internal experience, he will emerge from the shared dissociative cocoon and consciously experience the "something

else" that is going on, without knowing what it is. As he begins to find a way to address it in the moment, with his patient, the work is then drawn into a potentially productive dialectic between the "here and now" and the "there and then." To be fully in the moment is, as Kihlstrom (1987) has stated, to be fully allowing new affective (as yet unprocessed) experience to interface perceptually and linguistically with episodic memory, thus optimizing its potential for symbolic integration into narrative memory and, ultimately, enriching self-narrative, the goal of any form of treatment. Bucci (2002), in a similar vein, conceptualizes this process as pivoting around whether changes take place in what she terms *emotion schemas*—specific types of memory schemas dominated by subsymbolic sensory and somatic representations. She presents an argument much like my own, that

> emotion schemas can be changed only to the extent that experiences in the present and memories of the past are held in working memory simultaneously with the pulses of core consciousness that depend on activation of the bodily components of the schema. . . . *The activation of the dissociated painful experience in the session itself is central to the therapeutic process. This is a very different perspective from the metapsychological principle that structure depends on the inhibition of drive or desire* [italics added]. (Bucci, 2002, p. 787)

It is no easy task to do clinical work from this perspective. Because of the relative absence of intersubjectivity during enactment, an analyst, regardless of theoretical persuasion, will often tend to concretize the event as something taking place solely within the patient, whereas the therapeutic leverage is always in the potential for negotiation between the patient's and the therapist's realities. The hope of analytic success depends on whether the shared processing of their respective experiences of the here and now will come to feel increasingly safer affectively for the patient, leading to a gradually more enduring capacity for experiencing and resolving internal conflict. These are the moments when the work in the transference becomes more and more possible and both analyst and patient start to derive their knowledge from verbal and nonverbal sources simultaneously.

Thomas Scheff (1989), whose writing bridges communication theory, sociology, and psychotherapy, asks a critical question: How shall a therapy best make progress toward growth while simultaneously maintaining the patient's experience of safety? His answer, which supports Helen Block Lewis's (1971) finding that "fully analyzed" patients who later developed "new" problems were shown to have the most shame pathology, is that when shame is evoked but not acknowledged, an impasse occurs that can lead to either a treatment collapse or a pseudosuccess. Scheff believes, as do I, that working within the here-and-now affective experience between patient and analyst is the most powerful context for growth, and that shame cannot be avoided as part of the process. The heart of the work, as I have already stated, is in watching for it so that when it occurs, the shame evoked by the therapeutic process itself can begin to be addressed in a relational context, and the traumatic affect held by a dissociated aspect of self can enter into the coconstruction of an intersubjective experience at the level of thought.

It is not necessary (or possible) to avoid encounters that might feel threatening to the patient. Anxiety and trauma are not the same, and there is a difference between being scared and being scarred. Trauma is followed by dissociation, but as Sullivan (1953) has stated, routine anxiety allows learning from experience because dissociation is not needed. "Severe anxiety," he wrote,

> probably contributes no information. The effect of severe anxiety reminds one in some ways of a blow on the head, in that it simply wipes out what is immediately proximal to its occurrence. . . . Less severe anxiety does permit gradual realization of the situation in which it occurs. (Sullivan, 1953, p. 152)

Sullivan used the term "severe anxiety" rather than the word "trauma," but what he clearly had in mind are experiences that are, in current terms, distinguished as being traumatic in nature. When *trauma* makes its presence felt, what is affected is not simply mental *contents* but the cohesiveness of mental *structure*—the very experience of *selfhood;* the affect evoked is not simply *unpleasant* but a disorganizing hyperarousal that threatens to overwhelm the mind's ability to think, reflect, and process the experience cognitively. An experience of affective dysregulation so great that it threatens self-survival by carrying the person too close to the edge of self-fragmentation and sometimes self-annihilation is no longer describable by the term "anxiety." A different word is required, and it is the term "shame" that, currently, is most often used to describe the affective flooding created by trauma—the horrifyingly unanticipated sense of exposure of oneself to oneself. Shame, as Helen Lynd (1958) writes,

