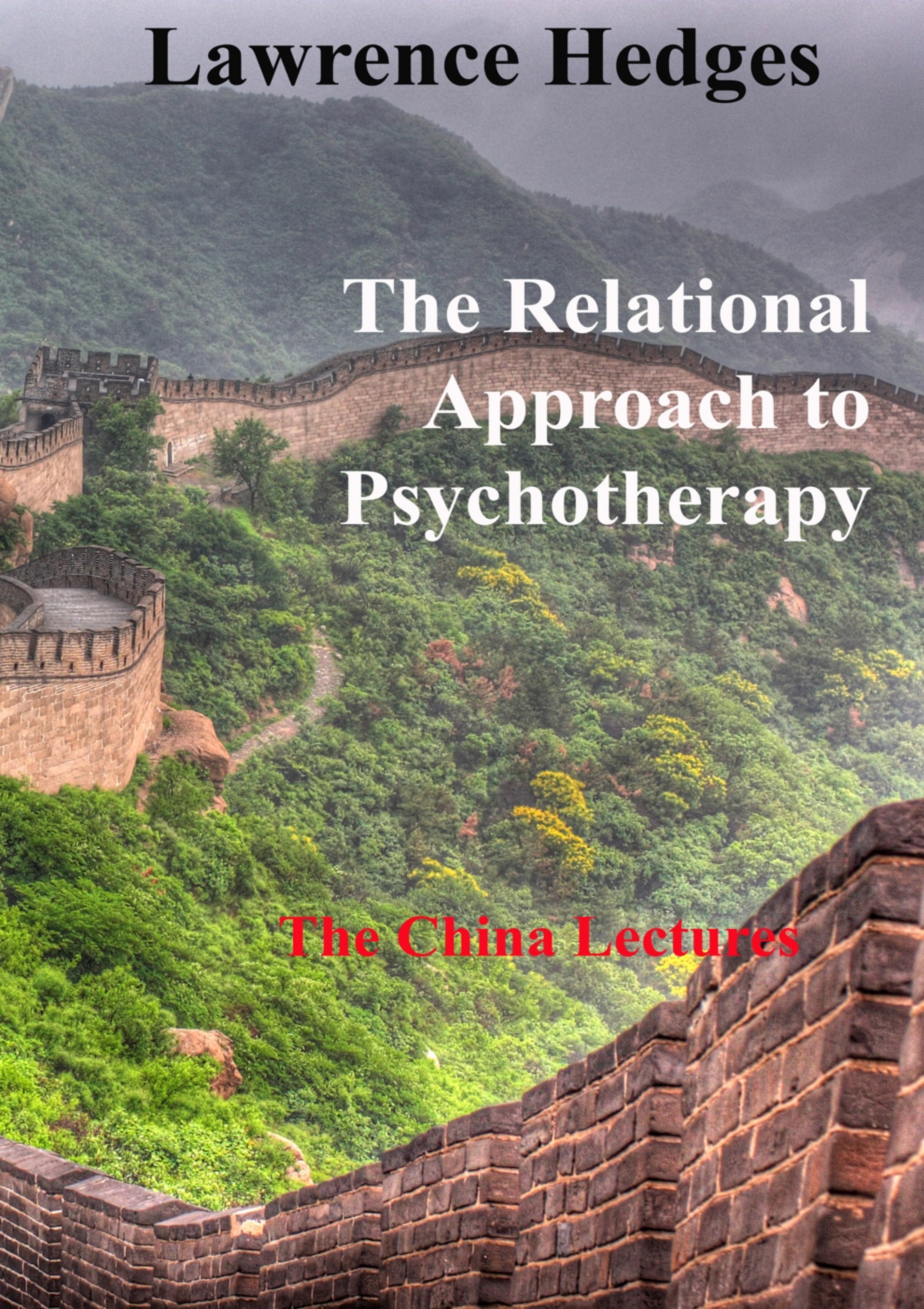
Lawrence Hedges
The Relational Approach to Psychotherapy
The China Lectures

The Relational Approach to Psychotherapy

—The China Lectures—

Lawrence E. Hedges

Compiled and edited by Greggory Moore

Copyright © 2023 Lawrence E. Hedges
All Rights Reserved

e-Book 2023 International Psychotherapy Institute

This book contains material protected under International and Federal Copyright Laws and Treaties. This book is intended for personal use only. Any unauthorized reprint or use of this material is prohibited. No part of this book may be used in any commercial manner without express permission of the author. Scholarly use of quotations must have proper attribution to the published work. This work may not be deconstructed, reverse engineered or reproduced in any other format.

Created in the United States of America

If you downloaded or accessed this ebook from anywhere other than www.freepsychotherapybook.org please report the offending organization to ebooks@theipi.org.

For Zhili Wu (吴知力)and
Sami Wong (黄申申),
as well as the many other psychotherapists all over
China to whom these lectures are addressed.

Holding hands across boundaries is wonderful!

Table of Contents

Introduction: The Zheng Dao Lectures

Acknowledgments

Foreword

Lecture 1 WHY "RELATIONAL" PSYCHOTHERAPY?

Perspectives in Science

The Infinite Complexity of the Human Mind

Perspectives for Generating Personal and Interpersonal Knowledge

Lecture 2 FOUR RELATIONAL LISTENING PERSPECTIVES, WITH SEVEN REACHING EXPERIENCES AND SEVEN RELATIONAL FEARS

Therapeutic Change: Dialogue, Intersubjectivity, and the Present Moment

Overview of the Relatedness Listening Perspectives

I. THE ORGANIZING RELATIONAL EXPERIENCE

II. THE SYMBIOTIC RELATIONAL EXPERIENCE

III. THE SELFOTHER RELATIONAL EXPERIENCE

IV. THE INDEPENDENCE RELATIONAL EXPERIENCE

Lecture 3 PSYCHOTHERAPEUTIC ALTERATIONS, EXPANSIONS, AND TRANSFORMATIONS

I. Therapy with the Organizing Experience

II. Therapy with the Symbiotic-Separating Experience

III. Therapy with the Selfother Experience

IV. Therapy with the Independence Experience

Lecture 4 TRANSFERENCE, RESISTANCE, AND COUNTERTRANSFERENCE: THE CENTRAL CONCEPTS OF RELATIONAL PSYCHOTHERAPY
The Origins of Relational Psychotherapy
The Emergence of Countertransference
Countertransference as a Listening Tool
Strategic Emotional Involvement

Lecture 5 DORA: A COUNTERTRANSFERENCE FAILURE
The Arrival of the Muse
The Countertransference Opening
Discussion
Countertransference Interpretations
Three Common Errors

Lecture 6 TERRIFYING TRANSFERENCES
The Ethic of Relating
Terrified by Disconnecting Rage

Lecture 7 RELATIONAL INTERVENTIONS WITH ORGANIZING EXPERIENCES
Introduction: Relational Listening
Psychotherapy as Relationship
Considering "Lower Level" or "Difficult to Treat" Clients
Content vs. Process Treatment Approaches
The History of the Psychotherapeutic Relationship
Developmental-Relational Listening
Two Relational Intervention Principles
Identifying and Engaging the Organizing Transference
Three Brief Case Examples of Fight-Flight-Freeze Predefenses
Disconnecting Modes: "The Clamor"
Brief Case Illustrations of How Clamor Works in the Organizing Transference

A Thought Experiment for Understanding the Organizing Experience
Considering the Thought Experiment and the Organizing Experience
The Energy Arc Metaphor
Therapy with the Organizing Experience
Optimal Responsiveness with the Organizing Experience
Working Through the Organizing Transference and Resistance
Varieties of Common Countertransference Relational Experience
Four Kinds of Countertransference to the Organizing Experience

Lecture 8 RELATIONAL INTERVENTIONS WITH SYMBIOTIC/ATTACHMENT EXPERIENCES
Elements in Replicated Symbiotic Scenarios
Case Study: Jody Messler Davies: "Love in the Afternoon"
Case Study:Stephen Mitchell: The Horror of Surrendering
The Symbiotic Replicated Transference-Countertransference
Therapy with Symbiotic Relatedness Scenarios
Passive and Active Transference-Countertransference Enactments
Resistance to Relinquishing Symbiotic Modes
Case Study: Donnel Stern: "Perhaps you should have called me."
Summary: Developmental-Relational Listening to the Symbiosis
The Realization of Relational Interventions
The Listening Perspectives Approach
So What Are Relational Interventions?

Lecture 9 FACING OUR CUMULATIVE TRAUMA: AN INTERPERSONAL/RELATIONAL APPROACH
The Force Is with Us!
Life's Traumatic Experiences
Some Historical Notes
Hold It! Let's Go Back a Few Steps
Personal Identity as Traumatically Constructed
The Postmodern, Social Construction Perspective
Let's Start at the Beginning
Listening Relationally to Trauma
Resistance to Re-experiencing Trauma
Reality: The Therapist's Dilemma
Some Imprecise Definitions
Listening to Cascading Traumatic Experiences: September 11, 2001

Lecture 10 THE CALL OF DARKNESS: LISTENING TO SUICIDALITY
Richard Cory
Ten Statements Regarding Suicidality
The Relational Perspectives Approach
Preverbal Relatedness Potentials
Why the Call to "Darkness"?
Four Psychological Formulations
The Major Psychological Perspectives on Suicide
Considerations of Liability
Managing Suicidality in Clinical Settings
Conclusions

Afterword

References

About the Author

Other Books Authored and Edited by Lawrence Hedges

Introduction:
The Zheng Dao Lectures

When Wu Zhili from the Zheng Dao clinic in Taizhou, China, contacted me to see whether I would be willing to teach a 22-session Continuing Education class for hundreds of Chinese psychotherapists across China, I was honored and delighted. I quickly realized that this was the challenge I was waiting for to pull together a lengthy summary of a cross-culturally compatible clinical research program highlighting the relational approach to psychotherapy that more than 450 Southern California Therapists have been collaborating on for the last 50 years. There were to be ten 90-minute prerecorded lectures, ten live streaming supervisions, and two Q&A sessions. I immediately set to work pulling together the most important ideas and illustrative case studies from the 20 published books that the psychotherapists and psychoanalysts at the Listening Perspectives Study Center in Orange, California, and the Newport Psychoanalytic Institute in Tustin, California, have painstakingly put together. This book presents the substance of those ten lectures taken from the original notes I prepared although the final oral presentations in

many places had to be shortened in the interests of time. As a sidenote, it has been fun for me to watch Chinese subtitles scroll across the screen while I am talking and to see my PowerPoint slides translated into Chinese!

I must apologize in advance for my necessarily not being able in this summary to properly credit the numerous complex formulations contributed by the many individuals involved. However, all of the sources that these ideas are taken from are mentioned and all of the credits and quotations are given properly there.

Wu Zhili and his moderator and translator Sami Wong carefully worked with me week after week to produce these lectures. Unfortunately, the interspersed supervision sessions cannot be published due to confidentiality. A number of their colleagues served as presenters and panelists for questions and discussions, which enriched the program greatly.

Greggory Moore (greggorymoore.com), longtime editor and organizer of my books and papers, has gathered everything together in his usual coherent and succinct style!

I hope you enjoy these lectures, which will soon be available on YouTube (with Chinese subtitles!). Check out my website, ListeningPerspectives.com to see what other books, papers, and video recordings may be of interest to you. Also,

check out the website of the International Psychotherapy Institute, FreePsychotherapyBooks.org, where most of these books are now available as free downloads. Alternatively, all of these books are now being offered in paperback on Amazon for $19 each.

Lawrence Hedges
Orange, California
November 2022

Acknowledgments

I am deeply grateful to Daniel Uribe my husband for his patience and understanding while I worked hard to put these lectures together! Thanks to Wu Zhili and Sami Wong for their steadfast support in producing these lectures. Greggory Moore worked many hours getting everything collected, assembled, and edited. As usual, my daughter Breta Hedges and business partner Ray Calabrese have been instrumental in supporting me all along. The many therapists and other contributors to our field have been credited in the source materials. Works like this rest on the shoulders of many brilliant and compassionate clinicians and theoreticians. Thanks to all!

Foreword

Dr. Marty Klein

All human activity involves a dialectic. We see only what our life's various paradigms allow us to see. What we see reinforces our confidence in our paradigms (psychologists call this "confirmation bias"). It's the rare individual who modifies one of their fundamental paradigms based on unexpected experience.

We reify our paradigms as "Reality" and "Truth," denying their constructed nature. And this is a key element of what brings people into therapy.

Therapy involves a dialectic, too. Patient and therapist train each other, attuning each other's ears and hearts. When the patient feels angry, hurt, or misunderstood, the therapist both sympathizes about the reality of the feelings, along with discussing alternate realities out in the world (present or past).

Being only human, therapy's practitioners can fall prey to the everyday reification imperative as well. Larry tries to alert

professionals to this human tendency, inviting therapists to acknowledge and get beyond this human reification project as best we can. Larry describes his methodology for doing so in Lecture 1; the rest of the lectures here describe various aspects of implementing these methods.

Larry understands that getting people to see that their experience of life relies on a series of constructions (rather than on Truth or Reality) can be a turning point in their lives. The question of the impact or quality of these constructions is important, but that is impossible to examine without the original, radical insight that construction is the human way of experiencing all of reality.

Yes, water is wet no matter who experiences it or what their perspective is. But each person's experience of that wetness—and the rest of water's qualities—is a strictly subjective, constructed affair.

The denial of this ongoing constructing can itself be a source of difficulty in life. For example, it can make a person extremely rigid, to the point of limiting their ability to enjoy life or function effectively in their job or family. And it can make us insensitive to the truthfulness of others' realities—a prime problem that brings individuals and couples into therapy.

Here is how Larry translates this insight into a description, both humble and practical, of the therapeutic project:

> [W]hatever it is we do in psychodynamic therapy cannot possibly be conceived as fully or deeply understanding another human being. So what are we doing?
>
> What is said to us and the ways we are related to has various impacts on us which we register and respond to in the best ways we know how in the moment...the purpose of our training is to enable us to engage in a relationship in which longstanding deep unconscious relational habits on both sides become enacted, discovered, discussed, transformed, and expanded.

So therapy is both a grander and more modest project than we may suppose.

Larry formulated "Relational Listening Perspectives" to guide clinicians, in his words, in "defining ways of being emotionally and interactively present so as to encourage the emergence of inhibiting relational habits into the current interactive [i.e., clinical] moment."

What a generous guy!

***

Countertransference is a big part of Larry's world. He sees countertransference not as a bad thing, but as one of many sources of data. This takes skill, and is not the same as being self-indulgent.

The book's many lectures on countertransference—from the abstract to the practical—are both innovative and valuable. Hedges works to normalize the experience so therapists aren't as scared or judgmental about it. He reminds them to get back to work, especially when they feel nervous:

> A format [affect] for presenting countertransference interpretation is a tentative and slow head-scratching, yawning attitude, such as, "I've had some thoughts I can't account for. Perhaps they are relevant to our experience."
>
> The first-person plural pronoun reflects the symbiotic sense. Comments such as, "I have some feelings about you ..." or "Perhaps others react to you in similar ways ..." are social commentary, but are not interpretations of intrapsychic experience. The sense of the "symbiotic we" always needs to be present.

***

I believe Larry would agree that regarding sexuality, our sex-negative culture has infected therapy, mostly preventing the

field from using its own clinical tools to understand what it does in the world, and to learn what it can do better.

As a result, therapy has fairly rigid ideas about "normal" sexuality, and is closed to the broad range of actual human sexual expression. This stance serves to protect the therapist from grappling with their own shame and guilt about their own sexuality—the same protection that patients unconsciously seek. Thus, therapy's effectiveness in the area of sexuality is as poor as some might predict.

Most therapists are uncomfortable engaging patients in discussing the details of their authentic sexuality; they generally don't pursue many such details, which clients inevitably omit because of their (culturally encouraged) shame and confusion. I believe that most therapists are less likely to tell patients that their ideas about sexuality are constructed (rather than "True") than they are when the topic is non-sexual. And of course this mirrors therapists' own ideas about how their own sexual narratives are "True" rather than constructed.

***

> No general theories of mind will help us bring forth the uniqueness of the subjective worlds of therapist and client and the intersubjective/interactive field they co-create.

This is the most radical position a therapist can take, and Larry has articulated it in a practical yet non-simplistic way for decades. He continues to do so in this book of lectures.

Larry challenges us to be radically present with clients, and not to take comfortable refuge in assuming we know more than we do, or that thinking alone will instruct us in what to do. The most effective tool we have is our brave willingness to participate in an inevitably messy relationship—using our self, risking our own self-exposure along with exposure to a client's reality.

In some ways, reading these lectures is like walking with Larry through a dream. This is no accident or coincidence. These lectures are structured in a way that invites the reader's participation with both a linear and non-linear mind—as in a dream. Reading these lectures is a relational activity, as we create their unique reality for ourselves while we read. Put another way, these lectures invite us into a relationship with Larry that will change us; and as we observe our participation in this relationship, and our response to the material, we will be in a better position to invite our patients into the same kind of collaborative, productive relationship—and to participate in it ourselves.

Over 2,000 years ago, Archimedes famously said, “Give me a place to stand, and a lever long enough, and I will move the world.” We therapists are always looking for that place to stand, from which we can use the levers of therapy.

In Relational Listening Perspectives, Larry has found that place, and created an innovative set of levers. You hold these tools in your hand, his profound gift to you. May you make the most of it.

———

Dr. Marty Klein is a Licensed Marriage & Family Therapist and Certified Sex Therapist for over 40 years in Palo Alto, California. The award-winning author of seven books about sexuality and relationships, he lectures and supervises therapists across Europe, Asia, and North America. His clinical specialties include pornography, infidelity, sexual dysfunction, intimate communication, and cultural influences on emotional and relationship function. He can be reached at www.SexEd.org and Klein@SexEd.org.

Lecture 1

WHY "RELATIONAL" PSYCHOTHERAPY?

> The general form of propositions is: "This is how things are."—That is the kind of proposition that one repeats to oneself countless times. One thinks that one is tracing the outline of the thing's nature over and over again, and *one is merely tracing round the frame through which we look at it*. (italics added)

Ludwig Wittgenstein
Philosophical Investigations 1:114

Imagine yourself at high noon in a large square of a great city. Thousands have gathered from all over the world for the grand unveiling of Picasso's last great sculpture.

For months the square has been filled with scaffolding and drapery. A great shroud of secrecy has cloaked the artist's masterpiece until today. The mayor and town councilmen are giving speeches honoring the artist and the citizens whose devotion and donations made the commission possible.

On the portico of the courthouse sits a group of courtroom artists, sketchpads in hand. A photographic society has members strategically stationed at all angles in hopes of publishing a

portfolio of the event. Critics from a dozen magazines carry recorders while television cameras scan the crowd. People jam the windows and the balconies all around.

Many will be writing letters to friends or home to Mom. Many came solely for personal experience—to feel sheer joy or inspiration in the presence of great artistic creation.

The dedication ceremony ends and a hush falls over the crowd as the rush of many fountains and splashing water begins. The scaffolds are quickly drawn away, the great canvas drops, and a silent chill passes through the crowd at the first glimpse of this momentous creative achievement.

What one sees, of course, depends on *who* one is, *where* one stands and *what* one wants to look for. As the sun passes its zenith, shadows entirely change the visage. In the evening, lights illuminate the dancing waters, adding a magical quality of mystery to the angles and convolutions. When the city has gone to bed the moon transforms the stone and steel into a nocturnal spectacle.

In applying this metaphor to the problems inherent in observing and communicating observations about the human mind, three problems are immediately brought into focus:

1. What is seen and experienced when considering any complex phenomenon is, to a large extent, a function of the

observer, and the observer's interests and background.

2. What a person sees is also a function of whatever points of view or perspectives one assumes in time and space.

3. *Communication* about what one sees or how one thinks is a function of the medium and the "purpose" of that communication. Meaningful communication, further-more, implies some common set of terms based on shared experience and a system of symbols.

In other words, psychological theories are necessarily going to reflect *who* one is, *what perspective* one takes and *what purpose* one has in forming theories.

Edgar Allan Poe in his essay "The Poetic Principle" (1850) studied this set of issues in the context of the poetic experience. Poe pointed out that the poet has a primary experience of something such as a landscape.

The poet's task is to render in words and form a comprehension of the experience in his reader. The reader's primary experience remains the poem and only secondarily, the landscape. In considering the complex problems of perception and communication, Poe alludes to Plato's cave image to indicate that the poem may be the only reality the reader knows but that the poem is only a "shadow" on the cave wall compared to the rich experience of the poet.

Perspectives in Science

In this same regard psychological theories, like all scientific theories, are necessarily limited when compared to the richness and complexity of the human phenomena the theory purports to describe or account for.

Freud's own theorizing was based on a Newtonian model of scientific inquiry and a philosophical commitment to the Hegelian dialectic. He never tired in his effort to make psychology a logical extension of biology.

A more modern perspective highlights the paradigmatic nature of theorizing. It marks a post-Einsteinian cultural movement away from "belief" in constructions to an awareness of the use of various models, often seemingly contradictory ones, as mere vehicles for thought, i.e., arbitrary conceptions to be cast aside when their usefulness is past.

A popular analogy is the wave" versus "particle" theories of light which are thought to be contradictory and yet various observations involving light can be understood only on the basis of one or the other of the theories.

Modern theorizing is also based on a view of epistemology which holds that inquiry into the nature of "reality" may best be thought of less as discovery and more as "creativity." A simple but illuminating statement of this approach is contained in

Joseph Chilton Pearce's small volume, *The Crack in the Cosmic Egg* (2002). Pearce envisions humanity as living in the midst of a dark and endless forest, gradually carving out of the wilderness a world and a reality largely of human invention and design.

A scientific theory might be thought of first as *a logical and internally consistent system of thought*.

Scientific theory is an abstraction, a set of ideas, assumptions, and postulates which are on the one hand presumably derived from data, but on the other hand serve as a framework for limiting, collecting, and organizing data.

A theory need not be thought of as "correct" or "true." A theory neither stands nor falls on the basis of data or facts. Recall the example of the two theories of light, both of which remain useful, but each of which is contradicted by certain facts.

The contradictory or unique event has no direct sway over theory. The unique event remains of interest only insofar as it may give rise to hypothesis formation, hunches, or intuitive leaps, which further aid theory formation.

Traditionally considered, the theory which tends to be most useful is

- the one which makes the fewest number of assumptions,
- provides the most parsimonious explanations,

- is successful at making predictions,
- is refutable,
- and has heuristic value, i.e., is rich enough in its terms and postulates to continue to generate thought and further investigative hypotheses.

A theory must also come to grips in some way with the problem of the observer. Usually mechanized and standardized methods of observation are sought. In analytic psychology the tool for observation is human, and controls remain difficult to establish.

In what ways might a theory fail to serve adequately or might lead one astray?

1. The prestige value of a theory may cause uncritical acceptance of many of its postulates.
2. A theory is logical and continuous while one forgets that phenomena in nature are not.
3. A theory by definition seeks to limit and guide perceptions and thoughts into certain patterns so that one indeed continues to see data which support the point of view to be explored, i.e., a theory tends to be self-confirming, especially psychological theories. The confirmed hypothesis depends upon the terms in which it was cast.
4. Psychological theories "used" in a clinical setting often destroy (by changing) the very phenomena to be observed,

i.e., the spontaneous verbalizations or interactions of the clinical encounters.

5. The theory may cause one to "see" or to "infer" what is not there, just because in similar instances one might infer such things.

6. Uncritical extension of theory from one set of data to another is unjustifiable.

7. Failure to separate theory from observation is common. The example here is the statement that "white light is composed of all different colors." Is this a theory or an observation?

With these thoughts in mind one can approach the study of psychotherapy more thoughtfully seeking to grasp what Freud was originally interested in, where other writers have gone, where their ideas may be useful and which ways ideas have carelessly been extended into areas far afield from the basic data.

The Infinite Complexity of the Human Mind

We now realize that the most complex phenomenon in the known universe is the human mind. Understanding this infinite complexity of mind, we now see the impossibility of the so-called "modern" approach to scientifically studying the "true nature" of the human mind. Rather, our contemporary studies must yield to a humbler "postmodern" approach that privileges

the construction of various perspectives for learning about aspects of our minds that interest us.

In psychotherapy we seek to alter minds. We approach this task with trepidation because, in dabbling with an infinity of possibilities, we can hardly know which way to turn, what perspectives we can construct that will help us learn about what we would most like to learn about. Where do we start? What exactly would we like to know about our clients and ourselves? And why?

We begin with the assumption that human beings are born genetically endowed with a complex brain and central nervous system. We further assume that this human central nervous system grows in complexity over time due to inborn natural processes as well as through its interactions with the physical and socio-cultural environment.

We also assume that earlier developments—both phylogenetically and ontogenetically— provide basic templates for guiding later developments, although spontaneously emergent alterations also occur.

A final assumption would be that many trajectories of human mental development might be defined for study, but none are of greater interest to human life than how human relationship

possibilities are able to expand in complexity and consciousness over time.

This last assumption raises the questions as to how expanding relational possibilities can become stopped, blocked, arrested, or repressed. And under what conditions can relational expansion be resumed? That is, how can we understand what the mind-altering process of psychotherapy might be about?

Perspectives for Generating Personal and Interpersonal Knowledge

In my 1983 book, *Listening Perspectives in Psychotherapy*, I proposed what was for that time a radical and far-reaching shift in orientation for thinking about the ways that therapists can come to know things—a shift which has yet to be widely appreciated.

I cite philosopher Ludwig Wittgenstein as pointing out that the form for our human beliefs and propositions is generally "this is the way things are." But in fact, this way that we habitually formulate things as "true" is invariably merely a lens or frame through which we perceive things—not whatever unknown and unknowable "truths or realities" the things in themselves might have. That is, according to Wittgenstein, *realities are much too complex to pin down for all time so we*

develop lenses and frames that provisionally suit various purposes.

Thus, while theories or models of human nature may provide us with a sense of security about what we think we know, when we actually encounter another human being we need to realize that person's internal world is entirely unique and totally unknown and in many ways forever unknowable to us.

True, common sense, cultural narratives, and psychological science may provide some cultural-specific generalized dimensions of human experience for us to consider, but the personal inner world of the living, breathing individual human being before us defies such generalized understandings. In other words, whatever it is we do in psychodynamic therapy cannot possibly be conceived as fully or deeply understanding another human being.

So what are we doing with all of our insightful ideas, brilliant inquiries, and wise interpretations? I say, we are merely stirring the soup! That what is said to us and the ways we are related to has various impacts on us which we register and respond to in the best ways we know how in the moment. In our fumbling efforts it is not that we are stupid or that we have not been well-trained in our discipline, but rather that, as Freud and many others since have taught us, the purpose of our training is

to enable us to engage in a relationship in which longstanding deep unconscious relational habits on both sides become enacted, discovered, discussed, transformed, and expanded.

The Interpersonal psychoanalyst Edgar Levenson holds that in psychotherapy we first set up the arrangements for our meetings. Second, through detailed inquiry or free association we gather the details and themes of the person's life. And third, we discover how we are unconsciously mutually enacting these same themes in the here-and-now of the therapeutic relationship. The process of extended inquiry, discovery, and discussion outlined in this simple algorithm carries us away from ineffective and inefficient relational habits toward increasingly expanded consciousness and relational capacities.

Out of all of these complex and, at times, dismaying considerations arises the notion of formulating "Relational Listening Perspectives"—i.e., of defining ways of being emotionally and interactively present so as to encourage the emergence of inhibiting relational habits into the current interactive moment.

In other words, if we cannot possibly know the "true nature" of another human mind, and if formulating preset models of the mind against which to compare individual experience runs the risk of biasing the listening/interactive experience, what

stance can we possibly take in a therapeutic relationship that allows us to move forward while honoring our necessarily perennial uncertainty?

My answer to this question as early as 1983 was by the construction of Relational Listening Perspectives. I used then, as I always have, the term "listening" in the broadest possible sense —meaning being emotionally present, paying close attention, interacting, processing, and responding in as many relevant ways as humanly possible.

The Relational Listening Perspectives, simply defined as a series of increasingly complex relational possibilities, make no particular assumptions about the nature or content of human mind except that human minds develop and expand in a relational context. In my 1983 research covering a century of psychoanalytic studies, four main watersheds of relational complexity emerged.

Some years later when I studied listening perspectives from the standpoint of relational fears and the ways they manifest in our bodies, those four watersheds became divided into seven distinctly different kinds of relational experience and fear.

I follow up the seven relational fears with seven corresponding perspectives for ways of reaching out for relational connectedness that are as culture- and gender-resonant

as possible. Any particular number of defined perspectives is, of course, arbitrary, but these seven are what have emerged from my research and clinical studies.

Since I published *Listening Perspectives in Psychotherapy*, the concept of perspectives has become fairly popular in psychoanalytic parlance. I am seldom credited with any priority of thought—I think because most people still do not grasp the radical perspectival vision of my book.

There are, of course, many standpoints from which anything can be considered, and people get that. But that fact was by no means the full thrust of my book.

Using Relational Listening Perspectives as I conceived them requires a total re-orientation of one's therapeutic mindset—a radically revised sense of how we come to know about and resonate with significant mental events and processes in ourselves, our clients and our emotionally significant others.

Allow me to briefly explain my notion of Relational Listening Perspectives by using the computer metaphor of hardware and software. We might consider human beings as endowed with incredible genetic and constitutional hardware. Also, the human socio/cultural/economic/linguistic environment as it has evolved over millions of years acts as part of the human hardware system.

The individual zygote/ fetus/ infant/ child/ adolescent/ adult is impacted minute-by-minute throughout his/her life by idiosyncratic environmental forces such that virtually all mental content is totally unique—however much it may be formatted into common language and cultural features learned along the way.

No general theories of mind will help us bring forth the uniqueness of the subjective worlds of therapist and client and the intersubjective/interactive field they co-create. If the therapeutic consciousness-expansion goal of Levenson's three-step algorithm is to be realized then the unique themes, patternings, modes, and habits of relatedness of both participants must have an opportunity to emerge in fullness in the here and now relationship experience.

That is, in the course of growing up at all levels of relational complexity development we each ran into barriers of various sorts leaving myriad memory traces and inhibitions.

The relational adventure of psychotherapy is one of coming to re-experience these habits and relational modes and how they operate beneath awareness in the here-and-now of life and psychotherapy. Simply talking about them will be insufficient for significant life-changing expansions. Our relational habits and

modes must be enacted, lived in relationship and brought into mutually engaged consciousness.

It follows that the questions arising for the therapist are: "How can I be of some use to this person wishing to expand her consciousness?" And after the therapy gets going, "What's going on here anyway," "Where is our relationship taking us," and finally, "What is there to do about all of this?"

My answer to these questions is simply, "Pay close attention and involve yourself in the relationship according to Levenson's three-part algorithm." Whatever knowledge is to be gained will be a product of two people collaborating, enacting, and expanding their joint consciousness.

Recall that "consciousness" is from the Greek words meaning "knowing together." In other words, what we are searching for in the psychotherapy encounter is the ongoing mutual construction or re-construction of life narratives as spoken and enacted in the here-and-now of relating.

Stated negatively, we are *not* looking for any diagnostic or developmental categories or models or any character structures, content, or processes that occupy complex realms of mental structures or mechanisms, but rather personal expressions of life relational experiences and revelations of how those experiences

are alive and well in our present relationships including the therapeutic relationship.

The next questions: how exactly are the Relational Listening Perspectives best formulated? And how exactly is one to make use of them?

In the next lecture I will provide a schematic overview of the Relational Listening Perspectives, as well as the seven experiences of relational reaching out and their corresponding fears.

In the third lecture I will address psychotherapy alteration, expansion, and transformation.

In a few brief lectures I cannot possibly cover the extensive research and clinical experiences that have given rise to these ways of working, but here you will get a fair introduction and an overview of our 50-year clinical research project.

Lecture 2

FOUR RELATIONAL LISTENING PERSPECTIVES, WITH SEVEN REACHING EXPERIENCES AND SEVEN RELATIONAL FEARS

Therapeutic Change: Dialogue, Intersubjectivity, and the Present Moment

In considering the nature of psychological change and summarizing a century of psychoanalytic theorizing and practice from classic Freud through the carefully defined Ego Psychology of Anna Freud and Heinz Hartmann, to the numerous contemporary theoreticians and practitioners of Intersubjective psychotherapies, psychologist-psychoanalyst Roy Schafer outlines the seeds and forerunners to the contemporary relational approaches pointing out that for some time now "*dialogue and intersubjectivity* have been moving to the center of psychoanalytic interest.... To put it briefly, 'dialogue' conveys the idea that in the course of [psychotherapy] the understandings and the changes that take place can only come about through an evolving dialogue between [therapist] and [patient]; in other words, the definition and reshaping of the self and other only take place in verbal and nonverbal dialogue. And

'intersubjectivity' conveys the embeddedness of each person's cognitive and emotional position and his or her dialogic orientation in so-called real or imagined relations with others."

Schaefer holds that it has always been intuited and vaguely understood that the agent of change in psychotherapy is *the dialogic nature and intersubjective reach of the therapeutic relationship itself*.

The question of how exactly to consider psychological change from the standpoint of two-person psychology has been tossed about by many theoreticians and clinicians for some time now.

Especially prominent participants in this widespread conversation have been the infant researchers and scholars in the Boston Change Process Study Group. After years of study and intense research they have generally concluded that *change processes occur between two or more people in a given moment in time*.

The clearest statement of the human change process emanating from that group comes from infant researcher Daniel Stern (2004) in his book, *The Present Moment*. Stern's wide-ranging studies reveal that the basic unit of human experience—the present moment—lasts eight to 16 seconds—the time for a phrase in language, music, and dance.

Like the illustrations in our Psychology101 text that demonstrated that we do not see in sweeping panorama but rather in momentary points of visual fixation, so too our sense of living an ongoing life panoramic experience is derived from our brain's putting seamlessly together a series of eight- to 16-second "present moments."

What are the implications of these findings from infant research for relational psychotherapy?

According to Stern, in ongoing intimate relationships ordinary "present moments" often move toward special "now moments" that threaten the status quo of the relationship and the intersubjective field as it has been mutually created and accepted up until then. That is, a relationship can be developing quietly in a series of present moments that lead up to some rift or rupture, some misunderstanding, divergence of views, or other interpersonal disjunction.

These emotionally intense "now moments" represent a relationship crisis that needs resolution. The resolution of the relationship crisis occurs in what Stern calls "a moment of meeting...an authentic and well-fitted response to the crisis created by the now moment. The 'moment of meeting' implicitly reorganizes the intersubjective field so that it becomes more coherent, and the two people sense an opening up of the

relationship, which permits them to explore new areas together implicitly or explicitly."

For example, an intimately relating couple moves forward connecting in a series of "present moments" toward a moment of difference or disjunction causing a relationship crisis—a "now moment" that is, an emotionally charged rift.

If two are then successful in creating a "meeting of minds," new understanding and new intimacy is created that is part of the relationship-building journey. If not, repeated unresolved crises lead to relationship disruption, to stalemates, to distancing, to divorce.

Stern's moment-by-moment analysis of what is going on in relationships that promote change permits us to consider that *whatever motivational systems for reaching out to another may be operating, they are immediate and intense in intimate relationships*.

We know how difficult it can be for us to live in and to cultivate on an ongoing basis transformative present moments and moments of meeting in our intimate relationships. The lesson is clear: *whatever importantly motivates us in relationships is operating in the here-and-now present moment and deserves our mutual attention and focus. If we cannot live together in the present moment our relationships are dragged*

down by the past or weighed by anxieties about the future—neither of which we can do anything about at the moment.

The clear conclusion is that lasting meaningful change is only possible through *an emotionally charged present relationship* that is imbued with mutual concern and intention. This psychological truth has recently been heavily underscored by advances in our understanding of the brain and the neurological unconscious.

Overview of the Relatedness Listening Perspectives

Relational Listening I:
Development, Transference, Countertransference

Age	Developmental Thrust	Transference	Countertransference
> 3 yrs.	Self and Other Relational Experiences	From Independent, Ambivalently-held Others	Overstimulating Experiences as Distracting or Impediment
24 to 36 mos.	Self-consolidating, Recognition Experiences	From Resonating or Injuring Self-Others	Facilitating Experiences of Fatigue, Boredom, and Drowsiness
4 to 24 mos.	Symbiotic and Separating Scenarios / Interactive Experience	From Interacting and Enacting Others—Replication	Resistive Experiences to Replicating Demanding, Dependent Scenarios
4 mos.	Organizing Merger and Rupturing Experiences	From Engaging and Disengaging Others	Dread and Terror of Unintegrated Experiences

Relational Listening II:
Resistance, Listening Mode, Therapeutic Intervention

Age	Resistance	Listening Mode	Therapeutic Intervention
> 3 yrs.	To the Return of the Repressed	Evenly-Hovering Attention, Free Association, Equidistance	Interpretive Reflection: Verbal-Symbolic Interpretation
24 to 36 mos.	To Experiencing Narcissistic Shame and Narcissistic Rage	Resonance with Self-Affirmation, Confirmation, and Inspiration	Empathic Attunement to Self to Self-Other Resonance
4 to 24 mos.	To Assuming Responsibility for Differentiating	Replicating and Renouncing Symbiotic and Separating Scenarios	Replication Standing Against the Symbiotic & Separating Scenarios: Reverberation
4 mos.	To Bonding Connections and Engagements	Engagement: Connection, Interception, Linking	Focus on and Interception of Disengagements

I. THE ORGANIZING RELATIONAL EXPERIENCE

Infants require certain forms of connection and interconnection in order to remain psychologically alert and enlivened to themselves and to others. In their early relatedness they are busy "organizing" physical and mental channels of connection—first to mother's body, later to her mind, and then to the minds of others—for nurturance, stimulation, evacuation, and soothing.

