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Shrinking the Tsunami[1]

I begin with something personal–my mother's favorite story about me–a one-liner that took place when I was 4 years old. Even back then I was given to reverie states and while I was sitting next to her, silently lost in thought, I suddenly "woke up" and asked, "Mommy, when I was born how did you know my name was Philip?"

I'm still trying to figure it out. At 4, the concept of nonexistence had begun to interest me but I was still young enough to not worry about it. I simply knew I existed before I was born and I was trying to learn the details. There was no such thing as "nonbeing" much less the shadow of an abyss or a thing that grownups called "death." It was unthinkable; nonbeing had no personal meaning for me. Where was I before I was born? Wherever I was, Mommy must have been with me. There was no discontinuity in self-experience. For me, self-continuity had not yet been subjected to developmental trauma serious enough to tamper with it. Is that possible? Sure, but only to a degree, and only if we look at trauma not as a special situation but as a continuum that commands our attention only when it disrupts or threatens to disrupt the continuity of self-experience.

There are, however, certainly people for whom my little tale can have no meaning, people who in one way or another have had experiences, often terrifying experiences, of nonbeing. Even at the age of 4. Or earlier. For such people my question to my mother touches on a topic that is never to be touched on. Something inside them tells them

[1] An earlier version of this chapter, "Shrinking the Tsunami: Affect Regulation, Dissociation, and the Shadow of the Flood," was published in *Contemporary Psychoanalysis, 44*, 2008, 329–350.

that nonbeing is a real threat, that a powerful and terrible tsunami of chaotic and disintegrating affect lurks within.

If we accept that developmental trauma is a core phenomenon in the shaping of personality then we also accept that it exists for everyone and is always a matter of degree. If that is so, then the stability achieved by even secure attachment is also a matter of degree. That is to say, everyone is vulnerable to the experience of having to face something that is more than his mind can deal with, and the differences between people in how much is unbearable is what we work with in the large grey area we call "developmental trauma" or "relational trauma."

The "Giftie"

Robert Burns (1786), the Scottish poet, wrote, "Oh wad some Power the giftie gie us/To see oursels as ithers see us" (p. 44), but it is not all that easy to accept an image of yourself as seen through the eyes of an "ither," and it is especially hard when the other's image of you is based on what for you is a dissociated part of self–a "not-me." So whenever I hear that line of poetry, there is a part of me that feels like telling Burns to do you-know-what with his "giftie" and to be careful what he prays for.

Nevertheless, the giftie to which Burns refers is undeniably a developmental achievement even though using it involves a lifelong internal struggle, a struggle that includes those times you would like to return the giftie to the store for an exchange. But, irony aside, it may be the most valuable gift that any human being will ever receive–the gift of intersubjectivity.

When you are able to see yourself as others see you, while not dissociating from the experience of how you see yourself, you are relating intersubjectively. The problem is that a human being's ability to relate intersubjectively is variable, uneven, and sometimes requires what feels like having to stare at sunspots. For anyone, seeing oneself through another's eyes can become too stressful. Why? Because the other's view may feel too starkly discrepant with one's ongoing self-experience at the moment for both views to be held in mind simultaneously. When such is the case, the mind is geared to ease such stress by the defensive use of a normal brain process–dissociation. We are accustomed to thinking of dissociation as triggered by internal cues, but in fact the signal initiating the process typically comes from an

"other," no matter whether the other is another person or another pa of self. Regardless, overly disjunctive self-experiences are then adapta tionally held in separate self-states that do not communicate with eac other, at least for a while.

For some people, "for a while" means briefly; for others it means very long while or even permanently. For people in the latter group dissociation is not just a mental process to deal with the routine stres of a given moment but a structure that rules life itself by narrowin the range in which it can be lived. The mind/brain organizes its sel states as an anticipatory protective system that tries, proactively, t shut down experiential access to self-states that are disjunctive wit the dissociatively limited range of the state that is experienced as "me at a given moment. This rigid sequestering of self-states by means o dissociative mental structure is so central to the personality of som people that it shapes virtually all mental functioning, while for othe its range is more limited. But regardless of degree or range, its evo lutionary function is to assure survival of self-continuity by limitin reflective function to a minor role, if any. The mind/brain, by severel limiting the participation of reflective cognitive judgment, leaves th limbic system more or less free to use itself as a "dedicated line" tha functions as what van der Kolk (1995) calls a "smoke detector." It i designed to "detect" potentially unanticipated events that could trigge affect dysregulation.

Because it is a proactive solution, the diminished capacity for cog nitive self-reflection in favor of an automatized emphasis on safet comes with a price. It requires the person to, at best, "smuggle in a life that is secondary to a process of constant vigilance–a vigilanc that, ironically, mostly produces what information theory calls "fals positives." It might seem that, if such is the case, the person woul sooner or later figure out that there is a connection between somethin being wrong with his life and the fact that he spends most of it waitin for something bad to happen. The reason a person tends not to mak that connection is that the dissociative structure is itself designed t operate out of cognitive awareness. Each state holds a relatively non negotiable affective "truth" that is supported by its self-selected arra of "evidence" designed to bolster its own insulated version of reality. the person tries to reflect on the question, "Why am I living my life th way?" the potential for an internally destabilizing affective collisio between incompatible versions of personal reality is triggered. Even t formulate such a question is a threat to the integrity of the dissociativ mental structure that, to the mind/brain, is the only reliable safeguar

against affective chaos. Nevertheless, the question is asked at least indirectly, often out of desperation. Sometimes it leads the person to seek out a therapist, albeit with certain parts of the self denouncing the idea so ferociously that, by the time he arrives at your office, he may not be able to tell you why he is there.