> is the outcome not only of exposing oneself to another person but of the exposure to oneself of parts of the self that one has not recognized. . . . This comes about in part because one doesn't know how to fit shame into the network of other emotions with which it is interwoven. . . . It is as if a self of which we were not aware makes us unable to grasp the situation and to control what we do . . . when what is suddenly exposed is incongruous with, or glaringly inappropriate to, the situation, or to our previous images of ourselves. (pp. 31–34)
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> What is exposed in shame is *oneself.* I am ashamed of what I *am.* Because of this over-all character, an experience of shame can be altered or transcended only in so far as there is some change in the whole self. . . . It is pervasive as anxiety is pervasive; its focus, [however], is not a separate act, but revelation of the whole self. The thing that has been exposed is *what I am.* (p. 50, italics added)

In trying to communicate the experience to another person (such as a therapist), the effort to find language that conveys one's experience as a humanly recognizable affect is painfully difficult, and the closest a patient can typically come to "naming" it is that one part of the feeling, at least in the telling *about* it, is "shame." Lynd (1958) illuminates this situation as follows:

> Because of the outwardly small occasion that has precipitated shame, the intense emotion seems inappropriate, incongruous, disproportionate to the incident that has aroused it. *Hence a double shame is involved;* we are ashamed because of the original episode and ashamed because we feel so deeply about something so slight that a sensible person would not pay any attention to it. (p. 42, italics added)

Shame is, of course, the affect that signals a loss of personal identity—"I don't know who I am"—but in the context of retelling, the word fails to capture the full magnitude of the experience when one was threatened with traumatic loss of selfhood. It is only through its reliving (the last thing that a patient wants to face) that it can be known by an "other"—hopefully this time an "other" who will have the courage to participate in the reliving while simultaneously holding the patient's psychological safety as a matter of prime concern.

In the face of imminent de-personalization and collapse of selfhood, the mind falls back on its ultimate safety measure, what Frank Putnam (1992, p. 104) has called "the escape when there is no escape," its capacity for the defensive utilization of the otherwise normal process of fluidly and creatively withdrawing consciousness from certain aspects of immediate experience while enhancing other aspects. I am referring again to the process of dissociation—the hypnoidal unlinking of incompatible patterns of self-experience so that the domains of meaning that have been most adaptive to preserving sanity and

survival are preserved by preserving in uncompromised purity, the self–other modes of interaction that define them.

What was formerly a *configuration* of self-states that enabled the person to "feel like one self while being many" has becomes a *multiplicity* of selves without coherence (the most extreme form of which is labeled *dissociative identity disorder*), each now rigidly boundaried within its specific pattern of interpersonal engagement that gives it self-meaning. The hypnoid isolation *between* self-states gives personal identity a subjective sense of consistency and continuity *within* each self-state regardless of which has access to consciousness and cognition at a given moment, because the individual states are unlinked from one another so as to function when needed. The security of the personality has now become totally linked to a trauma-based view of reality. Some dissociated aspect of self is "on call" because the individual cannot *afford* to feel safe. Our work as analysts always involves enabling restoration of the links between these dissociated aspects of self to take place so that the conditions for intrapsychic conflict and its resolution can be present. The hermeneutic process of interpretation in psychoanalysis depends on these conditions being there, because repression cannot always be assumed to exist as a dynamism.