Framing organizing patterns for analysis entails studying how two people approach to make connections and then turn away, veer off, rupture, or dissipate the intensity of the

connections. The Organizing Experience is metaphorically conceptualized as extending from four months before birth to four months after birth.

Perspective 1: Reaching Out to Have Our Needs Met

Infants are programed genetically in many ways to reach out into the human environment for stimulation, nurturance, soothing, and evacuation. When an infant repeatedly reaches out in whatever ways possible and the environment is unresponsive, the infant's reaching slumps and withers—thus forming an internalized habit of painful inhibition and withdrawal.

- *The First Relational Experience Fear:* We dread reaching out and finding nobody there to respond to our needs. We fear being ignored, being left alone, and being seen as unimportant. We feel the world does not respond to our needs. So what's the use?

Perspective 2: Reaching Out to Make Connections

Infants are genetically programmed for bonding through mutual affective regulation with their caregivers. When they reach out and experience rejection or injury they quickly learn to "never reach that way again."

- *The Second Relational Experience Fear:* Because of frightening and painful experiences in the past, connecting

> emotionally and intimately with others feels dangerous and potentially hurtful. Our painful life experiences have left us feeling that the world is not a safe place. We fear injury so we withdraw from connections.

II. THE SYMBIOTIC RELATIONAL EXPERIENCE

Toddlers are busy learning how to make emotional relationships (both good and bad) work for them. They experience a sense of merger and reciprocity with their primary caregivers, thus establishing many knee-jerk, automatic, characterological, and role-reversible patterns or scenarios of relatedness.

Framing the symbiotic bonding or attachment relatedness scenarios entails noting how each person characteristically engages the other emotionally and how interactive scenarios evolve from two subjectively-formed sets of internalized self-and-other interaction patterns. The symbiotic attachment experience is metaphorically conceptualized as spanning from 4 to 24 months—peaking at 18 months.

Perspective 3:
Reaching Out to Form Attachments

Attachment or bonding through processes of mutual affect regulation is a fundamental biological drive. The self and other bonding scenarios or dances established are life sustaining.

Being unable to find one's bonding partner(s) is terrifying and disorienting.

- *The Third Relational Experience Fear:* After having connected emotionally or bonded with someone in some way, we fear either being abandoned with our own needs or being swallowed up by the other person's needs. In either case we feel the world is not a safe or dependable place, that we live in danger of emotional abandonment. We may become clingy and dependent or we may become super-independent—or both.

Perspective 4: Reaching Out to Assert Ourselves

Human babies are not only pre-programed to emotionally resonate and attach but they are also pre-programmed to push away from the attachment figure in search of independence. When a child's attempts at self-assertion and separation-individuation are thwarted, frustration and anger usually results —anger that may get severely squelched.

- *The Fourth Relational Experience Fear:* We have all experienced rejection and punishment for expressing ourselves in opposition to others. We come to fear asserting ourselves and our needs in relationships. We feel the world does not allow us to be truly ourselves. We may either cease putting ourselves out there altogether or we may assert ourselves with a demanding vengeance.

III. THE SELFOTHER RELATIONAL EXPERIENCE

Three-year-olds are preoccupied with using the acceptance and approval of others for developing and enhancing self-definitions, self-skills, self-cohesion, and self-esteem. Their relatedness strivings use the admiring, confirming, and idealized responses of significant others to firm up their budding sense of self.

Framing for analysis the Selfother patterns used for affirming, confirming, and inspiring the self entails studying how the internalized mirroring, twinning, and idealizing patterns used in self-development in the pasts of both participants play out to enhance and limit the possibilities for mutual self-to-Selfother resonance in the emerging interpersonal engagement. The Selfother experience is conceptualized metaphorically as extending from 24 to 36 months.

Perspective 5:
Reaching Out for Recognition

As separation-individuation proceeds, the growing child seeks recognition from others of his or her worthiness and competence as an independent self. At times the child needs affirmation, at times confirmation, and at times inspiration—all

in order to develop a strong, healthy sense of independent selfhood.

- *The Fifth Relational Experience Fear:* When we do not get the acceptance and confirmation we need in relationships, we are left with a feeling of not being seen or recognized for who we really are. We may then fear we will not be affirmed or confirmed in our relationships. Or we may fear that others will only respect and love us if we are who they want us to be. We may work continuously to feel seen and recognized by others or we may give up in rage, humiliation or shame. Or we may deny the need through grandiosity.

IV. THE INDEPENDENCE RELATIONAL EXPERIENCE

Four- and 5-year-olds and beyond are dealing with triangular love-and-hate relationships and are moving toward more complex social relationships. In their relatedness they experience others as separate centers of initiative and themselves as independent agents in a socially cooperative and competitive environment.

Framing the internalized patterns of independently interacting selves in both cooperative and competitive triangulations with real and fantasized third parties entails studying the emerging interaction patterns for evidence of repressive forces operating within each participant and between the analytic couple that work to limit or spoil the full interactive

potential. This experience is metaphorically conceptualized as extending from latency, though puberty and throughout life.

Perspective 6: Reaching Out to Cooperate and Compete in Love and Hate

Once the child has established a firm sense of independence as a self she or he begins effectively interacting in triangular relationships in family and community with other selves recognized as fully separate and independent. Love triangles engender cooperation and competition that lead at times to a sense of success and at times to a sense of failure.

- *The Sixth Relational Experience Fear:* When we have loved and lost or tried and failed, we may fear opening ourselves up to painful competitive experience again. When we have succeeded or won— possibly at someone else's expense— we may experience guilt or fear retaliation. Thus we learn to hold back in love and life, thereby not risking either failure or success. We may feel the world does not allow us to be fulfilled. Or we may feel guilty and afraid for feeling fulfilled.

Perspective 7: Reaching Out to Be Fully Alive

As children learn to experience love and hate as well as success and failure in triangular relationships, they are prepared for the cascade of triangular relationships that are met as one

moves on to puberty and adolescence—toward creative group living.

- *The Seventh Relational Experience Fear:* Our expansiveness, creative energy, and joy in our aliveness inevitably come into conflict with demands from family, work, religion, culture, and society. We come to believe that we must curtail our aliveness in order to be able to conform to the demands and expectations of the world we live in. We feel the world does not permit us to be fully, joyfully, and passionately alive. Rather than putting our whole selves out there with full energy and aliveness, we may throw in the towel, succumb to mediocre conformity, or fall into a living deadness.

Lecture 3

PSYCHOTHERAPEUTIC ALTERATIONS, EXPANSIONS, AND TRANSFORMATIONS

Note: In Lecture 2, a two-part Relational Listening chart was provided. I open this lecture by elaborating on each point in that chart.

I. Therapy with the Organizing Experience

The Developmental Thrust

Whenever the organizing experience is in play in the therapeutic relationship—whether with a person who lives a pervasive organizing experience or with a person who is living only momentary pockets of organizing experience—the most important feature for observation is the movement toward connection and engagement and the subsequent disconnection from that engagement or potential engagement.

That is, the developmental thrust of an infant in the months immediately before and after birth is one of searching for merger with the maternal body and mind for nurturance, soothing, stimulation, and evacuation.

In Donald Winnicott's (1949) words, the baby's task is "going on being." The needed environmental response he called

“primary maternal preoccupation.” But things can and do go wrong with this primary thrust toward merger connection—from toxemia in pregnancy, alcohol fetal syndrome, genetic and constitutional disturbances, incubators, adoptions at birth, maternal and family difficulties, insanity in the environment, and numerous other uncontrollable sociopolitical and economic intrusions.

Since perfect parental responsiveness is never possible, we understand that all babies experience traumas of one sort or another—to a greater or less degree. And that the impact of those traumas necessarily gives rise to internalized expectations of later relational traumas of a similar type.

As listeners we can imagine that a continuum of potentially faulty or traumatic disconnections or ruptures can be experienced ranging from a total absence of response that produces lethargy, withering, and withdrawal to an intrusive or hurtful response that produces severe body constrictions of various types.

Either way the questing mind collapses and the message “never reach that way again” becomes emblazoned on the neurological system. This will mean that in later relational encounters which the mind/brain experiences as similar, a primitive withdrawal or constrictive response of a similar nature is likely to result.

The Transference

All mammals are genetically programmed to search for the warm body or die. To me this accounts for why so many primitively organized clients search out trust relationships that they invest with hope. But no sooner than trust begins to build so that the person is encouraged to reach out for an enlivening connection than the impact of the traumas of the past resurface in the relationship to rupture any possibility of gaining or sustaining that connection.

This connecting-disconnecting process can be readily observed in the micro process of an hour when there seems to be some movement towards connection which is then followed by some kind of disconnecting move. It can also be tracked on a macro level between sessions and over a long period of time.

The process for the therapist to track is the idiosyncratic way that each person manages to show an inclination toward some kind of engagement and then how the client manages to spoil it or break the link in some way. Because each person has a unique developmental organizing experience, the manner of approach and avoidance is likely to be difficult to observe and absolutely unique. It will likely first be noted in transferences to people and situations in the outside world and then eventually will be discernible in the therapeutic relationship.

The Countertransference

It is well known that a therapist struggling to stay connected to a client who perennially disconnects or becomes disoriented tends to feel extremely frustrated and often disoriented himself.

It is not just that the client's changing the subject or turning away or canceling sessions or whatever is in and of itself so frustrating, but that these collapses and ruptures invariably occur at a time when the therapist is experiencing the hopeful possibility of something good happening between them.

We can understand this as a transferential fear of connecting on the part of the client and a loss of a sense of continuity for both client and therapist. Sitting with a person living an organizing experience frequently produces a withdrawal and disorientation in the therapist as she is not having her own relational needs responded to.

The Resistance

"Resistance" in analytic parlance always means resistance to fully and consciously experiencing the transference reaction—not resistance to the therapist or to the therapy.

Since the organizing experience trauma was once known in relation to some person in the early environment, what is anticipated and resisted is connecting to someone again only to

be re-traumatized. This means that the person will do anything and everything to avoid, veer off, not notice, block, and/or rupture any developing emotional engagement.

This resistive disconnecting process has severe consequences for growth, in that human beings are programmed for symbiotic attachments from which they can learn more advanced forms of relatedness—and disconnection disrupts those learning processes.

When a person pervasively living organizing experience attempts to connect interpersonally, the connection is always blocked somehow, and learning more complex modes of regulating is blocked.

With a better-developed person who is only experiencing momentary blocks, the rupture is likely to occur at some moment when trusting possibilities are available and therefore frightening so that certain kinds of subsequent relational learning are blocked.

The Listening Mode

Our sole analytic goal in working with organizing experiences is finally to intercept possible connections and to find some way to encourage and sustain moments of interpersonal engagement. But since the person living an

organizing experience is hell-bent on not allowing an emotional connection to take place our job early in therapy is to find gentle ways of promoting safety and connections.

Since people living pervasive organizing experiences often have elaborate reasons and extravagant stories to tell us it is important not to get caught up in the content but to stay focused on the moment-to-moment movement toward and away from interpersonal connections.

The Therapeutic Intervention

From the outset in treatment it is important for us to be on the lookout for all of the ways that the person avoids, veers off, shuts down, changes the subject, and/or ruptures any forming connections.

Every intervention needs to be aimed at pulling the client into the interpersonal life of the room and into emotional relatedness with the therapist using whatever means can be mustered. The most important comments will be geared toward showing the client the disconnecting process and attempting to relate it to a lifelong tendency to avoid interpersonal connections and some ways of considering why. This therapeutic task is extremely difficult, painstaking, and requires a great deal of time.

II. Therapy with the Symbiotic-Separating Experience

The Developmental Thrust

Babies from 4 to 24 months are learning emotional relatedness scenarios as they develop personal and stylized attachments with their primary caregivers through processes of mutual affect attunement. Not only are they developing relatedness templates from the standpoint of the baby, but in order to understand the unique personality of the mother/other they must also develop internal relatedness templates that reflect the mother's emotional interactive role in the relationship—that is, infants must learn to identify with the reciprocal parental role.

But babies are not only pre-programmed to attach emotionally to their caregivers, they are also pre-programmed to separate and individuate. After the baby has established a reliable attachment pattern, she must also be able to push away as if to say, "I know how you want me to be, but I want to do things my own way, to become my own separate person."

Mothers of toddlers are fond of calling this developmental phase "the terrible twos" because there is so much opposition and often anger and aggression expressed on both sides.

The Transference

Every toddler has the task of learning the unique emotional interactions mutually engaged in with their primary caregivers. Thus in psychotherapy both client and therapist bring their symbiotic and individuating emotional scenarios to color or determine the relationship.

Therapists work to set aside their own preferred ways of emotionally interacting in favor of allowing and thereby understanding the well-established scenarios that the client insists on transferring into relationships.

Primary attachment patterns involving mutual affect regulation are preverbal so that they cannot possibly be spoken to the therapist but rather they must be enacted by both participants in the therapeutic relationship so that the therapist eventually becomes able to initiate a process of translating the enactments into words—a process often also engaged in by clients. That is, enactments necessarily precede new perceptions of the engagements.

The Countertransference

Since the symbiotic and individuating patterns to be observed and understood in the therapy are preverbal emotional

interaction modes, the verbal dialogue between client and therapist will not at first reveal them.

Rather, the countertransference will be a crucial informer as the therapist begins to sense the relatedness expectations and demands of the client. It is easy enough to see that some emotional interaction expectations are transferred directly from the client's early experience of their parents.

But the role-reversal transferences are less easy to discern. This is where the countertransference may be a very useful tool. That is, the client begins treating the therapist as he/she was once treated and the therapist begins getting the emotional message that can then be verbalized to the client.

These patterns may become discerned and discussed after being enacted in the relationship by the client, the therapist, or by both.

The Resistance

The symbiotic scenarios once learned in primary emotional relationships become deeply embedded in personality and character structure. As such, they are the ways we all seek familiar relationships and are extremely resistant to change.

In psychotherapy, once characteristic scenarios have been identified in the transference-countertransference matrix, it will

likely be the therapist who confronts the scenarios basically insisting that the person must relinquish them if greater relational freedom is truly desired. Giving up one's familiar life-long ways of engaging people is always a difficult task and necessarily entails some grieving.

The Listening Mode

Symbiotic-separating scenarios are preverbal and cannot become known and narrated until they have first been enacted by two in an intimate interpersonal relationship. In the early phases of replicating and elucidating a particular scenario the therapist seeks to be as empathic and pliable as possible.

Using the ongoing question, "What's going on here, anyway?" two can began to discern the way this scenario operates in the here-and-now and the ways they are both engaged in perpetuating it. Then begins the analysis of the resistance—the reluctance on one or both parts to relinquish long held emotional interaction patterns.

The Therapeutic Intervention

Therapy begins with the client enacting a variety of nonverbal emotional scenarios that originated in the second year of life. The therapist works to step back and allow the replication

of familiar scenarios in the therapeutic relationship so that they can become known and worked through by the couple.

It is to be expected that in the process the therapist will also be experiencing and enacting emotional templates from his or her early life.

An ongoing open dialogue is encouraged based on the question "What's going on here, anyway?" The therapist often has to point out, "You have found that I can interact with you comfortably in the ways that are most familiar to you—but after all, I am 'hired help.' If you want to be free of these long-standing patterns you have to dare to develop new ways of relating to me, of experiencing who I am and ultimately of learning to discover the unique qualities of other people."

III. Therapy with the Selfother Experience

The Developmental Thrust

Three-year-olds are preoccupied with confirming their sense of who they are, developing basic talents and skills, and establishing self-esteem. They are forever looking to others to recognize, affirm, confirm, and inspire a strong cohesive sense of self. The term *Selfother* derives from the fact that they are using an other to perform consolidating functions usually assigned to

the self. “See me! See me! Recognize me! Affirm me!” cries the 3-year-old.

The Transference

When Selfother affirmations and recognitions have been inadequate during the developmental phase of self-consolidation and cohesion, the client searches for this affirmation, confirmation, or inspiration from the relationship with the therapist through what have been called “the mirroring transference,” “the twinship transference,” and “the idealizing transference.”

The Countertransference

When a client is expressing some form of Selfother transference therapists often become bored, drowsy, or even irritated or disgusted. This is because they are being used as a part of the client’s self-confirmation process and ignored for who they might be as separate independent people.

The Resistance

There is often a reluctance for clients to express their Selfother needs for affirmation, confirmation and inspiration. This reluctance is based on the fear that they will feel ashamed for their selfishness or self-centeredness or that they will become enraged for lack of narcissistic recognition. Yet we all need basic

recognition and narcissistic supplies throughout our lives in order to continue to feel strong, healthy, and worthwhile in our relationships and endeavors.

The Listening Mode

Heinz Kohut, who has done more than anyone to clarify this particular developmental stage, advises us to resonate with the client's needs for affirmation, confirmation, and idealization so that the person can resume the growth of their cohesive self. He advises us to extend our empathy the best we can to the experiencing of narcissistic needs.

However, sooner or later our empathy will falter or fail and a narcissistic injury will result. It is at that time that we can review with our clients what they were needing from us that they failed to get and the exact nature of their disappointment and disillusionment with us.

Over time, with empathic failures and repair, the client internalizes the therapist's Selfother functions in order to be able to regulate her ongoing needs for affirmation and recognition for herself.

The Therapeutic Intervention

Kohut advised empathic attunement to the state of the client's self and the particular needs the client has for Selfother

recognition. When the sense of self seems to be flagging or fragmenting it is important for the therapist to be able to resonate with the failing Selfother functions, thereby bolstering the development of self-cohesion.

IV. Therapy with the Independence Experience

The Developmental Thrust

Four- and 5-year-olds who have consolidated a strong sense of self are ready to engage in complex interactions with other independent selves. The model of complex independent interaction is the emotional-triangular relationship.

In each significant intimate relationship the child is working out the problem of "who is who to whom under what conditions?" The specimen problem to be worked out under different conditions is, "Who am I to Mommy with and without Daddy? And who am I to Daddy with or without Mommy? And who am I when Mommy and Daddy are together and I am left out, alone?" At this age children are capable of repressing painful and otherwise forbidden or overstimulating unwanted impulses and feelings.

The Transference

Most of our lives are spent dealing with triangular relationships with other loved and hated people. Early ambivalent emotional attitudes developed in triangular relationships are regularly transferred into contemporary relationships including the therapeutic relationship.

Sometimes the third-party is a family or community value or an allegiance that interacts in various ways to influence a twosome. As adolescence and group life develop a cascade of triangular complexities evolve which are regularly transferred into the therapy arena. The most painful feelings here are, of course, those of being left out when we want to be considered, valued, and included.

The Countertransference

When clients are transferring to us independent experiences of a triangular nature many thoughts and feelings may be stimulated in us. But Freud warned us that under such circumstances of independent relating these feelings are usually our own and seldom of any real use to understanding what the client is experiencing.

If anything, strong countertransference reactions to an independently relating client are likely to be distracting from

whatever triangular situations the client is working on herself.

The Resistance

At this level of development, repression of painful and unwanted feelings makes triangular relating easier or simpler for the growing child. The resistance in therapy is to the return of these overstimulating painful, shameful, repressed, or otherwise defended thoughts, impulses and feelings.

The Listening Mode

The therapeutic modality for listening to Independent Self relating is the one par excellence that Freud and the classical psychoanalysts have taught us. In classical terms we are urged to allow the client to free associate without judgment as repressed thoughts and feelings return to consciousness. The stance is one of neutrality and remaining equidistance from the forces and functions of id, ego, and superego.

The Therapeutic Intervention

The verbal-symbolic interpretation of resistances to repressed unconscious conflicts is the recommended intervention for Independent Self relating in which triangular complexities are possible.

Lecture 4

TRANSFERENCE, RESISTANCE, AND COUNTERTRANSFERENCE: THE CENTRAL CONCEPTS OF RELATIONAL PSYCHOTHERAPY

The Origins of Relational Psychotherapy

More than a hundred years have passed since Bertha Pappenheim coined the phrase *the talking cure* to describe the relief she experienced from her numerous physical complaints as she daily related the thoughts and fantasies that preoccupied her to her physician, Dr. Joseph Breuer.

His curiosity and attentiveness led him to go considerably out of his way on occasion to accommodate her insistence. During one period she actually required him to make lengthy and frequent train rides to her country residence in order to be with her. At another time it was necessary for him to feed her daily when she refused to eat otherwise.

The relationship metaphor of her spending days in "dreamy clouds" until her doctor came in the evening to "penetrate her unconsciousness with hypnosis, thus relieving her agonies like a

"chimney sweep," would not be missed by modern analysts as transference fantasies. Nor would the timing of the upsurge of her physical complaints, which coincided with her beginning to nurse her beloved father through a terminal illness, be overlooked today.

At the outset Bertha was, by all standards, a "basket case." She presented a wide variety of physical and mental symptoms. Today she might be seen as "borderline psychosis, severe," but in the early literature she was referred to as an hysteric. Devoted as he was to her care, Dr. Breuer simply did not understand what all of her symptoms and metaphors were about. His new wife, however, understood a few things quite clearly because she was apparently becoming increasingly jealous of the relationship.

It is not difficult to imagine Mrs. Breuer's feelings when, just about the time dinner would be ready to go on the table, she would receive a message from her husband that he would be late. Bertha was requiring extra time again. Dr. Breuer felt the strain that Bertha's treatment was placing on him and on his marriage.

After considering the matter from many angles, the good doctor must have recognized the need to press for some sort of relief as rapidly as possible so that he could terminate the burdensome relationship. Through suggestion and his influence as her physician, he induced Bertha in a variety of ways to give

up her symptoms, a technique we today might call a "false self" cure.

We can imagine the day that Dr. Breuer was to declare Bertha cured. His wife no doubt arranged a special candlelit dinner celebration with all of the expectable intimacies of a long overdue romantic evening together.

Suddenly there came a knock at the door. Bertha's family had sent for the doctor. He must come at once. There was an emergency. The candles were snuffed and the dinner reluctantly placed back in the oven to keep warm. Dr Breuer dutifully put on his coat and headed for Bertha's place.

When he arrived Bertha frantically reported a dramatic resurgence of all her troubling symptoms. But there was something new. Bertha announced that she was pregnant and that the baby she was carrying was his!

With Dr. Breuer's reactions to Bertha culminating in his decision to leave her and her false pregnancy, we witness the birth of what we now call countertransference.

Dr. Breuer's (Breuer & Freud 1893-1895) early work with Bertha Pappenheim is known in the literature as the specimen case of psychoanalysis, "Anna O."

Events had so upset Dr. Breuer and his wife that he transferred the case immediately to his friend and colleague, Sigmund Freud, and promptly fled on a second honeymoon.

Freud later recalled that upon hearing about Breuer's work with Bertha, he first understood the power of the relational unconscious.

From manifestations in Breuer and Pappenheim's relationship, Freud intuited the important connection between unconscious fantasies and psychically determined physical manifestations. Moreover, he understood that *highly personal unconscious influences in both doctor and patient could be mobilized and laid bare for observation under the influence of an intense personal relationship*.

(As a sidenote, it is interesting to learn that Bertha Pappenheim became a well-known social worker, noted both for her work with juveniles and her pioneering efforts in the women's movement, for which she was recently commemorated on a postage stamp.)

After extensive psychoanalytic investigation of unconscious processes, Freud (1912) is able to articulate how *psychoanalysis moves forward based on an understanding of the ways one person experiences and relates to another.* He formulates that distressing ideas and affects from the past tend to become

reactivated in the context of the intimacy of the present relationship. These intense relatedness possibilities deriving from prior experience with significant others make their appearance in the present relationship through emotional experiences that emerge in response to the setting of the relationship (analysis) and to the person of the other (the analyst).

Freud defines the analyst's role as being like an opaque mirror whose relationship function is to elicit and then to reflect (through interpretation) these intense and recurring personal unconscious experiences, which he termed *the transference*. Freud speaks of transference in a cursory way in *Studies on Hysteria,* conducted in collaboration with Joseph Breuer from 1893 to 1895. But he structures no explicit or comprehensive formulation of transference manifestations until 1912.

In his paper "The Dynamics of Transference," Freud (1912) discusses the nature of the transfer of unconscious relatedness patterns from one significant emotional relationship to another and how this tendency reappears in the intimacy and privacy of the analytic relationship.

He concludes that transference is the greatest obstacle yet to be encountered in the search for relief of neurotic symptoms. Freud observes that as people begin to establish the kind of relationship with their analyst that would lead to the elucidation

of the neurotic symptoms, specific and troubling contents from past relationships become automatically and unconsciously activated and transferred to the setting of the analysis and onto the person of the doctor.

The memories of old fears, hatreds, neglects, abusive intrusions, loves, and seductions become reactivated not so much, as Freud had anticipated, in the progressive unfolding of the free associational content of the analytic work per se, but rather *in the context of the evolving relationship* with the analyst.

Freud writes that these relatedness memories transferred to the analytic situation and onto the analyst regularly intervene to disrupt the treatment before the neurotic symptom can be analyzed. That is. thoughts and affects transferred from the past into the present relatedness situation interfere with and often prevent the full understanding or analysis of the various elements that have been symbolically linked together through past experience to form neurotic symptom complexes.

Freud soon comes to realize that the apparently disruptive experiences transferred onto the analytic relationship paradoxically turn out to be manifestations of the very memories that the analysis could, and should, be seeking to understand. That is, *the very thoughts and affects that serve as resistance to*

the free flow of discussion and relatedness between the person and his or her analyst-listener are themselves transference!

Thus, the second great obstacle Freud encounters after transference in the analysis of neurotic symptoms is *the resistance to deepening the analytic relationship occasioned by relationship patterns or templates transferred from past relationships into the analytic setting or onto the person of the analyst*.

The Emergence of Countertransference

No sooner does Freud become able to define transference and resistance as attitudes brought by the psychoanalytic speaker-patient into the relationship, than he finds it necessary to begin considering the analogous attitudes in the analyst-listener.

These attitudes have come to be called *countertransference* and *counterresistance* (Freud 1915a).

The natural countertendency on the part of the listener to transfer ideas and affects from his or her past into the analysis is considered, like transference at first, an unwelcome influence. Freud formulates countertransference as likely to act as an impediment to the psychoanalytic process—to detract or to distract from the analyst's mirroring capacities.

The “impediment theory of countertransference,” as I shall refer to this view, reflected Freud’s earliest ideas, which have been exceedingly influential in subsequent thought about listener responsiveness.

If the analyst’s reactions emerge disruptively, Freud’s basic prescriptions are consultation on the case with a colleague, followed by more personal analysis for the analyst if the troubling features do not subside after consultation.

These two time-honored recommendations, like many psychoanalytic concepts, are tinged with a hidden morality that has exerted a crippling influence on subsequent theoretical developments. If countertransference is, by definition, unconscious and dilatory because it is an impediment to the therapeutic relationship, then the analyst-listener “should” get help in order to stop “bad” things from happening as a result of listener bias. This moralistic attitude still represents the dominant way in which countertransference is considered by many.

Countertransference as a Listening Tool

Historically, the definition of countertransference as a tool for psychoanalytic research has emerged more slowly than definitions of transference and resistance, perhaps because of its elusive nature.

But there has also been a tendency in the field to guard the privacy of the analyst who reports his or her work to colleagues for scientific scrutiny. This need for privacy on the part of teaching and publishing analysts has meant that the most enmeshed aspects of analytic work have remained largely unscrutinized.

Another major obstacle in the systematic elaboration of countertransference as a study tool has been the difficulty encountered by the requirement that the analyst function simultaneously (or alternatingly) both as objective observer of another person's ideas and affects and as subjective receiver.

The information and interactions received in an intense analytic situation are bound to stimulate personal reactions in the listener that demand scrutiny by his or her own free associative processes. As if studying another person's actions and activities weren't enough, must the analyst also be required to study his or her own reactions and their possible relevancy in understanding the relationship?

Perhaps the best answer in the traditional attempts to study neurosis would be: no. But for a variety of reasons, the scope of psychoanalytic study has been increasingly widening for the past five decades. With this expansion has come the necessity to study psychological constellations other than those called

neurosis, and for that reason countertransference has become a crucial area of increasing focus.

Just as transference and the tendency to oppose or resist its establishment have come to be understood as the awakening of relatedness memories relevant to the current analytic work, so too has countertransference provoked by the relationship gradually come to be understood as a source of valuable and relevant information in psychoanalytic relationships.

Despite the fact that countertransference reactions, by definition, reflect the personal, unconscious relatedness patterns of the analyst-listener's past emotional life, they are increasingly coming to be viewed as worthy of careful scrutiny as listening tools in various systematically specified circumstances.

Freud's impediment theory of countertransference responsiveness held a firm grip on the psychoanalytic community until the 1950s, in London.

Following the Second World War, Winnicott began treating psychotic patients and in 1947 wrote the kickoff paper of this series, "Hate in the Countertransference." He expressed the view that psychotic states in people expectedly elicit a sense of helplessness, frustration, and hatred in the analyst. The hatred is not to be ignored, but to be taken into the analyst's overall understanding of the patient.

Next in this remarkable series is Paula Heimann's 1950 paper, "On Counter-transference." Reacting to a tendency among candidates in psychoanalytic training to develop a certain ideal of the detached analyst, she developed the thesis that "the analyst's emotional response to his patient within the analytic situation represents one of the most important tools for his work. The analyst's counter-transference is an instrument of research into the patient's unconscious" (p. 81). She held that in addition to freely hovering attention, the analyst-listener needs a freely roused emotional sensibility so as to allow understanding of the patient's unconscious through his own—"the most dynamic way in which his patient's voice reaches him." Heimann adds:

> The analyst's immediate emotional response to his patient is a significant pointer to the patient's unconscious processes and guides him towards fuller understanding. It helps the analyst to focus his attention on the most urgent elements in the patient's associations and serves as a useful criterion for the selection of interpretations from material which, as we know, is always overdetermined.... The analyst's counter-transference is not only part and parcel of the analytic relationship, but it is the patient's *creation,* it is part of the patient's personality. (Heimann 1950, p. 82)

Heimann speaks of the patient dramatizing his conflicts in the analytic relationship. She interprets Freud's demand that the analyst recognize and master his countertransference to mean not

that the analyst be emotionally detached, but rather that he or she use emotional responsiveness as a key to the patient's unconscious. "The emotions roused in the analyst will be of value to his patient, if used as one more source of insight into the patient's unconscious conflicts and defences." She does not, however, recommend disclosing the countertransference.

Margaret Little (1981) followed with a series of courageous papers demonstrating how with preneurotic (so-called preoedipal) patients, the analyst's countertransference feelings provided necessary material for the analysis. Not only did she maintain that all countertransference feelings might be useful, but she held that the analysis cannot go forward adequately without the feelings of the analyst taking center stage at certain points.

Little's work stimulates thinking about how, whether, and under what conditions the analyst might usefully communicate his or her feelings to the patient (the so-called disclosure issue that has been hotly debated in recent years).

Little wrote about a case in which it appeared retrospectively that the analyst had been envious because his patient was going to be on a national radio broadcast. At the time, the analyst interpreted the envious feelings as a wish that the patient's recently deceased mother could hear him speak.

It wasn't until the analysis was terminated and the analyst by chance came into contact with the patient at a social gathering that the patient provided material that made it clear that the feelings of the analyst upon which the interpretation was made were very much to the point, but because the analyst was defending against his own envy, the interpretation was wrong. (Years later, Little revealed that this case example was taken from her own training analysis with Ella Freeman Sharpe.)

Work on understanding the countertransference has gone on more or less quietly in London, particularly in the so-called "Independent" group. But only more recently have the findings of a long tradition of study paid off in a series of breakthroughs in clinical work that are bound to have a profound impact on all psychotherapy.

Contemporary studies center on issues concerning when and how to make systematic use of the countertransference for developing and sustaining intense emotional relationships.

A key paper in the series is Bollas's (1983) "Expressive Uses of the Countertransference." In his brilliant paper, rich with clinical illustrations, Bollas demonstrates how countertransference thoughts and feelings freely roused in the course of listening can serve to represent various aspects of the

infantile position of the patient-speaker that are otherwise unrepresentable.

He further demonstrates how, in speaking the countertransference, feeling and bodily states of the analyst can be shown to contain crucial memories belonging to the patient and can be given interpretive value.

In my 1992 book, *Interpreting the Countertransference*, I demonstrate how listener responsiveness evolving in a relationship serves to point toward the elucidation of representations of the speaker's infantile states that continue to be experienced and known about but have not yet been brought into the realm of symbolic thought—in Bollas's language, to begin discovering and putting into language what he calls "the unthought known."

Strategic Emotional Involvement

Freud's intention was to formulate psychoanalysis along conceptual lines established by 19th-century medical science. However, his texts regularly oscillate between an objective, deterministic approach and a humanistic, purposive approach.

Throughout his lifetime Freud never relinquished his personal sense of identity as a philosopher. On occasion he even

asked why psychoanalysis arose from the field of medicine rather than, say, religion, philosophy, the arts, or the humanities.

But the facts of the history of psychoanalysis are that its powerful medical applications have inextricably colored, determined, and dominated the formation of its vocabulary and growing fabric of concerns.

During the last four decades psychoanalysis has witnessed a radical shift in thought away from an emphasis on healing and toward an enterprise of consciousness expansion. The new conceptual paradigm of psychoanalysis that accents issues of interpersonal relatedness now calls for a systematic study of the emotional responsiveness of the therapist as well as the patient.

Many ideas have begun to evolve to guide the therapist through some of the ambiguities and uncertainties that characterize contemporary psychoanalytic work.

Rudolf Ekstein, in his foreword to *Listening Perspectives in Psychotherapy* (Hedges 1983), envisioned a sequel entitled *Talking Perspectives in Psychotherapy,* which would survey speakers' ways of free-associating in analysis. Ekstein writes, "It is my belief that each symptom, each emotional or mental illness, is in some way a Talking Perspective, a way of communicating, albeit a pathological way" (p. xiv).

In the numerous case studies presented by different therapists with different orientations in the *Listening Perspectives* series we hear speaking patients deeply engaging their listening therapists in complex and enigmatic webs spun on the basis of past patterns of emotional entanglements.

The listener's critical tool for receiving this emotionally charged interactional material is the fabric of his or her own emotional life, replete with its idiosyncrasies that are also brought from the past.

What sort of map can the listener and speaker use to sort out the intricate and interwoven meanings that are bound to emerge in the course of relating?

The four *listening perspectives* that have served to organize my thinking and teaching for two decades provide ways of listening to the four distinct types of strategies of emotional involvement utilized by speakers in their relatedness experiences with listeners. According to this view, the psychoanalytic task entails listening for what mode or modes of self-and-other relatedness are being spoken or lived at the moment or over time, and then seeking through empathy to establish interpersonal attunement through various forms of "strategic emotional involvement."

That is, in listening to interpersonal issues that are defined metaphorically as related to four watersheds of development of the human relatedness potential, the emotional life of the analytic speaker can be most effectively engaged or met through distinctly different strategic forms of emotional involvement.

Lecture 5

DORA: A COUNTERTRANSFERENCE FAILURE

The Arrival of the Muse

Like so many of my colleagues in recent years, I have turned my attention to the problem of countertransference—to the many experiences that I, as analyst, undergo while listening to and interacting with the people who come to my consulting room.

Aware that many new ideas about therapists' feelings were being discussed in the professional community, I committed myself some time ago to teaching several classes on countertransference in order to force myself to do the work required to catch up with what was happening.

In my own training programs, like in most others, the expectable feelings of the therapist in response to the interpersonal encounter of psychotherapy were generally neglected. This meant that we all squirmed in silence, trying our best not to notice the deep emotional reactions our work was stirring up and making sure not to mention them to our

supervisors. Those troubling feelings were to be all worked out later in our training analysis. But for now, we must try to be objective and not to become over involved with our clients.

The more I read about countertransference and the more conferences I attended, the more interested and the more confused I became. Prominent clinicians held very divergent views on the subject. The traditionalists insisted that countertransference feelings were always an indicator of a personal overinvolvement on the part of the therapist. Others held that feelings should be taken into account, but only very judiciously, and perhaps never shared with clients.

The most daring and dynamic clinicians were taking positions that seemed much more truthful and down to earth. They held that it was crucial for us to find ways of utilizing our subjective emotional lives actively and directly in the therapeutic relationship. Certainly honesty and directness are qualities we strive for in all of our relationships. But an analytic relationship by its very nature is very complex. There are so many things to be attuned to at every moment.

By what criteria are we to judge the relative importance of feelings we may be experiencing at the time? How do we weigh the importance of countertransference expressiveness against other aspects of the relationship that are also of crucial

importance? Are there certain kinds of analytic encounters or certain moments in which open acknowledgment of our emotional reactions is paramount? Likewise, are there other times and circumstances when, regardless of how impelling our affective responses may seem, they are of relatively lesser importance in the immediate situation?

And most importantly, if there is a special skill involved in tuning into our feelings and making optimal expressive use of them for analytic effectiveness, how do we go about cultivating such a skill?

These were the kinds of questions I set about to investigate for myself, both in theory and in everyday practice. Finally, I committed myself to pull together an all-day seminar on "Countertransference and Its Relation to Empathy and Interpretation."

With a deadline approaching, I lay outside in my hammock one sunny afternoon, clipboard in hand, staring blankly off into the national forest, waiting for a muse. I began thinking of Dora, of how painful it was when she had stopped coming to see me several years before. How often I had ruminated over what went wrong, with no sense of resolution. At times I blamed myself. At times I blamed her. But the bottom line was that I didn't know what went wrong in our relationship and I felt badly about it. I

began to jot ideas down on my clipboard. Page after page was ripped off, wadded up, and tossed at my favorite cactus. But suddenly my pen began to flow. In what seemed no time at all, with clarity and conviction, I wrote the account that follows. The moment was an inspired one. At last I had found an understanding that provided a sense of relief. This was the moment when countertransference issues began coming alive for me.