Once in treatment, the fact that he or she is "of more than one mind" about being there leads to the enacted emergence of another question–and the ongoing struggle over allowing it to be put into words might be said to shape the entire course of the therapy. Implicitly, this second question might be seen as: To what extent is the protection against potential trauma worth the price paid for it? Initially, the question is played out in the form of an internal dispute among a patient's panoply of self-states, some championing affective safety, others endorsing what is life-enhancing even if it involves risk. This self-state war pulls the therapist/patient relationship into it, thus giving them a chance to participate enactively in a here-and-now externalization of the patient's fraught relationship with his own internal objects.

Shrinking the Tsunami

Enactment is a shared dissociative event. It is an unconscious communication process that reflects those areas of the patient's self-experience where trauma (whether developmental or adult-onset) has to one degree or another compromised the capacity for affect regulation in a relational context and thus compromised self-development at the level of symbolic processing by thought and language.[2] Therefore, a core dimension of using enactment therapeutically is to increase competency in regulating affective states. Increasing competency requires that the analytic relationship become a place that supports

[2]My preference is to limit the term *enactment* to the patient/analyst relationship even though this dissociative communication channel is indeed a fundamental and omnipresent aspect of all human discourse. I refer the interested reader to an astute and illuminating discussion by Tony Bass (2003) about this dilemma, in which he proposes a temporary means of differentiating the respective uses of the term in published papers by identifying its *clinical* usage through capitalizing the first letter of the word, as [E]nactment. This suggestion, not unlike the effort to distinguish "massive trauma" from "developmental trauma" by writing the former as "Big T" [T]rauma, addresses a pragmatic need but, as we both recognize, leaves the deeper questions still haunting us.

risk and safety simultaneously–a relationship that allows the painful reliving of early trauma, without the reliving being just a blind repetition of the past. It is, optimally, a relationship that I have described as "safe but not too safe" (Bromberg, 2006a, pp. 153–202), by which I mean that the analyst is communicating both his ongoing concern for his patient's affective safety *and* his commitment to the value of the inevitably painful process of reliving.

Fine phrases, but I am not the patient. For a trauma survivor, "safe but not *too* safe" initially has no meaning because relative safety as an *experience* has no meaning as subjective reality. For the trauma survivor, the shadow of the tsunami looms. Indeed, when I speak of "safe but not too safe" I am aware of a part of me that holds an unspoken sense of apology that is not dissimilar to what I felt when I came up with the title "Shrinking the Tsunami." I am pretty sure that if I had personally experienced an actual tsunami, close up, I would not have been able to use that word figuratively in my title. It would have hit too close to home. For a trauma survivor, language holds the potential to trigger an affective reliving of dissociated traumatic experience. By contrast, I was as free to play with the word *tsunami* as I was to play with the word *shrink*. In therapy, the growing ability to play safely with something that has so far existed only as a dissociated shadow of past trauma is what I mean by "shrinking the tsunami" and is what the rest of this book is mainly about.

I shall describe how, through interactions that constitute "safe surprises" (Bromberg, 2003b), a patient's ability to emotionally distinguish nontraumatic spontaneity from potential trauma (the shadow of the flood) is increased. I shall address here the transformation in analytic treatment of unthinkable "not-me" self-states into enacted here-and-now events that, in the form of safe surprises, can be played with interpersonally, compared with the analyst's subjective experience of the same event, and become part of the patient's overarching configuration of "me."

I offer the view that the transformative process of shrinking the tsunami not only leads to a greater capacity for affect regulation, but also is fundamental to the core of the growth process in psychotherapy, which for me has never been better described than by Ronald Laing (1967) in his phrase, "an obstinate attempt of two people to recover the wholeness of being human through the relationship between them" (p. 53).

The foundation of this growth process is an analytic situation that permits collisions between subjectivities to be negotiated. The

negotiation takes place through the creation of a shared mental state–a channel of implicit communication that supports what Buck (1994) calls a conversation between limbic systems (cited in Schore, 2003a, p. 276)–amounting to nothing less than the cocreation of a relational unconscious that belongs to both persons but to neither alone. The patient/analyst relationship becomes a therapeutic environment to the extent that the boundary between self and other becomes increasingly permeable.[3]

When I speak of the traumatic past of the patient being played out, the concept of play, as I use it here, is similar to what Philip Ringstrom (2001, 2007a) calls *improvisation.* It is a form of play in which the mutual recognition of each other's subjectivity is, in Ringstrom's terms, more implicitly played with than explicitly enunciated. His point overlaps with my concept of collision and negotiation (Bromberg, 2006a, pp. 85–150) and with Schore's (2003a) concept of state-sharing (pp. 94–97), but Ringstrom (2007b) underlines something additional that is worth repeating: "Improvisation often entails playing with the other as an *object* [because] when the two parties can play with one another as objects they intrinsically reveal something about themselves as *subjects.*" This is especially important because the collision part of what I call the process of collision and negotiation is, indeed, all about the developing capacity of patient and analyst to move from experiencing the other as an object to control or be controlled by, to being able to play with each other (although at first as objects). I believe it is this meaning of *play* that makes possible the negotiation that then leads to intersubjectivity–experiencing each other as subject.