Consider, for instance, a patient I'll call William—a man of superior intelligence who, as a young child, had been humiliated as a sexual plaything by his older sister and survived the experience through major utilization of dissociation. As he grew up, he came to believe that the reason he did not have full use of his mind and could not think clearly was located in a genetic defect. As we began to look more closely at the relationship between his dissociative defenses and his feeling of cognitive haziness, the dissociative structure began to become less rigid. While still protesting that his mind was genetically incurable and that he had no feelings of any kind toward his sister, positive or negative, another part of him slowly began to take seriously the possibility that what he called his "intellectual inadequacy" might indeed be related to his having had to make certain, as a child, that his mind would never again be vulnerable to being flooded by more than it could handle and that his strange absence of feeling toward his sister might relate to that. But there was always another part of him watching, an aspect of self whose job it was to humor me but not take me seriously, while making sure that I never realized the horrible truth that I was just another well-meaning but intellectually limited fool. During this particular session, in the midst of protesting that not all intellectual inadequacy is due to psychological causes and that some people are simply stupider than others, William tried to underscore his point with what he believed to be humor—a one-liner that just "came to him" about the "village idiot who didn't know the difference between incest and arson, and so, sadly, set fire to his sister." Unlike previous occasions where he would stay concretely wedded to the literal meaning organized by a single state of consciousness, this time he "got it." He knew he was also speaking about *me.* And he got it without dissociatively "setting fire" to the potentially traumatic confrontation between us, a risk he acknowledged to be something he could feel as both exciting and dangerous.

The vignette represents a point in time when William's capacity to experience intrapsychic conflict had started to take hold and he was becoming more able to reflect on this shift. How did this happen? Let me quote once more from Bucci (2002):

> In the session, the threatening dissociated affect must be activated to some degree, but in trace form, regulated sufficiently so as not to trigger new avoidance, and with some transformation of meaning. The questions of how much and when to activate or to permit this activation, so as to repair the dissociation rather than to reinforce it, must be addressed specifically for each patient. (p. 787)

So, with regard to William, I ask again, "How did this happen?" What permitted William's ability to make the shift from dissociation to a capacity for intrapsychic conflict? (Bucci, 2002, pp. 767–768, asks, "What permits dissociation to be repaired?") My answer may or may not surprise you, but I have little doubt that his increased self-reflective competency was facilitated by my "interpretive" interventions during this phase, though I am using the word in a way that goes beyond its classical meaning.

I had for a while been verbally underscoring, in the here and now, those moments when I was most aware, sometimes even shocked, that William was *not* dissociating. I would comment openly, and with considerable affect, about the things I perceived and personally felt that suggested to me that in that moment he was feeling our relationship as more trustworthy and maybe even a bit safer than he had in the past. I also commented on how remarkable it felt to me that even though he was frightened, he was able to let himself stay in the moment despite moving into a dangerous area that could threaten the stability of our connection. This might not seem to be such a big deal, but it really was, because not so long ago the risk he felt of being emotionally overwhelmed and out of control was so great that the ability to live with an experience of "being frightened" wasn't even possible. It automatically would have triggered "his checking out" to keep our connection intact.

Unlike his response to my words *earlier* in treatment, during this phase, my words were mostly not felt as hollow, devoid of meaning, and immediately gobbled up by a dissociated enactment. I seemed to have a partner in the room with me who would listen—mainly with ambivalence—and more often than not would think about how my perception of things compared with his. It is my belief that this part of him—this "partner"—was best able to share an overlapping space with me when my words matched my perceptual/affective experience of our relationship as it existed at that moment in time, rather than my words being mainly carriers of ideas. When my spontaneous perceptions that matched William's state of mind were engaged by William's perceptions of the same event, then something new would happen—something not predictable from the past. Parenthetically, I might add that it was only from the shared affective/perceptual field that ideas were generated that began to link past and present in a way that felt right, rather than being just persuasive.

In an article on narcissism and the treatment of narcissistic disorders (Bromberg, 1983), I made use of the term "structuralizing interpretations," a concept formulated by Horner (1979). As a way of looking at the role of language in psychoanalytic growth, particularly in relation to the dialectic between conflict and dissociation, I find the concept especially useful because the analyst is speaking from a stance that is inherently experience-near, rather than struggling to hold a basically interpretive posture while trying to be *also* experience-near. The analyst speaks and listens from a perspective that views what has been traditionally called an ego defense as an expression of an alternative reality coming from a different "self-state" or self—a different part of who the patient *is.* As a way of hearing and relating to one's patient, the clinical impact is notable, because it addresses each self-state as standing for something valid, necessary, and perhaps even felt as required for survival. Most important, the analyst is aware that an alternative, seemingly unadaptive "way of being" may for the patient be a self-organizing necessity that is not "resisting insight" but is refusing to be "interpreted out of existence." As an analyst, I have found that this perspective makes me more aware of those moments when I am demonstrating favoritism to certain aspects of a patient's self (those I prefer) and neglecting other parts, some of which, for certain patients in particular, may be feeling what I am saying

as equivalent to an invalidation of their reason for existing without any wish on my part to hear what that reason is.