The woman I will speak of, Dora, saw me two to three times a week for the better part of two years in the late 1970s. After nearly twenty years of positive professional experiences, my work with her came to be and remains what I consider the only clear-cut treatment failure I have ever suffered. Since I have not asked permission of this woman to discuss her work, I will limit my remarks to countertransference issues that now seem to me to be the cause of the disruption that ended our work together, leaving me with a very painful and defeated sense of failure.

I always saw her as a very gifted woman whose intelligence, creativity, and physical beauty had somehow not been put to good use for her own enjoyment or harnessed for purposes of self-enrichment and personal growth. To her, everyday existence in most of its particulars had come to be remarkably drab, commonplace, and deeply discouraging.

The Countertransference Opening

In our relationship Dora vacillated between elation that I could see and appreciate the wonderful person that she hoped she was to an almost delusional suspicion that I viewed her as sick, depressed, ugly, and basically the disgusting person she believed she really was. As bright and articulate people, we both were able to discuss these concerns in great detail and to relate them to current life circumstances, as well as to many growing-up experiences. I used the developmental metaphor borderline to describe for myself her chronic and, to her, depressing ways of relating to people around her.

The particular thread of our relationship that I wish to follow here was what we both came to see as her sexualized attraction toward me. Held in silence for more than a year, she confessed with trepidation one day that she had always had a weakness for blue eyes—especially in the exact combination with brown hair that I have.

Several of her significant men friends have been of similar coloring and build. I handled her anxious confession with a series of inquiries meant to elucidate associations about why it had taken so long to share this with me. What problems was this attraction posing for her? If I was her type, as she said, why couldn't we simply enjoy that together? I wasn't sure what made her so uneasy over this issue. Was there anything I was doing

that made things difficult? Was there anything I could do to make things easier?

Our discussions brought her relief, and in subsequent months a series of expressions emerged. She was concerned that she wasn't supposed to be attracted to me, but she couldn't help it. Yes, at times her attraction had made it difficult to speak with me about certain issues, but if there ever were anything really important, she believed that she had been able to overcome it. She believed me to be a very accepting person.

At the end of good hours she would often sit up a few moments before leaving and let me know what a pleasure it was simply to look at me and to feel that I was okay with her looking. She would sink into the couch in deep and pleasurable relaxation, feeling deeply reassured.

One day, while telling me about a friend of hers who had just been diagnosed with Kaposi's sarcoma and explaining to me AIDS, the then-new disease among gays, she confessed her concern that I might be gay. She was afraid I would be offended by her saying so and had carefully avoided any mention of the topic. Over the years she had been close to a number of gay men and had wondered about the implications of that closeness for herself and her sexuality. She had recognized several attractions to women friends in the past but had never wished to develop the

sexual side of these relationships. Perhaps she was projecting her latent homosexuality onto me, she thought. I asked if the idea that I might be gay was reassuring to her. She immediately saw the potentially protective side of her fantasies, saying, “Then I wouldn’t have to be concerned about my attraction toward you.”

But she hoped that I wasn’t gay because her recently-diagnosed friend had been miserable for years, searching bathhouses and bars every night with one disastrous relationship after another. She hoped that, whatever my personal circumstances were, I wasn’t miserable and that I was safe from agony, disease, and death. She spoke of potential abandonment and her fear of being left alone.

She concluded by reassuring either herself or me or both of us that there was really no need to worry since she was sure I wasn’t gay. I must be a “good fuck,” she said, the kind she had always imagined having for herself.

Now, many will feel critical of my technique upon learning how, throughout this time, I handled numerous and frequent demands for reassurance. Did I think highly of her? I did. Could I see her artistic creativity in the productions she brought me? I could. Did I find her an attractive person? I did. And so on. I had attempted early on the usual set of inquiries about what brought these concerns up at this particular time. Was her question

possibly related to other things she had been talking or thinking about? My inquiries not only failed to elicit associations but regularly increased her agitation. When I followed it up, the result was either deep feelings of worthlessness because I probably really didn't like her, or feelings of rage toward me for playing a cat-and-mouse game with her. After all, she believed she had a reasonable right to know what I thought of her. Even if she granted me the privacy of specifics, couldn't I at least acknowledge feelings and thoughts we both knew about anyway?

In response to my suggestions that answers would reassure her and that then the anxiety, depression, and anger that she felt might be overlooked by both of us, she responded, "Bullshit—bullshit, bullshit, and more bullshit! There is no reason why we can't be honest here. After all, you are supposed to be completely analyzed, aren't you?"

In some profound sense she seemed to be right, and when I felt freer in my expressions toward her, our work went much more smoothly. But for some reason I was not happy having to serve a reassuring function for her so frequently. On several occasions she stared at my arms and chest with delighted squeals. She declared she had always been a "chest woman" and that my general build, and specifically my chest and the little

black hairs that occasionally “peeped out” of my open shirt just drove her crazy.

In reviewing my feelings on the matter, it is clear that in many ways I enjoyed her sexual attraction to me. However, I came to be aware of feelings of self-consciousness, and in the morning I occasionally found myself sorting through which shirt or pants to wear on a day I would be seeing her. But all my attempts to make any analytic headway on these developments in our relationship resulted in a bland response.

However, she gradually replaced most of her wardrobe and began paying attention to small details in makeup and hair. Her current sexual relationship improved considerably. She discussed this jubilantly as her progress at getting out of her “drab, weepy, homely self.” She was enjoying making the best of what she had. She attributed the changes to new freedoms she was developing as a result of her therapy—something I believe in many ways was true. She was further able to say that seeing herself through my eyes made her alive to the fine person she was and to the ways she might come to enjoy herself, others, and the world in general. There was similar evidence of increased self-esteem in a variety of social and occupational shifts. Her improvement in fact was dramatic—in retrospect, perhaps, a sign to me of the developing problem.

Looking back, I see that what was perhaps never made fully explicit was how much the improvements in self-esteem and related activities remained dependent upon my real or fantasized estimate of her. At this point in writing up my work, I found myself developing a severe headache—a frequent complaint of hers.

In general, however, we both felt good about the analysis, and others close to her experienced a considerable easing of tension. A temper tantrum or terrible-twos quality that she called "bitchiness" would occasionally appear that we could relate to her relationship to her mother.

Later, in grasping at straws to understand what was going wrong, I was able to formulate for consultation with colleagues a detailed set of interactions or scenarios I had been considering. I still believe these dyadic interaction patterns to be accurate descriptions derived from her early relationship with her mother. But no amount of work on the symbiotic and separating replications was able to avert the impasse that developed. We both saw and could talk about her behaving toward me as she had toward her mother. We could even discuss her behaving as her mother had behaved toward her in her actions toward me.

The usual "regressions" and "resurgences of symptoms" occurred prior to weekend and holiday breaks. I might add that

Kohut-styled interpretations of empathic failure were seldom useful. On the other hand, she took readily to developmental metaphors.

Once she saw a copy of Kaplan's *Oneness and Separateness* (1978) lying on my desk and asked to borrow it. She derived much mileage from the book in terms of understanding her own ambitendent relationship with her mother and the pronounced but erratic mood swings to which she was prone. Another time, just before a holiday, she brought a lovely black pebble that she had found on the beach and had taken to have polished for me. It sits to this day in an antique inkwell—my grandfather's—in my office. I occasionally pick it up and think of her fondly.

The seeds of the trauma that eventually resulted in her breaking off our relationship were sown one day about midway through the two-year period of analysis. She had begun enjoying her new found capacity to tell me about her attraction toward me and to just sit quietly for periods, taking pleasure in listening to me or looking at me. I felt squirmy when she did this, but at some level I also enjoyed being looked at and being enjoyed in the deep and satisfying way she took me in. I was pleased that she derived a great deal of pleasure from our interaction, because there were so few pleasures for her at that time.

One day, however, in what way I don't know, she caught my discomfort. I was trying hard to be there for her in the way I was sure she wanted me to be and was cautious about letting my uneasiness show. But my guard must have been down, and she caught me flinching or averting my gaze in some way or another. Nothing was said at the time. I had been painfully aware for a while of my growing dislike of her parading her erotic attachment in front of me and my wish to escape her gaze, her intensity, and the sense of intrusion that stimulation by this very attractive woman was provoking in me.

The following session she came in bedraggled, wearing old clothes and no makeup. She lay down on the couch wordlessly. I waited a long while until quiet sobs began. She had frequently cried bitterly, but this seemed somehow different—much deeper and worse. Not until she began talking was I aware that she had detected my discomfort in the previous hour. She had concluded that our whole relationship had been a giant fraud, just as she had vaguely suspected all along. I didn't really like her—it was a therapeutic trick: "make the patient feel better so they keep coming." She had been wasting her time. She had hoped after all the years of never being recognized or responded to that at last she had found someone who could like her and be her friend. There was more withdrawal and hurt, and then anger. I sensed no qualities of manipulation or even hope—rather, there was a total

collapse of all that had been experienced as good, and a very deep sense of despair and rage.

I have often wished I could recall my exact responses during that hour, but it passed too quickly. I was struggling so hard to stay afloat that I am not even sure I could have recalled the details sufficiently to make notes. I was basically able to empathize with how perfectly terrible she must feel and was even able to add specifics from my understanding of her that portrayed her devastation even more vividly and related it to past devastations and losses.

But while she acknowledged and appreciated my empathy, it could not, as she said, "put Humpty Dumpty together again." It seemed clear to me that I must try somehow to acknowledge the truth of what she saw. So often in the past her correct perceptions had been invalidated by adult opinion. Somewhat reluctantly, I confirmed that in fact I had become uncomfortable with her admiration of me and my body, and I was not completely sure exactly what I was feeling yet. However, I told her that as nearly as I could tell she was wrong in her interpretation that I hated her, that I was perpetrating an analytic hoax, and that it was all an act, presumably for her own good.

Hoping to save the scene and to ease her out of her dreadfully painful state, I told her that she should not hold

herself responsible for my reactions to her admiration. I disclosed that my emerging feelings of discomfort more likely related to interfering features from my own past than to her way of relating to me in the sessions. In fact, while I did not mention it to her, I had been occupied for some time in attempting, as a result of my uneasiness, to dredge out some experiences from my own preadolescence, when for a protracted period of time I had felt subjected to similar erotic-intrusive staring and the parading of an erotic attachment that had produced similar feelings of overstimulation and uneasiness in me.

When she registered astonishment and disbelief at my taking responsibility for "flinching," as we came later to refer to the incident, I partially revealed some of my previous experience and apologized for its intrusion into her processes in this very painful manner. The disclosure and the apology were authentic and did serve to pull her out of her disastrous state.

Summarizing the aftereffects of the incident, I will say that our work resumed its regular pace after a few halting sessions. She did, however, carefully refrain from "overwhelming" me again by staring or making a point of enjoying me. My inquiries into why she felt she had to alter her spontaneity to protect me were met on the one hand with responses somewhere between an understanding and respect for an area that was sensitive to me personally on the one hand, and on the other with a mild sarcasm

that meant she must not express to me her true self and risk offending or upsetting me or my abandoning her.

When I challenged this, she acknowledged that she didn't really think I was so fragile, but she liked me a lot, and part of what she had been working on everywhere as a result of her therapy was becoming a better person to people—a trend she was having some good integrating experiences with.

I remained unconvinced of this explanation of the alteration in our relationship and from time to time told her so. The flinching incident came up in a variety of ways over the next year and was put to good use on a number of occasions by both of us.

The final blow took me entirely by surprise. For a full year she had been preparing for an advanced examination relating to her career—taking classes, studying, and working through trial exams and review seminars. Her preparations were loaded with anxiety but also full of forward-looking hope and creative prospects. She was doing much better than people who had far more experience than she. The exam came and she felt pleased that she had maintained well, budgeted her time efficiently, and completed the test with a reasonable sense of security.

The day of triumph came several weeks later with an on-top-of-the-world sense of glee, a split of champagne, and two

champagne glasses for us to celebrate her having attained the highest possible percentile score. It was 11 o'clock in the morning so I managed to beg off the champagne with a few celebration sips. She was in her glory. We celebrated all of her successes over the last two years and the immense prospects for her future career in the new placement that the exam had made possible.

As in most such champagne reviews, we were discussing the before-and-after picture, jointly taking credit for the big step forward into a new, never-before-dreamed-of sense of success and independence. During our review she asked me to tell her how I viewed our work together. Trying as much as possible (as is my custom) to stay with the metaphors provided by the person in analysis, I said, "When we began, you were so invested in thinking of yourself as 'weepy, drab, and homely.' Now we've proved that all wrong." At first she seemed pleased with my assessment. But after a few moments, her whole affect suddenly changed to enraged grief and our celebration came to a screeching halt. The truth had finally come out. All along I had seen her as a weepy, drab, homely person and now she had heard it with her own ears. She knew it was true. I had even tried to lie my way out of it, saying my flinch was personal and unrelated to my feelings about her. She would never be able to trust me again.

She screamed at me with huge tears running down her face and at last stormed out.

To say I was speechless wouldn't be entirely correct, but nothing I could say seemed to help. She was adamant that she had not misunderstood me; I simply had finally confirmed what she had known all along. She called and left a message canceling all future appointments.

However, after a few weeks, she consented to come in and see me several times again. It was very clear that our therapy was over and no effort on my part to turn the tide was of any use. She did, at my request, consult with a woman therapist I suggested. During the three sessions the consultant reported back to me, Dora voiced a constant desperate desire to see me again and restore our relationship, but a firm unwillingness to do so because her trust had been so entirely shaken. No other possibilities could be entertained.

I telephoned her several times. She always seemed pleased to hear from me but saw no point in our trying to get together again. I was a good person who had helped her greatly and she very much appreciated that, but there was no way to continue.

Her new career work was exciting and going extremely well. She felt better than ever about most aspects of her life and relationships, except the loss of her analysis. Her comments

seemed free of accusation, manipulation, or guilt induction. By the second call, she had read *August* (Rossner 1983) and had started seeing a woman who could relate to her warmly, the way she felt the analyst in *August* had.

I found myself soundly defeated. I had taken a number of opportunities to consult on my work with colleagues, but was ultimately dismayed and, I must say, mildly disenchanted and disgusted when she told me the kind of warm, accepting therapist she had found. I was not personally acquainted with her new therapist, but I had given her several names of people I knew to be good. Somehow I doubted now that she would get what she needed.

There are many points at which discussion of such an unhappy story might begin. Those versed in separation-individuation themes in therapy with borderlines will be quick to point out the loss of symbiotic at-oneness that the jubilant ascension into independent selfhood may have precipitated. Her sudden affect change might be considered as heralding an abandonment depression with its accompanying helplessness, rage, and disenchantment. Or the enraged grief might be considered an attempt to restore the stormy symbiotic mode of relatedness she was losing as a result of her analytic work.

I can assure such observers that these themes had been present all along in the therapy and that I believe for the most part they were attended to by both of us rather well, though at the climax, I'm sure these must have been some of the active components. However, she refused adamantly all attempts to interpret along these lines at the time. And, I might add, this refusal came from a bright and perceptive woman who did not want her analysis destroyed.

The content of the opposition scenarios, which I have mentioned but omitted details of in this write-up because they are her private material, might also be looked to for explanatory themes that were no doubt also active in the climactic break. But all attempts at interpretation of various interaction patterns or scenarios in this area were rejected also.

Potentially questionable issues regarding my technique, such as reassurances, gratifications, mutual expressions of interest, breaking the frame with sexual looking and champagne, would all have a definite but, I believe, minor place in any systematic attempt to reconsider this work. I would, however, reject out of hand any old-guard hypotheses about untreatable pathology, insurmountable ego weaknesses, or charges of my attempting inappropriately to do analytic work when I should have been doing supportive work.

As in any depth analysis, there are many places where issues of technique might be fruitfully raised, but what critical element, theme, or activity might be isolated in order to gain a meaningful perspective on this precipitous break?

I now believe that the self-disclosure is related to the problem. Yet we all know that self-disclosures per se frequently do have their place when analyzing preoedipal issues. Kohut (1977) even speaks of a brief oedipal period that regularly follows the long analysis of a self disorder. He speaks of how important it is for the person to feel the analyst's personality in concrete utterances and to have emerging oedipal curiosity valued and responded to warmly and humanly. Any notion of negative effects from a break in the frame per se caused by the disclosure would also be too simplistic an explanation for a piece of work in which two people were so attached and were working so well. So to what, then, would I attribute the disastrous break, now that I have several years of hindsight and considerably more experience with counter-transference responsiveness under my belt?

I can now see ever so clearly that she was right—that in essence I had been living a lie with her all along and that she knew it while I did not! Furthermore, I now believe she did the right thing in stopping the therapy. She could sense that I had

not, and could not at that time, have spotted the problem—as sincere as she knew I was in trying to understand her.

And what was the lie I was living? The lie was that I told her I did not dislike her for intruding, that I did not loathe the way she stared at me and spoke of my sexual appeal for her, that I did not hate her for the way she made me be on my guard every moment, to not let her see how uneasy, how vulnerable, and frightened she was making me feel.

Instead, I felt forced to reassure her of what a fine person she was, how much I liked her, and how her intrusions were no bother to me. True, my disclosure hit the mark in telling her the genetic history of why *I* was uneasy, but it carelessly sidestepped what she needed me to see—that we had succeeded in our relationship in replicating the traumatic circumstances of her childhood.

I had fallen into the position she always occupied in relation to her fragile, vulnerable, and demanding mother who watched her every move like a vulture, measuring her own self-esteem and fullness by the child's good false-self conformity.

Dora had always portrayed her mother as a horrible person. But we can now ask, "Was her mother as intrusive and vicious as she maintained?" From one standpoint, yes. Her mother fostered the development of this dreadful way of responding and relating.

From another standpoint, no. Her mother’s own frightened, fragile personality always stood in danger of collapsing in despair and rage if her daughter’s responsiveness was not approving, apologetic, self-effacing and, in many ways, on guard and conforming to the mother’s relatedness demands. This sensitive child, out of a deep sense of attachment to her mother and a thorough knowledge of her mother’s vulnerabilities, systematically warped her own personality to support her mother’s perpetually fragmenting self states and precarious confusions.

Dora was doing to me what had been done to her, and at some level she knew it. I had not yet understood her communication through the interactions, and when confronted, I basically lied, as she had always done. I was not fully aware of the nature of the lie I was perpetuating until much later.

This process is not new to psychoanalytic writing. In a similar vein, Freud spoke of the tendency in human development to turn passive trauma into active mastery. Anna Freud formulated this kind of phenomenon in terms of identification with the aggressor. Klein spoke of projective identification. Kernberg speaks of alternating self- and object-representations projected into the analyst.

All of these formulations of role-reversal experiences point toward a general set of events in analytic work in which the analyst comes to experience the relationship in much the same way as the person once experienced basic attachment and separation relatedness in early childhood.

At a paraverbal or nonverbal level, this woman knew all of these things and tried her very best in a most creative way to show me her life story—to show me by doing, by engaging and involving me in her relatedness patterns. *Her creativity had found a way of replicating her truth in our relationship*. She was relying on me to find some way of reverberating, of resonating, and ultimately of reflecting her truth to her at a higher level of representation—one that would have the power to transform her adult life.

I failed her. I flinched, which wasn't so bad in itself. In fact, flinching was very much to the point, indicating my personality's response to her lifelong position with her mother and later with everyone else. My attempts to acknowledge responsibility for my personal contribution to our interaction, that is, my disclosure per se, wasn't necessarily faulty either. She had found an ingenious way to use my personality sensitivities, to replicate the flinch, and thereby to register accurately the central problem for which she sought analysis.

She had found a way of stimulating my hatred for her for what she was doing to me. I had found no way to experience or to show her my hatred and then to show her how I could now understand the treacherous nightmare she had lived in relation to her mother for her entire life. I was not successful in articulating how my position toward her was stunting me, strangling out whole areas of my spontaneous creative personality functioning, and forcing me into unnatural and guarded responsiveness.

When I failed to find a way to acknowledge that in certain ways I had indeed experienced her as the weepy, drab person she projected that she was, and when I failed to understand and admit just how she had succeeded in stunting my personality, in alienating me, and in arousing my hatred toward her, she realized that I could not help her further. I had let her down with no indications whatsoever that I would be able to do better in the future.

Discussion

One interesting feature of this vignette common to a number of replication/counterreplication engagements is the sexualization of the analytic exchange.

While the sexualization may take various forms and be attributed to many different causes, a few common themes often

emerge. One frequent determinant for the sexualization of the replication of early dyadic experience is the fusion or confusion between affection and sexuality. This confusion results from the prolonged period required for human development. That is, certain kinds of affectionate attachments from early childhood are retained in the personality through puberty, when they become enmeshed in an individual's sexuality. The sexualized affection is then transferred to all or to certain subsequent relationships, including the analytic one.

Another cause for sexualization of replicated interactions arises from the ways in which mind-body boundaries form imperfectly or fail to form in early childhood relationships. In various ways, mind-body boundaries may remain defined idiosyncratically and, to a greater or lesser extent, be imbued with erotic or incestuous overtones. Early ego functions surrounding issues of interpersonal boundary definition may have been limited or peculiar for a variety of reasons. The result is that later sexual development does not become integrated smoothly into conventional definitions of interpersonal boundaries and certain merger experiences may remain erotized.

In the present vignette a third possibility, different from those ordinarily encountered, arises to account for the sexualization of the replication. *Here, the sexualized replicated transference shows up as a function of the therapist's personal*

vulnerabilities or sensitivities, which would not need to be at all sexual in nature. When a symbiotic or separating dyadic exchange is replicated in the analytic relationship, it is the affective mode of relatedness that is reestablished on a pre- or nonverbal basis. The creative ingenuity of people in analysis to establish, on a nonverbal or preverbal basis, emotional qualities in a relationship, is uncanny.

The *content* of the interaction is often not of particular interest in itself, but what is of crucial importance is the affective nature of the emotional interchange to be replicated. What had to be replicated here, in order to be communicated, was a particular style, pattern, or mode of early mother-child relatedness in which the child felt that whole sectors of her spontaneous and creative potentials had to be suppressed in order to support mother's vulnerable personality functioning. Mother's dependency hung heavily on this child as she demanded incessant reassurances, leaving the girl feeling elated that her mother loved her and simultaneously helpless and stifled by her mother's attention, so totally fixed on her in order to maintain mother's cohesiveness and functioning in the world. This woman had derived remarkable enjoyment and satisfaction from my permission to let her gaze at me and to feel consolidated as a result of her erotically tinged scrutiny.

So far as I could determine, there was no history of overt incest in her family, although her brother was obnoxious with double entendres with off-color implications. I would have to surmise that she was very skillful in ferreting out an aspect of my personality that was vulnerable to a similar quality of emotional threat that her early relationship with her mother, and possibly also with an insinuating brother, contained.

In teaching therapists about this particular symbiotic skill, I have often said that *people have an uncanny capacity to sense the unconscious reactions of the analyst in such a way as to use the personality qualities of the therapist to recreate the emotional or affective constellation that serves to represent their own replication*. The analyst is incorrect to assume that it is the personal countertransference in the narrow sense that is the important aspect of such interactions. That is, the person in analysis who wishes to represent the preverbal emotional exchange with his or her caretakers must do so paraverbally since the exact experience to be transferred into the analysis relates to *an emotional way of being with someone*.

Mother and child develop an idiom of being and interacting that is peculiar to that dyad. *The emotional exchange or interaction then becomes the person's way of representing in the analysis the emotionality of early childhood that must be analyzed*.

My assumption that the problem was created by a series of episodes in my preadolescence or a vulnerability in my personality dating to my own symbiosis ignored the possibility that she was actively employing this vulnerability at a level not conscious to either of us for the purposes of recreating a certain stylized and highly charged emotional atmosphere.

In considering the countertransference material in the narrow sense and acknowledging a specific vulnerability in my historical past, I failed to appreciate the replication involved. I thereby lost the opportunity to move the consideration of the replication of uneasiness, fear, hatred, confinement, and strangulated creativity onto the plane of the analysis.

I have since learned to identify quickly countertransference responsiveness that arises from a reversal of roles or from the therapist's identification with the projected child self that has been subjected to emotional demands from older people. As a supervisor, I have also learned to apply this role-reversal understanding. with the general result that symbiotic issues become more understandable and workable through detailed analysis of the countertransference.

But exactly how does one come to work with or to interpret countertransference reactions? My first response is, "Very carefully!" Countertransference interpretation takes months of

collaborative work to accomplish. It is subject to considerable creative interaction between two people.

In replication, the unique personality features of the analyst are utilized for expressive purposes. The relevant dimensions can be expected to become embedded in or entangled with the personal images and idioms peculiar to the analyst's personality. Thus, the analyst is never in a favorable position to make a clear or clean-cut interpretation of the countertransference, which is independent of his or her personality or personally biased ways of experiencing the world.

Stressing that he is not referring to the analyst's thoughtless discharge of affect that might be relieving to the analyst but only serves his or her own self-cure, Christopher Bollas (1983) speaks of "countertransference readiness" as a cultivated state of "freely roused emotional sensibility" that is available to the analyst through hunches, feeling states, passing images, fantasies, and imagined interpretive interventions. Like many clinicians, Bollas entertains the possibility that for differing reasons and in varied ways analysands recreate their infantile life in the analytic relationship. Patients may enact fragments of a parent, thus inviting us to learn unconsciously, through experience, how it felt to be the child. Or they may hyperbolize the child to see if we become the "mad" parent.

Bollas holds that preoedipal patients tend to create idiomatic environments in which the analyst is invited to fill differing and changing self and object roles. (My experience is that all people attempt to recreate troubling aspects of their symbiosis in the analytic ambience in one way or another.)

Bollas emphasizes that we must sustain long periods of not knowing how we are meant to function while the person manipulates us through “transference usage” into “object identity.” More often than not, he says, we are made use of through our affects, much as a baby “speaks” to mother by evoking a feeling-perception in her that inspires some action on the baby’s behalf, or leads her to put the object use into language, thereby “engaging the infant in the journey toward verbal representation of internal psychic states” (p. 204).

Bollas’s working technique follows Winnicott’s (1974) attitude in regarding the analyst’s thoughts as subjective objects to be put into the potential space between—objects with which two can play. As examples, Bollas might preface a feeling or subjective statement with “‘what occurs to me,’ ‘I am thinking that,’ ‘I have an idea,’ … [or] ‘now I don’t think you are going to like what occurs to me but’ … [or] ‘this may sound quite mad to you but’…” and then proceed to say what he thinks or feels (p. 206). Bollas points out that, like the early situation with mother, the analyst seeks out and relates to the unconscious gestures of

the patient. That is, the analyst is finding and supporting the infant speech in the analysand and doing so, ironically, by speaking up for his own nonverbal sensations. Bollas believes that responsible and comfortable rootedness in subjective experience, shared by two, leads toward a mutual "sense of appropriate conviction that the patient's true self has been found and registered" (p. 210).

Countertransference Interpretations

I have developed several suggestions regarding interpretations of countertransference arising in response to symbiotic replications.

1. At this level the best interpretation is often action—simply being there in some important way (rather than the abandonment previously experienced).

2. A format for presenting countertransference interpretation is a tentative and slow head-scratching, yawning attitude, such as, "I've had some thoughts I can't account for. Perhaps they are relevant to our experience." The first-person plural pronoun reflects the symbiotic sense. Comments such as, "I have some feelings about you ..." or "Perhaps others react to you in similar ways ..." are social commentary, but are not interpretations of intrapsychic experience. The sense of the "symbiotic we" always needs to be present.

3. It is often valuable to discuss the "two levels" of our relationship: (a) the real level ("All is going well between us as part of the analytic hours") and (b) the fantasy of transference and countertransference work level ("I am beginning to feel angry, bored, deprived, hungry, depressed" implies "You're causing me to feel that way" or "I'm picking up a certain message from you." The tone here would be: "You have fantasies and dreams about me or us that are helpful for us to examine and perhaps we can also learn by examining sensations, feelings, or dreams of mine—'we' are in this together)."

4. Here are two rules regarding interpretation that I find helpful when I am not certain of the developmental level involved: (a) content-wise—I try interpreting at the lowest level first, that is, at the level of symbiotic need and deficit rather than the level of conflict of thoughts, desires, and inhibitions. If I am wrong, the effect is harmless or, at worst, regarded as Pollyanna, whereas if I interpret at the highest (oedipal) level, I may create a major misunderstanding and therefore a break of empathy; (b) form-wise—I interpret or respond at the highest level of abstraction first, that is, at the verbal-symbolic level rather than the selfobject or merger interaction levels. If I am wrong, I simply won't be heard, whereas if I interpret at the lower level I may not maximize the symbolic possibilities of the moment.

Three Common Errors

In attempting to analyze merger or symbiotic scenarios, three technical errors commonly arise in handling the countertransference. The first and perhaps most widely noted

error is the therapist's simply ignoring disturbing feelings because he or she knows them to be related to recurring personal issues or sensitivities or simply does not know what to do with the feelings.

The second technical error is the therapist's disregard of probable countertransference distortions or idiomatic biases in favor of getting some fix on what is really happening—perhaps in the form of a theoretical notion borrowed from or confirmed by a well-known authority. Armed with the truth, the therapist may then assail the person in analysis with an interpretive line in an effort to establish the validity or correctness of the analyst's view—an endeavor with which the person in analysis is altogether too likely to cooperate. Now two can agree that what is happening relates to themes of defensiveness, splitting, narcissistic rage, incestuous entanglements, empathic failure, emerging archetypes, or whatever.

This report of my countertransference entanglement with Dora illustrates yet a third variety of technical error, perhaps even more devious in its effects than the first two: *a readiness on the analyst's part to assume personal responsibility for the emerging disruption of untoward feelings*. In assuming the disruptive feelings are solely my own I sidestep completely the more important interactional component that contains the crucial

processes and images of the analysis, whose emergence two people are resisting.

The collaborative untangling work required is always long, difficult, and frequently touchy to one or both of the participants. As therapists, we frequently require collaborative consultation with our colleagues in order to help us sort out the various sources of countertransference entanglements.

TERRIFYING TRANSFERENCES

There is a level of stark terror known to one degree or another by all human beings. It silently haunts our lives and occasionally surfaces in therapy. It is this deep-seated fear—often manifest in dreams or fantasies of dismemberment, mutilation, torture, abuse, insanity, disease, or death—that grips us with the terror of being lost forever in time and space or controlled by hostile forces stronger than ourselves.

Sometimes these overpowering forces are perceived as coming at us from the outside world. At other times we may be frightened that the source of the overwhelming terror is inside ourselves. Or worse, we may be caught wavering somewhere in between, not really feeling sure whether the danger is out there or somewhere inside. Will we be tortured, attacked, mutilated, or killed?

Or will we fragment in wild and uncontrollable insanity? Whether the terror is felt by the client or by the therapist, it has a disorienting, fragmenting, crippling power. How we can look directly into the face of such terror, hold steady, and safely work

it through is the subject of this lecture based on my book *Terrifying Transferences: Aftershocks of Childhood Trauma*.

Many therapists do everything in their power to keep the therapy process interpersonally clean, theoretically sound, and rationally comprehensible. In working hard to keep things totally neat and tidy such therapists never allow confusing, fragmenting, and frightening regressions to occur. More courageous therapists may tiptoe to the brink or even drop into the mire. But then they may become so confused, discouraged, disoriented, frightened, or even ashamed that they struggle through in silence as best they can. Then they try to put the whole painful and upsetting set of circumstances as far behind as possible.

Shame or embarrassment is a frequent response to regressions that are deeply trying because therapists too often believe that they should somehow be on top of all situations that arise in therapy. Or therapists believe that they should know how to conduct therapy in such a way that confusion, fragmentation, and terror do not result.

But in the midst of the kinds of episodes that try one's soul, all therapists know that they have done things they probably should not have done, that they have made decisions they probably should not have made. And therapists would rather not have to deal with those unpleasant uncertainties.

Another group of therapists have been doing deeply disturbing work quietly, courageously, and efficiently for years. But they have felt a need to remain in the closet about it. That is, their human compassion and intuition has successfully pointed the way through some difficult and traumatizing pieces of therapy.

But since they have never read about such cases in textbooks or never heard about such strange work in their therapy training, they are understandably shy about revealing their work and its many trials and uncertainties to anyone.

Additionally, they may feel guilty or incompetent because they fear they don't know enough about what they are doing or that they should have called on colleagues for help. Perhaps they fear that if they had referred the client to "someone more knowledgeable" the work would not have been so difficult, or not have taken so long, or not have ended so badly.

For fifty years I have consulted on difficult cases with therapists who have expressed all of the above feelings . . . and more. I have worked with therapists who feel they barely got through some difficult situations by the skin of their teeth. I have been called upon to witness for therapists who were doing their best when the situation collapsed with them inadvertently ending up in a legal or ethical investigation.

The most tragic cases involve therapists who have attempted to stay with a desperate client in order to do a difficult piece of work but in psychological areas where they had some limitation in their understanding, training, or therapeutic technique. The client needed to transfer some deep, horrible, abusive life situation into the therapeutic relationship—but these therapists simply did not have the training or understanding to enable them to protect either the client or themselves from the coming disaster.

Most psychotherapy training fails miserably at teaching therapists about how to recognize and to work with deep and treacherous transferences. As a result, therapists sometimes get caught in a frightening crossfire of psychotic anxieties and then end up in an investigation that may completely wreck their careers and personal lives.

Considering *Terrifying Transferences* takes us directly into the darkest recesses of the psychotherapy situation, where primitive psychotic anxieties silently await a rendezvous with therapist and client.

I am convinced that such primitive anxieties are, at least to a limited extent, universal—except that ordinary life protects us from encountering them most of the time. But the psychotherapy engagement seeks relational representation of all the

psychological forces that impinge on our lives, including the dark and dangerous ones.

Psychotherapy is an invitation *for* the forgotten, hidden, silent anxieties of childhood and for traumas suffered in infancy to be reawakened—transferred onto the therapist and into the therapeutic relationship.

Therapists willingly make themselves inviting targets, sitting ducks for the transfer or for the projection of primitive anxieties *for* the aftershocks of childhood trauma. Clients and therapists never know when they start therapy what kinds of terrifying and treacherous experiences they are setting out to liberate from the darkness of the past.

I want to sketch some rough maps—mind-body maps of our deepest fears and how they operate. But where shall we begin?

I usually start at the point where two people are approaching each other without having the slightest idea of what they are going to do with each other or how they are going to get along. One reaches out in some way and the other reacts. We might say that one speaks and the other listens and responds. We each bring to this moment of speaking and listening all that we are or have become in a lifetime. And so our encounter or conversation begins.

So what kind of a map can orient the adventurer without presuming to know what the adventure will be like? What kinds of maps suggest possibilities, places to begin, while expecting that the imagination and creativity of the journeyer will make the trip enriching, worthwhile, and fulfilling?

I will attempt some maps. But you must let your creative resources run free—thinking, exploring, imagining, and feeling.

Terrifying Transferences is about the fears that haunt our lives, many of them silent, irrational, and elusive, but nevertheless quite powerful in their effects on us.

In therapy we have a speaker, a listener, and a conversation about their encounter. Where better to begin to think about two people and how their encounter is bound to arouse fear?

We now know that traumatic experiences early in life leave emotional scars that affect our later relationships. When over- or understimulating traumas occur in infancy—or even before birth—a particular kind of scar is left.

The situation is quite simple. A baby experiences some need and begins some sort of extension, movement, or signal to express that need. Since conception the baby's needs have been signaled and responded to. But at some point the need-fulfillment

cycle becomes traumatically impinged upon or somehow interrupted.

When the unmet need then gathers momentum, intensity, agitation, and distress result. After a period of distress marked by various attempts to signal its needs—restless stirring, screaming, thrashing, arching its back, holding its breath, or throwing up—the baby may finally give up, stop the signaling altogether, and weaken or wither in fatigue or defeat. Or, in the process of extending a distress signal, the baby may encounter some sharp pain—perhaps something from the environment such as a loud angry shout, a tight squeeze, or a slap. Or perhaps the baby encounters something from its body like a sharp hunger or gas pang, an uncontrollable itch, an unquenchable thirst, or an overwhelming rage response.

A contraction or constriction process begins, tightening various parts of the baby's musculature. At first the tightening seems to control or quell the pain. But in time the self-protective contracting or constricting process itself becomes painful. With repeated experiences the constriction or contraction response comes to be chronically held for fear of encountering the initial (and in the child's mind) life-threatening need or signal pain again.

Whether the baby's early response to trauma is of the weakening, withering, giving-up kind or the tightening, contractive, constrictive kind, a strong message is permanently inscribed on the nascent neurological system—"Don't go there again, don't reach, don't express that need or that part of yourself again because if you do it will be unbearably painful."

A block to further relating to others in specific ways is thus set up in the foundation of the child's mind. No one can know at the time what the future implications of that block will be or how in later life that basic neurological blockage may become mentally represented. But we do know that it will be marked by fear, signal pain and agitation, and will bring about a chronic avoidance of various kinds of interpersonal relating.

Whether the trauma is caused by a neglectful or abusive environment or by the unavoidable realities in the infant's early life—an incubator, a cleft palate, an allergy to milk, an alcoholic or depressed mother or father, family stress, or Holocaust conditions—the child creatively blocks the paths that have brought in the frightening, painful, or traumatic experiences.

Later psychotherapy seeks to discover how that blockage lives on in the person's mind and body to systematically limit relationships and life experiences. When these primitive blockages are at last brought forth in the therapeutic relationship

for analysis and transformation, the memories that must be relived in the here-and-now relationship are body-mind experiences of unbearable physical and psychical pain and unspeakable terrors of being retraumatized.

Depending on the patient's overall ego development, on her or his current life situation, and on the nature and viability of the current trust relationship, the person may or may not be able to negotiate a full bodymind memory of the infantile pain and trauma so that it can be experienced and worked through in the present relationship.