For instance: I am committed to the value of the analyst's sharing with his patient his subjective experience of the relationship itself–including the details of his states of mind and his awareness of the shifts in mind/body experience that take place during a session. In my writing I have made a point of the importance of communicating to the patient one's personal concern with the effect on her of what one is doing, including the effect of the *sharing,* so that your patient knows you are thinking about her affective safety while you are "doing your job." Do I always remember to do that? No. Do I hear about it when I don't? Frequently! Do I like hearing about it? Not especially. But the more I can accept my patient's "giftie" of seeing myself through her eyes (especially those aspects of self I had been dissociating), the easier it becomes for my patient to negotiate the transition from experiencing me as an object to control or be controlled by, to experiencing me as a person who is committed to recognizing her subjectivity even though I am doing it badly at a given moment.

[3]My perspective here (see also Bromberg, 2007) resonates with Jessica Benjamin's (1988, 1995, 1998, 2007) formulation of "thirdness," which she describes as the shared process that opens up "the coexistence of opposites."

Alicia

Let me tell you about a session in which such a moment of transition was particularly vivid. Alicia was a woman who had achieved fame, financial success, and critical acclaim as a novelist but lived as a recluse. At the time she became my patient I had been a fan of Alicia's writing for many years and was also familiar with her well-known reputation for social isolation. What I was still to find out, however, was that her reclusiveness hid a shocking inability to engage in authentic discourse with another human being, a truly bewildering incapacity for authentic interpersonal communication. As an author, Alicia described social interactions with penetrating wit, sophistication, and a flair for the deliciously unexpected. The characters in her novels were clearly crafted by a mind that understood the complexity of human relationships, but, as I was to find out both from her and with her, in the few social interactions she could not escape (she of course refused book tours), it was an open secret that the very qualities that made reading her books such a delight, existed in face-to-face encounters only in their opposite form.

The early phase of our work was not easy for me. It was confusing and frustrating, and, because I had eagerly anticipated being with the stimulating person I knew through her writing, I also lived with a partly dissociated experience of disappointment–almost as if someone else had written Alicia's novels and I would never get to know her. In our relationship her personality was characterized by an unimaginative concreteness that informed everything she said, although she did not come across as unintelligent, nor did her literalness appear to stem from depression. The one-dimensional quality of her thinking and mode of relatedness was, as she herself put it, "just the way I am around people." It was not too difficult to recognize that her self-state as a writer was dramatically dissociated from her self-state "around people," though early on there was no clear route to addressing the discrepancy without both making her self-conscious and heightening

her concreteness. Which is to say, early on there was no clear route to free ourselves from what was being enacted.

Over time, the *processing* of enactment began to play an increasingly greater role in our work, and slowly the dissociative gap between her disparate self-states lessened. It became easier to recognize the presence of the "writer" in the way Alicia talked about herself in sessions even though the qualities of wit and playfulness that were so evident in her writing remained minimal in our direct interactions. Nevertheless, I found the change that was taking place so heartening that I told myself that the increase in coherence across her self-states was more stable than it was–and I got lazy.

In the session I describe here–a "moment of transition"–Alicia and I were once again participating in our enactment. As I had often done in the past, I shared with her my experience that something was feeling affectively "off"–something felt discrepant with what was being spoken in words. But unlike similar moments in which I had been careful to inquire about the impact of sharing my state of mind, this time I did not attempt to find out from each of Alicia's separate self-states what effect my act of self-revelation had on each. Even in the moment, I was slightly aware that part of the reason for my laziness was that I had been yearning for a chance to have a stimulating conversation with one of my favorite authors, and I was hoping to create the occasion by unilaterally deciding that she no longer needed me to treat her as if she was "just" a patient. As I ended my self-disclosure and readied myself for the hoped-for pleasure of a creative negotiation of our respective experiences, she replied with just a single sentence–a "one-liner" that was more than I could ever have hoped for. Alicia looked at me with a twinkle in one eye and a glare in the other and said, "I think you are starting to have delusions of *candor*." I broke up in laughter and so did she. There it was–spontaneity, wit, and feisty playfulness–emerging in a way that belonged to neither of us alone. It belonged to the joint creation of a relational unconscious that became infused with a life of its own–a joint creation that allowed my concept of "standing in the spaces" to become embodied as a physical (see Ogden et al., 2006) and interpersonal reality, a conjunction that invited us to play together with what was in both of her eyes, her twinkling eye and her glaring eye.