In William's case, this way of working helped him symbolize, in language, his growing capacity for affect regulation, making it something thinkable, without ignoring the feelings held by other parts of self that remain dedicated to preserving safety at any cost. In object-relational terms, one might say that I was affirming William's valid need for his existing self and object structure, rather than responding to the content through which the need for that structure was being expressed at that moment. Particularly during the difficult transition from dissociation to conflict, this way of relating helps a patient more easily reflect on his character structure as a functional part of his personality rather than a shameful piece of "illness" for which he is being blamed under the pretense of being helped. One could say that the message I was trying to get across to William was this: "I'm feeling you right now as more fully present in our relationship, and as starting to experience the difference between being frightened and being traumatized. Let me tell you, William, what that experience was like for me and what made me notice it."

I expect you will have observed that in illustrating the kind of thing I would say to William—about moving into a dangerous area that not so long ago would have triggered the felt risk of being emotionally overwhelmed and out of control—I did not try to attribute a psychodynamic meaning to the emotion. I stayed with the structural implications of the experience—the effect on his mind. It was not that psychodynamic possibilities didn't suggest themselves, such as murderous rage or out-of-control lust—meanings that might be heard in the "joke" about setting fire to one's sister. I've found that in working in the way that I do, dynamic interpretations of content will inevitably "invite" themselves to be made when the mind feels safe and, I might add, without the kind of intractable resistance one might typically encounter at such moments. So I rarely worry about neglecting the content and thereby "missing," for too long, an area of intrapsychic conflict that needs psychodynamic interpretation. Research support for this way of viewing clinical process is accumulating rapidly and speaks to a nonlinear relational theory of therapeutic action. The Boston Change Process Study Group has, in fact, come to the conclusion (Lyons-Ruth & Boston Change Process Study Group, 2001) that it is the process of communication ("implicit relational knowing") rather than the *content* of the communication that is the foundation for the therapeutic action of psychoanalysis. Fundamentally, what makes for personality growth, they conclude, is change in procedural memory—knowing *how* rather than knowing *that*—and contrary to the long-held axiom of classical theory about making the unconscious conscious as a necessary condition for change, "process leads content, so that no particular content needs to be pursued; rather the enlarging of the domain and fluency of the dialogue is primary and will lead to increasingly integrated and complex content" (Lyons-Ruth & Boston Change Process Study Group, 2001, p. 16). To let Philip Roth have his say once again:

> Since we don't just forget things because they don't matter but also forget things because they matter too much—because each of us remembers and forgets in a pattern whose labyrinthine windings are an identification mark no less distinctive than a fingerprint—it's no wonder that the shards of reality one person will cherish as a biography can seem to someone else who, say, happened to have eaten some ten thousand dinners at the very same kitchen table, to be a willful excursion into mythomania. (Roth, 1997, p. 55)

It may well be process rather than content, knowing *how* rather than knowing *that,* which accounts for such astounding differences in memory between "witnesses" to the same event. As Roth says, things can matter too much, and when they do, memory is

particularly state dependent. The state that organizes self-experience during a particular highly charged event also organizes its recall. A person will "remember" the event only in details that are compatible with that self-state and are consistent with maintaining its integrity. One person may have been a passive witness to the same event in which another was an active participant. What is remembered by each may have fundamentally to do with the degree to which dissociation was operating and the function it served. What Roth calls "the shards of reality" are pieced together to form not a snapshot of the event but part of a state-dependent personal biography—a self-narrative that is cherished as absolute truth.