We now know from considerable clinical experience that at these moments of intense body-mind remembering, there is often excruciating pain and overwhelming terror. And that the fear of and resistance to further experiencing traumatic memory becomes directed at the only other human being present—the therapist or other person in the trust relationship who invited and called forth the pain by *being present and available for intimate relating and somatopsychic remembering*.

If the therapist does not fully understand the process of trauma re-creation or is not prepared to move profitably and creatively forward with the client through the re-experiencing of the physical pain and psychological terror and the accusation that the therapist is responsible for it, then we are in for trouble. The

client feels the pain, knows that the therapist is responsible for eliciting it, and, from the primitive place being experienced at that moment, *cannot fully distinguish* the emerging past body-mind memory from the present experience of pain and terror in relation to the therapist. The inevitable conclusion? It is the therapist who is hurting me.

A background theme of *Terrifying Transferences* is how terrifying transferences that have been successfully elicited by trust relationships of various kinds but not fully worked through in the context of that relationship can and do give rise to false accusations against the therapist or the other person in the trust relationship. These accusatory cries are a regular part of the working-through process and are at high risk for being acted out in the outside community as charges of misconduct against the therapist or other trusted and/or admired persons.

The Ethic of Relating

Most of us grow up assuming that other people are more or less like us, that each person is a freewheeling, freethinking, independent center of initiative not unlike ourselves. The grammar of our language and the ideas of our culture assume that each person is an independent actor or agent doing, speaking, thinking, interacting, or being.

It comes then as a bit of a shock in psychotherapy training when one discovers that this belief in our individual freedom and independence doesn't quite hold water, and that people aren't quite so free and independent psychologically as it might seem.

"Yes, we know we are tied by the demands of many relationships. But don't we choose which people we want to relate to and under what conditions we want to be bound to relating to them?"

"Oh, that isn't quite so either? Why not?"

The simplest answer to the riddle of how we are affected by relationships is: "We are beings conceived and born into an interacting milieu from which we cannot escape. Nevertheless, our individual consciousness strives to gain a measure of freedom and independence within our significant relationships. And we are successful in this in very many regards. But we delude ourselves if we believe that we can ever be completely free of our past conditioning and the influence it holds over us."

"Okay. But so far we haven't said very much."

A more sophisticated answer might be: "All of our experiences of relating to others teach us how to be and how not to be when considering how to make our own choices and how to achieve our own aims in life. We learn ways of interacting that

serve us as young children. We later modify those ways to suit our needs as we grow up."

"Yes, but we still haven't said much."

How about: "We are creatures of habit. Based upon our earliest significant relationships, we develop emotional habit patterns of relating to others that persist throughout our lives. As the twig is bent so grows the tree." Better?

"Perhaps, at least for now."

And what about the automatic-pilot side of all of this? We know from our dreams and slips of the tongue that we have an unconscious side. "The unconscious, too, belongs to a creature of habit.

Except that unconscious habits are the worst ones to try to give up, because we never quite know how those knee-jerk responses got conditioned in the first place and so we can't know very much about how to uncondition them.

We have only to think of very basic, everyday habits to see how resistant to change unconscious habit is. The ways we eat, drink, sleep, move through the day, greet family and friends, and think about ourselves are all so seemingly fixed that we consider these unconscious habits a part of our fundamental character

makeup. We are only too painfully aware of how little power we have to change longstanding, automatic patterns.

Over the last century, depth psychology has made the observation that large portions of our lives are silently and automatically governed by longstanding and entrenched habits of relating. Psychotherapy has evolved as a practice or as a discipline geared toward exposing those habits and seeing what kinds of creative transformations might be possible.

Unfortunately, the legitimate consciousness-raising goals of psychotherapy have been corrupted by market pressures oriented toward promoting concepts of illness, disease, and cure.

When we consider as some form of sickness the inevitable limitations of our unconscious habits of relating—formed in early childhood as they were—we easily fall into yet another bad habit! Then we get sidetracked wondering "What's wrong with me that I always . . . ?" It's hard to pay close attention to who we are and how we operate in relationships when the minute something odd about ourselves catches our attention we label it as an indication of weakness, craziness, or as a symptom of some kind of disease or illness.

Also thwarting the consciousness-raising goals of psychotherapy is the wish to be objective about a person's subjective self—certainly a contradictory endeavor. It's not that

we can't find systematic and helpful ways for studying our subjectivity, but let's not call that objective science! Certainly the overall practice of psychotherapy lends itself to scientific scrutiny. But studying personal subjectivity and working on consciousness-raising about one's relational habits is not a science but a creative narrational activity.

Psychotherapy, it turns out, is a form of storytelling—the oldest and most respected of all human communication and knowledge-enhancing activities. Whatever vital truths about our nature have been passed down through the generations have been embedded in narrations—stories, myths, archetypal experiences—that we come to appreciate in various ways.

Psychotherapists have realized from the beginning that if we want to know better who we are, we must tell and re-tell our personal stories. We can't simply tell our story once, or in one way. Nor can we expect it to be coherent or sensible when we do tell it, because we have numerous stories to tell, many of which don't make the slightest bit of sense! Stories we tell about ourselves are embellished, outlandishly exaggerated, or blatantly untrue. But they exist for a reason and serve some of our purposes.

Many of our stories contradict one another. Others have huge gaps in time, place, memory, continuity, and meaning that

we can't quite account for. Nevertheless, we endlessly occupy ourselves trying to create seamless narratives that flow coherently, make perfect sense, and are eminently plausible. We crave a sense of coherence and certainty though we know our entire existence is marked by incoherence and uncertainty.

If we buy into the notion that we are essentially flawed beings, that there's something fundamentally wrong with us or sick deep down there somewhere, then we run into other problems. We soon come to believe that if we could just remember—if we could only find a way to get to the bottom of it all, then we would find out what really happened to us and then we could be okay. In trying to remember in order to get better, we end up searching for the truth of a forever elusive historical past and how it somehow ruined us. And if we go very far in this search for the Grail, the Cure, the Way, we are very likely to come to believe that there is a royal road to self-discovery—and perhaps that we now know what it is!

Needless to say, the "how to do it right" ground is a fertile place for religious zealots, peddlers of dogma, charlatans, and marketeers. "If you are weak, wounded, despairing, or worn out searching for the truth of what ails you, then come to me because I have the answers and the way." This may at times be appropriate in religion, but it makes for poor psychology. In going down this road we lose sight of the fact that our quest is to

discover how our unconscious, automatic emotional patterns affect our *present* everyday relationships.

But if what we are looking for are ways of noticing and dealing with our entrenched emotional habits of relating, then there must be many ways of attaining our own personal enlightenment. There must be many ways of discovering and defining our subjective truths, many ways of allowing our consciousness of ourselves to expand. Simply adopting another fixed set of metaphors—like medical or scientific ones—to replace the old personal ones we want to be free of may well put us ahead in the short run of the self-discovery game. But in the long run our flexibility will still be severely limited because we haven't been absolutely truthful in noticing all of the expectable uniqueness and strangeness that is ourselves.

Psychotherapy is then a narrational enterprise in which two or more are gathered together with designated speaker(s) and designated listeners(s) for the purpose of expanding consciousness. The storytelling begins. Each listener questions the story from the vantage point of his or her own life experiences, trying to extract the messages, themes, puzzles, and codes of the evolving and emerging narratives. Each listener is attentive to the emotional load of the stories—from the nonverbal content and body reactions that accompany the narrations through the sequencing, the pacing, the language

employed, the tone of voice, and the various other physical movements, to emotional expressions, energetic vibrations, and muscular constrictions.

The psychotherapy dialogue expands as both speaker and listener attend to the evolving stories and to the ways they are coming to consider those stories and their reactions together. In time, a complex collaboration or joint cooperative endeavor evolves.

This collaboration in developing meaning, in struggling to define themes and movements, is expanded consciousness itself. Listener and speaker might agree to focus, to interact in many different ways depending on who they are and on what their past experiences have been. But the consciousness expansion or consciousness-raising that has come to characterize psychotherapy arises from a dialogue centering on personal relationships and personal modes of meaning and relatedness, using stories and the interpersonal relationship of therapy itself as a jumping-off point.

Is it so outlandish to think that in human life the very unconscious habit structures that determine the flow of our minds and of our consciousness itself have to do with relationships? Is it really so strange to imagine that the entrenched habits of our emotional life revolve around how we have come to experience

ourselves in relation to various others who have been important to us? And is it such a far reach to say that how we experience and relate in the present must surely be strongly colored by how we have learned to relate in the past? *Psychotherapy is about noticing present patterns and the way they operate in the here-and-now to color all of our meaningful relationships, especially the psychotherapy relationship*.

We engage in storytelling rather than, say, playing tennis, taking a hike, or noticing how we sit in a chair for two reasons. First, because storytelling is the oldest and most richly evolved form of human communication and therefore has the highest possible yield in terms of information about a person's unconscious relatedness habits. And secondly, because good stories are full of imagination, nonverbal associations, subtle motivations, and varying contents that all point toward lively self-definitions that may be useful in the development and expansion of the joint consensus of the psychotherapy consciousness-raising endeavor.

"And just what are we trying to raise to consciousness by partaking in therapy?"

Psychotherapy seeks to define the unconscious relational habits or patterns that govern the way we live all of our relationships every day. Without a working knowledge of these

repetitive, characterological patterns or mechanisms, we haven't got a ghost of a chance of altering them, of exploring options, or of developing novel and creative approaches to how we live our relationships.

"But people have real symptoms—nervousness, tension, sexual dysfunctions, memory lapses, concentration difficulties, attention deficits, addictions, chronic fatigue, and eating problems—to mention only a few. What do all of these symptoms have to do with meaning and consciousness-raising, with emotional habits of relating?"

That question has given rise to one of the most ingenious marketing strategies ever devised. By convincing people to consider psychological issues as symptoms of some hidden or mysterious illness or disease process, we psychotherapists can then sell our wares. We can then promise an understanding and a cure.

Not that psychological issues don't interface with various constrictions and disease processes in our bodies, because they certainly do. But failing to appreciate how profoundly our physiological processes are reciprocally influenced by psychological processes blinds us to the ways that our emotional-relatedness habits influence, to a greater or lesser extent, all that

we are and everything that we do—in every relationship every day of our lives!

Whatever is going on with us is not so very mysterious, and it isn't a disease process; *it is the diversity and uniqueness of who we are*. Noticing how we are connected mentally and relationally to others and to our bodies is what counts.

From before birth human beings know about relationship. In vitro fertilization studies have shown us that a dozen or more eggs often become fertilized. Many of them immediately attach themselves to the intrauterine wall and, if conditions are hospitable, begin developing. Those who survive must compete in effective relating to the maternal body. They must start an immediate and robust communicating and relating process or they will die. And so on from there—relate, relate, relate!

All aspects of our minds and bodies are oriented toward relating to others. Our entire beings, all of our emotional (mind and body) patterns and habits, come to be structured according to the ways of relating that are required for the infant, the toddler, the child, the adolescent, and the adult in order to survive and thrive—given the specifics of each person's immediate emotional environment.

The ethic which is becoming clarified by modern psychotherapy is simply the imperative in human life to relate!

In order to get our needs met on this planet, we must relate—and we must do it well.

"But what exactly does that mean: *relate*?"

To relate means to recognize that each person who approaches us or who speaks to us is living out, in the way he or she relates to us, the full history of his or her emotional patterns of relatedness.

Every person's history is unique, diverse, and rich in its own way. Every person's story is unique. And every person's consciousness about his or her personal automatic patterns of relating is limited in a variety of ways.

Psychotherapeutic listening means relating—working hard to see, to define, to understand, and to respond to all of the relationship habits brought to the encounter by both speaker and listener in as many ways as we can.

"But shouldn't relating be free and spontaneous? Why do you speak of hard work?"

All day we struggle with myriad kinds of relationship demands. And in any meaningful, ongoing relationship we need to be fully prepared for periods of turmoil, strife, struggling together, and conflict resolution.

“Then this consciousness-raising you are talking about can occur in the hard work of relating in any relationship.”

Yes it can, and it does. But the trials and tribulations of our days as well as our need for a certain amount of solace in our significant relationships at the end of the day make it difficult for us to keep up the hard work of relating that is required to keep both parties alive to each other every minute.

We tend to become lazy and sloppy in our close relationships. And for this reason it is not uncommon for our relationships to fall into various kinds of trouble. But over time it has become increasingly clear that the value of studying our patterns of relating is so great and the personal gains so significant that we are willing to dedicate a great deal of time and energy to the cause of therapy and to designate a professional listener whom we are willing to pay. With that listener we hope to become more able to spell out in consciousness how we typically approach people, how we set up expectations for our relationships, and how we systematically engineer relationship disasters that profoundly affect our minds and our bodies.

Systematic consciousness-raising can be a part of any relationship. And good relationships are always rewarding in this way. Therapy is simply a special form of two or more people coming together dedicated to the process.

The psychotherapeutic situation has forced therapists to systematically examine the problem of relatedness for more than a century. Some extraordinary people have devoted themselves to the study of relatedness over the last hundred years and have left a formidable body of ideas that continues to evolve. But the bottom line is that if you can't see or feel where people are coming from with their emotional-relatedness patterns, then you certainly can't relate very personally to them or help them see how they are relating to you, to themselves, or to others.

Striving, thriving human beings prosper in all ways in their lives by paying close attention to how they relate to themselves and to other people in their lives. It is through studying all of their unconscious habits of relating that truly enlivened people learn how to cultivate new options for themselves.

The psychotherapeutic dialogue teaches us how to create greater flexibility in relating to others for more joy, richness, and fulfillment in life. Relationship experiences from all four levels of self-and-other development are emotionally transferred, and re-experienced in relation to the therapist in long-term, intensive psychotherapy. Whether they are explicitly talked about and interpreted in the here-and-now of the therapeutic relationship or whether they are ignored and acted out depends upon the cleverness and insightfulness as well as the purposes and goals of both speaker and listener.

Any child could have been exposed to intrusive, traumatic, or terrifying experiences at any age and might need to relive that fear later in psychotherapy with the therapist assuming a variety of roles in the re-creation of the emotionally traumatic experience. But by the time a child is 2½ or 3 years old, he or she has a wealth of resources available for dealing with frightening, fragmenting experiences, so that fear becomes progressively less likely to totally overwhelm the existent ego or self-structure.

Truly terrifying and deeply traumatic experiences are therefore more characteristic of the earliest stages of development—the Organizing and the Symbiotic experiences. And it goes without saying that a child (or anyone) subjected to overwhelming terror during an earlier phase of life is vulnerable to having a similar overwhelming level of terror restimulated in later frightening or fragmenting circumstances. A corollary of these two propositions—(1) that a propensity to experience overwhelming terror is most likely to begin very early in life, and (2) that people terrified early in life are highly vulnerable to later retraumatization—would be that (3) people are more likely to be able to recall with some clarity later traumatic experiences that occur after perception and memory are well developed, whereas early overwhelming trauma usually cannot be directly recalled and recounted because when it took place ordinary

forms of perception, judgment, and memory were not yet in full operation.

In the "recovered memory" controversy a few years back we had a whole group of therapists colluding with their clients trying to image through "truth serum," hypnosis, and guided imagery what was at the bottom of their lifelong dissatisfaction. The images that were conjured up to convey the sense of what horrors had happened to them in infancy repeatedly turned out to be a series of archetypal stories and pictures masquerading as recovered memories. Through body-shaking memories of past lives, alien abductions, and childhood molestations to the dissociations of multiple personality, out-of-body experiences, and satanic ritual abuse, speaker and listener were jointly conveyed to realms of horror and terror by the images and drama that emerged. What was missing, of course, was a careful study of how these same terrors were emerging concurrently in relation to the therapist and to the pressing psychotherapeutic demand to relate emotionally. Both speaker and listener could be transported to "way back then," struggling to remember exactly what atrocities occurred and identifying just who perpetrated them. Both participants could then react with disgust, horror, and outrage, thereby enabling themselves to collude in engaging in activities allied with resisting or avoiding the task at hand, that is, the revival in the here-and-now trust relationship of the

transference terrors associated with interpersonal emotional intimacy and the transfer into the present of the accusatory cries of the past.

I want no one to misunderstand me: plenty of childhood abuse has occurred—much more than any of us would like to think about. But as the various task forces of the mental health professions have reported: (1) most seriously abused people have memory for some or all of the childhood abuse; (2) not all memories of abuse are about things that actually happened; (3) the earlier and more vivid the recovered memory, the less likely that it actually happened in the exact way it is recalled; (4) infantile abuse is remembered in somatic and relational modes, not narrational and pictorial modes; and (5) construction of memories that reflect emotional truths is not uncommon.

Remembering, Repeating, and Working Through Childhood Trauma (Hedges 1994b) studies how focal as well as cumulative strain trauma in infancy leaves imprints on the personality that are likely to be recalled later through (1) archetypal narrations, (2) replicated interpersonal interactions, and (3) deep and terrifying somatic abreactions. A brief word is in order about each, as these forms of memory are related to terror being reexperienced in the transference of psychotherapy and other trust relationships.

1. *Archetypal narrations* are stories of trauma that serve like dreams to condense, symbolize, and represent the emotional sense of the remembered trauma. Archetypal narrations such as abduction, ritual abuse, and past lives serve as metaphors to express the emotional sense of "what I know I must have gone through at one time long, long ago."

2. *Replicated interpersonal interaction* is a well-known form of memory accomplished by re-creating, living out, and acting out in contemporary personal relationships—usually again and again—the traumatic situation that one was once caught up in, exposed to, or trapped by. This compulsion to repeat earlier trauma in present relationships is presumably based on an attempt to master the trauma through repetition with the hope of a better outcome, or, through a role reversal, to turn an enduring sense of passive defeat into active victory.

3. *Deep somatic abreaction* such as shaking, convulsing, vomiting, breath holding, ritualistic obsessions, panic attacks, hysterical paralysis or blindness, and other psycho-physical manifestations may *be* critical memories of infantile trauma, although there is often some event, story, or interpersonal context that is relevant to the triggering of the somatic abreaction. These reactions can be sudden, dramatic, and at times even dangerous to both client and therapist, but they usually emerge in a context of threatened or successful interpersonal contact, connection, or intimacy. That is, *it is in the anticipation of or in the wake of some successful move by both participants in the relationship to achieve some form of viable and meaningful interpersonal connection that the somatic abreaction*

> *occurs*. As such, it expresses terror of contact and functions to rupture, to prevent, and/or to foreclose the interpersonal connection that is forbidden by primordial conditioning. The *physical abreaction itself* is *the memory, and whatever narration accompanies it usually serves as a decoy concern to derail the intimacy being approached or achieved by the two in the moment*. That is, intimate relating in the past was the instrument of the abuse or trauma, and therefore it is intimate connecting in a true interpersonal interaction in the present that is feared.

Webster defines terror as stark fear and as a running from fear. We may say we are terrified of being somehow disabled, helpless, or trapped. We may feel a terror of not being able to move, to breathe, to think, or to speak. We may awake terrified from a nightmare in which we cannot pass an examination, cannot talk or scream, cannot escape an approaching disaster, or are paralyzed in the face of overwhelming and unavoidable danger. A "reign of terror" is a frightening, oppressive, and damaging political situation that cannot be escaped.

Fear is known to all of us. Although it may be externally triggered, fear itself is a natural physiological response that arises from *within* our bodies to alert us to potential danger, thus making the fear response itself adaptively important and somehow inescapable. And yet our *experience* of fear is invariably linked to some external stimulus, an outside threat that elicits, triggers, or causes it. We may be suddenly startled and

then relieved when we realize there is really nothing to be afraid of.

Certain situations may elicit fear for prolonged periods of time until we find some escape, some safety, some relief. But for many people chronic fear has been conditioned into their minds and bodies by the ongoing and frightening circumstances of their childhoods. Some people have experienced severe traumas and major disasters later in life that leave them perennially vulnerable to being once again seized by panic and terror.

Needless to say, our media play endlessly on our many terrifying vulnerabilities—real and imagined. The fears we feel have a constricting effect on our minds and bodies. Chronic fear leaves us paralyzed and crippled and increases our vulnerability to stress, fatigue, and disease. We cringe with arthritic fear. We shake with heart-stopping terror. Our eyes open wide in sudden shock and horror. We clench our fists. We try to scream or run. We freeze with fright, get cold feet, shiver, curl up in a ball, double over with pain, curl our toes, hold in our breath, pull into our shell, strike out in panic, fight for our lives, run for safety, hang on for dear life. Body-mind terror is not so far away as we might like it to be!

The critical feature from the Organizing experience that becomes central to *Terrifying Transferences* is the recreation in

contemporary relationships of deep-seated fears conditioned by relationship-related traumas experienced in infancy. As Winnicott (1949) has shown us, in utero and in the earliest months after birth the infant mind can be characterized as having a sense of "going on being" that allows it to evolve unperturbed.

Intrusive impingements of intensity, frequency, or duration into that nascent sense of continuity and well-being leave a mark on the infant mind by forcing it to react to strong external stimulation before it is ready. Significant intrusive impingement constitutes trauma for the infant because the nascent and developing ego-self structures cannot adequately receive, process, and attribute meaning to overwhelmingly strong stimulation. We hear a loud, sudden noise and watch the infant awake—startled, tense, constricted, wide-eyed, terrified.

And then comes the cry, the clamor to be picked up, the need to be soothed, the plea to be allowed to return to preconscious reverie, to a sense of personal well-being and to the safety of mental continuity.

In trying just now to visualize terrifying infantile trauma and the mind-body constrictions it gives rise to, I have alluded to the clamor that over- or understimulation inevitably gives rise to. We hear it incessantly in-depth psychotherapy. I don't know what else to call it. I know the clamor comes from deep distress

and pain. And I don't mean to sound pejorative—but it is a clamor, and our psychotherapy rooms are filled with it. Clamor to me implies two things. First, an incessant cry or demand for more, for special consideration, for "what I legitimately need and have a right to *now*—before I fragment or die."

But secondly, clamor is a cry that is so intense and so intrusive as to be annoying, alienating, and contact-rupturing.

Undoubtedly the original function of the cry was to signal distress and to demand that the mothering partner restore a mind—body state that could be enjoyed or tolerated. But when the cry becomes a conditioned part of an infant's life that cannot be adequately calmed, it can become a conditioned response to any perturbation. Subsequently, the clamor is systematically paired with or conditioned to a sense of the presence of the (m)other who is failing to relieve the perturbation or pain.

So through simple conditioning the trust relationship itself becomes the object of terror, in proportion to whatever extent it was originally unsuccessful in quelling the rising tide of overwhelming distress and pain.

Later trust relationships or trust situations are then imbued with this conditioned fear and its accompanying clamor. The clamor thus comes to serve as an alienating wedge between people to prevent the danger of intimate relating.

Clamor takes myriad forms. But *in therapy it functions to produce a breach in interpersonal connection or to limit the possibility of sustained connection*. Therapists with good training in empathy try to ride out the cry, to empathize with the need—the demand associated with the clamor—and with the frustration that it is not being adequately met. But empathy with only the content of the clamor serves to escalate its intensity, delay its punch, and reinforce its alienating function.

What is not being realized by such a limited form of content empathy is that the *content* of the clamor cannot be satisfied because, as cry, it is a memory with a purpose but not necessarily a relevant content.

The clamor is an angry memory of what I needed and didn't get. But the conditioned clamor-memory now functions in the service of preventing intimate or reciprocal interconnections that in the past were known to be traumatic. what is remembered is the pain of a previous relation or connection that was experienced as dangerous or terrifying.

Muscular constriction to withdraw from, ward off, or quell the pain then provides its own form of permanently conditioned pain response which, over a lifetime, the patient comes to fear. The trust relation rouses this contiguous physical-psychological pain response. The cry or clamor serves to ward off present and

future connections by alienating the other and creating a safety zone to prevent future relationship trauma. Once an expression of pain in relationship, *the clamorous cry now functions as a defense against relationship retraumatization through foreclosing meaningful emotional connections*. The person is terrified of connections, of relationship, because interconnectedness in the primordial past was known to be hurtful. To connect in the present is to run the risk of stimulating pain again. There are many ways to prevent relatedness—one is a clamorous cry for "more," for "what I deserve," for how "you're not treating me right," for how "you're not giving me what I need," or for how "I can find somebody better who will."

"Abandonment!" in one form or another is the cry. But it is essentially bogus because it is used not to promote relating, not to search for ways of re-establishing empathic attunement, but for purposes of preventing connection or creating a break in connections!

One man who was born with a birth defect that prevented sucking sought older women prostitutes and then complained that he couldn't orgasm with them. Soothing sensual contact was what had been missing, and when he now goes for it in ways that are self-limiting, he then focuses on his sexual dysfunction rather than on his self-frustrated yearning for closeness and his terror of relationship. A woman client who had been mechanically

managed by her mother out of a sense of obligation and duty in infancy begged her therapist for physical touch because she was internally prevented from feeling his mental presence and touch. He knew that the soothing physical touch that she longed for was available to her in many ways in her life. Her clamor for physical touch from him not only kept him uneasy and distant in the relationship, but prevented the very mental and emotional closeness and soothing that would allow her to participate in transformational relating. Another man maintains a schizoid or bored demeanor in relationships until the other almost forcibly approaches him with overriding, warm, affirming interest. He thinks he is afraid to approach others because he might be rejected, but in fact his manner staves off the possibility of connection that he is terrified of. When there are brief moments of connection with his therapist, he suffers terrifying nightmares and phobias. He remains stuck in the belief that others "don't relate well, don't approach me right." Numerous therapy relations end with the client bitterly complaining about the shortcomings of the therapist. Yet when the interaction is closely scrutinized we can see that the clamor and accusatory cries only serve to justify the client's retreat, and that there was an unwillingness or inability to continue negotiating the relating. derailing the therapeutic process. The content is designed to fend off intimate and meaningful relating.

Terrified by Disconnecting Rage (by Sean Stewart)[1]

Hedges's Introduction

A regular aspect of countertransference in response to Organizing transference is the arousal or revival in the therapist of a fragmenting fear that *we* are not being heard, responded to, or being acknowledged as a real and present person in the therapeutic relationship. Our own deepest fears date back to infancy when we reached out hoping or needing to connect to our own (m)others. And either no one was there or we were somehow painfully rebuffed. When the Organizing transference is operating, we therapists find ourselves reaching out, struggling to be responded to, and collapsing or fragmenting in our own sense of despair and/or terror. The following is a transcript of a case conference that had everyone in the room on the edge of their chairs as the client created an episode of full-blown psychotic rage. It is a rare portrayal of two people living together in terror.

Case Study

Sean: Eddie and I are in our eighth year together now. I want to report an amazing encounter we recently had. Eddie and I set up a week when we were going to meet three times instead of our regular two—on Monday, Wednesday, and Friday—and also have five-minute phone contact every night. The regular contact calls we've been having for

some time now give us a sense of connection, even if they're just a couple of minutes. Eddie has seemed to use the calls to help him with creating a frame to bring into our relationship the Organizing or psychotic transference.

In his own way Eddie can describe the theory of the Organizing transference—he puts it in terms of his reaching out for contact with mother and encountering some type of Violent intrusion that breaks the contact, and then the pulling back of the reaching tendril with the resolution to never go there again. Basically, Eddie now understands the sense of violent intrusion he often feels when he is with me as being replicated from much earlier in his life. He now understands experienced intrusions as sometimes very real and at other times as transferred representations of his life's earliest intrusions. Usually the associations start with something present and take us back in time.

Eddie has come to believe that the violent intrusions started for him before he was born, when his mother's not wanting to be pregnant affected him. She was schizophrenic. He believes that her body was biologically pulling away from his even while he was a fetus.

Larry: Why did you decide now to increase the contact time?

Sean: Because Eddie and I had not been able to get together enough the previous month in our usual

twice-a-week way. I thought it was because he was having troubles at the homeless shelter that he now manages. He has a separate apartment from the homeless psychotic people now instead of being housed with them, which is his way of differentiating himself from them concretely. His car was breaking down. There was rain that flooded the streets. He's been having some problems with his teeth so he was going through a period of a lot of pain. We just weren't able to meet as often as usual. So we had to spend more time on the phone. Phone time is different than being with him. After missing him for so long I found myself saying, "You know we haven't seen each other much lately, Eddie. Your car is working now. Who knows what's going to happen next week? We really need more time together. Let's get it on, come on in." I gently pushed and he was up for it. So we decided on three times weekly for awhile. We've done that occasionally, even if things were going fairly well.

Sean: (*Reading from session notes)* The first Monday on our new time schedule Eddie comes in feeling very good, with his dentures in.

Mary: That's a sign he's feeling good?

Sean: That's a sign, because his dentures often hurt him and he can't or doesn't wear them. He's looking great! He's very color coordinated. He's well dressed, which is a sign. There's a connection to social consensus for him by how well things are

put together. And he's laughing. He's feeling good. The first thing he notices in that session is Mullon handing me my coffee. (*Note: Sean is in a wheelchair; Mullon is his assistant who helps him start the day.)* Eddie had come in early, and I'm still setting things up. I just let him come in. He doesn't usually talk to Mullon. Mullon's bringing my coffee over to my desk. Eddie's engaging Mullon saying, "Why don't you let me do that?"

Larry: If we're going to watch an interesting week develop now, it's important that the kickoff is with Sean noticing that they're relating to the third (i.e. social consensus). And that Eddie's wanting to relate in the triangle. It's a seemingly small piece of business but as a kickoff to a week in which both participants have made a renewal of commitment it may be critical in understanding the events of the rest of the week. The other thing present at this time is budding narcissism, in terms of his dress and prideful demeanor. Recall how bad his hygiene and dress had been in the past.

Sean: Yes. As a matter of fact he was color-coordinated and feeling pretty dapper—quite a feat for someone who has been so socially inept for so many years. When we started, anyone would have seen him as a "burnt-out schizophrenic," a total emotional and social wreck.

Larry: Did he elicit a comment from you?

Sean: (*Smiling)* Yes. He came in smiling with his glasses on. He knows he looks good. I say, "Eddie you look wonderful today! This is the best I've ever seen you look." I was sincere and I really was thinking that I wouldn't mind having a shirt like that! He was able to take my compliment in and laugh, to tell me "thank you," and to feel good about it. Mullon was still present and was allowed to be a part of the jovial interaction.

Larry: So we have two higher levels of development being activated at the beginning of this week, which you tell us is significant. We have a touch of body narcissism and enjoyment with the selfobject function of feeling good about being admired. And we have an emotional triangulation presumably in response to your invitation to have more committed time together into a psychotic part of him hearing voices.

Sean: The spontaneity and repartee were fun for both of us. By the way, no voices at all this day. He often still hears murmuring of some sort or another. But no murmuring today. He's able to engage me playfully today. I can be angry with him and say, "You can't do that." And Eddie is able to respond, "I can very well do what I want." It feels like this exchange is consolidating for him. Part of his growing sense of consolidation is that he's realizing he's able to take me on a bit—to stay with the conflict and no demon comes in and says, "You're a piece of shit," which used to happen to him quite frequently. He's getting built

up in this moment. So this is the essence of Monday.

Larry: You're characterizing the interaction as a 2-year-old separation movement--that phase mothers call "the terrible twos." We feel aggression, playful opposition in the service of individuation.

Sean: Yes. We are definitely in a separation-type process.

Larry: That's what the fighting is about.

Sean: Yes.

Larry: "I have my own mind."

Sean: Absolutely. That's why I characterized him in the 18- to 24-month-old phase, because in his own way he's separating and individuating.

Larry: So you've got three higher-level functions all operating in this hour—a touch of the oedipal triangulating ambivalence, a touch of the narcissistic search for selfobject recognition, and some separation-individuation material.

Sean: With a previous month of his just being very absent—physically withdrawn, and with everything breaking down in his life. This one worker at the day treatment was saying horrible things about him to his clients, who would come back and tell him. Then he would go tell his boss. It was quite disturbing and he had a hard time separating reality from paranoid delusions.

Cindy: Did he confront that person?

Sean: He's confronted that person. Although this person, I have a feeling is also pretty disturbed. So his engaging the other person is not solving anything. But I did encourage him to confront his boss more. I'm saying, "Eddie, your boss knows you. You've been managing this place for three years. She just got you your own place to live. The owner loves you. If you're going to confront anybody, go confront them with the issue.... That's Monday basically. We talked briefly on the phone that night. We talked briefly again on Tuesday. Wednesday's session was similar. He's well-dressed, doing good. But I'm noticing that it's not quite as good. Where Monday was a 10, Wednesday was a 7. We're doing the same thing, but I'm also noticing it's in me as well, in the countertransference. I'm not feeling as good about him, about us. We talked again Wednesday night. We had made solid interpersonal contact Monday. And predictably, by Thursday he's breaking down. He's not feeling good, he has headaches. The voices are beginning to speak to him—the murmuring started late Wednesday night. Murmuring meaning audible hallucinations that he can't quite make out. But by Thursday he's hearing the voices again, and he's feeling strange things. There are a couple of problems at the shelter with clients. Things aren't going right in his life. There are many little details that are going sour on him. He's deteriorating in the wake of the

great Monday session and a good Wednesday session—both of which were containing and solid interactions with real personal contact occurring between us.

Larry: So watch out now! Connection has been made and felt.

Sean: Eddie wakes up Friday morning. This is going to be our third session this week. He's noticing early in the morning that there's a police officer patrolling the area where he lives. He had a bad encounter in the early seventies where he had a problem with a cop. It was so bad he actually got a settlement from the city. Eddie is Hispanic so there was not only violence but racial overtones. By Friday morning he's really in a psychotic place. So in his mind the police officer is not merely patrolling the neighborhood (which so far as I can tell he's doing). But the cop is experienced as actually watching Eddie, spying on him, and out to get him. The cop is waiting for an opportunity to attack him—just as he was attacked in the early seventies, and beaten up badly. By Friday morning his body is in all kinds of hypochondriacal pain. He's hearing the voices saying, "You're a piece of shit. The Man's gonna get you." He's having all kinds of physical problems. He can't put his dentures in because he hurts so much. So he comes in with bare gums. I think that's important because that's a 4-month-old infant quality. And his teeth—his aggressive potential—are removed. He gets to

my office safely. He was all right driving. But he felt that the policeman was following him. He felt that the policeman was talking to other cops, that they were monitoring him with their radios. He's looking in his rear-view mirror feeling very scared. The terror is intensifying the closer he gets to my office ... it's a strange thing as he expresses it. On one level he feels like he's fleeing the cop and at another level he feels like he's coming to some type of even worse terror as he gets near my office and our time together. He walks in and I'm not doing my best that day either. So the countertransference is exquisitely responsive to the transference psychosis! He's not dressed nearly as spiffy as he has been lately. His hygiene isn't as good. He hasn't showered. He doesn't have his teeth in. He's got his sunglasses on again. On Wednesday he came in and took his sunglasses off, set them on the table, and we laughed together as we reflected back to the days his sunglasses were used to shield him from contact with me. This is always in our minds now. When we think about the old days of his always hiding behind his sunglasses we laugh because it was wonderful working through that. So Friday when he comes in he doesn't take his glasses off, he's feeling paranoid and angry. A bystander might again say, "You have a paranoid schizophrenic in your office right now. He's very unstable and he's probably dangerous." He was so visibly agitated that I was feeling scared. This was only the second time I have ever felt scared

with Eddie. As I talked to him he was breathing heavily and irregularly.

Jeanne: His breathing is important here.

Sean: When your diaphragm is paralyzed it's even more important. I didn't really have to ask him much. I said, "Tell me what's happened." Right away he knows why he's there. He knows he's there to tell me what's happened. So he sits down and he begins to just go off into a tirade about how this police officer, this motherfucker cop, is patrolling him, out to get him, and "God damn it, if he comes near me, God damn it, he's goanna have to draw his gun, 'cause I'm goanna get him." He's saying this with intensity, sunglasses on. He's furious. He starts off talking about the cop, about the situation, but he is talking wildly *at* me. He's raging at me telling me all this. It's so intense and his controls seem so tenuous that I'm feeling scared.

But Eddie and I have worked long and hard to get to this moment. So I allow myself to feel scared. It's a way of seeing where he's at. But while I'm feeling frightened by this madman in front of me, I also feel strangely very safe. I think, "We've spent a lot of years structuring a safe frame for this to occur in. There are people in the office, secretaries and others whom I can call on in a moment's notice. I've got my phone at hand with 911 buttons I can hit. So right now I'm safe, just like he knows he's safe here. And what I'm doing is I'm allowing him to go into it.

I say, “I want you to be able to feel my presence.” And I just let him go. He heard me. He’s gummy like an infant because of his teeth. The voices in his head are very loud for him. He is convinced at this moment that these are demons and that they’re outside of him, screaming at him. He’s talking about this cop, his face is grimacing—almost as if to say, “Let yourself experience me.” It almost looks like his face moves closer to me. All of a sudden the full-blown rage is directed right *at* me. Like I’m the motherfucker cop. He’s calling the cop a motherfucker, but he’s shouting and glaring at me. It’s as though he’s shouting at another invisible person by talking to me. I feel the emotional force of it directed fully at me. I’m feeling as scared as I’ve ever felt. This is intense. I’m letting myself feel scared. Deep terror is a strange thing—it vibrates through your entire body. But another part of me is saying, “I don’t care what anybody says, I know I’m safe. I know this man is not going to get up and hit me, or do any damage to my furniture, and he knows it too.” He’s allowing himself to be in a very scared place—a feeling that he reported later on when we processed this session.

During his tirade it slipped out that he had forgotten to take his antipsychotic medication today. This is important because forgetting for Eddie now functions very differently than it did for him in his first year. Now there is “purpose” in his forgetting. He doesn’t simply “forget” or

lose track of things any more. I realize he is unconsciously saying, “We’ve made a frame where we can experience my psychosis together. I can hang onto Sean while I’m feeling quite crazy. The medication is going to get in the way of my having the experience I need to have so I’m not going to take it.” I think unconsciously that’s how he thought about it. Maybe even consciously. I also thought, “We need to just experience this now. Later on I’ll give interpretations.”