There is little doubt that this transition out of enactment, or rather through it, facilitated a powerful shift in my patient's capacity for spontaneous creativity in a relational context–an achievement that I believe provides direct support for the treatment model I am advancing. But,

if this is indeed such a great treatment model, why does such a shift take so long to appear? Why is the balance between safety and risk in working with enactments so difficult to achieve, and what makes the balance so unstable during the course of the analytic process? Although I cannot answer these questions with any great confidence, I think that the road is most brightly illuminated by understanding why such a patient's interpersonal capacity for creative spontaneity needed to be sacrificed in the first place and, once sacrificed, why the sacrifice needs to be preserved. This takes us back to the shadow of the tsunami and the threat to self-continuity.

Michael Cunningham (1998), in his brilliant novel about Virginia Woolf, *The Hours*, signals in two wickedly provocative lines that when the natural harmony between multiplicity and wholeness is disrupted, the safe boundary between creativity and madness must be protected: "Laura Brown is trying to *lose* herself. No, that's not it exactly–she is trying to *keep* herself by gaining entry into a parallel world" (p. 37, emphasis added).

In treatment, 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 own perceptual awareness that she is safe entails a risk that is felt as dangerous to her stability of selfhood. The risk is due to the fact that the safer she feels in the relationship the more hope she starts to feel, and the more hope she starts to feel the less will she automatically rely on her dissociative mental structure to assure hypervigilance as a "fail-safe" protection against affective dysregulation. Consequently, the parts of self that are dedicated to preserving affective safety will monitor and oppose any sign that the patient is starting to *trust* feeling safe but not too safe.

A dissociative mental structure is designed to prevent cognitive representation of what *may* be too much for the mind to bear, but it also has the effect of enabling dissociatively enacted communication of the unsymbolized affective experience. Through enactment, the dissociated affective experience is communicated from within a shared "not-me" cocoon (Bromberg, 1998a) until it is cognitively and linguistically symbolized through relational negotiation. In the early phase of an enactment, the shared dissociative cocoon supports implicit communication without mental representation. Within this cocoon, when the patient's self-state that is organizing the immediate relationship switches, the therapist's self-state also switches, equally dissociatively, to a state that over time can receive and react to the patient's dissociated state-switch.

Because mental representation is compromised by trauma, it is worth reflecting on Laub and Auerhahn's (1993) famous observation: "It is the nature of trauma to elude our knowledge because of both defense and deficit. ... [T]rauma also overwhelms and defeats our capacity to organize it" (p. 288). Traumatic experience may take the form of episodic memory, often inaccessible to the person except affectively, but it may also consist only of either somatic sensations or as visual images that can return as physical symptoms or as flashbacks without narrative meaning. Which is to say that the sensory imprints of the experience are held in affective memory and continue to remain isolated images and body sensations that feel cut off from the rest of self (P. Ogden, 2007). The dissociative processes that keep the affect unconscious have a life of their own, a relational life that is interpersonal as well as intrapsychic, a life that is played out between patient and analyst in the dyadic dissociative phenomenon that we term *enactment.*

The analyst's job is to use the enactment in a way that the patient's "not-me" experience can be given representational meaning as a shared phenomenon by enabling a perceptual link to be made in the patient's working memory between the dissociated experience and the here-and-now self as the agent or experiencer. The process begins by the "not-me" entering the here and now implicitly–through an affectively disjunctive event in the *analyst's* internal world occurring simultaneously as a reciprocal phenomenon linked to the patient's dissociated subjectivity.

What makes the process feel so unstable is that it is nonlinear. Enactments take place repeatedly, each time being processed a bit more. The reason for the seeming repetition is that a highly limited representation of trauma is the only kind of representation a traumatized person is likely to have at first, and each enactment can be considered an effort to symbolize further an episodic memory that slowly becomes cognitively representable in long-term memory (see Kihlstrom, 1987). The more intense the unsymbolized affect, the stronger the force that is attempting to prevent communication among the isolated islands of selfhood that among them hold separate realities vis-à-vis the past and how or whether to deal with it. For working memory to represent the unsymbolized aspect of the trauma during its dissociated reliving in an enactment, the analytic relationship must contain an interaction between two essential qualities–safety and growth. The patient's experience of the enactment must be one in which the shadow of the destabilizing affect is strong enough to be felt but not strong enough to *automatically* increase the use of dissociation (see also Bucci, 2002).

In distinguishing between traumatic affect and anxiety, Sullivan (1953) used the term *severe anxiety* rather than the word *trauma,* but what he had in mind are experiences that, in current terms, are understood as being so potentially destabilizing that they lead automatically to dissociation. The affect evoked by trauma is not merely unpleasant but is a disorganizing hyperarousal that threatens to overwhelm the mind's ability to think, reflect, and process experience cognitively. This is especially true of affective dysregulation that carries the person to the edge of depersonalization and sometimes self-annihilation. Continuity of selfhood is here most truly at risk, and it is here that shame most contributes its own terrible coloring.