A patient's shift from dissociation to conflict is a complex process in which realities that have been kept apart by discontinuous states of consciousness are gradually able to be held within a single transitional state of mind. This transitional state, which is often closer to a dream than to waking reality, permits the coexistence of opposites, and its "illogic" must be not only accepted by the analyst but also *engaged* as a valid relational context in its own right and not viewed as less "real" than any other, as if it were simply a way station to something healthier. I put it this way in a 1996 essay:

> A space for thinking between and about the patient and the analyst—a space uniquely relational and still uniquely individual; a space belonging to neither person alone, and yet, belonging to both and to each; a twilight space in which "the impossible" becomes possible; a space in which incompatible selves, each awake to its own "truth," can "dream" the reality of the other without risk to its own integrity. . . . How is this phenomenon possible? My answer, 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 experiences of incompatible self-narratives that were formerly dissociated. (Bromberg, 1996/1998b, p. 278)

Consider this in the context of Bion's (1962/1977) formulation of "reverie" as a state of mind in the mother "which is open to the reception of any 'objects' from the loved object and is therefore capable of reception of the infant's projective identifications whether they are felt by the infant to be good or bad. If the feeding mother cannot allow reverie . . . this fact will be communicated to the infant even though incomprehensible to the infant" (p. 36). Bion (1962/1967) further suggests that "the mother's capacity for reverie is the receptor organ for the infant's harvest of self-sensation gained by its conscious" (pp. 115–116).

Bucci's (1997a, 1997b) writing on "referential processes," which zeros in on this phenomenon from another angle, provides an important cognitive-research link between what I have called "intersubjective space" and Bion's (1962/1977, 1962/1967) work on "reverie," recently elaborated by Ogden (1997). Bucci writes:

> In addition to its function of linking subsymbolic systems to one another and to symbolic forms, the referential process has the further role of linking one individual's internal representations to another's, creating a new, shared referential space by this means. From its earliest development, the referential process, as applied to emotional experience, includes not only connections between one's own subjective state and overt expressions, but also connection between one's inner experience and the expressions of others. (Bucci, 1997b, p. 220)

I would like to conclude by elaborating just a bit further on what I feel is a potential interface between LeDoux's research into the experience of fear (LeDoux, 1989, 1994, 1995, 1996, 1999) and my own thinking about clinical process (Bromberg, 1998c, 1999, 2000a, 2000b). LeDoux (1989) suggests that

> if we can work out how representations of stimuli and their affective significance come to coincide in working memory, we may be well on the way to understanding how these then interact with representations of the self to generate emotional experience. (p. 282)

During enactments, what LeDoux (1996) calls the fear system is activated under safe (but not "too" safe) conditions, in which the analytic relationship inevitably repeats the failures of the patient's past but must do more than just repeat it. Something new must occur—something that has to emerge out of what patient and analyst do in an unanticipated way. I've called these unanticipated relational events "safe surprises," because it is only through surprise that a new reality—a space between spontaneity and safety—is coconstructed and infused with an energy of its own (Bromberg, 2000b, pp. 14–15). Edmund Burke (1757/1998) labeled this phenomenon as "safe shock" (see Edmundson, 1997):

> If the pain and terror are so modified as not to be actually noxious; if the pain is not carried to violence, and the terror is not conversant about the present destruction of the person- . . . they are capable of producing delight; not pleasure, but a sort of delightful horror, a sort of tranquility tinged with terror. . . . Its highest degree I call astonishment; the subordinate degrees are awe, reverence, and respect . . . distinguished from positive pleasure. (p. 30)

It is that thin line between the unanticipated but containable shock and the unanticipated but uncontainable shock that separates what is perceived as potentially traumatic from what is perceived as safe but "on the edge." The goal is for patient and analyst to "stand, together, in the spaces between realities" and move safely, but not *completely* safely, back and forth across the line (Bromberg, 1999, pp. 65–66).