Cindy: I’m really impressed. This is very helpful to me to see how present you are with yourself, and how present you are with him as this fear surfaces. I know you’ve worked hard to get to this place.

Sean: That’s a welcome comment because I know you’ve followed this work with Eddie for a long time. I’ve struggled for years trying to stay present during our sessions, not to be bored or irritated, not to daydream. I’ve struggled to get him to be present, not to wander off in his delusions or little green men. It’s a function of our work together to be able to stay present with each other. We don’t daydream any more. And I’m certainly not daydreaming in this session! (*Group laughter)* I feel good that I’ve developed the ability to stay present and to focus this psychotic transference onto me, in what I believe is a contained way. When I heard he had “forgotten” to take his medication,’ which he never does, I knew for sure we were where we

needed to be. But I will admit, even though I feel I'm safe, I'm using my countertransference to assess his fear. It seems you can't deal with this level of transference terror without really feeling on the edge of danger. Terror is an experience you can only know, not intellectualize about.

Larry: I'm hearing you say there are two things going on in the room simultaneously. On the one hand, you know and it also seems like Eddie knows that there's a frame or a "setup" that you've both spent a long time working on so that a certain quality of interpersonal experience can occur. You both feel the setup is essentially safe. But the experience that needs to occur within that frame is of a frightening, terrifying, or dangerous nature. So both of you are allowing it. He didn't take his medication. And as you're feeling closer and more scared, he's allowing himself to move toward being more out of control. You're feeling the fear he's lived with since infancy with his raging psychotic mother. But neither of you goes into a panic. You both know this situation must be lived out. You've both certainly rehearsed it many times together in miniature forms before you now actually try to live it out together so vividly.

Sean: *Yes. And as he gets out-of-control…his out-of-control is being* carefully focused *on me. So there is a control in his "out-of-control" and both are directed at me.* That's the interesting paradox here; he's in charge of this *out-of-control*

experience. He *wants* and intends to get me to be with him, to know, to share in his lifelong terrifying experiences. He needs to know that I know, to see that I see him and that I know him!

Larry: Right. It takes a long time to reach such a mutual understanding, a consensus, such a delicate balance in the working alliance.

Sean: It's not merely directed out to the universe. Most psychotic episodes are diffuse, chaotic, fragmented, and basically undirected or uncontrolled. This is an intense and interactional communication and both of us are feeling our parts.

Larry: Exactly. This is so very important to understand in order to be able to assess your and his safety.

Sean: We were living in a controlled "out-of-control."

Larry: There's no question he's in the room with you, that he intends for you to share his experience, to feel his demons talking to you. He knows he's scaring you and that you must *feel* this to understand him, and for him to come to understand this part of himself.

Sean: That's what I've gotten so much of from being this group. An understanding of how we can follow these primitive states.

Gary: So Eddie's now able to bring all the paranoia into the session.

Larry: You've finally got the psychotic transference active in the here and now and you judge that its expression is safe. At the level of the intended communication the reality testing is functioning. But at the level of the interpersonal contact he has lost the reality testing function.

Sean: The paranoia isn't about the little green men he used to literally see on the wall. Now the little green man is coming out of my mouth and my eyes. It starts off in a diffuse way with his talking about the cop but as we hone in on it we focus on me and I'm allowing it. Feeling the fear, assessing the safety...

Larry: It's *"You're* a motherfucker, and *you're* out to get me."

Sean: Right. There's something to say about feeling on the edge here. Because if he ever did haul off and hit me I'm sure he would be surprised. I know I would be.

Larry: There's always a sense when exploring psychotic anxiety that you're on the edge. This is why Kohut [1984], when talking about this, basically said he didn't know why anybody would want to revive this primitive and chaotic pre-self experience for analysis. He believed that in principle this work could be done. But he knew he couldn't personally do it—the tools were not available then. But he knew the strain it would have to be on both patient and therapist and he wondered why anyone would be willing to put

themselves through it. Eddie is, of course, the reason.

Sean: My sense is that during this session my ego is split in two. One part knows I'm safe and with the other part I'm letting myself feel the fear of this man. The split allows me to assess and to hypothesize about the nature of the psychotic transference arising from an early developmental experience. The experience to be remembered cannot be recalled directly but has to be enacted by allowing this type of emotional reliving. Because of the strength of our relationship, if this man were really on the edge and we were to fall off the edge because I've misjudged, I believe he would protect me and hit the lamp and not me. That's him protecting me. I would also be more afraid if there was a history of violence.

Larry: This therapeutic relationship has taken eight years to develop. Sean has been saying in many ways "Let me be your psychotic mother, let's have an experience here between you and me. I know you're afraid of it. And perhaps I will be afraid too. But let's see how much of the early experience that has damaged you so much can be remembered by our living it out together." Eddie has done everything possible not to be present during a month when his psychotic core has been realistically activated. But finally Sean says to him "Get yourself in here, we're going to really look at this now." And so we start off with a high-level triangle. We see the narcissistic urge

for respect. We see the terrible twos—the growing independence of separation-individuation. And it's all directed at his therapist. It's all carefully structured. The dare is on, the ego nets are in place. So now we're going to drop into the psychotic place. And, as we see, it's structured too. Winnicott understood the structured qualities of the psychotic transference when he made his patients "line up" and take turns to experience therapeutic regressions with him. He knew they could wait and he knew the regression they needed to experience could begin on cue! He also knew that he could only handle working through one psychotic transference at a time!

We have to trust the structuring effect of having worked for many years on the organizing transference so that Eddie can finally and safely direct his primitive rage at Sean in full force. And he's doing it right after this very nice set of connections for the week has been made. Which is exactly what we would predict—a terrified response to real interpersonal contact. Then, on cue, "You're trying to damage me, you're out to get me." And, "If you get near me, you're going to have to use your gun." So *within the context of the transference development*, it's, a highly structured response.

But, the ongoing and careful assessment of safety is critical. I have often enough seen therapists in denial who foolishly believed that

"this person would never hurt me." We have numerous records of therapists who were not careful and who have been badly hurt and even killed. But Sean does not seem to be in denial here. They are both afraid but they are both engaged in working to know and understand the fear. Our anxiety for their safety is appropriate. But we have to trust these two and their process together.

Sean: There's been a lot of thought in preparation for having a moment like this. This is not our first month or year together "Well, let's give it a try," you know. When we finally drop into the Organizing level it does start off slowly as we both get ready. We become attuned to each other over time as Eddie waits for me to get ready for this. As I become more prepared, he begins to focus in on me. And now suddenly—but not really so suddenly at all—I'm being called a motherfucker. I'm being called a bastard. I haven't asked him to take off his sunglasses because I'm too scared. I'm feeling very frightened. I'm backing up in my wheelchair. He's leaning forward. He's in a very tense stance. All kinds of things are happening—go down the list of what a paranoid schizophrenic is for a diagnostic litany, and they're all there. Now the real question is, how long am I going to be able to tolerate this. *(Group laughter)* I'm giving him ego support that says, "You need to experience this ... this has to be focused on me. We need to keep this going and contained. You

have to be experiencing and assessing—we'll be processing this later. Part of you must also be noticing how you're experiencing me." So now Eddie's ready and he's really giving it to me. But it's rough on me and the question is how long I can take it. Now my own primitive psychotic part is being provoked internally, which I won't go into now because that's for my own therapy. *(Group laughs)* But in a moment like this I have to deal with my own internal psychotic mother abandoning and raging at me. I become frightened, in some sense immobilized by terror, and I want to back off or flee.

Larry: Because at this moment you're afraid you can't reach him like you once couldn't reach her?

Sean: Right. And everything else that connects or fails to connect gets replicated. I let him run on intensely for at least a half hour with the thought, "It's just Eddie, you're safe." I'm wanting to get more information out of our experience. It's getting more intense. As he's sitting forward in the chair it's escalating. I have to back up. At that point it's more than that the voices are louder. Demons are now everywhere around us. And the demons are coming from me. I'm becoming a demon for him and he's raging at me. Finally, I'm too scared, too overwhelmed. And here's where I know that I'm safe. I finally say, "Eddie, you've got to calm down. You've got to stop now." And he instantly went from looking like this to

looking like this: *(Demonstrates shift from threatening to contrite)*

Gary: You touched him?

Sean: No, I didn't touch him; I simply told him, "Eddie, I'm too scared now. I've had enough of your psychotic mother. We have to stop now." And when I told him to do that he instantly shut it off. But there was an immediate sense of depletion. It's like he has some kind of container for his psychotic mother in his body. He released her to fill his body, to fill the room, and to be directed at me. Then when I asked him to stop he pulled it all back in—let it all go back into that depressed and depleted container. Then he's exhausted, spent, and empty. And so am I. I notice myself thinking, "Whew! I really am in control here, thank you God!" (*Group expressions of relief)* That's evidence that I am. And now I'm asking Eddie to relax. I'm asking myself to relax. "Why don't we just be quiet for a moment and just be together. This has been intense for both of us." This is toward the end of the session. I give him very little in this depleted place ... I'm saying it more for myself. I say, "Eddie we've had some really meaningful personal contact this week that provoked something very intense in you. This is what happens when we get this close and we have this much good time together. We're going to spend some time looking at this. How should we end?" He wants to pray. And that's something we've done before. He just reaches out and holds

my hand. This is interpretive touch, in that this is concrete touch that fills him back up, that he has learned allows him to stay present for a while longer. He regains vitality through my containment, our touch, and our silent prayer together. I'm feeling relieved. We can touch and we can have a true connection that he isn't terrified of. The silent interpretation is that we can weather this and be together. Now he's able to pray to Jesus and not be pulled into a psychotic dimension. The session ends not quite as nonpsychotic as I'd like it to be, but enough for now. I say, "We're going to have to be talking on the phone this weekend. I want you to go home and take a Trilafon. I want you to go home and listen to your music. I want you to take care of business and do only what feels good." Then we say goodbye and he leaves. So this was our week.

Larry: We only have a few minutes remaining. Do you have a summary or a follow-up?

Sean: We had set up an experience of the psychotic transference that we were able to analyze in the following two meetings in a phenomenal way. That's about all I can say right now. I would love to say how the analysis of that transference has brought him into better ego function, created more ego space, and brought us closer together via more connection with others in his life. Everything about Eddie is vastly more functional than when we began. His teeth are back in now,

he's feeling better than ever, and he's physiologically much better. It's clear we reached a core experience.

Jeanne: Can I ask you a question? Did he come back and apologize for what he said to you or for screaming at you?

Sean: What's there to apologize for? No, he didn't apologize, because I had invited the expression and he gave it to me.

Larry: "We both knew that this was what we've been trying to do. So there's no reason to apologize." They both knew the experience was transference expression and not real.

Jeanne: Does he acknowledge that "I did it," or "We did it?"

Sean: Yes.

Larry: It's not that he did anything to Sean. It's that "We did something together."

Jeanne: That's acknowledged by him?

Sean: Right. I'm being used. He's using me for transference experiencing.

Larry: Your experience is very moving to hear about, Sean.

Sean: I'm very excited. As I think about the next two sessions that followed and how we analyzed the transference, Eddie said many important things

to me about his past, his mother, and the demons. He was alert, thinking, and intact. He could have been here with us today dressed normally, feeling like us, and being able to read in the book about how he appeared on his first session eight years ago. This is not to say that if something were to hit him broadside tomorrow he wouldn't regress. Nor is it to say that our transference experiencing is over. I don't know about these. But I do know we finally got to a place in his infancy where he experienced monstrous terror and rage. Some of what he expressed was an infant raging at his mother for coming too close, for traumatically intruding. Some of it seemed to be identification with the aggressor—his raging at me and frightening me the way his psychotic mother did him. He needed to relate his infant needs to her, but she found them intolerable and tried to frighten him away by raging intrusiveness. He knows that I have a personal need to relate to him and he must attempt to frighten me away. I feel good about our work.

Group: Good! You should! Congratulations! Great work! Thank you for sharing this. It's been very insightful.

Hedges's Comments

At this point I want to take the opportunity to comment on an essential aspect of psychoanalytically oriented psychotherapy —the "as if' quality, or the mutually agreed upon game that

speaker and listener engage in for a therapeutic or analytic purpose. This aspect of therapeutic processing is distinctly different from any realistic “holding,” “containing,” and/or “re-parenting” aspects of the therapeutic relationship.

I and many others have attempted to distinguish re-parenting, ego-building, and *constructive* “educational” relationship-building processes that sometimes go on in psychotherapy from the more crucial dismantling, taking apart, destructive, “analytic” processes that have always essentially characterized psychoanalysis but are sometimes difficult to conceptualize apart from the ego enhancement or psychological growth aspects of therapy.

The “as if’ or game quality of the psychoanalytic encounter necessarily persists in the analysis of structures built at all levels, although the encounter seems more “realistic” when working on developmentally earlier levels where the issues are farther removed from symbolization. That is, at all developmental levels of psychic structure brought for analysis, two people engage in a real relationship for a purpose—the purpose of bringing into the relationship for both to see and to know about, long-standing emotional relatedness habits and patterns so that they can be known, talked about, and lived with together. And in the process of living and talking they are giving

a new symbolic place and perspective in both peoples' lives—the very meaning of "consciousness."

While this process of bringing forth from the "unthought known" (Bollas 1987) or putting words and symbols on heretofore unrepresented, unreflected, and unsymbolized psychological habits may require different kinds of techniques for different developmental levels in differently structured people, the aims of the psychoanalytic process remains the same. The subject of *Strategic Emotional Involvement* (Hedges 1996) is the contrast of different developmental structures and their differential accessibility through various kinds of emotional strategies that serve to bring transference and countertransference material into the known of the here-and-now therapeutic setting and relationship. Through representation and symbolization of heretofore unavailable, unknown, and unconscious psychological habits or psychic structures in the therapeutic relationship, both participants develop more *flexibility* in their ways of knowing about, processing, and participating in relationships.

In Sean's intense encounter with Eddie we can see how long it took to build safety in the relationship and how many years it took for the two to develop a language and a style of experiencing and talking about the deepest transference aspects of their relationship. At the moment of the encounter Sean tells

us that he is clearly experiencing an ego split, that there is a part of him committed to experiencing the fear that Eddie has come today to show him. And there is a part of him that is observing, reviewing the safety nets, remembering their purposes, chuckling to himself when he finds that Eddie has "forgotten" to take his meds today, and conversing with his supervision group in his head, being sure that everything is in order and reassuring himself that this is a "focused, intentional, and controlled out-of-control" experience. For Eddie's part, he checks out the relationship on Monday and Wednesday to be sure everything is in place between himself and Sean. Then Wednesday night and Thursday he allows the regression to develop and cues Sean in over the telephone, so that by Friday morning Eddie is flying on the wings of his lifelong persecutory madness. The two meet in an emotionally intense encounter, Eddie using his sunglasses as a device to alert them both to the break in realistic contact that this episode entails. He even slips Sean the information that he is winging it today without his anti-psychotic meds. The in-your-face rage that has tormented Eddie a lifetime and from which he has been forced by the world to retreat is now to be given full reign and they both know it and live it fully for thirty minutes. Finally Sean says he can't take it anymore, asks Eddie to stop, and Eddie collapses, totally depleted, the message from the depths of his soul at last fully expressed, fully heard and responded to.

There are many ways to understand such an intense interaction, but I am at this moment most fascinated by the "as if' quality, the analytic game of discovery and how these two play it. We see in the follow-up the memories that emerge and the new representations that develop between Sean and Eddie with the later expectable relief on both sides, and notably better functioning for Eddie—and for Sean as well. We cannot fail to be transformed by such deeply involving experiences.

The important point Sean's work and these vignettes bring out is that at the earliest level of making contact with the mothering person many babies have had to learn to read a complex and traumatizing emotional situation and to warp their physical and mental responsiveness in an attempt to hold on to their perceived sources of survival. Thus, early Organizing experiences often take on a quality of coerciveness, manipulativeness, and inauthenticity. How such early warped learning sets up vicious cycles with caregivers that persist into later relationships to alienate others is the subject of much current psychoanalytic study.

It seems that several important lessons are to be gained from these observations:

- Therapists need to be exquisitely tuned in to countertransference feelings as vital sources of information (Hedges 1992, 1994c, 1996).

- When working Organizing experiences the connecting/disconnecting dimension must at all times be in the forefront of the analyst's mind so that every detail of relatedness can be scrutinized with this lens.

- *Various aversive reactions that analysts often have to Organizing states must not be carelessly overlooked*, either for their connecting/disconnecting potential or for their manipulative, coercive/inauthenticity qualities.

Every baby is born with the wisdom of knowing how to track, adapt to, and connect with the available essential sources of nurturance, comfort, and survival. When, for whatever reason, there is a deficient or faulty baby-environment meeting, the infant must do whatever she/he can to ensure survival. Being forced to react, to search, to think, to respond before she or he is ready is inevitably traumatic—whether visible at the time or not—and leaves deep organizing scars. It is these scars, like the ones Eddie's schizophrenic mother left him with, that must be brought to light in analysis. Working with these early scars is always a significant strain on the analyst.

Note

[←1] This is abbreviated form of the original. The full version of this case is published in Hedges, 2000.

RELATIONAL INTERVENTIONS WITH ORGANIZING EXPERIENCES

Introduction: Relational Listening

As psychotherapists we strive to be useful to people struggling with life's many problems. But how exactly do we do this?

We begin by studying the many competing theories of the mind and theories of therapy now available to us and we choose the ones that make the most sense to us. Only much later are we able to realize that our choice of theories actually expresses what we intend to do in therapy—that is, how we believe we can best make ourselves useful to our clients.

Further complicating things, we are today beset with a vast array of medicalized descriptions of people—diagnostic categories devised by psychiatrists to justify to the public and to courts of law their choices of medications and other somatic therapies.

To the extent that as psychotherapists we get snagged into medical diagnostic thinking, we have also to contend with the diagnostic system's assumptions and biases—thus adding further complexities to our work. These many theoretical, technical, and diagnostic complications can easily cause us to lose sight of what is truly important in our work—finding ways to make ourselves useful to people.

These lectures deal with what we can actually do in psychotherapy to best position ourselves to intervene in people's lives in ways that will be truly helpful to them.

The central tool of all psychotherapies is transference—by whatever name it may be called. *Transference* is simply a description of the ways we bring habits of perception and interaction learned in past relationships to bear on present relationships. Psychotherapists, regardless of theoretical or technical persuasion, are always paying close attention to transference, though they may conceptualize and work with it very differently.

The moment we understand the centrality of transference in psychotherapy, we can also realize that psychotherapy is essentially relational. That the help we have to offer to our clients is help with relationships. This insight helps us narrow

our focus considerably from a wide range of competing possibilities.

But how do we help with relationships when what the person brings to us is a list of complaints and troubling symptoms? What kinds of interventions can we devise to help with the essential problems that are coming up in their relationships while at the same time empathizing with life's many pressing difficulties? These questions pose the challenge of this series of lectures.

Psychotherapy as Relationship

Neuroscience now teaches that we are first and foremost a relational species. That is, modern technologies now reveal that our entire nervous system—including our brains as well as our endocrine, hormonal, and neurotransmitter systems—actually organize themselves according to what kinds of relationships are and are not available to us in the earliest months of life.

Furthermore, we now know that our brains and nervous systems continue to generate new neurons and new neurotransmitter pathways throughout our lifespan—depending on what kinds of relational experiences we choose to involve ourselves in.

These emerging neuropsychological findings make clear that all emotionally intimate relationships—especially the psychotherapeutic relationship—hold forth the possibility of profound and enduring personality change.

Another line of relational research comes from a task force recently organized by the Psychotherapy Division of the American Psychological Association (Division 29) that reviewed thousands of empirical studies and found that the single most consistently important factor determining the overall outcome of all psychotherapies is *the relationship* between the therapist and the client (Norcross 2002). What clients remember years later is not what their therapists said or did, but the relational moments in which they experienced emotional connection with and emotional recognition from a very real person, their therapist.

Thus, good professional work in any clinical setting demands a good working personal relationship—whether the individual practitioner acknowledges the power of the relationship or not.

Our professional choices manifest our personal ways of relating—in how we think about and perform our work. Some therapists choose to ignore the relational dimension while other therapists choose to focus heavily on what's going on in the relational exchange.

But all highly-skilled, seasoned professionals are acutely aware of what's going on in the relationship at all times and are carefully aiming their work into each relational matrix as it unfolds—no matter from which theory or school of therapy they hail.

I think of family therapist Virginia Satir, whom I once watched conducting a family therapy session in front of a large audience, spontaneously bursting into tears while directly telling a sullen teenager that her feelings were hurt because he thought she was ganging up against him with his parents when she was working so hard to find a way to let him at last speak what he needed to say to them.

I remember behaviorist Joseph Wolpe telling a group of us about a little girl who had been to numerous therapists for compulsively cutting out paper dolls. After a few attempts to get her attention away from the dolls she was cutting, in exasperation Wolpe stood up towering over her and angrily yells at her at the top of his lungs, "Stop cutting out paper dolls!" And she did.

I once watched Alexander Lowen, father of bioenergetics body psychotherapy, aggressively provoke a large, burly man who had barehandedly killed several people in the course duty in his law-enforcement career, to the point that everyone in the

room was terrified Lowen was going to get slugged. Lowen got right in his face and was pounding on his chest until we saw the man crumple on the floor in deep heaving tears and pleas for his father to stop beating him.

Each of these gifted therapists—working in their own way—demonstrates perfect relational empathy under the circumstances.

Even one of the founders of Cognitive-Behavioral Therapy Aaron Beck, after reviewing the neuropsychological research on relationships, describes the crucial importance of relational context and asserts, "The therapeutic relationship is a key ingredient of all psychotherapies, including cognitive therapy.... Many of the basic interpersonal variables common to other psychotherapy (i.e., warmth, accurate empathy, unconditional positive regard) serve as an important foundation for cognitive and symptomatic change" (Beck & Dozois 2011, p. 401).

So since relational variables are an essential and unavoidable part of professional work at all levels it behooves us to fine-tune ourselves to the relational question, "What's going on here, anyway?"

Considering "Lower Level" or "Difficult to Treat" Clients

Traditional DSM diagnoses are well-known to all therapists but the more sophisticated, relationally-oriented diagnostic approach of the Psychodynamic Diagnostic Manual (PDM 2006) is less well known. The PDM defines "borderline-level" relating as between normal/neurotic and psychotic levels of relating. That is:

- Higher = normal/neurotic relational issues
- Borderline = character relational issues
- Lower = psychotic/bipolar/schizophrenic relational issues

Most clinicians today dread working with individuals who might be seen diagnostically as "borderline, bipolar, schizophrenic, psychotic, or character disordered." Furthermore, it is not uncommon for people seen as normal or neurotic under circumstances of extreme stress or when undergoing therapy to "regress" to experience "difficult to treat pockets" of borderline or even psychotic experience.

But there is no need for therapists to have such dread! The fact is that the personality features involved in "lower level" or "more primitive" mental states are organized in relatively simple relational modes that eventually yield to effective relational interventions.

It remains for the treating therapist to grasp the nature of the personality organization or feature involved in order to go with the flow of the forming relationship and eventually to find ways of being with and enjoying the person who is working what might be called early developmental levels.

The central treatment flaw of most therapeutic approaches is that they are content-oriented rather than relationally process-oriented. Most therapists tend to listen to and then attempt to respond to the subjective narrative or the list of concerns or symptoms provided by the client or by some theory of therapy.

But the central issues these "lower level" clients are struggling with are relational issues that have little or nothing to do with the narrations or lists of concerns they can muster regarding their partners, children, bosses, work colleagues, or their physical, addictive, symptomatic, or sexual issues, or their personal histories.

This lecture will consider the psychotherapeutic relationship with people and aspects of people that have historically been described by the *DSM* and later by the somewhat more enlightened PDM with mid- to lower-level relational capacities.

But clearly we have outgrown this diagnostic history and our profession needs new ways to speak about aspects of ourselves and our clients that have become unnecessarily

constricted in the process of growing up, aspects of ourselves that are seeking new "relational freedom" (D.B. Stern 2015).

Content vs. Process Treatment Approaches

Content-centered therapeutic approaches to borderline- and psychotic-level personality organizations leave the therapist floundering with cognitive, behavioral, dialectical, or other symptomatic issues, which bypass what the client came to treatment for.

Why is a content approach so useless with these populations? Because the issues that are giving them trouble originated in such an early developmental period of their lives that there were and still are no words, pictures, or stories to depict the problems—no recognizable content, as it were.

While some contents may metaphorically point toward deeper issues, more often than not, the words, pictures, stories, and symptoms actually tend to derail the therapeutic investigation. The struggles of these individuals are predominately relational and therefore manifest in the ways they relate to us and to the therapeutic setting. That is, very often people cannot tell us what the trouble is, they can only show us by doing it to us, by engaging us in the fray of their inner lives.

As a foretaste of where I'm going in terms of describing the Organizing experience or lower-level issues, let me say that the central issues most psychotherapy clients are dealing with today have to do with various forms of engagement and disengagement in actual here-and-now relatedness situations.

Knowing that we are looking for individual styles of engagement and disengagement makes it considerably easier for a clinician to focus on what is important and to leave the rest of the content—what I call the "clinical chatter or clamor" to the side.

We can't, of course, completely avoid or ignore the content because content is the main thing people know to bring to us. So we have to engage as empathically as possible in the stories, symptoms, and issues brought forward—but such empathic engagement is essentially a trust-building and relational information-gathering technique. We don't have to assume that the stories and symptoms we hear are critical to why they are coming to us. Rather, we need to attend carefully to the ways they approach us and then back away. We need to pay close attention to the kinds of interpersonal engagements they draw us into on a regular basis and the kinds of countertransference responsiveness they evoke in us.

What we are looking for in learning to be with and to enjoy these otherwise difficult to be with people or aspects of people is how they engage us and how they disengage us. That is, since borderline and psychotic-level issues are fundamentally relational, all people know to tell us about these basic aspects of personality is what's going wrong in their lives and in their bodies at the time. At the beginning of treatment they have no idea that their modes of engagement and disengagement are what's setting themselves up for mental and physical distress.

We might even go so far as to say that effective treatment consists of people coming to actually experience in the treatment situation itself just how their personal styles of engagement and disengagement limit and set themselves up for relational problems.

As people come to experience themselves in their habitual relatedness modes in relation to the therapist and then to see for themselves how limiting their modes are, they tend toward developing more flexible and less stressful relatedness modes that serve them better in the world and in their bodies.

Donnel Stern, from an Interpersonalist/Relationalist perspective, speaks of "unformulated experiences"—dissociated in both client and therapist—that become mutually enacted in the transference-countertransference matrix. When engaged and

perceived there is a release of relational constrictions that have come from the past so that both participants experience new "relational freedom" (1997, 2015).

This mutual therapeutic work is so emotionally intense, draining, and time-consuming that effective treatment can be expected to span several years—optimally at more than once a week often with periods of telephone contact in between. This is not only a widespread clinical finding, but the empirical research supporting the PDM makes clear that successful psychodynamic therapy necessarily spans a number of years.

The strain on the therapist involves:

(1) holding steady sometimes for lengthy periods,

(2) building trust by empathically responding to the content offered, and

(3) commenting regularly on the actual relational engagements and disengagements in the therapy setting until the client gets the gist of what their relatedness issues are and what their relatedness patterns are costing them.

(4) Then comes the struggle. Like a good parent encouraging a frightened child to walk or ride a bicycle or to engage in some other daunting task, the therapist must stand by and firmly insist on moving forward into new and breathtaking relational ventures—despite the overwhelming fear, fragmentation, and physical agony necessarily involved.

Typically we see a long period or a series of periods in which the client experiences discouragement, depression, dysfunction, and deadening fragmentation and fear before she/he can be coaxed into trying new relational modes. Therapeutic victory only slowly dawns—but not without numerous demoralizing collapses and setbacks on the part of the client with frequent periods of frustration and despair on the part of the therapist.

This process is what we will look at from several different angles. First, let's think about what's actually involved in "the psychotherapy relationship."

The History of the Psychotherapeutic Relationship

Over the century since Sigmund Freud first invented psychotherapy or "the talking cure," many helpful ideas and practices have emerged. Psychotherapy started as a medical science partly because Freud was a physician and partly because the scientific paradigm of objectifying things was in its heyday and the human mind was viewed as another thing to be scientifically investigated. In his early studies of hypnosis with Charcot in 1885 Freud first grasped that many physical symptoms had an unconscious psychological origin and could be relieved through psychological interventions.

But it was not until he listened to his colleague Wilhelm Fleiss discuss the startling case of Anna O. (Bertha Pappenheim), who had developed a false pregnancy in the course of her treatment, that Freud first understood the power of the unconscious. From manifestations in their relationship Freud intuited the important connection between unconscious fantasies and psychically determined physical manifestations. Moreover, Freud understood that highly personal unconscious influences in both doctor and patient could be mobilized and laid bare for observation under the influence of an intense personal relationship.

Descriptive psychiatry, however, has historically remained allied to a medical model searching for the cause, course, and cure of mental diseases. The evolution of this medically oriented approach is well documented in a succession of editions of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*. In the many *DSM* revisions proliferating pathologies continue to be generated and abstracted, along with presumed causes, treatment, and cures. But worse than pathologizing unnecessarily and being merely descriptive, the *DSM* is relationally barren. No real person with all of her eccentricities is depicted as in any real way interacting with any other real person with all of his eccentricities. That is, there is no real sense of how the depicted traits or behaviors might have

evolved in the context of real relationships or might have an opportunity to be understood or transformed through real therapeutic relationships. It's as if descriptive psychiatry knows nothing about our relational origin and nothing about our relational destiny and how it can be enriched and transformed through intimate relating.

"What's wrong with you and how can I fix you?" is the central medical question that has been mistakenly imported into the field of psychotherapy. The same question, "What's wrong with you and how can I fix you?", echoes the worst of all messages we received from our parents, teachers, and caregivers during the course of growing up. From a psychological standpoint, "What's wrong with you and how can I fix you?" is hardly a decent way to relate to any human being because it immediately sets up a non-mutual, non-equal "one-up, one-down" relational situation whose implicit aim is to establish superiority and control over and perhaps even to shame and humiliate the other into submission or compliance. So while determining "what's wrong with you" may be relevant to the practice of medicine, it's certainly not helpful to the practice of psychotherapy. We understand that many physical symptoms result from psychological stress and trauma, but the "what's wrong with you" question serves to focus on the physical or mental symptom, not on the underlying relational templates that

have given rise to that symptom. Additionally, for a client to be encouraged to ask, "what's wrong with me" puts that person immediately into a place of insecurity, shame, fear, and "one-down," usually with an accompanying sense of incompetency, and/or self-loathing—not at all helpful attitudes in the psychotherapeutic inquiry.

In order to address early-learned relational modes, psychotherapy must be understood first and foremost as a relational practice that aims for expanded mutual understanding (consciousness) of ourselves and the ways we habitually relate to others—not a fixing or curing of anything.

In addition to theories of pathology, we have inherited theories of personality, theories of human development, and theories of how people change. Implicit in all of these theories is a positivist belief of "how things really are, how the mind really works." But in human life and in therapy, we know there are no clear truths to be found, rather many ever-changing truths to be spoken and listened to.

In the more than a century since psychotherapy began, many brilliant clinicians have attempted to articulate in diverse ways what to them constitutes psychotherapy. Running throughout the history of our theoretical and clinical work is a recognition of the importance of the relationship between the

client and therapist and how each experiences the other. But only with recent neuropsychological and psychotherapy research has it become clear that the centerpiece of psychotherapy is the actual therapeutic relationship itself.

This singular finding changes forever how we conceptualize therapy and what we understand to be important in therapy—regardless of how each practitioner chooses to practice. That is, if what is finally decisive in human development and life is emotional relatedness then how do we form theories that help us listen for each person's relationship experiences on a moment-to-moment basis?

In my writings I have emphasized the need for theoretical approaches that aim not to tell us how this person's mind or life really is, but rather theories that provide Listening Perspectives on the idiosyncratic ways each person experiences the world, themselves, and their relationships.

It's not that our accumulated wisdom gathered in a positivist truth mode is misguided because it isn't. Rather, the relational aspect—engagement and disengagement—explicit and implicit in all therapies now takes center stage.

Having understood at last the centrality of the relationship in psychotherapy—no matter what one's personal clinical orientation—let us move to considering the wide range of human

relatedness potentials that we might listen for during clinical hours.

Developmental-Relational Listening

Over the last century four distinctly different Listening Perspectives in psychotherapy have evolved for listening and responding to the unique relatedness qualities that each person lives out on a daily basis (see Hedges 1983, 2005). These Listening Perspectives are essentially metaphors derived from observing relationship developments in early childhood.

Four relatedness levels or perspectives is an arbitrary number based on logical considerations of self-and-other relationship possibilities. That is, from a developmental standpoint we can say that the simplest relatedness modes are those that developed in early life, while the more complex ones require considerably more relational experience and learning. So we might say that borderline, bipolar, schizophrenic, psychotic, autistic, and characterological relatedness modes that developed early in life and the relational fears associated with them are relatively simple. For different listening purposes different perspectives are needed. For example, when considering relational desires and fears that develop along the way it is convenient to consider seven relational fears.

The four Listening Perspectives organized on an axis of increasing complexity, along with seven accompanying relational fears, are listed in Table 1.

Table 1:
Four Developmental Listening Perspectives and Seven Relational Fears

I. The Organizing experience (*approximately ± 4 months after birth*)

1. The fear of being alone
2. The fear of making connections

II. The Symbiotic experience (*4-24 months*)

3. The fear of abandonment
4. The fear of self-assertion

III. The Selfother experience (*24 to 36 months*)

5. The fear of being unacceptable

IV. The Independent experience (*36 months through adolescence*)

6. The fear of failure and success
7. The fear of being fully alive

A person could experience focal or cumulative trauma in relationships at any stage of life and need to re-experience that trauma in a therapeutic relationship in order to work through the post-traumatic experiences that are still creating problems.

But truly terrifying and deeply traumatic experiences that impact the fundamental ways the personality organizes itself are more characteristic of the earliest stages of development—the Organizing and the Symbiotic experiences.

Anyone subjected to overwhelming terror, intimidation, or shame during one of the earliest phases of life is vulnerable to having similar overwhelming levels of fear, constriction, and/or fragmentation triggered by intimate relationships later in life.

Two Relational Intervention Principles

Based on the above sketch of relatedness-potential going from simpler to more complex, it might appear as if I am offering a developmental theory of relatedness rather than articulating a series of metaphors that can serve as Listening Perspectives during the course of psychotherapy. I am absolutely not! That’s the old-fashioned medicalized way of considering patients with illnesses that the well doctor is going to fix. That’s the positivist way of approaching science with an observed object and an observing subject. That’s the modernist way of viewing truth as something that can be finally discovered and known. As psychotherapists we have come too far to allow ourselves these outmoded ways of thinking and being.

We live now in the age of consciousness-raising, of subjectivity and intersubjectivity, of postmodernism where realities are socially constructed and ever changing. This means that we are forever in a soup of uncertainty struggling to construct ways of perceiving that move us along toward new possibilities!

In therapy, this means constructing Listening Perspectives—points of view we can momentarily assume to help us grasp what is happening in the moment between us and our clients. Pat theories and techniques are for the faint-hearted! We must be ready to shift on a moment's notice. This means that our own relational histories that have left us with constrictions in thought and affect are at all times engaged with our clients and that we are, therefore, in for constant surprises about ourselves.

In addition to being universal, the earliest four relational fear experiences—or what elsewhere I have called fear-reflexes (Hedges 2012a, 2013a)—are more basic and less complex than later learned relational modes and relational fears. When carefully approached and understood, a therapist can develop an ease and even an enjoyment in being with early forms and aspects of personality organization.

Unfortunately, many therapists so easily become confused and overwhelmed with content or their own dissociations that

they fail to attend to the relational processes involved in treating developmentally early experiences. As a corollary, all people have experienced these earlier relational modes in the course of development and have created relational solutions to the dilemmas they experienced during their own early levels of development. Therefore, even people capable of highly complex relatedness modes have "pockets" of borderline or psychotic experience that can be triggered in certain kinds of stressful relational situations and that may need to be therapeutically explored.

For us therapists this point is particularly cogent because the nature of our work brings us into contact with all manner of emotional stresses that we cannot afford to be overly defensive about if we are to be effective therapists. Said differently, the intense relational demands that we therapists face on a daily basis make it essential that in our own therapy and ongoing personal and professional development we develop as much relational freedom as possible—and that includes the freedom to be stuck, confused, defeated, and despairing in our work.

The two relational intervention principles I will elaborate in this lecture are based on engagement and disengagement:

1. When therapeutically responding to bipolar, schizophrenic, autistic, and other psychotic organizations (Listening Perspective I) there is a need to study the person's

approaches to engagements and then to intervene in affective or cognitive disengagements—in whatever ways possible.

2. When responding therapeutically to borderline and character personality organizations (Listening Perspective II) a full affective replication (enactment) of symbiotic (dyadic) relational experience is required before the scenarios can be perceived, reacted to, confronted, and relinquished.

A frequent error is for the therapist to be seduced into thinking some more complex relatedness interaction is occurring when actually some form of early Symbiotic engagement or Organizing disengagement is occurring.

Additionally, it is therapeutically important to distinguish between relational moments that stem from the Organizing experience and ones that stem from the Symbiotic experience—a distinction that is not always so clear (not surprisingly since Symbiotic experience is built upon relational templates first set up in the Organizing experience). Listening to engagement and disengagement processes as they occur on a moment-to-moment basis in therapy can best be accomplished by considering developmental levels of relatedness-complexity along with developmentally-based relational fears.