Sudden shame, a threat equal to that of fear, signals that the self is or is about to be violated, and the mind-brain triggers dissociation in order to prevent a recurrence of the original affective tsunami. Shame that is linked to trauma is a horrifyingly unanticipated sense of exposure as no longer the self that one has been. Shame is not the affect associated with something bad that one has *done.* As Helen Lynd (1958) described it, "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" (p. 50). When trauma is relived in the here and now of analytic treatment, a patient's attempt to communicate the relived experience in language is painfully difficult because of what Lynd (1958) called a "double shame":

> 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)

One of the hardest parts of an analyst's job is searching out the shame that is evoked by the therapeutic process itself so that it can be addressed in a relational context. I use the phrase *searching out* rather than *being attuned to* because the shame is embedded in a here-and-now "shame about the shame" that most often leads to the entire shame experience becoming dissociated. To the degree the patient's shame is indeed dissociated in the here and now, the analyst is highly unlikely to notice it, especially when he is attending mainly to the patient's words. Thus, when working in areas where the reliving of trauma is taking place, the manifest absence of shame is a cue to search for its

whereabouts. Shame as part of the process cannot be avoided, and the essence of the analytic work is for the patient to know you are thinking about it. If he knows that you are, then, with you as a companion who is holding his dissociated here-and-now shame in your mind, he can make it back from the edge of the abyss because he has an "other" whose act of recognition can make possible the transition to self-reflection. To put it more succinctly, one might say that the goal in working with enactments is to help a patient recognize the difference between feeling *scared* and feeling *scarred.*

Clinically and neurobiologically, evidence is increasing that successful psychoanalytic treatment restores an impaired capacity for affect regulation through affective/cognitive communication between patient and therapist that facilitates the development of intersubjectivity. The importance of this to psychoanalytic "technique" becomes especially profound when we accept that repression as a psychodynamic resource cannot always be assumed to exist and that part of our work as analysts is to enable the restoration of links among sequestered aspects of self so that the necessary conditions for intrapsychic conflict and its resolution can indeed be present. That is to say, the effectiveness of conflict-interpretation is always tied to its dialectic relationship with affect dysregulation and dissociation.

Except for highly unusual occasions, the therapeutic reliving and cognitive processing of unsymbolized traumatic affect does not create an experience that is genuinely traumatic even though patient and analyst may both feel at times close to the brink (Bromberg, 2006a, pp. 92–95). What makes it not real trauma? The scenario is enacted over and over with the therapist as if the patient were back in the original trauma, which one part of the self is indeed re-experiencing. But this time there are other parts of the self "on call," watching to make sure that they know what is going on and no surprises occur, and ready to deal with the betrayal they are sure will happen. Through this enacted scenario the patient relives mini-versions of the original trauma with a hidden vigilance that protects him from having it hit without warning (the sine qua non of trauma). But for a seriously traumatized patient the experience is frequently one of being dangerously "on the edge."

Some of the most rewarding experiences in my own work are sessions when a patient becomes aware of his own dissociative processes and the function they serve. Such moments are almost inevitably unanticipated, and I believe this is because change always precedes insight. Here is an example of such a moment that may help clarify

why I place such emphasis on recognizing the here-and-now nonlinearity of the psychoanalytic growth process.

Mario

Mario had been extremely dissociative to the point that he was virtually unable to be present in the here and now with another human being. He had no idea of what it meant to engage with another person intersubjectively–to know the other through how he is experiencing the person experiencing him, and vice versa. Mario used his extraordinary ability to "size-up" people from outside his relationship to them and then related to them through what he had observed. Otherwise he was basically "mind-blind."

In sessions when Mario felt himself beginning to feel hopeful about finding new ways to relate to people, he would enter a self-state in which he experienced himself as an ugly, forbidding presence, and in this state he would divert me with a mantra about how his grotesqueness placed him beyond the pale of what would be acceptable, say, to a dating partner, much less a marital partner. Over time we came in the sessions to look at this self-state and the mantra that came with it as the core of an enacted response to having his shame and fear be insufficiently recognized by me. In one way or another he could feel that I was not attending to the importance of his need to protect himself against taking risks in a world of people with minds of their own and the danger of his being overwhelmed with shame if he were to relax his vigilance and trust that spontaneous interchange could be safe.

The following vignette took place many years into Mario's treatment, at a point where he was relying only minimally on dissociation as an automatic response and had developed, simultaneously, a greater capacity for self-reflection, spontaneity, and intersubjective relating. In this session, as though it were no big deal to him, Mario recalled that the previous night as he was getting ready for bed he had an insight into his mantra. It is noteworthy that this recollection came as a response to my having just voiced a blatantly self-confident pronouncement that his current anxiety about a woman with whom he was developing a friendship showed that he no longer had the "same old" problem with women, but that he was relating to this woman in a way that was very different. I told him that the kind of difficulty he was now having is part of the normal angst that everyone feels when they are trying to negotiate a new relationship. I added that I could feel his

presence when he was with her to be very "related" and that, regardless of what ultimately happened with this woman, I could feel that he had inside himself an ability to make dating a part of his life that was not fraught with dread. A rather pompous celebratory speech like that would typically have evoked Mario's self-state mantra of being so grotesque and so ugly that no one would ever want him as part of a couple, and I had the thought that I should probably curb my enthusiasm. But I was not *feeling* wary of triggering that self-state switch. It was as if somehow we were sharing a new piece of affective turf that did not yet have words–just a shared willingness to take a risk in what we could say to each other that had not been possible before. Strangely, although my words struck me as remote I was not feeling unrelated.