Obviously, the impact of life-threatening or sanity-threatening trauma shouts for our attention and, justifiably, receives it. Who knows? Were I to live my childhood over, I might even find within me a wish to help Adolf. But our need to account for and understand the existence of dissociative pathology in the *absence* of the kind of gross invasion of mind and body associated with mental, physical, and sexual abuse or with the kind of sudden, unanticipated, and unspeakable horror to which we were subjected on September 11th is no less significant. "Perceptions to which another does not respond remain unknown, in the sense that they cannot be represented or formulated in the mind as experience, and are unthinkable by efforts at self-reflection" (Whitmer, 2001, p. 832)—the often undramatic but equally impactful trauma of living day in and day out in a family that systematically disavows the existence of a child's subjective experience and discredits the validity of that child's emotional states. The child is left without hope in what Nathanson (1992) terms an "interpersonal situation forbidding surcease or solace relevant to the affects really involved" (p. 424), and it is our job to help rebuild faith in self–other experience, regardless of how it came to be lost or compromised.

References

Bion, W. R. (1967). A theory of thinking. In *Second thoughts* (pp. 110–119). London: Maresfield Library. (Original work published 1962)

Bion, W. R. (1977). Learning from experience. In *Seven servants* (pp. 1–111). New York: Jason Aronson. (Original work published 1962)

Bromberg, P. M. (1983). The mirror and the mask: On narcissism and psychoanalytic growth. *Contemporary Psychoanalysis, 19,* 359–387.

Bromberg, P. M. (1998a). "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* (pp. 241–266). Hillsdale, NJ: Analytic Press. (Original work published 1994)

Bromberg, P. M. (1998b). Standing in the spaces: The multiplicity of self and the psychoanalytic relationship. In *Standing in the spaces: Essays on clinical process, trauma and dissociation* (pp. 267–290). Hillsdale, NJ: Analytic Press. (Original work published 1996)

Bromberg, P. M. (1998c). *Standing in the spaces: Essays on clinical process, trauma and dissociation.* Hillsdale, NJ: Analytic Press.

Bromberg, P. M. (1999). Playing with boundaries. *Contemporary Psychoanalysis, 35,* 54–66.

Bromberg, P. M. (2000a). Bringing in the dreamer: Some reflections on dreamwork, surprise, and analytic process. *Contemporary Psychoanalysis, 36,* 685–705.

Bromberg, P. M. (2000b). Potholes on the royal road: Or is it an abyss? *Contemporary Psychoanalysis, 36,* 5–28.

Bucci, W. (1997a). Patterns of discourse in "good" and troubled hours: A multiple code interpretation. *Journal of the American Psychoanalytic Association, 45,* 155–187.

Bucci, W. (1997b). *Psychoanalysis and cognitive science: A multiple code theory.* New York: Guilford Press.

Bucci, W. (2001). Pathways of emotional communication. *Psychoanalytic Inquiry, 21,* 40–70.

Bucci, W. (2002). The referential process, consciousness, and the sense of self. *Psychoanalytic Inquiry, 22,* 766–793.

Bucci, W. (2003). Varieties of dissociative experiences: A multiple code account and a discussion of Bromberg's case of "William." *Psychoanalytic Psychology, 20,* 542–557.

Burke, E. (1998). *A philosophical enquiry into the origin of our ideas of the sublime and the beautiful.* London: Penguin Group. (Original work published 1757)

Davies, J. M. (1996). Dissociation, repression, and reality testing in the counter-transference: The controversy over memory and false memory in the psychoanalytic treatment of adult survivors of sexual abuse. *Psychoanalytic Dialogues, 6,* 189–218.

Davies, J. M. (1998). Multiple perspectives on multiplicity. *Psychoanalytic Dialogues, 8,* 195–206.

Edmundson, M. (1997). *Nightmare on Main Street: Angels, sadomasochism, and the culture of gothic.* Cambridge, MA: Harvard University Press.

Emerson, R. W. (1945). Borrowing. In D. McCord (Ed.), *What cheer* (p. 321). New York: Coward-McCann. (Original work published 1851)

Harris, A. (1996). The conceptual power of multiplicity. *Contemporary Psychoanalysis, 32,* 537–552.

Harris, A. (1998). Psychic envelopes and sonorous baths: Siting the body in relational theory and clinical practice. In L. Aron & F. S. Anderson (Eds.), *Relational perspectives on the body: Psychoanalytic theory and practice* (pp. 39–64). Hillsdale, NJ: Analytic Press.