Identifying and Engaging the Organizing Transference

Identifying transference experiences from the earliest level of development begins with the assumption that if psychological attachment—the bonding or symbiotic dance—has not occurred or has only partially occurred, there is a reason.

Extensive attachment research among mammals makes clear that biological attachment is a fundamental genetically-determined drive mechanism (Fonagy et al. 2002). In the human species a well-known set of psychological attachment styles predictably follow. So when, for whatever the reason, psychological attachment has not or has only partially or insecurely occurred, we can surmise that some sort of irregularity arose in the earliest months of life to restrict expectable interpersonal engagements.

Closed-off psychic channels for human connection and somatic constrictions that make physical extensions painful are retained in the personality and in the body structure in ways that can be observed in later life as the Organizing (or psychotic) transference.

This earliest of transferences represents or expresses learning experiences of the infant that occurred whenever he or she emotionally extended or reached out and was somehow

turned away, not met, or negatively greeted. The questing activity was met with environmental response that taught the infant not to strive in that way again. The "never go there again" lesson effectively marks infant attempts to organize experience —marks that can later be identified as transference in the therapeutic relationship.

With people living Organizing experiences, the transference structure can be seen as systematically functioning to limit the achievement of or to prevent the maintenance of sustained human emotional contact. That is, the person learned as an infant that emotional contact is dangerous, frightening, traumatic, and/or life threatening. Relatedness learning during the earliest months of life becomes organized around limiting the extension or reaching-out experience and preventing all potential forms of contact felt to be frightening, unsatisfying, or unsafe.

Framing the Organizing transference involves studying how two people approach to make connections and then turn away, veer off, rupture, or dissipate the intensity of the connections. It goes without saying that unless the treatment situation is successful in stimulating a desire to connect and encouraging successive attempts at connecting, we cannot hope to study the ways that connection is avoided or the disconnect is accomplished.

Three Brief Case Examples of Fight-Flight-Freeze Predefenses

Three case examples highlighting what Selma Fraiberg (1982) has called fight-flight-freeze predefenses—primordial ways of avoiding connections—will illustrate how an Organizing experience can appear and how we as therapists can gain some grasp of the meaning of the Organizing transference experience.

1. Fight in the Organizing Transference

The first case example is from a female therapist who has been treating a woman twice a week for three years. An intense therapeutic relationship has developed. The client is a very bright and sophisticated professional. She lives very comfortably in the everyday world but suffers privately from what she refers to as a "multiple personality." The most troubling switch is when, without apparent reason, she goes into a rageful self. Her therapist sought a crisis consultation after she got this telephone call after their last session: "I'm not coming in anymore because there's something wrong with our relationship." The therapist inquired about the nature of the problem. The patient replied, "I can tell you feel there's something wrong with my relationship with Naomi." Naomi is a lesbian with whom the patient has developed an intimate relationship. She continued, "You don't think that it's right, or you think there's something wrong with Naomi. There's no point in our going any further so long as you

think that way." She was angry, shouting at her therapist, and then she listed a number of other things, "You don't listen this way … and you're not that way …"—a tirade of complaints and accusations.

Her therapist is in a state of shock, feeling she may never see her client again. She is not even clear about what might have been said to upset her. She tells the consultant that her client is basically not lesbian: she had three or four relationships with women, but ones in which she was looking for soothing contact with a woman, possibly in order to feel mothered. She cannot develop relationships with men because she does not know how to relate to men. She is confused and frightened by men. She has said various times that, even though she is having a sexual relationship with a woman, she does not feel she is lesbian—she does not feel like other lesbians. The client feels certain she is really not a lesbian. At one point the therapist had said, "I really don't think you're a lesbian, either."

I have reported extensively elsewhere (1994c) on this case and the two that follow, but for present purposes we can see that the reflective comment the therapist made about her not really being a lesbian is used by the client in order to accomplish a rageful disconnect. The therapist reviewed the misunderstanding and learned from the episode that rage becomes the way of accomplishing relationship ruptures when intimacy of certain

types threatens. Of special interest here is a screen memory in which the patient, who grew up in poverty conditions, witnessed her mother have an abortion and flush the fetus down the toilet. The mother's rage at having needy children appears to have been one of the sources of the rageful disconnecting mechanism. In the counter-transference, the therapist was able to report the passing fantasy of letting the patient go because she promised to be so difficult.

This episode represents the patient's first tentative foray into working the Organizing transference directly with her therapist, though a series of parallel transferences with friends had been discussed extensively. Now the therapist has a clearer view of the nature of the disconnecting transference replication. The Organizing transference typically is worked through in a series of waves or episodes. The therapist will be more prepared to act quickly next time to deal with the disconnecting intent. The interpretation may be accomplished in the nonverbal or preverbal way; the therapist stays with her in her rageful self and invites her to stay connected and to live out her terror of being with the therapist together rather than to disconnect or rupture the connection with rage.

2. Flight in the Organizing Transference

The second example of Organizing transference involves a female therapist who has been seeing a client for three or four years. This client has been driving an hour and a half each week to her appointment ("So there's a long umbilicus," the therapist says). The client has presented as tenuous in her ability to maintain relationships. In the last six months she has talked frequently about terminating therapy because of money and distance. She canceled her sessions in bad weather and during the winter holiday rush. On several occasions the therapist has empathically tried the following, "Well, okay, I can understand how busy you are and how far it is. You have accomplished a number of things in therapy, so if you want to consider termination, we can talk about that." She has even suggested helping the patient find a therapist who was geographically closer. But that all became taboo. The client was allowed to talk about termination, but the therapist was forbidden to talk about it.

On the occasion in question, the client called during the Christmas holidays and, without any warning, canceled all future appointments. Her therapist made several phone calls to contact her. She sent a Christmas card. She did everything she could to reach out to her. The therapist thought, "Well, maybe it's best

that she stop—and this is her way of stopping. Maybe I shouldn't pursue her." In my view this laissez-faire attitude may be appropriate for listening to more differentiated forms of personality organization but is clearly not empathic when working an Organizing transference in which the client cannot initiate or sustain connection and is frequently compelled to break it through some form of flight. The therapist is an empathic and intuitive woman who remained persistent in her attempts to restore the connection. They finally did connect by phone, and the therapist discovered what happened. The client said, "In the last session I was telling you about my friend Valerie, and you turned away. Then I knew you didn't care for me, so there wasn't any point in coming back."

The consultant says, "She's found a way to live out the Organizing transference of mother disconnecting and used the Valerie content to accomplish it. This is the window to the Organizing experience we are waiting for. We patiently wait for the moment in which the reenactment of the turning away, the breaking of contact, the rupture of experience happens in the transference." As the case was reviewed, therapist and consultant located a number of such breaches in which the client needed to flee the developing intimacy of the relationship.

The therapist was fired up with these ideas because they seemed to make sense and to organize in her mind many past

incidents. She is ready to talk to her client about all this right away. The consultant cautioned her not to rush into verbal interpretations about something that is perennially lived out nonverbally. The therapist tunes in quickly and says, "I feel like where we're at right now is both lying down in a playpen, and I have to wait for her to come to me." The consultant reminded her that the baby has to be allowed to find the breast, but it must be available to be found—not somewhere in flight and not through talk. The transference to the psychotic mother will be reenacted again and again, so there will be ample time to discuss what is happening. But the therapist can use her new understanding to simply be with her client in new ways. She was reminded of what she already knew from her studies of the Organizing experience: that abstract verbal interpretations per se will not touch this very early transference.

Interpretation at the Organizing level must be a concrete activity, often manifest in some token physical gesture, interpretive contact, or touch at the specific moment when the analytic client is actually in the act of pulling away from contact, of (transferentially) creating a rupture. Viable interpretation of the Organizing transference often involves some form of actual, physical, concrete reaching out by one person toward another to communicate, "I know you believe you must break off our personal engagement in this way now. But it is not true. As an

adult, you have the ability to stay here now with me and to experience your long-standing terror of connectedness. How can you manage not to leave me now? Can we find a way to remain in contact for just a few more minutes?" Clients needing to work on Organizing experience terror often deliberately (and perhaps wisely) conduct the early phases of therapy at quite some distance from the therapist by spacing appointments far apart or arranging long and difficult drives. They often sit at a distance from the therapist and talk about seemingly unrelated things. They know that interpersonal closeness can only be experienced as traumatic. Thus, the invitation to sustain contact must be cautiously offered and episodes of flight anticipated and responded to appropriately.

3. Freezing in the Organizing Transference

In the third example of how Organizing transference works, an emerging theme of an otherwise very-well-developed woman has been related to the Organizing period. This example is from a much later working-through period of the analysis (with a male therapist) and occurs in a personality much more capable of verbal abstractions than the previous two. The woman's mother, during the baby's early months of life, was afraid to pick her up for fear of "breaking" her. The client actually believes she can recall her mother frequently lurking or hovering just out of sight so she would not beg to be picked up. In transference she would

often lie on the couch absolutely motionless for long periods listening to the quiet sounds of the analyst breathing, clearing his throat, or stirring in his chair. It has been discovered through several years of intensive psychotherapy that there were many strengths this mother was able to stimulate in this child, but at the deepest psychic level there remain connecting difficulties. The emergent theme over several weeks to be reported was the analytic client's rage that occurs on a fairly regular basis in social situations when she knows that the person she's interacting with can indeed do more for her and be more there for her, but somehow flakes out. In short, her rage is mobilized at people when they have potentially more to offer than in fact the person is actively living in the current relationship.

In a key session she develops the theme further. Early in the marriage, she says, her husband was far more warm, giving, and available than he is now, and she is angry that he is not more available when she knows he can be. She becomes exasperated to the point of feeling utterly helpless and frozen. By the same token, she indicates that what attracted her to a close friend was that this other woman had so much to give. The friend is well-traveled and well-read. She is alive, active, versatile, a good conversationalist, and much more. But, in a recent example, when her friend had the flu and could not get out of bed to go to her son's very first baseball game: "Then I don't see her any

longer as what she could be or might be for me if she can't [even] be there for her own son. I become angry and disillusioned with her and withdraw into myself. Now I know what has been bothering me so much lately about her in our relationship: too often she cancels, flakes out, or blobs out when I know she doesn't have to, when I know she has far more to give but is choosing not to. I become completely immobilized, frozen, in impotent rage."

In the discussion of various examples that have occurred with her husband and her friend, she said, "Now I'm finding that not only when I'm enraged at the other person for not living up to their potential do I not get what they have to offer me, but I also see that when I'm enraged I am totally unable to take in, to get, to make use of that which they can in fact offer me." She referenced some examples from previous transference experiences in therapy in which she, in complaining bitterly about the therapist's seemingly endless unavailability over the holidays and weekends, was so preoccupied in her hours leading up to the holidays that she was unable to make use of whatever good experiences might be possible in the sessions. Her comment is "Something always happens." The emphasis here is on the subjective statement of the disconnecting experience being impersonal. It's not "I'm disappointed with the other" or "The other lets me down" or "The other fails to live up to his

potential." It's "We're interacting, and then something happens, and the potential that is there isn't being lived out, and I fall into a lost state of sadness and grief, which is usually manifest in instantaneous but frozen rage."

At this point in the session the client realizes she has lost or repressed a further insight regarding her husband and friend that she was very excited about only a moment before when she connected to it. But just as quickly as the insight came, it fled and she was very disturbed for some time about having lost this insight. After a few thoughtful moments, she said, "It sounds like a reason to break contact." The therapist quickly replied, "No, it's the way you break contact." The client then said excitedly, "That's exactly what I lost. I was trying to formulate the problem with my husband and my friend in terms of how I break contact, but I couldn't quite get there. If I'm always living in what a person could give me but isn't, then several things happen: One, I have reason not to relate to them; two, I'm not relating to them at all but I'm relating rather to my fantasy; and three, they do have something to give or I wouldn't be relating to them, but in my distress and frozen anger I'm completely missing what they have to give to me. I break the contact by being sad and enraged, complaining about what I'm not getting."

At this point she slowed down and indicated that she was emoting very deeply, that she felt she'd reached a very profound

point. “I know somehow that this can change my life if I can finally get hold of it. If I can find some way of fully knowing about this, I will be able to change many things.” Her therapist said, “It seems as though you have located the mechanism regarding how the contact is broken and how it relates to the early experiences of your mother who, much of the time, was there so that you knew full well what things she could provide. But when she was preoccupied, or not willing or able to give, or frightened about how she might harm you, she bowed out, leaving you stuck, knowing that she could give more but that she was not giving it. No wonder she reports that you were such a good baby and slept a lot! The content of the transference is ‘You could be giving me more, but you’re not.’”

“Now,” she continued, “I find I’m a little scared about knowing all this. Things keep clicking in my mind—more and more examples. It’s like my whole life is built on this single mechanism. No wonder I wasn’t happy when John, my supervisor, failed to tune in to me completely when I knew he could. If I finally identify this, I may be able to change. I am excited, but I think I’m mostly very scared. I think the scare is that I won’t remember this, I won’t be able to take hold of it, I won’t be able to make it my own.” The therapist said, “No, the scare is that you will remember it. You are in the process of deep change, and as you are changing you are coming face to face

with a terror you have avoided all your life. The terror of having to encounter a real live person who has some good things to offer but who may not, for a variety of reasons, be willing or able to give fully in all areas. Sooner or later in every relationship you encounter this situation, and it brings back the agonizingly sad and rageful reactions you had to your mother during your earliest months of life. So you have been unable to continue relating or you have given up the relating when the conditions are not met rightly. What you are scared of is actually allowing yourself to negotiate the uncertainties of relationships and to survive the positive possibilities as well as the painful disappointments which are bound to be a frightening and powerful consequence of fully knowing and living out what you are now discovering."

"I know you're right," she says.

Each of these three examples illustrates how the rupture of the Organizing experience is repeated in transference. In each instance, multiple interpretive possibilities exist. The decisive moment of Organizing transference interpretation is not visible in any of these examples—in the first two because the relationship had not yet arrived there, and in the third because the in vivo interpretations had already begun and the client was in a later stage of "owning" the interpretative work (though she expresses fear of losing it). The presence of Fraiberg's (1982) three "predefenses" of fighting, fleeing, and freezing is suggested

in these three case vignettes and may be seen as the clients' ways of achieving a rupture of contact in the relationship that, due to transference projections, is threatening to become overstimulating.

Disconnecting Modes: "The Clamor"

Psychotherapy with Organizing level transference is full of all kinds of content and behavior, even if that content should take the form of extreme belligerence, withdrawal or silence.

Over the years I have come to stigmatize various disengagement modes emanating from the content of the Organizing transference as "the clamor of the therapy hour."

Clamor implies two things. First, clamor is an incessant cry or demand for more, for special consideration, for "what I need and have a right to now—before I fragment or die." But secondly, clamor is a cry that is so intense and so intrusive as to be annoying, alienating, and contact-rupturing.

Undoubtedly the original function of the cry was to signal distress and to demand that the mothering partner restore a body-mind-relationship state that could be enjoyed or tolerated. But when the cry becomes a conditioned part of an infant's life that cannot be adequately calmed, it becomes a conditioned response to any perturbation.

Subsequently the clamor is systematically paired with or conditioned to a sense of the presence of the (m)other who is failing to relieve the perturbation or pain. So through simple conditioning, trust relationships later become the object of terror in proportion to whatever extent they were originally unsuccessful in quelling the rising tide of overwhelming distress and pain.

Later trust relationships are then imbued with this conditioned fear and its accompanying clamor. The clamor thus comes to serve as an alienating wedge between people to prevent the danger of intimate relating. "Clamorous" content or behavior thus becomes a conditioned method of averting the challenge necessarily posed by interpersonal engagements.

Clamor takes myriad forms. But in therapy it functions to produce a breach in interpersonal connection or to limit the possibility of satisfying and sustained connection. Therapists with good training in empathy try in the therapeutic process to ride out the cry, to empathize with the need—the demand associated with the clamor—and with the frustration that needs are not being adequately met. Unfortunately, empathy with the content of the clamor often serves to escalate its intensity, delay its punch, and reinforce its alienating function. What is not being realized by limited content-based empathy is that the content of the clamor cannot be satisfied because, as cry, it is a memory

with a purpose but not necessarily a relevant content. The purpose is to prevent or forestall empathic contact which is perceived as dangerous. The clamor is an angry memory of what I needed and didn't get. But the conditioned clamor-memory now functions in the service of preventing intimate or reciprocal interconnections that in the past were known to be traumatic. What is remembered is the pain of a previous relation or connection that was experienced as dangerous or terrifying. Either total muscular collapse or muscle system constriction that functions to withdraw from, ward off, or quell the pain then provides its own form of permanently conditioned pain response —which, over a lifetime, the person comes to fear. Successful relational therapy eventually involves re-experiencing the agonizing body-mind-relationship pain and releasing it.

In summary, the trust relationship itself mobilizes conditioned physical-psychological pain responses. The cry or clamor serves to ward off present and future connections by alienating the other and creating a safety zone to prevent anticipated re-occurring relationship trauma. Once an expression of pain in relationship, the clamorous cry now functions as a defense against relationship re-traumatization through foreclosing meaningful emotional connections. Since emotional connections, mutual affect regulation experiences, are necessary prerequisites for learning the many lessons of life, the person's

growth remains severely limited. The person is terrified of connections, of relationship, because interconnectedness in the primordial past was known to be hurtful. To connect in the present is to run the risk of stimulating pain again.

There are many ways to prevent relatedness—one is a clamorous cry for "more," for "what I deserve," for how "you're not treating me right" or how "you're not giving me what I need" or for how "I can find somebody better who will." "Abandonment!" in one form or another can be another clamorous or accusatory cry. But with Organizing level relatedness it is essentially bogus because it is used not to promote or to restore relating as it might be in a symbiotic relatedness mode. Rather, the clamorous abandonment cry serves to forestall or to prevent connection or to create a break in connections! Virtually all "psychotic symptoms" serve the purpose of clamor, of keeping others safely at bay.

Brief Case Illustrations of How Clamor Works in the Organizing Transference

One man who was born with a birth defect that prevented sucking sought older women prostitutes and then complained that he couldn't orgasm with them. Soothing sensual contact was what had been missing, and when he now goes for it he does it in ways that are self-limiting, he then focuses on his sexual

dysfunction rather than on his self-frustrated yearning for closeness and his terror of relationship. "It's their fault. They don't satisfy me."

A woman client who had been mechanically managed by her mother out of a sense of obligation and duty in infancy, begged her therapist for physical touch because she was internally prevented from feeling his mental presence and touch. He knew that the soothing physical touch that she longed for was available to her in many ways in her life but that it didn't relieve her internalized agony over lack of touch from him. Her clamor for physical touch from him not only kept him uneasy and distant in the relationship, but prevented the very mental and emotional closeness and soothing that would allow her to participate in transformational relating.

Another man maintains a schizoid or bored demeanor in relationships until the other almost forcibly approaches him with overriding, warm, affirming interest. He thinks he is afraid to approach others because he might be rejected, but in fact his manner staves off the possibility of connection that he is terrified of. When there are brief moments of personal connection with his therapist, he suffers terrifying nightmares and phobias. He remains stuck in the belief that others "don't relate well, don't approach me right."

Numerous such therapy relations end with the client bitterly complaining about the shortcomings of the therapist. Yet when the interaction is closely scrutinized we can see that the clamor and accusatory cries only serve to justify the client's retreat, and that there was an unwillingness or inability to continue negotiating the relating. Somehow the therapeutic relationship had not developed the interpersonal safety needed for two to work through the terrors of connectedness together. The plea is always somehow "Don't abandon me, I need you." But the plea comes in the form of a clamor bound to alienate and replicate the original abandonment.

Suicidal and other self-destructive and self-effacing behaviors usually serve the same alienating purposes. The clamor stems not from abandonment fear, as the client is inclined to claim, but from the terror of meaningful connections. The memory expressed in this way is the danger of connecting, the terror of a deeply personal I-thou exchange that has the power to transform. The content of the clamor invariably revolves around some charge—aimed at the therapist or at others—of rejection, neglect, abandonment, misunderstanding, or abuse. The therapist is thrown some tantalizing bone to chew on which serves as resistance to the two experiencing the full impact of the terrifying transference—thus derailing the therapeutic process. The content is designed to fend off intimate and meaningful

relating. The content is designed to take the focus away from the mutually enacted disengagement from intimate connection.

A Thought Experiment for Understanding the Organizing Experience

Imagine yourself approaching someone with whom you are in the process of developing or expanding an emotionally significant relationship. Your companion likewise approaches. It could be your spouse, your child, one of your parents, a sibling or a friend, or even someone special with whom you work or play. Perhaps it is one of your clients if you are a therapist. Perhaps your therapist if you are a client.

You feel alive and happy to be seeing your special person and excited by all that is mutual in the approach. There is a smile on both faces and warm greetings in both voices. Both sets of eyes gleam with eager anticipation. Two hearts pick up their pace as the relating dance begins. You two have been in this pace many times before, co-creating experiences of joy, laughter, sadness, grief, anger, inspiration, mutual regard, and love.

Try right now to conjure up in your mind such a relational situation. Put the book down for a moment, close your eyes, look at your relating partner with your mind's eye, feel the approach and the anticipation, and imagine something wonderful starting to happen between you. As the relating dance begins, each

makes her or his own move, and each mutually responds, reciprocating with an expanding resonance leading to the creation of intense harmonies and cacophonies of sound, sight, shadow, color, texture, stillness, excitement, life, and movement.

But then, almost before you realize it, just when things are starting to get good, the intensity of the relating game somehow starts to diminish. You begin feeling something happening in your body, in your mind, in your soul. Your sixth sense has a hold on you and is slowing you down somehow, pulling you back, inexplicably dampening the intensity of the momentarily achieved and longed-for connection. Perhaps you are thinking of how many things you have to do today. Or some part of you is drifting off toward unrelated thoughts and pictures. In your reverie you mind find yourself feeling drowsy, moody, tired, or cautious for no reason you can really think of.

You make a quick, valiant attempt as the relating dance continues to figure out what's going on with you, or what's going on with your partner in the interaction. You wonder what's happening in your bodies and in the relationship at the moment that's causing this slowing, this distancing, this breach in the intimate contact.

As therapists we have some skill at the relating game so you may attempt processing with our relating partner the physical

and mental impingements that have just cropped up for you. “Why am I so uncomfortable or distracted or feeling this way at this particular moment?” Perhaps you feel edgy, nervous, hypersensitive, distracted or constricted. Perhaps you find yourself losing interest, slumping, or rapidly dropping in energy level. An invisible wall has gone up. Emotional distance is threatening. “What’s happening around here, anyway? This is the child I love so deeply. These moments are fleeting and precious, why am I feeling bored? This is my spouse, my love with whom I would rather spend time with than anyone else on earth, so why am I mentally fleeing the scene. This is my friend, my trusted colleague, my valued client or my therapist with whom I truly treasure my time, so what’s happening to spoil my enjoyment, to wreck these few precious moments of intimacy, to limit my opportunity for enrichment and transformation?”

You attempt a quick recovery. Maybe you are able to take a deep breath and dive back into the rapid-paced fray of the relating dance and be okay. Maybe not. Perhaps the processing has helped momentarily. Maybe you suspect that the particular trend towards disconnection that you are experiencing at this moment haunts the bigger picture of your relationships, your intimacy, your love. And this does so in subtle or perhaps not so subtle ways for a lifetime.

"How does what I am experiencing now fit with the bigger picture of my life? What are my hopes and desire here? What are my dreads and fears?" You may even go so far as to ask yourself, "What's the matter with me? What's my problem? What do I do this so much—stray, lose interest, close down? Why and in what ways does this loss of connectedness frequently happen with me?"

Or instead of the *guilt* route, you may go for *accusation*, silently blaming the other for being so shallow, so boring, so demanding, so distracted, so unrelated, or so forth. Or you may blame the situation itself or the relationship for not offering enough. But we have already learned that guilt and accusation get in the way of unraveling complex here-and-now I-I interactions. *Here, guilt and blame serve to disconnect us further from relating*. What kind of relatedness modes or patterns can be operating in the here-and-now of the relationship?

Considering the Thought Experiment and the Organizing Experience

Involuntarily disconnecting this way happens to all of us in various ways all the time in relationships—but we seldom consciously focus on the process. At certain moments of building excitement, of increasing intimate connecting, we find ourselves feeling cautious, silently backpedaling, inexorably withdrawing,

or allowing ourselves to wilt, to cringe, or to fall into disconnected reverie. We find ourselves withdrawing, jumping from thought to thought or blanking out entirely. And thereby—often much to our chagrin—inadvertently rupturing the developing links to whatever is occurring and to whatever might be able to happen.

Retreating from Contact and Intimacy: Why Do We Resist Loving Contact?

If loving contact is what we desire most in relationships, how can we understand the universal resistance to intimate contact? Psychodynamically oriented psychotherapists now make the assumption that human minds are organized by relationships (*PDM* 2006, Norcross 2002). The mental and physical activities we engage in on a daily basis have been conditioned by the emotional relationships that have been available to us throughout a lifetime. When it comes to relationships, our more fortunate experiences have taught us to reach out hoping to find various kinds of loving connections. While our less fortunate experiences have taught us to fear and to retreat from certain kinds of intimate relationships. On the basis of our past experiences in relationships it stands to reason that we would naturally search out relationships which are likely to be good for us. And that we would avoid relationships which are likely to be bad for us.

Unfortunately, we do not choose our most significant relationships in this way! Why not? Because in our earliest months and years we all experienced disappointing, frustrating, and painful emotional relationships that influenced us in formative directions. As the twig is bent so grows the tree. As babies and growing children we learned a series of lessons about emotional relationships, which have been fundamental in organizing our personalities and in determining our choices in later relationships. We learn quickly how to mold ourselves to what we perceive to be important emotional realities around us. So that our most basic sense of safety and love soon resides in the familiar patterns of emotional exchange we learned from our first caregivers—no matter how self-limiting or self-abusive those patterns might appear to an objective observer (Lewis et al. 2000). We are attracted to that which is familiar in relationships, not to that which might be good for us. We are vulnerable to repeating interpersonal emotional experiences that are known to us and are often oblivious to or neglectful of those possibilities that might be best for us but are unfamiliar (Hendrix 1988).

Therefore, when we find ourselves moving toward more intimacy in a relationship and then at some point we find ourselves silently backpedaling, the obvious inference is that some form of avoidance has been previously conditioned to this particular pathway to intimacy. The further inference is that at

some similar previous juncture relationship-pain was encountered that was severe enough to post an unconscious signpost that says, "Never go there again!" What has been *transferred* from past experience is wariness or fear of certain kinds of intimate contact. What is being resisted is exposure to an intimate form of relationship that in our minds runs the risk of producing intense pain similar to relationship pain known in the past. What many people find surprising is that *our own minds actually produce intensely painful, aversive, and even confusing and disorienting experiences in order to warn us away from types of intimate contact and connection that have been known in the past to be disappointing or hurtful!* This warning usually operates automatically or unconsciously so that we are not aware of the signal pain or anxiety involved, but simply of a strong aversion to or a tendency to change the direction of the relating.

Summary

The term "Organizing" refers to the fundamental activity of Organizing a channel, a pathway, or a link to another human being that either

1. fails to take by virtue of unresponsiveness of the human relational environment thus giving rise to the first fear of no one being there, to the fear of being alone in the universe, or

2. aborts by virtue of the conditioned pain that prevents ongoing reciprocal connecting thus giving rise to the second fear of ever connecting again.

In either case the person is left perpetually Organizing a reaching channel toward others and then—based on transference and resistance learning—either

1. withering out of discouragement, or
2. constricting out of fear.

Corollaries are that both varieties of "Organizing experience" are universal to a greater or lesser extent. And both kinds of Organizing transference form the universal foundations for all subsequent kinds of relational learning.

The Energy Arc Metaphor

A metaphor for further understanding the Organizing experience would be useful at this point. Imagine yourself in a lively interaction with another human being. Visualize an energy arc beginning where the other person's body touches the ground. The arc of energy rises to fill and animate the other person's body. The flow of the energy arc approaches you across the space between by way of the other person's eyes, voice, gestures, and emotional projections entering your body, animating it, and extending down to your own grounding. In a mutually enlivening engagement such as conversing, playing ball, dancing, or

suckling the energy flows freely and reciprocally in both directions along the arc with each person being fully attuned to the life force within themselves while simultaneously responding to the lively emanations from the other person. An emotional union is achieved that is not reducible to stimulus-response analysis. It is through lively and enlivening participation and mutual engagement that human communication occurs and that consciousness of the cultural achievements of the human race are passed through the mind and body of an adult into the mind and body of a child. And later from one person to another.

But if this energy arc has not been experienced as sufficiently enlivening or has been experienced as the source of injury by an infant, she or he will fear being re-traumatized by again reaching out and being either disappointed or injured or both. The developing person who has been traumatically neglected or injured learns that human contact and connections are dangerous and to be avoided at all cost—turned away from, ruptured, broken, or abandoned by whatever means can be devised. By using the inventiveness and cleverness present in good cognitive and emotional intelligence, the person living Organizing experiences soon learns a variety of ways of limiting interpersonal relationships so that they can be experienced as somewhat safe. The diversity and complexity of human intelligence allows people to avoid certain kinds of emotional

relationships and to develop into fine human beings in many, if not most, ways. But intimate forms of relating deemed possibly dangerous and pain-producing are regularly avoided with accumulating consequences.

Notable among the unfortunate consequences are the tendencies to imitate human life (i.e., the mimical self) and to conform to human expectations (i.e., the false self) rather than to engage in the arduous task of negotiating the complexities of emotional-relatedness learning. As a result, the person may develop tendencies toward mania and/or depressive activities in order to join with or to avoid others—depending on the need, given her or his relational environment. Alternatively, the person may develop withdrawing, autistic, or schizoid tendencies in order to stay safely outside of the pale of dangerous human interactions. Or the person may develop what appear to others as unusual, persecutory, or bizarre thoughts and behaviors based on early cause and effect, approach-avoidance response patterns that originally had a motive to stay safely out of the way of interacting relationally with others perceived as frightening or dangerous. The person may have learned to dissociate one cognitive-emotional aspect of self from others in order to achieve a break in human connections, thus producing the sense of multiple personalities. Or compulsive and addictive patterns of consuming, holding, or evacuating various liquids, and solids or

a habituation to other substances and behaviors may have evolved to serve the purposes of keeping the person out of contact with the human milieu or its representations. In short, trauma in the two earliest expressions of desire (for contact and/or connection) sets up relationship fears that serve to prevent, to rupture, or to limit sustained relating with other human beings. The cumulative effect over a lifetime is to limit or restrict a person's relationship intelligence. Substitute adaptive behavior patterns (called "symptoms" in psychiatry) are developed by the child which may permit her or him to "pass," to survive amidst a myriad of relational demands that are perceived as dangerous and to be avoided. Many people mask their relational disabilities by deliberately cultivating idiosyncratic or eccentric personalities. Otherwise, the person may develop apparently quite well until the person finds her- or himself in situations where relationship demands are unavoidable—such as school, dating, sex, work, or marriage and family.

Before leaving the energy arc metaphor for listening and responding to Organizing experiences I would like to point out that the arc can be broken in many places. The obvious place is between two people. And in research films of mothers and infants playing we often see the child actually looking away in moments of high stimulation—as if to process what she is experiencing. The patient mother waits for her attention to

return. The insecure mother commences activities to get the child to look back at her. We note in therapy with Organizing transferences how often the client breaks contact within her own body with various somatic or psychological preoccupations. That is, imagine an infant standing to reach for mother's face—the legs can fail, something can distract, a fear can intervene, etc. Or, the client may have learned how to break the contact in the mind or body of the other, the therapist—"You know I sued my last therapist"—or some other equally distressing verbalization or activity.

Therapy with the Organizing Experience

Psychotherapists study all of the relationships in a person's life for clues that will permit formulations about how the person regularly moves toward human contact and connection. And then how that person regularly accomplishes some—transference or resistance-based—form of interruption or breach, which prevents sustained mutual and reciprocal relatedness. "Where exactly in the arc of energetic enlivenment has the person learned to interrupt the relating and in how many different ways can the interruption be accomplished by this person?" are the questions of the therapist. When considered in this way the task of psychodynamic psychotherapy with Organizing experiences suddenly becomes clearer.

1. The therapist must first spend considerable time and energy helping to establish an interpersonal atmosphere that the client can experience as somewhat safe.

2. Next the therapist must encourage whatever forms of contact and connection the client can allow.

3. Then the therapist must devise ways of holding the relating steady until the transferentially-determined resistance to relating appears.

4. Finally, at the moment of interruption in the relationship a relational intervention is offered. The relational gesture is designed to communicate somehow: "I see that you believe that you must pull away from our emotional contact now… But that is not true. You have repeatedly established for yourself that I am a basically safe person to be with. So now, if you try, you can permit yourself to remain in connection with me a little longer than you might ordinarily allow with someone else…The compelling sensation that you are in grave danger, that your body and mind may at any moment experience excruciating pain or fragmentation, that you are confused or lost, or that you must somehow compulsively pull away is essentially delusional no matter how real it feels…You have already established that I am safe to be with. You know that interactions with me can be useful and liberating. We have spoken of how terrifying it is for you to experience interpersonal intimacy in almost any form. You have the power to stay in connection with me now, despite your discomfort, restlessness, confusion, or terror…Contact between us can be safely tolerated for a little while longer. Try staying emotionally connected with me now so that we can see what further fears and demons lurk inside trying to

> pull you away, unnecessarily attempting to prevent your being hurt by our interaction…What do you feel in your body now? What shakiness, numbness, or terrors can you allow yourself to be aware of? Who am I to you at this moment? And how do you experience me and our relationship as a danger right now?

The working through of the Organizing transference consists of countless instances of encouraging the person in therapy to come to the brink of her or his sense of safety in the therapeutic relationship. And then for the therapist to find some concrete way of holding the person in emotional relationship a moment longer—long enough for some unsettling or terrifying reaction to emerge so it can be known and processed within the relationship.

The key feature here is for the therapist to encourage connection while simultaneously recognizing the terror being created by the attempt. I have written about the potential usefulness of token physical contact—such as touching fingers, holding hands, locking eye contact, demanding full voice contact or other concrete forms of contact—for the purpose of holding the connection so that the transferential terror can become known (Hedges 1994c, 2000b).

Discussing with the client in advance what moments of interpersonal contact might look like and having a well-understood informed consent in place create safety nets for the

otherwise risky process of elucidating primitive transference experiences through relational interventions.

Optimal Responsiveness with the Organizing Experience

Optimal responsiveness required to work successfully in the area of Organizing experience begins with the establishment of a safe interpersonal environment, which can take from months to years to accomplish. The therapist gently but persistently encourages movement toward dynamic emotional relatedness. The therapist remains constantly alert for subtle (and many times not so subtle) signs of an emotional retreat that signal the arrival of disengaging transference and a possible moment for a relational intervention. Optimal responsiveness to the Organizing experience entails a realization on the part of the therapist that interpersonal emotional contact and connection transferentially warns the client of an imminent re-traumatization, so that the person quickly moves into some safety-searching, contact-avoidant activity (or symptom). If the therapist is prepared and moves quickly enough, she or he may be able to seize the moment of retreat with a verbal or nonverbal relational intervention that prevents the rupture of the emotional contact now being experienced. And of the terror, numbness, or retreat mechanism which is serving to avoid or rupture emotional contact. From a technique standpoint the client can be

forewarned of the importance of such moments. And forewarned that the therapist will attempt some relational intervention at such moments in order to hold the interpersonal contact steady whenever the therapist senses it slipping. The forewarned client may then be willing to sustain the relating momentarily in order to experience whatever forms of pain, withdrawal, numbness, fragmentation, confusion, or terror may ensue so that two can experience them together.

Working Through the Organizing Transference and Resistance

The working through process consists of therapist and client learning together over time how to *catch in the moment the transferentially-based resistance to sustained emotional contact and connection*. And learning how to hold these contactful moments together through whatever body-mind-relationship-relationship reactions of terror, numbness, fragmentation, and/or confusion may occur in one or the other or both body-mind-relationships. Studying together characteristic modes of resistance to contact enacted by both participants allows both to be watching for the special ways connection is being avoided. It may be helpful to study the approach-avoidance patterns participated in by two in terms of basic fight, flight, and freeze reactions. It will also likely be interesting to notice how the client not only breaks contact within her or his body and between

two bodies, but also how the client arranges to break the reciprocal energy arc in the mind and body of the therapist by precipitating various countertransference reactions. Accusatory "clamoring for more," "demanding better attunement," or "insisting upon needed kinds of responsiveness" often become ways of disrupting the therapist in such a way that the interaction or "interacting energy arc" is broken in the body-mind-relationship of the therapist! (Hedges 1994a,c, 2000).

Varieties of Common Countertransference Relational Experience

I. *Organizing Level:* confusion, fragmentation, withdrawal, and/or distractibility when connections are avoided or ruptured

II. *Symbiotic Level:* unusual, untoward, perverse, rageful, and/or unbounded responses to projected scenarios and role-reversal scenarios

III. *Selfother Level:* facilitating boredom, drowsiness, and/or irritation at having one's own narcissistic needs neglected or thwarted

IV. *Triangular Relatedness:* overstimulating or intrusive sexual and aggressive reactions that threaten to interfere with or act as an impediment to the ongoing development of the client's material

Four Kinds of Countertransference to the Organizing Experience

Different forms of countertransference experience—that is, emotional responsiveness on the part of the analyst—are to be expected, depending upon the developmental level of the issues currently being presented for analysis. (See Hedges 1992 for a study of the variety of kinds of countertransference responsiveness.) Four distinct forms of countertransference have emerged with clarity that characterize therapists' responsiveness to Organizing experience:

1. *Denial of human potential*. The most common form of countertransference has seen Organizing personalities as witches, evildoers, hopelessly psychotic, and in other ways not quite human. In this attitude is a denial of human potential and a denial of the possibility of being able to stimulate desire in such a way as to reawaken it and to analyze blocks to human relating. We hear: "I can't reach you—you are too sick. You are untreatable, so we will lock you up or give you drugs to sedate or pacify you."