After a silence, Mario replied by telling me about the insight he had had the night before. He had been thinking about this girl and whether or not to call her. As he was about to get into bed, he found himself starting to repeat his mantra and realized that he did not want to say the mantra because it felt false. He recognized that he was anxious about calling this girl and that the effect of his mantra was to put him into a trance state that let him eliminate the anxiety, a necessity if he was going to be able to fall asleep. Mario then realized that by means of his mantra he made his self-image of grotesqueness more and more horrible as he repeated it, until he dissociated in order to escape it. Once he dissociated, he could then fall asleep because the anxiety about a potential phone conversation in the real world would not keep him up all night. For *me* this moment with Mario qualified as a safe surprise; I had never before been made privy to how Mario used his mantra when he was alone.

Mario's use of his mantra was equivalent to someone who stares at a spot on the wall until his eyes glaze over and he goes into a "safe place" inside himself. Rarely had I heard so clearly a formerly dissociative patient identify this particular type of self-abuse as being in the service of self-soothing by triggering a dissociative trance state. Although it has obvious similarities to binging and purging and self-mutilation, I think it is sometimes difficult for a therapist to recognize this form of trance-induction as a means of self-soothing because it is so easy to look at its quality as simply self-destructive or as obsessive-compulsive rumination.

The relationship between dissociation and right-brain to right-brain state-sharing has such a powerful impact on the patient/therapist relationship that Schore (2003b) writes that "dissociation, the last resort defensive strategy, may represent the greatest counterforce to effective

psychotherapeutic treatment of personality disorders" (p. 132). Mario was surely an example of this, but I want to emphasize that Schore simultaneously sees dissociation as a *communication process* whereby right-brain to right-brain state-sharing becomes the pathway to facilitating the very therapeutic process in which, as a defensive strategy, it represents a counterforce. He (personal communication, 2007) argues, as do I, that the sharing of mental states that are essentially private is what psychotherapy is all about, and I think that both Mario's and my own ability to take a risk at that moment is a really nice example of it.

Within a shared mental state, the frozen attachment patterns that help a patient adapt to early relational trauma become available to be experienced conjointly and processed cognitively and linguistically in a shared mental space. As this takes place, each reenactment permits a negotiated degree of intersubjectivity to develop, which is what makes the nonlinearity of reenactment not simply a process of repetition. As the nonlinear cycles of collision and negotiation continue, a patient's capacity for intersubjectivity slowly increases in those areas from which it had been foreclosed or compromised. The potential for the coexistence of selfhood and otherness becomes not only more possible, but also gradually begins to take place with greater spontaneity, with less shame, and without affective destabilization.

The complementarity between Schore's formulations and mine includes our mutual emphasis on the discontinuity between states, the nonlinearity of state changes, and the all-important fact that, as Schore (2003a) puts it, "discontinuous states are experienced as affective responses" (p. 96). Elaborating, he writes:

> Dynamically fluctuating moment-to-moment state-sharing represents an organized dialogue occurring within milliseconds, and acts as an interactive matrix in which both partners match states and then simultaneously adjust their social attention, stimulation, and accelerating arousal in response to their partner's signals.... [M]inor changes, occurring at the right moment, can be amplified in the system, thus launching it into a *qualitatively different state.* (p. 96, emphasis added)

The relationship between dissociation and state matching is especially notable in patients with a history of Disorganized/Disoriented (Type D) Attachment, a point originally made by Hesse and Main (1999) and expanded on by Schore (2007):

> [T]he disorganization and disorientation of type "D" attachment associated with abuse and neglect phenotypically resembles dissociative states. . . . During episodes of the intergenerational transmission of attachment trauma the infant is *matching the rhythmic structures of the mother's dysregulated arousal states.* (p. 758, emphasis added)

Matching the rhythmic structure of the other (synchrony) has long been a basic technique of hypnotic induction. I discovered this relation between synchrony and dissociation first hand while working with a patient, Gloria, who, incidentally, during the course of her long history of searching for the "right" therapist had studied with Milton Erickson.

Gloria

Gloria had for some time been one of my "favorite" patients–someone with whom I felt so wonderfully tranquil and at ease that I was not aware of anything amiss until one session when I was uncomfortably conscious that I did not feel like asking her about something I knew I should be addressing and that I knew she would not want to think about. At that point I began to emerge from the dissociative cocoon in which Gloria and I had jointly been held, and for the first time I became aware, *perceptually*, of something else–something right in front of my eyes: Whenever I changed my body posture, Gloria changed hers to mirror it.

Why did I not see this sooner? Gloria was someone whose way of life was characterized by doing things for other people and was so powerfully attuned to the other with seemingly total satisfaction that she appeared to be without self-interest. Her seemingly pleasurable adaptation to others came across as characterologically seamless. Indeed, I found it to be a hollow intellectual exercise whenever I tried to address with her the possibility of her attunement to others being at least in part self-protective and that another part of her might have more information about this.