Horner, A. (1979). *Object relations and the developing ego in therapy.* New York: Jason Aronson.

James, W. (1890). *Principles of psychology.* New York: Holt.

Kihlstrom, J. (1987). The cognitive unconscious. *Science, 237,* 1445–1452.

Klee, P. (1957). *The diaries of Paul Klee 1898–1918.* Berkeley: University of California Press.

LeDoux, J. E. (1989). Cognitive-emotional interactions in the brain. *Cognition & Emotion, 3,* 267–289.

LeDoux, J. E. (1994). Emotion, memory, and the brain. *Scientific American, 270,* 32–39.

LeDoux, J. E. (1995). Emotion: Clues from the brain. *Annual Review of Psychology, 46,* 209–235.

LeDoux, J. E. (1996). *The emotional brain.* New York: Touchstone.

LeDoux, J. E. (1999). Psychoanalytic theory: Clues from the brain [Commentary on "Emotions as viewed by psychoanalysis and neuroscience: An exercise in consiliance," by Jaak Panksepp]. *Neuro-Psychoanalysis, 1,* 44–49.

LeDoux, J. E. (2002). *The synaptic self.* New York: Viking.

Lewis, H. B. (1971). *Shame and guilt in neurosis.* New York: International Universities Press.

Lynd, H. M. (1958). *On shame and the search for identity.* New York: Harcourt Brace.

Lyons-Ruth, K., & Boston Change Process Study Group. (2001). The emergence of new experi-

ences: Relational improvisation, recognition process, and non-linear change in psychoanalytic therapy. *Psychologist-Psychoanalyst, 21,* 13–17.

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

Mitchell, S. A. (1991). Contemporary perspectives on self: Toward an integration. *Psychoanalytic Dialogues, 1,* 121–147.

Mitchell, S. A. (1993). *Hope and dread in psychoanalysis.* New York: Basic Books.

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

Nathanson, D. L. (1992). *Shame and pride: Affect, sex, and the birth of the self.* New York: Norton.

Ogden, T. H. (1997). *Reverie and interpretation.* Northvale, NJ: Jason Aronson.

Pitman, R. K., & Orr, S. P. (1990). The black hole of trauma. *Biological Psychiatry, 26,* 221–223.

Pizer, S. A. (1998). *Building bridges: The negotiation of paradox in psychoanalysis.* Hillsdale, NJ: Analytic Press.

Putnam, F. W. (1992). Discussion: Are alter personalities fragments or figments? *Psychoanalytic Inquiry, 12,* 95–111.

Rosenbaum, T. (2002). *The golems of Gotham.* New York: HarperCollins.

Roth P. (1997). *American pastoral.* New York: Vintage.

Scheff, T. J. (1989). Cognitive and emotional conflict in anorexia: Reanalysis of a classic case. *Psychiatry, 52,* 148–160.

Shakespeare, W. (1942). Macbeth. In W. A. Neilson & C. J. Hill (Eds.), *The complete plays and poems of William Shakespeare* (pp. 1184–1212). Cambridge, MA: Riverside. (Original work published 1606)

Stern, D. B. (1997). *Unformulated experience: From dissociation to imagination in psychoanalysis.* Hillsdale, NJ: Analytic Press.

Sullivan, H. S. (1953). *The interpersonal theory of psychiatry.* New York: Norton.

van der Kolk, B. (1987). The psychobiology of the trauma response: Hyperarousal, constriction, and addiction to traumatic reexposure. In B. A. van der Kolk (Ed.), *Psychological trauma* (pp. 63–87). Washington, DC: American Psychiatric Press.

van der Kolk, B. A. (1995). The body, memory, and the psychobiology of trauma. In J. A. Alpert (Ed.), *Sexual abuse recalled* (pp. 29–60). Northvale, NJ: Jason Aronson.

Whitmer, G. (2001). On the nature of dissociation. *Psychoanalytic Quarterly, 70,* 807–837.

Yovell, Y. (2000). From hysteria to posttraumatic stress disorder: Psychoanalysis and the neurobiology of traumatic memories. *Neuro-Psychoanalysis, 2,* 171–181.