2. *Fear of primitive energy*. When an analytic therapist invites the Organizing experience into a transference relationship, he or she is asking that the full impact of primitive aggressive and sexual energies of the client be directed squarely at the person of the therapist. Therapists fear the power of this experience because it can be quite disorienting and, if not carefully assessed and monitored, potentially dangerous. But fear of basic human affectivity

is irrational, and we now have at our disposal many rational ways of inviting and managing the Organizing level affects and energies.

3. *Encountering our own Organizing experiences*. When we as therapists invest ourselves emotionally in reaching out again and again to a client only to be repeatedly abandoned or refused, it stimulates our own most primitive experiences of reaching out to our own mothers during our Organizing developmental period, hoping for a response and feeling traumatized when the desired response was not forthcoming. Our own "psychotic mother" transference can reappear projected onto the client as we attempt to provide systematic and sustained connection for people living Organizing states. How each of us as individual practitioners develops staying power is the crucial question.

4. *Empathy leading to breaks in contact*. After the preliminary phases are well under way, we notice the client begins excitedly to see in outside contacts (as well as in the therapy hour) how the breaking of contact is being regularly accomplished. They begin a valiant struggle to maintain contact nearly everywhere they go—especially with the therapist. The therapist sense that the relating is "too much too soon" and titrates the emotional intimacy empathically.

RELATIONAL INTERVENTIONS WITH SYMBIOTIC/ATTACHMENT EXPERIENCES

Elements in Replicated Symbiotic Scenarios

Psychotherapists have had a keen interest in developmental theories since Abraham (1924) defined the psychosexual stages, Erikson (1959) set up the stages of ego development, and Mahler put forth her separation-individuation theory of development (1968). The assumption of these early attempts at developmental listening was that symptoms and transferences in adult psychotherapy could be traced back to the individual's developmental experiences in infancy and childhood.

Edith Jacobson (1954, 1964) shifted the paradigm from considering individual growth experiences *per se* to looking at the ways children in their early years come to internally represent their worlds of self and other and how those internal representations of relationships serve as silent guides in subsequent relational experiences. She was explicitly aware that the word "representation" was metapsychological and that what

she was reaching for was *the child's ongoing experiences as limited or constricted by past relational experiences*.

Following in her footsteps, Kernberg (1976, 1980) saw the building blocks of personality as (1) a representation of self, (2) a representation of other, and (3) an affect state relationally linking them. This was a crucial step toward recognizing what would later be called the interpersonal or intersubjective field and how freedom in the field is systematically limited by prior constricting experiences.

Hedges's (1983) four relatedness Listening Perspectives are derived from Mahler's and Jacobson's self and other developmental considerations. The four developmental Listening Perspectives define an array of relatedness possibilities from the least to the most complex.

The Listening Perspectives put forth various considerations of *how relatedness flexibility comes to be limited by experiences at each level of complexity*, i.e., from

I. the search for connections (Organizing), to

II. the establishment of reliable channels of mutual attunement (Symbiotic), through separation and individuation, to

III. the firming up of a cohesive sense of self (Selfobject), to

IV. the highly complex capacity for fully ambivalent triangulated experiences of self and other (Independent).

The liberating twist of the Listening Perspectives approach is not to be found simply in the overall reorganization of familiar clinical and developmental concepts along explicitly interpersonal relatedness lines. Rather, *a profound shift of mental organization on the part of the therapeutic therapist is required —a mental shift away from looking for what's "really" there in the person to experiencing what's happening in the here-and-now intersubjective field of mutual and reciprocal influencing*.

From the earliest beginnings of psyche, we can imagine channels being organized on the basis of reciprocal responsiveness between the mothering person's body and personality and the developing infant. We can imagine the "Mommy and me" dance that is forming in the mutual cuing and mutual affective regulatory behaviors being established by the third or fourth month of life.

These co-constructed psychological tendrils of mutual relatedness that have been metaphorically termed "symbiosis" by Margaret Mahler (1968) can be thought to evolve according to growing expectations of attuned and misattuned cognitive-affective-conative interactions.

In the symbiotic exchange that the infant presumably overlearns, the response of each partner comes to depend upon the response of the other—i.e., *mutual affect regulation*, as the neuropsychologists call it (Schore 2015).

Peaking by the 12th to 18th month, the symbiotic mutuality, the developing dyadic responsiveness, mutual affect regulation, or forms of symbiotic exchange can all be imagined to remain strong through the 24th to 30th month. Basic character and body structure dates from early in this period as the constitutional and personality variables of the infant come into play with the human relational environment creating the first sense of psychological familiarity and stability.

The possible dimensions for construction of the merged dual identity dance of symbiosis are necessarily limited by the foundations of the available connect and disconnect modes that were laid down in the physical and psychical patternings established during the previous Organizing period.

The particular emotional and behavioral patterns established in this symbiotic or primary bonding relatedness are thought to follow us throughout our lives (as *character structures*) as we search for closeness, for intimacy, for security, for familiarity, for physical security, and for love.

If some people's stylized search for security and love seems strange, perverse, addictive, or self-abusive, we can only assume that the adult search replicates in some deep emotional way the primary bonding pattern *as the infant and toddler experienced the symbiotic exchange with his or her caregiving others*.

The important aspect of this developmental narrative is not that child development can be demonstrated to proceed in this way, but that such imaginative features can be used in the therapist's mind to search for emotional-relational moves and movements being experienced in the here-and-now therapeutic exchange in order to break through mutual enactments in the transference-countertransference constrictions of the interpersonal field.

This Symbiotic Listening Perspective has been developed for use with what has come to be referred to broadly as "borderline personality organization" and the various "character disorders." (Kernberg 1976, PDM 2006), and is essentially a way of understanding various aspects of the preverbal interaction patterns that seem to be established during the symbiotic and separating periods of human development. *All well-developed people evolved interactional patterns or scenarios related to basic emotional bonding or Symbiotic experience*.

I have defined "scenario" as a listening device for highlighting the interactive nature of the early bonding experience as it manifests itself in the replicated or mutually enacted transference-countertransference experience based upon a therapeutic re-creation of relatedness forms, patterns, and modes of the symbiotic periods of both participants that are being mutually enacted. These patterns become replicated in some form when any two people attempt to engage each other emotionally. The (almost "knee-jerk") emotional dance that forms in any emotionally significant relationship can be studied in terms of an interaction, a drama, or set of scenarios that unfold based upon deeply entrenched ways each participant has established for experiencing and relating intimately with others.

This Listening Perspective seeks to bring under scrutiny *the predominantly preverbal engagement patterns and body configurations that mean attachment, bonding, and love, regardless of what individualized forms those patterns may take*. What follows are some case studies to illustrate the listening processes involved when attending to replicated scenarios or mutual enactments that point to symbiotic modes of relating.

Case Study:
Jody Messler Davies: "Love in the Afternoon"

I am here reminded of the wonderful case study contributed by Jody Messler Davies, "Love in the Afternoon" (1994). Her client had an intense dread of sexual stimulation in himself, but especially of perceiving arousal in others. At a decisive moment Davies stood against the character scenario of his childhood by telling him that she had indeed had sexual fantasies about him. This precipitated a storm of indignant outrage reminiscent of the frequent storms of outrage the client's mother had frequently directed at him. The client had often recalled how as a boy, following delicious afternoons in mother's bed snuggled up against her body with her reading exciting stories to him, mother would realize that he was in a pleasurable ecstasy intensely enjoying his time with her and then become outraged. Dynamically, mother would seduce the boy with delicious incestuous relating and then when she sensed he was enjoying and feeling aroused by the relating she would become indignant and angrily push him away. Little wonder that he had been totally unable to sustain sexual relationships as an adult. Davies's client had continued to regale her with tantalizing sexual imagery for some time that she had been fending off. But as her analytic curiosity allowed her to consider what this was all about for him she found herself having sexual fantasies and at a critical

juncture told him so. His sudden indignant outrage served momentarily to frighten and shame her, replicating how cruelly his mother had raged at and shamed him—and perhaps also signaling his realization that the delicious but perverse scenario with his therapist was crumbling—slowly coming to an end.

In my view her intervention was directly to the point and did serve to bring a long-festering internalized erotic scenario directly under analytic scrutiny. She dared to stand against the scenario by declaring that all of his sexual talk and imagery was indeed having an erotic impact on her whether he wanted to think so or not. Though his instantaneous rage and outrage were momentarily intimidating to Davies, in the confrontation she spoke what the boy's child-self could not speak—that he was stimulating her and that it was both titillating and invasive. And that in raging and shaming her he was attempting to blame her for a mutually stimulating situation that he was deliberately instigating and she was participating in. In role-reversal he had given her in the countertransference the untenable position he had been victim to in childhood. Her speaking up for herself, and therefore against what was happening gave voice to the client's child-self and unmasked the perversity of it all.

Case Study:Stephen Mitchell: The Horror of Surrendering

Anna Freud (1937) taught us that for a man to take in something from another man is psychically equivalent to surrendering to homoerotic longings, femininity, and the loss of male potency. But Mitchell (1997) points out from our modern point of view that perhaps all men in one way or another long to be liberated from the burdens of socially constructed male-gendered identity.

To illustrate this thesis Mitchell recounts an analysis he conducted with an artist who had gotten into a stalemate after seven years with his former analyst. Gender lines were tightly drawn in the client's family of origin. His father was a self-absorbed artist whose ambitions were greater than his talents. His mother had become embittered by his father's passivity and isolation and divorced him when the client was ten. He became closely aligned with his father because of his mother's hatred of all men but even so his father hardly saw him. Mitchell's client fantasized both he and his father to be superior, suffering and unrecognized geniuses. Although the son was a promising artist, much more successful than his father, he had a habit of sabotaging himself as if actively succeeding were somehow terrifying. He constantly sought leads and advice from others including his analyst about what he should do and how he should

spend his time. He valued more than anything else what someone else could bring or give to him. In sexual intercourse, he reported at times feeling confusion over whether the aroused penis was his or the woman’s. He was excited by the thought of what being penetrated by a penis might feel like.

The transference in both analyses was organized around the desire and dread of what he could get from the analysts, both men. The analysts were both seen as possessing precious knowledge that they sadistically withheld. He had read some things Mitchell had written and felt that he would be more interactive than the previous analyst, would give him more. But he was soon struck with how insightful the writings had been and how dull Mitchell seemed as an analyst in person.

What seemed not to have come out in the previous work was what a desolate image of masculinity this man had inherited from his father—an identity that condemned him to live in a depressive heroic solitude. His longing to be penetrated—by ideas, by a penis, by scintillating analytic interpretations—represented “both a desperate hope finally to get something from his father and an escape from the masculine confinement that constituted being a man” (p. 251).

In the transference Mitchell is granted superior knowledge making the client dependent on getting the analyst to deliver or

else suffering from deprivation. Early on he had a hard time remembering anything Mitchell said but finally fixated on one of the analyst's questions. In speaking of his last analysis he lamented that for him to change he would have to give up a sense of himself as special—which he wasn't sure he could ever do. Mitchell asked where he got the sense that the major factor in constructive change would entail his giving up something very precious to him. The question served to define a different kind of relationship that existed with Mitchell which didn't demand submission.

The first analyst seemed to be saying something like, "Your problems with assertiveness are due to your remaining your very special father's very special little girl. Cut it out; give all that up." Yet the patient experienced that injunction as implicitly claiming, "My penis/authority is bigger and better than your father's. I want you as my little girl. To make it with me, you have to give up him" (p. 252).

Gradually in the role-reversal countertransference Mitchell found himself implicitly or explicitly making such submissive claims himself:

> an envy of his relationship with his father, … seductive hints that he could certainly be a most loyal and rewarding devotee, if only I could convince him I had the right stuff; an intellectual

> toughness and competitiveness in him that made it clear that, if I was not man enough to make him want to be my little girl, he would certainly make me his; an admiration for his intellectual prowess and vast knowledge of things I was interested in that made a passive surrender to him both tempting and dangerous; and so on. (p. 252)

Using this case example, Mitchell holds the opinion that for contemporary analysts the decisive arena for working on gender and gender identification issues is in the complex interpersonal negotiations of the analytic relationship.

> This man needed to realize that he had co-created the impasse in his first analysis … with his horror of a surrender, which he also deeply longed for. Our joint task was to find a way for us to engage each other by which we could alternately give and receive, alternately exert power and be vitalized by the prowess of the other, and simultaneously lessen the threat of self-betrayal and humiliation. (p. 252)

The Symbiotic Replicated Transference-Countertransference

Self and other configurations or constrictions thought to originate in the symbiotic period of relatedness human development are secured for analysis through the replicated or mutually enacted transference-countertransference (Hedges 1983, 1992). Writers such as Winnicott, Ferenczi, and Michael Balint have held that special provision needs to be made in the

analytic relationship for these earlier relational issues to be seen and analyzed. Following Blanck and Blanck (1979), I speak of the transferences from this early period of development as more than mere transfer of instinctual feelings from oedipal parents (Hedges 1983).

Symbiotic or early bonding experiences presumably occurred at a time in the client's life when infant and caregiver engaged in a mutual cuing or affect regulation process in which two lived and experienced each other in many ways as one. The replicating transference-countertransference can be expected to be a reliving at an unconscious or preconscious emotional level of patterns, styles, and modes of relatedness once known in relation to the mutually affect-relating symbiotic (m)other. In the original symbiosis, the (m)other is hooked by the power of the relatedness.

In replication, the analyst must be equally hooked at a preverbal emotional level for the nature of the bond to begin to become apparent. Mutual affect regulation and interpersonal enactments comprise the replicating transference-countertransference matrix.

Frequently in case conferences I hear a therapist making remarks such as: "I am going to present this case because somehow I find myself doing things I don't ordinarily do in my

practice." Or, "This person has a way of manipulating me that I find upsetting." Or, "I feel like I'm being set up for something, that something isn't right, that I don't know what's going on with this person, that somehow I am being duped." Such expressions register the sense of interpersonal boundaries being tapped or stretched from the therapist's ordinarily expectable personal and/or professional guidelines and limits. Studying how the therapist experiences these boundary demands, crossings, or violations begins to give clues to the preverbal emotional replication being lived out in the therapeutic interaction by both parties.

One way of thinking about this is to say that the Client has the project of attempting to communicate preverbal memories to the therapist. In doing so he or she tends to ferret out and use various aspects of the analyst's personal responsiveness for the purpose of arranging an emotional replication or mutual enactment of the way things once were. To the therapist it often feels as though his or her Achilles heel has been found, that the client has learned how to "push my buttons."

That is, the earliest bond, the first love, and the foundational realities of our lives are derived from the assumptions we make about the environment and important people in it. This set of attitudes, beliefs, assumptions, and relatedness modes becomes so firmly entrenched that all intimate relationships can be

expected to touch upon how we experience the world through symbiotic templates. The merged sense we have regarding how intimate relationships "should" be is so automatic and entrenched as to be readily confused with reality. A very definite set of expectations and relatedness difficulties arises and the client is loudly or even silently adamant in the insistence that such and such is the way things must go between us.

An adversarial atmosphere arises (D.B. Stern 2015). Gradually the analytic therapist feels closed in on all sides or backed into a corner until he or she can find a way to make an effective relational intervention; a way to "stand against the scenario" (Hedges 1983). The resistance is often so severe as to make relinquishing of the sought-for patterns almost an impossibility.

Therapy with Symbiotic Relatedness Scenarios

The first problem in therapy with people experiencing borderline level relating is for the therapist to be able to place the difficulties in an interactive, symbiotic format so that exactly what the relatedness demand is comes into bold relief. Not only is this a cognitive task involving problem solving with new ideas, but *the emotional relatedness dimension itself necessarily has engaged the therapist in many unconscious or automatic*

enactments so that the therapist's own character defenses become activated.

But even when a therapist is skilled enough to be able to see the relatedness dimension insisted on by the client, and even when the defensive structure of the therapist can be more or less laid aside for the moment, making verbal interpretations of complex nonverbal experiences poses an entirely new set of impossible problems.

Therapists have been known to talk themselves blue in the face and what they were saying was well formulated but somehow it still didn't hit the mark. The client might even agree, even cognitively elaborate the therapist's ideas, or make behavioral changes in accordance with the interpretations, but still there is no connection to the deep, nonverbal emotional layers that the interactive dilemma springs from.

Verbal interpretations of preverbal symbiotic relatedness patterns are not effective until the issues are in active replication (mutual enactment) in the analytic relationship or in a parallel relationship and unless the interpretation functions as some sort of active confrontation of the relatedness mode in here-and-now relating.

"Confrontation" is used here cautiously and does not mean that the person or behavior is being confronted, but rather, the

forms, modes, or patterns of constricted relating that arise from experiencing emotional relatedness templates from the Symbiotic past are the object of the transference or enactment confrontation.

Furthermore, it may be the client who first has the "new perception" that leads to dissolution of the enactment (D.B. Stern 2010). Since the Symbiosis is thought to consist of a set of stylized relatedness patterns and modes that cannot be spoken, if they are ever to become known they will manifest themselves in the non- or para-verbal exchanges between two people.

Bromberg (2011) and Donnel Stern (2010) make clear that those enactments must *actually* occur before it is possible to know them or to formulate them into words. As the exchange proceeds, a pattern of relating will emerge with regular expectations of how therapist and client are to interact under varying conditions. These patterns are frequently referred to as "replications" or "enactments." The subjective "Mommy and me are one" dimension becomes inadvertently or unwittingly lived out in the exchange, beginning with the dependency or care aspects implicit in the therapeutic situation.

By looking for a recurring pattern or scenario that is regularly a part of the dyadic relatedness, the therapist becomes aware that the symbiotic or "Mommy and me" interaction pattern

gradually appears in each of its particulars as it is lived out in relatedness expectations. Too rigid or too loose boundaries on the part of the therapist may thwart the process. The study of symbiosis requires that the therapist maintain whatever minimal limits and boundaries are needed to preserve personal and professional integrity, and then watch to see how the client chooses to structure the relatedness and attempts to play with, stretch, or attempts to violate what might otherwise be considered interpersonal boundaries.

What can then be observed and opened to comment are the idiosyncratic ways in which the relationship becomes oriented and structured by the needs and demands of both therapist and client. That is, the replicated transference-countertransference enactments can be expected to be nonverbal and interactional in their impact, a silent development in the spontaneous relating of two human beings. A great deal of talk or chatter may occur as the therapist attempts to inquire and offer ideas, but the crucial event of transformation will not occur as a result of verbal work *per se*, but rather as a result of non- or para-verbal action, interaction, or enactment that may or may not later be formulated (D.B. Stern 2015).

Passive and Active Transference-Countertransference Enactments

Two major forms of the replication or enactment are to be watched for: the passive version and the active version.

The passive replication, though often unnoticed for long periods, is the experience in the transference of the therapist and the listening situation in some particular way like the preverbal interaction with an early caregiver. For example, the demand for a certain fee, or for regular and timely appointments becomes experienced like some demand from a symbiotic parent for time and energy to be directed not as the infant/client would have it but as the parent/therapist insists.

Countertransference studies have led to consideration of active replication of the symbiotic dimension in which a role reversal is entailed. That is, the client is "doing unto the therapist what was once done unto him." That is, a position of passive weakness or trauma is turned into active victory in the role reversal. The client acts in place of the parent, foisting onto the therapist relatedness demands that the client once experienced as being foisted upon him or her. An array of reactions might emerge in either participant of the passive replication: irritation, injury, rage, spite, excitement, rebellion, conformity, lust, etc.—

each would represent the revival of some emotional relatedness mode from early childhood.

Speaking or interpreting these things is often welcome and well received but typically goes nowhere. In the replicated transference, in the passive or active forms, a certain emotional climate is set up by the client and the therapist is expected to be in agreement or to conform to it. So long as the therapist is living his or her part well, things go well. But when the therapist fails to obey (inadvertently or through active confrontation of the scenario) the relatedness rules that have been laid down, a disturbance in the relationship ensues. This splitting of good and bad affective experiences keeps the therapist on target in understanding the exact nature of the relatedness hopes and expectations under study.

Freud's (1915) formulation is that of turning passive trauma into active victory. Anna Freud's (1937) formulation is "identification with the aggressor." Her interpretation rests on the truism that no matter how good the parenting process, the parental ministration is frequently experienced by the infant as an aggressive intrusion into his or her space for instinctual expression. Klein (1946) formulates in terms of "projective identification," noting that early incorporated "bad objects" are made available for analysis by projection into the person of the analyst.

Alice Balint (1943), in a brilliant tour de force, has detailed the process of primary identification and holds that we identify with what cannot be readily used and incorporated into the nurturing process. That is, it is the negative, the overwhelming or traumatic, that poses a problem for the infant. In primary identification as the infant attempts to solve the problem of negative intrusions, she or he builds a mental model of the parental emotional response to be understood because it is troublesome or intrusive. As the early model is built, it becomes a foundational part of the early structure of the child's mind. In active replication transferences these living modes based on primary identification emerge with clarity in the analytic interactions.

In addressing a group of Superior Court judges and mediators involved in child custody decisions regarding the subject of projections encountered in their work, I once spoke of "reciprocal scripting." Most everyone these days understands the notion of scripting—that we each have an emotional life script that we manage to live out again and again in different situations. With vignettes from therapy and extrapolations into parents fighting for custody of their children, I was able to demonstrate what sitting ducks mediators and judges are to being snared into these reciprocal scripts by parents and attorneys, into knee-jerk responses and judgments which may have nothing to do with the

task at hand of acting in the best interests of the child (Hedges 1994d). But the fresh twist in "reciprocal scripting" is to learn that our life script also contains exactly what the other person is to say or do in response to us. That is, not only is each of us locked into endlessly repeating patterns of personal relating, but we are equally locked into finding, creating, or stimulating circumstances in which how the other person is supposed to relate or respond is also unwittingly scripted by us. We tend to "do unto others what was done unto us." A scenario, thus constructed from observing the emotional exchange between client and therapist, is not expected to be an exact recreation of historical truth as it might have been viewed objectively at the time. Rather, the interactional patterns that become discerned, defined, enacted and perceived produce emotional-interactional truth. These relational scripts reflect the internal experience of the infant as recorded in the body and the style of affect engagement with others, rather than actual memories of any real or discrete events.

The pictures, affects, and words that emerge as a joint creation of the two participants serve to define real experiences of some sort and are often cast into a language of metaphoric reconstruction of past reality. Often a client will wonder if such and such an event that seems so true or is becoming so vivid in memory ever really happened. It does little good to speculate

about the veracity of the memory *per se* and certainly trusting the therapist's gut level belief that it really did happen cannot be safe since so much transference and countertransference is being evoked at such times. There can be no doubt that seductions and abuses are widespread and that, whether or not a particular event can be depicted as happening on a particular date in history, a violation or series of seductive intrusions did occur, even if only in the overall atmosphere of caregiving that existed at the time. But of much greater importance than the actual veracity of a certain seduction or abuse, is the question of how that seduction or abuse is being replicated in the here-and-now transference-countertransference engagement.

But even if we have been more or less successful in fixing on crucial aspects of projected replication experiences and putting our experiences into words and pictures for ourselves, we face once again the problem of how to communicate our understandings so that the client can make use of them for transformational purposes.

Whether the aspect of the countertransference we are trying to bring to light is the passive or active replication, we repeatedly find that in trying to put preverbal affective experience that has a quality of relational reality into pictures, scenes, and words that might define that experience, our words often either fail or fall on deaf ears.

Donnel Stern (2015) has expressed this in terms of not only "unformulated experience" but "non-verbal experience." Therapists often liken it to a mother speaking to an infant, explaining complicated things that the infant has no way of grasping. The infant may listen intently, study mother's face and the sounds of her voice, and respond in a variety of ways, but the verbal understanding cannot be received. Likewise, the infant carefully studies Mother's face and body for experiences she is having that she perceives but cannot formulate.

Kohut declares that a self develops because a mother addresses the child from the first day of life as though the child had a self. We need to keep in mind that many of our verbalizations are to keep ourselves oriented to the task at hand and while they may be received in many ways may not yet be comprehensible to the client.

Bollas (1987) holds that finding creative ways of speaking the countertransference is tantamount to putting words on preverbal experience that the client cannot at present verbalize. Speaking the countertransference represents interpreting the early mother-child idiom of being and relating (Hedges 1983, 1992).

Resistance to Relinquishing Symbiotic Modes

Perhaps the most difficult resistance at this level is to seeing the destructive and masochistic aspects of the replication in such a way that the person feels impelled to relinquish the relatedness modes that form the core of his or her identity, the relatedness memories that have come to spell love, or mother, or safety, or familiarity. The symbiotic relatedness modes are so foundational to the way we organize and orient our entire beings that a wholesale shift in lifestyle and interpersonal relatedness will be required if we wish to experience greater relational freedom.

People are not only reluctant but terrified to give up ways of being that are basic to how they experience reality. The cry of resistance is always heard in one form or another, "I can't do it, you must do it for me!" It can take many forms: "I can't change without a completely safe relationship." "Unless I can be held and allowed complete internal integration of my true self I can't possibility develop." "Your style of working or personality simply will not allow me to do what I must do. I need a therapist who...." The bottom line is: "I can't (or won't) give it up."

Clients do not want to hear the interpretation of active and passive scenarios because it would mean having to give up a way of relating dependently, safely, or familiarly with a (longed-for or

fantasized) maternal object who could be relied on for an expectable set of responses—be they good or bad.

We encountered this earlier in the Davies case study, where her client did his best to shame her into capitulation. To relinquish long-held ways of relating is tantamount to giving up our mother, letting her die, of being without our main ways of greeting the world. No wonder no one wants to individuate; it means a crumbling of ego function that was built on the old tried and true symbiotic modes of relating.

Relinquishing old symbiotic/character modes necessarily produces tremendous disruption, disorientation, and grief that our stable modes of relating are collapsing and that we are fragmenting, losing our footing, loosening our grip on what we once thought was real.

In principle I believe the relinquishing, as well as a working-through, of the psychotic or Organizing aspects of personality is always possible. But in practice we have to consider the personal resources available to the client as well as the therapist at the time, the strength of the conditioning factors as originally laid down, and the analyst's preparedness to experience Organizing regressions that a crumbling of symbiotic structures in the client are likely to stimulate.

I was interested in how Heinz Kohut (1984) expressed this possibility:

> In the psychoses, including those covertly psychotic personality organizations (central hollowness, but a well-developed peripheral layer of defensive structures) for which I reserve the term borderline states, a nuclear self has not been shaped in early development. ... In these cases the psychoanalytic situation [as classically conceived] does not bring about the long-term activation of the central chaos of the self within a workable transference that is a precondition for setting in motion the processes that would lead to the creation, *de novo,* of a nuclear self. In order to lead to a causal cure, the therapeutic process would have to penetrate beneath the organized layers—the defensive structures—of the patient's self and permit the prolonged reexperiencing of oscillations between prepsychological chaos and the security provided by primitive merger with an archaic selfobject. *It is certainly imaginable that, even in adult life, the repeated experience of optimal frustration in an archaic homeostatic selfobject environment brought about in the analytic situation would lead, as in earliest infancy, to the birth of a nuclear self.* (p. 8, italics added)

Kohut acknowledges that in expressing reservations about the analyzability of prepsychological states, he may be expressing his own personal limits as a psychoanalyst. As a diagnostic relativist, Kohut defines the categories of psychosis

and borderline as states of prepsychological chaos, which the empathic instruments of the psychoanalytic observer as traditionally conceived would be unable to comprehend. But Kohut acknowledges that the basis for his conviction may be his personal fear that in following a person empathically into prepsychological territory he would not be able to hold the empathic bond when the basic transference emerges and the person for protracted periods of time would have to “borrow the analyst’s personality in order to survive” (p. 9). Thirty years later the scope of psychotherapy has certainly expanded to include treatment of borderline and psychotic personality features in much the same way that Kohut envisions.

All people resist vigorously giving up their earliest and most foundational love bond in whatever form its memory is retained. And when it begins to crumble, suicidal and death fears abound that are properly interpreted as “Indeed, you are dying; the only self you have ever known is being killed off by what you are accomplishing in therapy.” Relinquishing symbiotic modes is also equivalent to severing the maternal bond, to killing off the emotional presence of the internalized mother. “You are afraid because there is nothing in your life experience to suggest that things will ever be any different.” The following case illustrates how the therapist replicates the scenario then after a

new perception of what's going on finds a way to "stand against" the scenario.

Bioenergetic therapist Sarah Turner-Miller (in Hedges 1996) recounts a year-long saga with her client, Maggie, whom she describes as a middle-aged woman, groomed but untidy with a worn, thrift-store look. Her large eyes not only stare but seem to look completely through Sarah. Clutching her purse, she declares that therapy is her last stop. She tells Sarah that she is agitated and cannot sleep; that she feels ugly like she does not belong on earth, like she doesn't exist.

Maggie was adopted at 4 months of age. Her adoptive parents had two older sons. Maggie bonded with her father, who died when she was 10. Mother remarried and her new husband had a son who had sex in the afternoon with different people and masturbated in front of her. She received no protection. "My mother is like a black apple. I feel pain and darkness—no hope. Why bother? I'm tired. Nothing works."

Sarah struggles to establish a connection with Maggie. Every now and then she sees a flash in Maggie's eyes that acknowledges that she is there. Sarah feels morbid when she is with Maggie, craving rest and sun. She feels she is with a person who is already dead as if Sarah has to provide meaningful existence for both of them.

Maggie clearly craves some kind of sustained connection, some symbiotic tie, with Sarah even though paradoxically it seems somehow life-threatening to her. Maggie unconsciously knows her limited experience of symbiosis to be so destructive that she loses either way—with or without connection. She wants Sarah to be a successful mother to her and to pull her from her deep schizoid withdrawal.

Sarah experiences Maggie as filling the room with a hostile oozing energy that is full of vile hatred. Sarah finds herself thinking: "I hate you! I hate you! Go away—disappear—don't kill yourself; just get out of my space. The countertransference is so pervasive and persistent that Sarah can hardly breathe, but now she knows how hated Maggie was. Says Sarah: "She needs to know I know, to feel that I have some sense of how hated she was. She needs to hear that I mourn her lost humanity and that I cringe at her deadening processes."

The countertransference needs to somehow be spoken. Sarah hesitatingly begins:

> I have some very important things to share with you today. These are feelings, thoughts, observations about myself when I'm with you that may help us understand your difficulties even more.... What happened to you was so early in your life there is no way for you to tell me just how terrible you feel. There is only the therapeutic dance that goes on

> between us for you to show me what goes on deep inside of you.… As we get to know one another I essentially become, in psychic experience, you the infant and you become your parents. Thus I come to know your experience by living out your inner life. … Often and from the very beginning, I have experience intense feelings that do not seem to be mine. I feel scared and confused around you. I feel I am not enough for you—that there is some awesome rage and chaos that I can't get out of easily. I feel depleted, drained of my life. I feel evil.… When I try to connect with you, I feel destroyed in my efforts. We know this is not your intention; not you, consciously. You are showing me something important. (pp. 130-131)

Maggie seemed somewhat dazed by this session and I checked on her later by phone. The next session Maggie brought in two watercolor paintings that she said were provoked by our last meeting. One was a pregnant woman painted black with a fetus of blue with a red center. The other was a design with a dark center. She said, "This is what it's like to be in the black hole. It starts at the center and bleeds out, the black hole contains it, controls it, and won't let it live.… I know you know something about us and I feel calmer."

Next, Maggie brought Sarah her "bad stuff" in a brown paper bag. Bad stuff refers to her favorite morbid movies, but she explains that she has left the most important one at home.

Shortly Maggie phones Sarah to tell her that she wants to kill herself and believes she can. Sarah convinces her to go to her trusted gynecologist and he got her to a psychiatrist who prescribed Prozac and Xanax.

Maggie then brings her favorite video, '*Night, Mother,* for safekeeping in Sarah's office. *'Night, Mother* is a play by Marsha Norman that probes deeply into a mother-daughter symbiosis that ends in a suicide dance of the deepest despair and loneliness.

Maggie happens upon the movie which becomes her transitional object. She has watched it hundreds of times. The interaction between daughter Jessie and her Mama has struck a deep place within Maggie. She, like Jessie, wishes to die and knows that her life as she lives it has to end. She is morbidly invested in every word. She wants Sarah to join in.

The movie portrays the evening in which Jessie tells her mother she is going to kill herself that night. We follow the two through gripping conversations in which painful aspects of Jessie's life, including her struggle with epilepsy, are worked over by the two. Jessie hurriedly rushes down the hall with Mama following screaming and banging on the locked door until the fatal gunshot is heard. "Jessie, Jessie, child ... Forgive me. (Pause) I thought you were mine."

Maggie wants Sarah to play *'Night, Mother* with her. Watching the movie and reading the script has enlightened Sarah about the nature of the transference-countertransference matrix she has felt so desperately caught up into.

> I feel like I've been struck in the head by lightning bolts. She carries the video around in a paper bag. She leaves it in my office for safekeeping with a great deal of pomp and circumstance. She tells me that as long as I have *'Night, Mother* in my possession, she won't do anything to hurt herself. She promises to leave it with me for so many weeks, then asks for it in the next session. Keep this dangerous movie away from me, she begs and then sneers at me and insists on having it back that instant! In spite of the rich material we discuss at length, the obsession exhausts us both. (p. 136)

Finally, Sarah has had enough:

> I've had it with this *'Night, Mother* spook show. I hate feeling responsible for keeping Maggie alive, as if I could. I know the agony of Mama. It's my turn to let her know how much I detest being in this position. The dialogue from that session went like this: "I can't be warm and caring when you turn me into a hospital or police person whose job is to keep you from killing yourself. I don't want that job! Your most important way to relate to life is in the *'Night, Mother* game. I cannot play it with you. I will not be your "'Night, Mother." It's not right for me. You've got to stop this! When you endanger your life, you

> can't have me.... Jessie had the last word with Mama, the blast of a gun. I know you're looking for a way to have the last word with me.... I really want to relate to you. We can connect in a real way; as two warm loving humans. (p. 136)

Maggie says somehow our last session when "You blew up at me" helped her to get some things into a new perspective, that she could feel Sarah better. She watched *'Night, Mother* again.... This time she saw a girl who had lived a lifetime of pain that she never expressed to anyone and how no one picked up on her pain, so they thought everything was fine. She also saw someone who was already dead basically; that killing herself was just the completion of the physical act of something that had long been dead.

She tells Sarah that she now knows that Sarah understands. That Jesse is someone who had been hurt all her life, yet had not given voice to that pain until that one evening when it all came out. Maggie told Sarah that she now understands why she identifies so much with that movie. She's going to read the script again to see if she can experience it from a different perspective.

Maggie shortly reports feeling more balanced. She even smiles at Sarah now. Maggie says she almost trusts Sarah, that she can see the craziness of *'Night, Mother* and how she used to feel a victim of it. She dreams, "I asked you what do you think of

your daughter? You said, 'I couldn't do without her. She's so good.'"

Soon Maggie wants a clean break from therapy so the two went through several months of termination. Maggie has no money and Sarah has been carrying a bill up to $5,000 because Maggie needed the therapy and because Sarah has feared for her life.

Two months after termination Maggie filed for bankruptcy, her whereabouts unknown. Sarah:

> It's as if the therapy was her birthright—that she shouldn't have to pay to exist in my office. What she owed me is really what was owed to her in nature a thousand times over: a real mother with goodness and love. Emotional bankruptcy was filed on her a long time ago. She played it out to the bitter end. From the position Maggie left me in I can now say, knowing what it means to her, "Good night, Mother." But at least it is I who am symbolically left for dead and she, as survivor, is on her own to find her way in the world.
>
> Wherever Maggie is, I wish her well. (p. 139)

In this therapy we witness the replication of the two participants' symbiotic scenarios until Sarah has a "new perception" of their mutual enactments of dissociated aspects of themselves (D.B. Stern 2010). At that point Sarah retrieves her

dissociated anger and “stands against” the symbiotic enactments, thus giving both a new degree of “relatedness flexibility” (Hedges 2013c,d) or “relational freedom” (D.B. Stern 2015).

Case Study: Donnel Stern: “Perhaps you should have called me.”

(I had the rare opportunity and pleasure to respond to a case presentation given at the Newport Psychoanalytic Institute on March 16, 2013 by Donnel Stern. The case of William is to appear in his “Relational Freedom” chapter of his then-forthcoming book (2015). Here are my remarks on the case that relate to the problem of confrontation and relinquishment of Symbiotic enactments.)

Don, let’s examine the material you have presented in your work with William, searching, as always, for transference and countertransference themes, dissociations, and enactments that might be limiting his and/or your relatedness flexibility or, in your terms, relational freedom.

Over the time you have spent with William he tells you about and enacts with you his “symbiotic false self compliance scenario” learned in relation to a self-centered mother who expects to be mirrored in her narcissistic grandiosity by his appreciation and gratitude—though his compliance is fraught with bitter resentment. This early symbiotic mode or scenario

was transferred—not necessarily inappropriately—by William onto his equally, we are told, narcissistic father.

"Symbiotic scenario" is a term coined in this particular Listening Perspective to denote the *internalized relational template* or *implicit object relations fantasy* operative at this preverbal level of awareness and *being "replicated"—actually lived out or enacted in emotionally significant relationships, including the transference-countertransference intersubjective field* (Hedges 1983, 1992, 2005).

Through a role-reversal—one endemic to replicated symbiotic relational templates or scenarios—William insists on selfobject appreciation and gratitude from his wife as well as his analyst, (and, like his own parents, no doubt in muted ways from his own three children). But unlike what we expect in the Selfobject listening perspective William is unable to benefit from empathic mirroring either from his wife Jan or you. Rather, William's family and analyst are compulsively assigned the reciprocal role from his family of origin of remaining emotionally distant or standoffish.