In this session, however, it was the very pleasure I felt in her synchronizing her rhythmic structure to mine that began to feel oddly uncomfortable. This type of discomfort has been aptly described by Donnel Stern (2004) as an "emotional 'chafing' or tension, an unbidden 'hint' or 'sense' that something more than one has suspected is going on in the clinical interaction" (p. 208). Once an analyst starts

feeling this, something new becomes *perceptually* noticeable that has been dissociated, and he finds himself thinking about the patient along certain lines that would have once felt forced but now feel authentic even though not well formulated. In Gloria's case, what finally came into focus for me was that more often than not she was unable to feel satisfied that she had done enough for the other and thus she could never quite appreciate her own generosity. What had seemed to me simply like dedication to the needs of others now began to include a compulsive element that spoke to a dissociated component. I began to look differently at the fact that the other person's needs dominated every interaction and were all that seemingly mattered to her. In time, so did she.

Saving Hamlet's Butt

I'm going to end this chapter with a clinical vignette–well, it's kind of clinical–that addresses the vicissitudes of shrinking the tsunami. It's a scene from Shakespeare's (1599–1601) *Hamlet* that also illustrates Schore's concept of state-matching as portrayed by the relationship between Hamlet and his friend Horatio. You shall see in a moment why I whimsically call this vignette "Saving Hamlet's Butt."

Hamlet, midway through the final act of the play (V, ii), reveals a secret. It is a secret that most of us who spend time at the gym would prefer remained so–that no matter how much you work out, eventually your butt is going to drop anyhow. Shakespeare, of course, puts it more poetically: "There's a divinity that shapes our ends, rough-hew them how we will."

In this scene, Hamlet has reached the end of his rope and is explaining to his friend Horatio that the reason he hasn't yet killed his uncle isn't his fault. What he says, in essence, is that we do not always succeed in following through on our plans because a higher power–a divinity–has a different agenda. At that moment, Hamlet becomes to me more recognizably human than at any point before or after. It does not have to do with whether I do or do not believe in a divinity the way Hamlet put it. It has to do with the great timing of his spiritual awakening, and with the old saw that there are no atheists in foxholes.

By the time Act V gets under way, Hamlet is a guy under a lot of stress. And why not? The play is almost over, he still hasn't taken action, and his ruminating about it is bringing him closer to the edge of madness. What to do? He has no prescription for Paxil, and everyone

around him has personal axes to grind except for Horatio. Horatio takes him seriously but is so even-handed that it is not easy to see exactly what good Horatio is doing him. What to do is certainly not obvious, but even so, Horatio's role invites us to look at him the way a therapist without a treatment plan is looked at by a managed-care company. To take action, Hamlet needs to free himself from the obsessing that has robbed his desire of what he calls "resolve." Horatio has no treatment plan.

But Shakespeare finds Hamlet a nifty solution–an insight into God that comes to him just at the right time. It has been said that Harry Stack Sullivan (1953) used to call those kinds of user-friendly insights "happy thoughts" because they solve the most painful dilemmas with astounding ease. Hamlet can now suspend his self-recrimination long enough to act. He has an external explanation–a "not-me" explanation–for the disturbing fact that no matter how much we sweat, our ends seem to have a will of their own. Maybe the bottom line, argues Hamlet, is that it's God's will–it's surely not *mine*!

"Yeah," says Hamlet. "It's not *me* that's the problem. It's 'not-me.' *I* want to kill Claudius. It's not *me* that gets in the way." And here the divinity enters with a plan of its own. Now, freed by the divinity from the tormenting impossibility of trying to turn an affective tsunami into something "thinkable"–internal conflict–Hamlet feels a sense of personal resolve in his wish to kill Claudius, a resolve that has been lacking. His formerly pale desire is now felt in color. What he calls its "native hue of resolution" has returned and lends an unquestioned purity of purpose to his taking action.

If you think about it, Hamlet's tendency to find "not-me" solutions was there right from the beginning of the play. Whose idea was it to kill Claudius in the first place? Not Hamlet's. It came from the ghost of his father. And his subsequent misgivings about it are not really felt as his either–they are felt as nameless flaws in his character that he cannot control.

Talking about "me" and "not-me" helps to make dissociative processes understandable as part of the human condition. Faced with a shadow that holds the potential to become a flood, the mind recruits its self-states into a covert survival team. Its members are aware of one another only on a need-to-know basis and they exercise their skills through their insulation from each another. Each self-state has its own task and is dedicated to upholding its own version of truth. Each is a piece of a larger-than-life enterprise designed to sequester the part of self that already knows the horror of a tsunami and then to obscure

the existence of the dissociation itself. A hypnoid brain process takes over whereby, in Laing's (1969) brilliantly convoluted language, we are unaware there is anything of which we needed to be unaware, and then unaware that we needed to be unaware of needing to be unaware.

Hamlet was no different in that regard. What was felt as "me" at one moment was "not-me" when a different self-state took over. To each "me" there were no opposing parts of self, so at any given moment he was haunted by the states that could not find a place in "me" for their own voices and desires. Hamlet had no place to hide. His torment had no resolution because his mother and his uncle were always in his face, and the disharmony of voices in his head would not leave him alone, even in bed at night. Shakespeare's choice of words in Hamlet's incredibly contemporary description of what trauma sufferers describe as "the war inside my head" echoes loudly for any therapist: "Sir, in my heart there was a kind of fighting that would not let me sleep" (V, ii, lines 5–6).

Notwithstanding all his self-reproach, Hamlet was unable to experience internal conflict about any of it, and in this regard his mental functioning is typical when self-state collisions are too much for the mind to bear and cannot be contained in a single state of mind. But I want to make it clear that I am not suggesting we are all just versions of Hamlet. Difficult self-state collisions are inherent to routine mental functioning and we are all vulnerable to affect dysregulation that has the potential to increase under certain circumstances. I see Hamlet's situation as an example of the power of early developmental trauma to make adult-onset trauma especially "massive" for some people and less so for others.

The murder of Hamlet's father was what we could reasonably call an adult-onset trauma that became affectively "massive" because it triggered earlier developmental trauma, doubtlessly involving his mother and father both. Hamlet's plan to kill Claudius was doomed to be no more than a temporary stop-gap because, like all one-sided dissociative solutions, there was another internal voice–another "not-me" that gave him no peace–and there was nothing to weaken the power of the dissociative gap between the voices.

So here's the point: Despite the fact that we are not simple versions of Hamlet, I do believe that the following is true for all of us. *It is impossible to permanently avoid an internal war between adversarial parts of the self simply by trying to increase the degree of power held by only one part.*

For everyone, there is a downside to dissociation when it is enlisted as an anticipatory defense. The person is able to more or less survive but is also more or less unable to live, and this is especially true for someone suffering the kind of emotional overload that Hamlet was facing while trying to keep intact the thin membrane separating developmental from adult-onset trauma.

Was Hamlet crazy? That is, psychotic? Opinions vary, and most of the play's main characters are pretty sure he was. My own view is that he was not, despite his enlisting a group of actors to create a "more real" reality for him. I would say that he was close to the edge but that Shakespeare "saved his butt" by giving him someone to talk to who listened–Horatio.

Although Horatio did not say anything like, "This must be awful for you," he was fully listening and was very responsive to Hamlet's state of mind. This is why Hamlet and Horatio are a good fit for Schore's concept of state-sharing as the foundation for therapeutically addressing affect dysregulation. When Hamlet was confronted by his father's ghost, Horatio did not say, "His *ghost*? I'm afraid I didn't see it. Perhaps we might look at what it might mean that you saw it." Nor did he suggest that Hamlet's sudden turn to religion might be worthy of comment. In fact, Horatio didn't talk a lot, and it is possible to view what he said when he did talk as no more than a caricature of, "That's interesting; tell me more about it!" From my reading of the dialogue between them, I would argue that it went far deeper. I suggest that Hamlet's relationship with Horatio was the main factor keeping the shadow of the tsunami from overwhelming Hamlet's mind even though he could not ultimately avoid death. Horatio's consistent ability to match Hamlet's state with a reciprocal state of his own calmed Hamlet enough to allow him to go forward.

Developmental trauma is a core relational phenomenon and invariably shapes personality in every human being. It contributes to every human being's potential for affect dysregulation, which is always a matter of degree even in those for whom secure attachment has led to relative stability and resilience. We all are vulnerable to the unanticipated experience of coming face to face with our own "otherness," which sometimes, albeit temporarily, feels more "not-me" than our minds can deal with. This is part of the human condition. The big difference between people is the extent to which the sudden affective hyperarousal touches an area of unprocessed developmental trauma and is not only unpleasant, but mentally *unbearable* and thus

unavailable to cognition. The risk of this happening is a central aspect of working with enactments. I argue that *for all patients*, regardless of how minimal the scope or duration of the vulnerability, enduring personality growth in analytic treatment is interwoven with the ability of the patient/analyst relationship to increase a patient's threshold for affective hyperarousal. This use of the patient/analyst relationship takes place through the nonlinear joint processing of an enacted (dissociated) communication channel in which the patient's fear of affect dysregulation (the shadow of the tsunami) is "shrunk" by the broader ability to safely distinguish the likelihood of mental shock that could indeed be affectively overwhelming from the kind of excitingly "edgy" experiences that are always interwoven with the risk of spontaneity. The patient's fear of dysregulation, as it is relived in the enacted present, becomes increasingly containable as a cognitive event, thus enabling the mind/brain to diminish its automatic reliance on dissociation as an affective "smoke-detector."

I believe that the transformative process of shrinking the tsunami is fundamental to the depth of the analytic growth process itself, and that it derives its power from the coexistence in the analytic relationship of two essential qualities, safety and risk. Through the creation of a dyadic space that includes the subjectivities of both patient and analyst but is not the exclusive property of either, the patient/analyst relationship becomes a therapeutic environment by being "safe but not *too* safe." As long as the analyst's ongoing commitment to doing the "work" involves an effort to communicate his being simultaneously concerned about his patient's affective safety *while* working, the coexistence of safety and risk becomes the essential element of therapeutic action that makes the reliving part of a growth process rather than a blind repetition of the past.