Other features of the symbiotic listening perspective discernible in the material presented include (1) the splitting of affects when compliance with the scenario is or is not being achieved in the transference; (2) chronic limitations in ego

capacities—in William's case debilitating anxieties in the area of social and romantic relations; and (3) personal identity development that is limited largely to work-related preoccupations.

And so, Don, you welcome and engage William and you two await the expectable, necessarily unconscious, split off, dissociated aspects of transference-countertransference replications as they fall into place. Over time the analyst and patient alert each other to experiencing and then to the perceiving of various aspects of their replicated interactional scenarios.

As you have so well observed, it's only a matter of time before an adversarial emotional atmosphere develops in the interpersonal field at the symbiotic level of relatedness complexity. "What's going on here anyway? Something is wrong here; something must be done to straighten matters out." For this reason, I have spoken of countertransference as the "royal road to understanding the symbiotic replication experience" (1983, 1992).

First, as therapists we find ourselves in the role of the early parents—some aspect of our analytic relatedness subtly *replicates or re-enacts* the damaging influences known in early childhood. But then we also find ourselves in a role-reversal—

experiencing in the countertransference the emotional life of the infant self of our patient, passively experiencing the misattunement and abuse foisted upon us by our patient's unwitting identification with his symbiotic (m)other.

Over time, through countertransference responsiveness, the confrontation slowly forms in our minds and bodies: "This has got to stop, I refuse to take any more of this misunderstanding and maltreatment. You are not relating to *me*! Subtext: "I'm only hired help and I have shown you that I can do it your way, the way you learned relatedness in early childhood. But as Exhibit A of other kinds of relationships in the world, you can't be this way and get away with it. You've got to stop this crappy way of engaging people and pay attention to who each important person in your life really is! The buck stops here!"

Now, of course, we never say any of this directly because the countertransference frustration is always heavily imbued with our own ways of experiencing exasperating interpersonal situations. But we do have to trust our feelings, our sense of our own being, our sense of our own individuated selves. *Our confrontation is not us confronting our clients, or even us confronting their behavior—our confrontation must be carefully aimed at the emotional template or symbiotic scenario that each client brings to the interpersonal field.*

And so we struggle to survive in the morass we are being handed. We struggle to formulate what's going on. We consult with colleagues trying to sort out countertransference in the narrow, personal sense from countertransference that might be usable in the broader interpersonal field to enhance mutual relatedness. We know we have been snared in our own enactments, but we aren't exactly sure just how this is happening—understanding will require an intersubjective engagement which, as the professional in the room, we must begin.

We sense the moment to strike is coming—the moment to confront what's happening between us, the moment to "stand against" the scenario being haplessly foisted upon us, the moment to stand up for ourselves in all this fray!

Don, you tell us with hindsight that for several weeks before this session you had somehow sensed something big coming, through you were not quite sure what or how. Also, with hindsight you can see that William entered this hour with some fresh openness which you must have unconsciously perceived—you begin the hour with, "One day William arrived for his session in a state of extreme upset." Neither you nor William was consciously aware of the nature of the upset or of the openness to new experience you both sensed was present—you from your curiosity and he from his extreme upset. Something huge was about to happen and you both sensed it.

So William launches into the upsetting spat he had had with his wife the evening before. In adversarial mode, you lie in wait watching the minutes tick by, waiting for your opportunity to take advantage of what you unconsciously perceive as a new vulnerability. You run down your countertransference checklist to be sure that whatever you are about to do truly feels like it's for William and not just for you. Your sword is drawn and, with time quickly running out, you quickly strike! "Maybe you should have called me." Tears, relief, gratitude. William is run-through, pierced to the heart with love. "Maybe you should have called me."

In the aftermath of the moment, it occurs to you that in all the years of hospitals and recovery from his horrible life-threatening automobile accident in college William never once called out for a witness, for someone to recognize his pain, discouragement, and fear, for someone to be emotionally dependent and vulnerable with, for a *Partner in Thought*. Life-shattering sobs ensue—the spell of the symbiosis has been broken.

In the role-reversal countertransference we could say that you spoke what William as a child could never speak to his parents. "Mother, in all of your narcissistic loneliness *you should have called me*—called on me to be your beautiful baby whom you could grow through by nurturing, reflecting, and witnessing

my developing being." "Father, you could have escaped you self-imposed isolation and frail sense of manliness if you had just called on me your beautiful, God-given son, to reflect your own proud fathering. But you did not call. Instead, you taught me not to be vulnerable, not to know my own dependency, not to call out for help in growing."

And then follows the *pièce de résistance* of the hour, the precipitating morning event with his wife and children turning their backs on their walk to school and leaving William painfully behind—the event that triggered William's opening extreme upset and signaled to you a new openness was available and at last an opportunity for you to "stand against" his lifelong scenario of emotional isolation and pain.

Simultaneous with William's emotional break-through, you let us know, that your part of the mutual enactment broke. Your confrontation of William's scenario that you had been hooked into for so long—"Maybe you should have called me"—came from a deep sense of *me, myself, and I*, from a deep sense of *what's right for* me *if I'm allowed to be a real person in this relationship. In one passionate adversarial moment two people experienced a new degree of relational freedom. "Maybe you should have called me."*

In response to my comments, Stern said, “Relational Listening Perspectives are very useful to have in mind because they draw your attention as a clinician to the various ways you can always hear the material. Sometimes we follow our own paths and forget about the others, and Listening Perspectives offers a reminder that there are always those four ways of making sense and relational impact.”

Summary: Developmental-Relational Listening to the Symbiosis

This Listening Perspective approach to what have been called Borderline and Characterological Personality Organizations is the product of many writers and researchers and stands firmly based on a long tradition of Ego and Self Psychology followed by later influences from the Interpersonalist and Relational traditions. Listening to symbiotic issues focuses on the experience of self which is fused or merged imperceptibly with the other—the “merger other.” Kernberg (1975) holds that borderlines present “stable ego pathology” with “primitive defenses” which require “a modified psychoanalytic technique.” Giovacchini (1979b) speaks of the “helpless patient” while others speak of the “difficult patient” or even the “obnoxious patient.” Volkan (1976) and Kernberg (1976) urge a consideration of “primitive object relations.” Mahler (1975) points to the developmental phenomena surrounding the early

mother-child “symbiosis.” Harold Searles (1979) suggests that studies of “countertransference” yield critical information while Spotnitz (1976) highlights “underdeveloped aggression” as a central concept. Masterson (1972, 1976) presents the idea of an “abandonment depression” as the universal experience of borderlines in response to inadequate mothering. Stolorow and Lachman (1980) focus on “prestages of defense” and “developmental arrests.” Michael Balint (1968) points to the early area of personality development he calls “the basic fault.” Margaret Little (1981) speaks of “basic unity” and “primary total undifferentiatedness.” Kohut (1971) has isolated one group of preoedipal conditions as “narcissistic disorders” but still considers borderline phenomena essentially psychotic in nature.

The complexities encountered in understanding borderline states have necessitated new conceptual approaches primarily due to the general observation that borderline states are not reliably available to verbal-interpretive transference analysis nor do they improve significantly through a traditional analytic study of conflict, defense and resistance. Psychodynamic developmental psychology as applied to the study of borderline conditions focuses on the experience of a merger other and on defining (1) what functions and integrations have or have not developed, (2) the conditions under which they are and are not available, and (3) the relationships of the developed and

undeveloped functions to each other and to the external world. That is, the interest is in observing and defining various specific and non-specific limitations in development and in understanding the many convoluted and/or distorted coping or adjustment attempts which have appeared to obscure or compensate for atypical development in the pre-oedipal and precohesive self periods of psychological development. The psychological structures built during this era may be regarded as retained relatedness modes from the early mutual cueing processes, overlearned ways for two to interact.

While the split affects characteristic of this period tend to make one search for heaven and fear hell in relationships, the subtleties and peculiarities of each symbiotic dance are what interest us most in therapeutic study. The search to define one's symbiotic modes is always unique, for they are always highly idiosyncratic, strange, and usually shocking to our higher sensibilities because they originate in early development. One woman experienced great relief when she finally could say, with violent shaking and tears, "I am nothing." At a pre-birth level, she now believes she was not desired by either of her parents and that she was emotionally handed over to another family member before she was born. To her parents she was "nothing," Her instinctive or unconscious knowledge of this situation, perhaps even in utero, governed all subsequent "layerings" of self and

other experience. Most of her childhood developed as a reaction formation of extreme determination to be something or somebody everywhere she went. Through good-enough parenting she became a well-developed woman, but every aspect of her relatedness potential bore the mark in one way or another of "I am nothing." At every juncture in analysis the "nothing" appeared as indeed something very important to define and analyze in its impact.

One man was finally able to state with conviction, "My deepest passion is to be beaten, raped, robbed, and left for dead." Another, "I have a hard dick for women who can't be there for me." Or another, "I wish to be passive until I am finally abandoned altogether." Or, "My deepest longing is for an empty teat." These statements of a person's scenario reflect years of psychoanalytic work and in each case are radically condensed into an almost bizarre bottom line that captures the deepest and worst of one's perverted relatedness desires and potentials based on some of the earliest relatedness strivings. This kind of deep realization about one's passionate involvements with others is usually reflected in unconscious sexual longings of a perverse, self-destructive, or masochistic destructive, nature. Unconscious masturbation or orgasm phantasies, as they come to light in analytic work, always strike one as perverse or self-destructive in one way or another but regularly point toward one's deepest

relational strivings. Short-term or non-analytic therapies rarely produce narrations of such basic symbiotic structures.

Ingmar Bergman’s films have been particularly adept at capturing the essences of these perverse characterological passions that originate in symbiotic interactions. It is as though an infant learns that the excitement or passion of being with mother results from relinquishing certain crucial aspects of his or her instinctual longings or true self. This painful surrender of aspects of self comes to punctuate regularly all of our relatedness strivings, especially in our intimate love relations. Adult sexuality in its many (polymorphous perverse) variations becomes witness to the early necessity of giving up selected aspects of self need or striving in order to have and to enjoy the excitement of being with the other. Thus all passionate attachments can be expected to bear the stultifying influence of our personal conditioning and histories.

Bergman’s *The Passion of Anna* graphically depicts the unfolding of Anna’s compulsive desire to maim, kill, or sacrifice the object of her passion, thus leaving her lost and lonely. Bergman shows how that scenario interacts with Peter’s reciprocal passion toward being crushed, crumpled, and distorted in love. Peter’s definition of his long and tenaciously held deformed version of potency and his desire for undistorted phallic potency is depicted in the last scene in which he is caught

against the horizon, pacing back and forth between the image of a bent, gnarled, deformed tree and a tall, straight, healthy tree. Peter is frozen between the two trees, between the self-destructive passion of the old and the prospects of escape to new forms of self potency as the final scene potency fades. As usual, Bergman has succeeded in capturing a universal human dilemma nowhere more evident than in our earliest patterns of relatedness spoken of in this book as Organizing and Symbiotic.

I have spoken against content-oriented therapies in favor of process-oriented therapies since the earliest glimmerings of personality are formed within a context of interpersonal relationships and can only become known as emotional relatedness becomes re-created in later intimate relationships. The therapist must be prepared to simply relate, to shoot from the hip, as it were. To simply use his or her best relational skills and then carefully note what transpires. Both participants will be caught in mutually enacting early relationship modes and in dissociating the earliest "not-me" parts of their personalities (D.B. Stern 2010).

Relational interventions then become a matter of perceiving what is happening and then mutually formulating it or realizing it (D.B. Stern 2015) in order for greater relational flexibility and freedom to result

The Realization of Relational Interventions

Clinical research in Southern California involving more than 450 therapists over a 50-year period has demonstrated that clients formerly considered "difficult-to-treat" or "untreatable" can, in fact, be successfully engaged in long-term, intense relational psychotherapy (Hedges 1983, 1992, 1994a,b,c, 2000b, 2005, 2013b,c). We have found that neither the symptom picture *per se* nor the subjective concerns of either the client or therapist preclude major transformational work. Rather, what limits the work are (1) *the treatment orientation of the therapeutic dyad*, by which I mean our field's former medicalized approaches to psychotherapy and the adoption of an approach committed to mutual conscious-raising through ongoing relational processes and processing; and/or (2) *the combined personal and financial resources of the dyad*, by which I mean the capacity and willingness of both participants to devote the time and emotional energy required to establish a robust project of reciprocal relating over a significant period of time.

Early relational fears necessarily influence how subsequent relationships and relational learning situations become experienced. Early-learned relational modes that limit personality development are understandably entrenched in personality and only yield to a long-term, intense process of

affective relating that serves to release constrictions that limit a person's relational flexibility and freedom.

Effective psychotherapy work requires considerable time and emotional intensity on the part of both therapist and client. We have found that significant changes in relational flexibility and freedom are the outcome of the combined efforts and resources of both participants in an intense ongoing intersubjective relational involvement. I do not see this form of therapy as an easy undertaking. But it can be very rewarding. Experience demonstrates that along the way both participants usually require some form of auxiliary support—case consultation or supervision for the therapist and outside consultative and/or support group experience for the client.

When Heinz Kohut (1984, p. 8) presciently envisioned what therapy work with borderline and psychotic clients might eventually look like—i.e., the development of an independent cohesive self *de novo* in therapy as in earliest life—he understood that the emotional strain would be immense on the part of the therapist. In order to accomplish this the client would need to be able to lean heavily on the therapist's emotional resources and psychic structures for protracted periods of time. Kohut also grasped the unbearably frightening and painful experience that the client would necessarily have to endure in giving up identity structures that have protected her for a lifetime

against prepsychological chaos while she simultaneously reaches toward new, uncertain-feeling interpersonal affect regulation modes offered by the therapist and the therapeutic relationship.

The Listening Perspectives Approach

The treatment orientation utilized in the Southern California clinical research project replaces the medical objectivist epistemology with a set of listening perspectives that utilize metaphors based on studies of relational development. These developmental metaphors describe an array of relatedness possibilities from the simplest possibilities that are thought to characterize early life to the more complex possibilities that develop with age and experience.

Along this axis of relational complexity four relational listening perspectives have been defined, along with seven relational fears thought to be characteristic of different levels of relatedness complexity. These listening perspectives are not aimed at describing stages of human development, rather they represent ways of considering from different vantage points what interactional processes may be occurring at any moment in time during the course of psychotherapy.

While the perspectives may at first appear to be only ways of describing the client's relational experiences of the therapist,

they also describe the therapist's relational experiences of the client as well as the relational matrix wherein each meets the other at the horizons of their experience.

So What Are Relational Interventions?

When we grasp that psychotherapy is basically about helping people with their relationships, our task is greatly clarified. *We aim to intervene in some way in people's habitual ways of relating*. Relational habits are transferred from the past into the present and so we are looking to help people understand how their relational habits from past relationships are getting in the way in current relationships.

In each of these "lower level" perspectives—the Organizing and the Symbiotic—we have the challenge of *actually relating* to the client in such a way that their relational habits or constrictions can become experienced and known and new relational freedoms can be experienced.

In the Organizing level, we intervene at the moments of disconnecting transference by encouraging—and perhaps at times even demanding—that they stay emotionally present rather than engage in some kind of disconnecting activity. Since we can't emotionally intervene in disconnections unless there are

connections, we spend a good part of the early period of therapy establishing safe ways we can be together.

In the Symbiotic level, we intervene by standing against the scenario that they want us to participate in because it constricts our relational freedoms just as it constricts theirs.

The early part of therapy is devoted to inviting any kind of relatedness that is personally and professionally tolerable so that we can learn what their relational habits are so they can be opposed in relational ways.

Lecture 9

FACING OUR CUMULATIVE TRAUMA: AN INTERPERSONAL/RELATIONAL APPROACH

The Force Is with Us!

Something within us wants to be set free. Set free from what? From the inner bonds and shackles that hold us captive to ourselves.

Myths from around the world have portrayed this journey—the journey of "the hero with 1,000 faces." Whether we must slay dangerous dragons, risk our life capturing the golden fleece, pass through treacherous narrows, resist the temptations of the terrifying sirens, or plunge headlong into the vast unknown universe, we somehow know that "the Force" is with us in our journey. The heroine finds herself surrounded by hordes of monsters and evil-doers, trudging through the steamy pits of Hell, and cursed by the envious gods. But the perilous Heroine's Journey—a saga not for the feint-hearted—continues in face of life's ongoing challenges and traumas.

This lecture is about freeing ourselves from the cumulative effects of our life's many relational traumas and the after-effects

of those traumas that continue to constrict our capacities for creative, spontaneous, and passionate living.

Our traumatic wounds were caused by breakdowns in human relationships. Our healing depends upon achieving safe and reliable relationships in which we can re-experience those wounding moments and set ourselves free from their constrictions.

Life's Traumatic Experiences

We have all endured a lifetime of traumas, even though we may have ignored or attempted to deny or pass over their emotional impact on us.

When most of us consider the kinds of traumas we have experienced and compare them with what victims of genocide, war, plagues, tsunamis, life-threatening diseases, disabling accidents, insurmountable poverty, racial prejudice, or severe childhood abuse have endured we count ourselves fortunate.

Yet we know that we, too, have suffered greatly in the course of growing up and establishing a good life for ourselves. While we have no desire to cast ourselves into the role of victims, neither does it help to pretend that we have not had our share of traumatic suffering—the impact of which lingers on to haunt our everyday lives and relationships in many ways.

Psychological and neuropsychological research over the past few decades into severe trauma and post-traumatic experience has fortunately given us many new insights into the nature of trauma and made clear that trauma and post-traumatic experience is not only universal but *necessary* for normal and healthy growth!

Historically, this is the way psychological studies have proceeded: Some extreme or “pathological condition” comes to the attention of clinicians and researchers. Then careful study of how the “pathological condition” operates shows us a new aspect of human life that is universal, but that had not yet been so visible in ordinary everyday experience.

An entirely new paradigm is now emerging for our understanding of the universality and the normality of traumatic and post-traumatic experience. Thus the formerly pathological Post-Traumatic Stress Disorder (PTSD) is now being referred to simply as Post-Traumatic Experience (PTE). We now understand there is a continuum of traumatic and post-traumatic experience —from ordinary and developmentally normal and expectable traumas and cumulative strain traumas to highly impactful extreme forms of focal and intrusive traumas.

Traumatic experiences can enhance our development by providing seemingly insurmountable challenges or they can

devastate us at any stage of life. The relational traumas that occur in early life are particularly devious, in that they lay a faulty foundation for later growth experiences. But whether they occur earlier or later, whether mild, moderate, severe, focal, or cumulative—the essential nature of trauma in human life remains the same, and the universal after-effects are by now well-known and predictable.

Some Historical Notes

Sigmund Freud's seminal discovery was that, given a favorable relational situation, a person could gain access—through inter-personal mirroring processes—to the ways that her internal world of experience had become structured and to the ways that she could free herself from her developmentally structured bondage.

More than a century has passed, with many brilliant people following Freud in attempting to define the nature of the human mind and how we as individuals can learn to transcend the effects of our necessarily limiting developmental relational experiences. Over the years many theories, traditions, and techniques have evolved.

Throughout all of this theoretical and clinical development it has always been understood that early traumatic experiences

have a profound effect on later life experiences. But the exact ways that traumatic experience *contributes* to human growth as well as gives rise to crippling constrictions and inhibitions has continued to elude us. That is, it has continued to elude us until recent technological advances have made possible a vast expansion of knowledge.

In the last three decades we have come to learn more about human genetics, infant experience, brain and mental development and the central role of interpersonal relational experience in human mental development than we have known since the beginning of time. This new knowledge has massive implications for the universal nature of trauma. For example, it is now clear to us that *each individual human brain is actually structured according to early emotional-relational experiences that are and are not available in infancy.* And that this early interpersonal structuring of the brain and the entire neurological system provides the essential foundation for all later mental development.

All this is to say that each human brain and neurological system is absolutely unique—and each person, based on early interpersonal emotional regulation and mirroring processes, develops her own internal, subjective world of experience that will guide her in her future development.

What has slowly emerged in our exponentially expanding awareness of human mental development, is *the central role of trauma in structuring each person's internal world of subjective experience*. As I will show shortly, the foundational aspects of *all* mental development are essentially molded by traumatic experience!

In common language, a traumatic experience is something terrible that happens to you—a horrible, overwhelming *and psychological* event that leaves you traumatized. However, in medical terms inherited from Ancient Greece, trauma does not refer to the blow itself or to the invasive event per se, but rather to *the body's healing response to the blow*—that is "trauma" refers to the processes involved in healing the wound.

The American Psychological Association still defines psychological trauma as "an emotional response to a terrible event like an accident, rape or natural disaster" (online definition). It follows then, that in our efforts to recover from various traumas we are not trying to make the original blow or event diminish or disappear because we can't—rather we are trying to overcome the cumulative effects of our internally structured responses to interpersonal blows that remain in our inner subjective worlds constricting our personal paths into the future.

Hold It! Let's Go Back a Few Steps

The great debate among psychologists and philosophers of the 19th century had to do with which was more important in the development of human beings—the influences of nature or the influences of nurture?

Sigmund Freud felt that his greatest contribution to human thought was the awareness that from earliest development a third influence, infinitely more powerful than either nature or nurture —though limited by both—was the gradual emergence of what he called the "internal world." That is, the raw ingredients of the "human mind"—taken from nature and nurture—become rapidly organized by each infant into patterns of expectation and responsiveness that exert powerful influences on subsequent mental development.

Freud understood that it was the social nature of our species, and the gift of being able to pass socially-derived learning down the generations through the cultivation of emotionally-derived symbols and culture, that constituted the genius of our species.

The socialization processes necessary for the mind of a child to enter the complexities of human culture necessarily required learning, relearning, and reformatting and then learning again. This relentlessly required relearning and reformatting

process is demanded by internal and external intrusions into the way the child and later the adult has structured her inner subjective world of experience at that point in time.

A creative response on her part—using whatever resources she might have available at the moment—aims at overcoming the effects of that intrusion either by smoothly *assimilating* the new information, or by traumatically *accommodating* the demands of the intrusion by re-arranging the established patterns of her internal world. Thus, assimilation of and accommodation to novel learning situations are understood to be universal and normal developmental processes. Assimilation does not require a traumatic repair or reconstruction process, but accommodation does.

The people who found their way to Freud's consulting room brought various patterns of traumatically generated accommodations for his consideration. Freud aimed his curiosity not so much toward the internal or external cause of the intrusion —the traumatic event itself—but toward the way the person's unconscious mind responded to or internally re-organized a pattern of reparative, re-orienting responses. Freud was the first to realize that from a therapeutic standpoint the intrusive event itself was not so important as the way the person experienced and internally organized the effects of that event—that *the*

relational patterns thus built might be developmentally enhancing or seriously inhibiting.

Thus, his aim as a therapist was on *creating a healing relational atmosphere* to address not the intruding blow or the symptoms per se but rather *the traumatic response*—that is, *to unravel the complex web of personal internalized meanings generated by the intrusion*. Contemporary Interpersonal/Relational Psychotherapy continues in this essentially Freudian tradition of privileging personal meanings over the facts of the traumatic event—the most important *therapeutic* insight of Freud's life.

The point here is that in normal developmental learning a child is constantly required to assimilate new information into her already existing internal world and to accommodate—to reorganize established features of it—in order to satisfy intrusive internal or external demands. *This process of internally re-organizing one's patterns of relational experience in order to accommodate the intrusive demands of reality is essentially the process of healing referred to in medicine and psychology as trauma*.

However, like all healing processes a scar remains to tell the story. The psychological scar is a pattern of habitual interpersonal emotional responses developed to accommodate

impingement in an earlier interpersonal situation. Unfortunately, previously established emotional relatedness patterns often do not serve well in later interpersonal situations. This was Freud's essential definition of "neurosis."

As a practicing physician, Freud's early focus was his treatment approach to crippling neurotic patterns in the person's ongoing internal life, as opposed to whatever its sources might have been in traumatically intrusive events. Only a century later have we been able to see the human imperative of the interpersonal or intersubjective field—that is, that the life of a human subject is at all times immersed in a field of social (interpersonal) or intersubjective relations. And therefore, that *all* intrusions into individual psychic life requiring accommodation, whether extreme or more developmentally ordinary, impact the development of the individual human body and mind and must, therefore, be understood as traumatic and taken into account in therapy.

Personal Identity as Traumatically Constructed

Almost as a sidebar, it is important to note that personal identifications—gender and otherwise—exist as internal defensive structures that are also traumatically constructed.

As Anna Freud first pointed out in her classic study of "identification with the aggressor" (1937), even the most favorable intrusions provided by careful and loving parental guidance and ministration are often experienced by the developing child as traumatic intrusions into his or her internal spontaneously arriving motivations. She saw these internal identifications as derived from a traumatically-generated interpersonal defensive process.

Alice Balint (1943) further developed the understanding that human identifications are based upon internalizing the effects of experienced interpersonal intrusions into personally organized subjective worlds of experience. Likewise, those who study gender identifications indicate that binary cultural gender definitions traumatically intrude into the young child's omnipotent and omniscient sense of self, i.e., "I can be anything and everything, not merely a boy or a girl."

Following Freud, Anna Freud, and Alice Balint, we can see that the individual human mind is structured according to its own constitution as determined by nature and nurture as well as according to its own internal relational patterns and identify structures as established by fateful encounters with influential interpersonally generated forces stronger than itself.

The Postmodern, Social Construction Perspective

We now recognize that the most complex phenomenon in the known universe is the human mind—and that the human mind is infinitely complex.

As beings on this planet, we have evolved over millions of years in what physicists tell us are ten or more dimensions—though we can only consciously perceive four of them. The implications of this new knowledge are staggering in the realization that many of the processes that have gone into our human and pre-human evolution and that guide our individual development and are critically influential in later dynamic processes of change will inevitably and forever remain unknown and unknowable. This understanding calls for a new approach to knowledge.

I recall once having heard the quantum physicist Heinz Pagels remark, "In trying to picture the strangeness of the quantum universe that we live in the question is, are we like Piaget's children of various ages who were presented with a number of bottles of different sizes and shapes on the shelf all filled to the same level with water. When the children were asked, 'do the bottles contain the same or different amounts of water?', the older more experienced children were able to give

more accurate answers than the younger ones. Or are we like our domestic pets who live in a world not of their own construction or understanding—but despite that fact have learned very well how to live comfortably within it and to work it to their advantage? We do not have the answer to this question" (personal communication).

Therefore, in considering the infinite complexities of human existence, rather than attempting to theorize in the "modernist" tradition of seeking to determine "the truths of the human mind," we can now recognize that we are living in a "postmodern" era which recognizes our human world to be essentially socially constructed by somewhat arbitrary conventions we call language and culture.

At this point in time effective research and practice necessarily follows an epistemology informed by evolution, relativity, quantum leaps, nonlinear systems, and socially constructed cultural and linguistic systems, as well as somewhat arbitrary human vantage points or perspectives from which to observe, in whatever ways we can, ourselves and the subjectively constructed worlds we live in.

Whatever else is active in determining our collective and individual existences remains unknown and, in principle, forever unknowable and has been labeled by Wilfred Bion as "O"

(1984). But there are other ways to conceptualize the infinite unknown of human experience. William James, in his *Varieties of Religious Experience: A Study in Human Nature* (1901-02), has given us a way to think about human nature in relation to the "mysterious beyond." Starting with the same supposition that Bion did some years later, James believes that what is originally given to the human species as real is the biologically-based capacity for sensations. Subsequently human linguistic and cultural history as well as childrearing practices have structured how a member of the species is to come to experience important survival realities.

We now know from DNA decoding that human nature over millions of years and even after the exodus from northeast Africa some 50,000 years ago has continued to evolve vigorously and robustly (Wade 2006, 2014). While some of that evolution may simply be genes switching "on" and "off" so that adaptation to environmental features can be made, other natural selection features have involved cultural institutions that appear in turn to have called for genetic modifications. Further, it is now clear from physics that we have evolved in ten or more dimensions though we can only perceive four of those—height, width, depth, and time (Greene 2003, 2004).

Prior to these contemporary findings, James intuited that there was a vast unknown beyond what human perception was

regularly capable of discerning. Yet knowledge of these other dimensions of human existence has been occasionally grasped by different individuals and by different social groups over the course of human history. This point has been repeatedly emphasized by J. Chilton Pearce in his *The Crack in the Cosmic Egg* (2002) and subsequent treatises on evolutionary forces.

James's eighteen lectures delivered at the University of Scotland in Edinburg in 1901 and 1902 form a detailed and scholarly account surveying different types of religious experience reported by individuals and cultural groups throughout time. His conclusion is that since time immemorial humans have known that they emanate from other realms than those that can be perceived by the culturally created four survival dimensions. Humans know this because of their capacity for biologically-based sensations that are founded in other dimensions, other realms of unperceived realities. While James acknowledges his own cultural proclivities for formulation of religious ideas and images based in Western Civilization Christianity, he makes clear that each cultural/religious group throughout the world has done its best to formulate the known but mysterious dimensions beyond in categories, dogmas and institutions that reflect the conditions of their environmental/cultural evolutionary heritage. That is, revelations of the beyond necessarily take on images and narrations

compatible with the four-dimensional cultural formulations that have preceded them in each cohesive socio-cultural group.

The visual metaphor that James employs suggests that we live in a culturally bound set of four-dimensional perceptions but that our biological knowledge through sensations goes considerably beyond these barriers. Our sensorial knowledge of our more complex beingness presses us ever toward knowledge of dimensions on the other side of our cultural/perceptual barrier. In his metaphor he speaks of the mysterious beyond as “thither.” And our cultural four-dimensional knowledge as the “hither.” He speaks of an opening or door through which from time-to-time humans—individuals and groups—manage some direct experience of and identification with the mysterious beyond. But when individuals or groups attempt to describe the thither in the hither, they are bound to the four-dimensional cultural linguistic systems that have formed their conscious minds. Therefore, people from different religious/cultural groups necessarily describe their revelations in very different terms. James details the ways in which this knowledge has become institutionalized in various cultures through practices and dogmas as well as the ways in which individuals and groups continue to press against the established dogmas into experiences of alternate states of consciousness and how those alternate states become imaged and communicated. James believes that religious experience is not an

anachronistic cultural practice doomed to wither away over time, but rather that resonates with our deepest sensations and will continue to do so. Like Bion, James became very interested in the ways that mystics have attempted to describe their experiences of the mysterious beyond.

In three remarkable books, science writer Nicholas Wade (2006, 2009, 2014) has collected scientific evidence from many disciplines that has much to say about where we are now in the course of human evolution. Like Bion and James he too cites religious experience as a vital aspect of human evolution—one that is aimed at understanding the vast mysterious unknown. Wade's views highlight the importance of cultural institutions that have arisen in various parts of the world in response to human adaptational needs. Wade's knowledge of DNA allows him to formulate that the gene pool among all humans is essentially the same. However, due to adaptations in institutional life in different locales certain variations have had local survival value and the forces of natural selection have continued to operate—even in the last 50,000 years. His thesis is that while all humans have essentially the same genes for social behavior, the differential survival value of various cultural institutions has led to different relational habits and forms of consciousness in the five continental groups as well as other smaller groups.

Let's Start at the Beginning

We are living a promise which is as mysterious and old as life itself. The promise is that if we reach out into our environment with interest, curiosity, and enthusiasm our reaching will be seen, recognized, and appropriately engaged to produce a sense of safety and personal growth.

Since the earliest replications of DNA molecules, the forces of life have been adequately met with enough environmental engagement to produce the pageant of the species. At the human level this life promise extends from the moment of conception. A womb is waiting to receive the zygote. At birth, mother's arms, eyes, breasts, and caresses greet the child. Behind the mother stands the father, the nurturing couple, the human family, and a society that aims at making life safe and rewarding for each human being.

But we know, despite these provisions and this promise, serious obstacles and frustrations arise at every turn. In each of our lives this promise has been fulfilled many times, but our reaching out for enlivening connections has often been painfully thwarted.

Both processes of assimilation and accommodation are assumed to be normal and universal—that is, both can provide healthy and strengthening challenges. But accommodations can

also serve as traumatic impingements in relational development that become devastatingly cumulative.

The subject of this lecture is setting up a relational scene for identifying and overcoming these cumulative relational traumas. There are, of course, degrees of intrusive traumatic impingement and there are many degrees of individual preparedness for impingement that can either stimulate challenges to creative growth or precipitate disastrous and defeating collapses. And, of course, the impact of various kinds of overstimulating intrusions are different at different times and at different stages of human development. Furthermore, different people respond differently to the same impinging forces—one may have an assimilating response while another may have a traumatically accommodating experience.

It is critical to have some concept of how we can grow from assimilating relational obstacles, as well as to understand how we come to develop internalized challenges and/or cumulative crushing and shaming collapses as a result of accommodating overwhelming negative relational experiences.

Listening Relationally to Trauma

Interpersonal/Relational Psychotherapy is about two people attempting to take personal responsibility for the lingering

internal effects of their past traumas—whether they be developmental, cumulative strain, or focal trauma. In contrast, the work of the trauma community tends to place emphasis on defining the realistic and narrational features of traumatic moments and their after-effects and then to promote actions to overcome, master, or heal the post-traumatic effects or symptoms.

As far as is possible, Interpersonal/Relational Psychotherapy moves in the direction of encouraging the gradual psychological and physiological *re-experiencing* of earlier traumas in the context of a safe, emotionally intimate, and supportive here-and-now therapeutic relationship.

Psychological and physical re-experiencing of traumatic moments—as much as is possible and within a timeframe that is bearable—is generally encouraged based upon the assumption that the terror and helplessness—including rage, shame, guilt, denial, and dissociation—of prior traumatic moments can be meaningfully integrated or managed better within the context of a later, emotionally intimate, safe, and supportive relational environment. This occurs with the traumatized person presumably having a more mature mind than she/he did at the time of the original traumatic moment so as to be able to understand what is going on more or less as it is being re-lived in the ongoing intersubjective therapeutic context.

The trauma community is generally invested in defining as many different ways as possible that people can be traumatized and then categorizing the post-traumatic experiences of various kinds of trauma. This cataloging includes the predisposing vulnerabilities and resilience capacities of the individual as well as the fortunate and unfortunate socio-cultural circumstances following the trauma which may contribute positively or negatively to the ongoing life of the individual involved.

This is essentially a public health model which attempts to generalize or average across populations for traumatic after-effects and treatment techniques. The many and varied theoretical and technical approaches to treating trauma and post-traumatic experience that have been put forth in recent years are generally based upon some specific rationale of the psychology and/or physiology of traumatic experience and some prescription as to what ameliorative measures ought to be taken—with positive results being widely reported.

Resistance to Re-experiencing Trauma

It is notable that regardless of the theoretical or technical approaches taken, all workers in the field are acutely aware of the forces of "resistance" operating in the treatment of trauma and post-traumatic experience. While forces of resistance may be formulated in many different ways, the bottom line of the

discussion is that none of us gracefully re-arranges habits in our psychological, somatic, or relational lives without grief and/or growing pains of one sort or another.

"No pain, no gain" is as true for growing our minds as it is for growing and strengthening our bodies and our relationships. We know that physical and mental strength as well as determined commitment and available resources (time, money, and the skill sets of the therapeutic other) are all key factors in promoting significant and lasting change—in our present concern, the change required to overcome the debilitating effects of cumulative developmental trauma.

From the vantage point of Interpersonal/Relational Psychotherapy, a key *resistance* is the tendency to feel personally—with cultural support—a victim to traumatic narratives and moments rather than *to search for ways of taking personal responsibility for the internal experience that we are retaining as a habit in the aftermath*.

The *therapeutic* questions are: "Yes, a blow landed, *but how did I respond to it?* What did *I* arrange or re-arrange in my inner life in order to deal with the blow and to respond the way I did? What were the prior forces in my life that determined my choice of reactions? And how do the effects of *my* responses linger on

in my mind, body, and relationships? What can *I* re-arrange *within myself today* to get past these debilitating effects?"

Reality: The Therapist's Dilemma

Through years of training psychotherapists, my number one difficulty has been how to encourage therapists to relinquish or loosen their hold on their own personally created realities in order to join their clients in discovering and unraveling the mysteries of *their* realities. That is, we each are born into a family with its own realities and every person in this family teaches us something new to add to our personal sense of what is to be counted as good and real and what is to be unseen, unwanted, and dissociated as bad, non-existent, or to be avoided. As we grow into the broader socio-cultural-linguistic community we are further introduced into other constructed realities. Yet later as therapists our education into professional life teaches us even more complex clinical and theoretical "realities."

As developing human beings we grow into accepting various kinds of constructed realities and value systems that are offered to us along the way. Then we grow into creatively constructing our own sense of who we are, how we are to be, and how the people and the world around us are or should be. That is, we develop our own identity, life story and personal corner on reality.

The question for a therapist in training or for a therapist on a new, more "in-depth" or "relational" career trajectory, is how to de-center from previously learned realities in order to be available to engage with clients in studying the determining effects of their own highly idiosyncratic internalized relational traumas in the present moment.

It is our task as therapists to listen—in the broadest possible sense of the word—carefully to others and to the ways that they have constructed their own unique worlds of experience and the ways they engage us in them. Further, there is an even more advanced step of listening not only to what is being consciously communicated to us, and not only to what is being affectively and unconsciously communicated to us, but listening in the moment to ourselves in our depths listening to our clients.

How and to what extent can each of us struggle towards relinquishing our own personal hold on our constructed realities in order to immerse ourselves in *re-living* with others their personally constructed realities? A stunning example of this de-centering process comes from fiction.

In her novel *Animal Dreams*, Barbara Kingsolver has a passage illustrating the de-centering process. The heroine, Codi, struggles with her disapproval of her Navajo boyfriend Loyd's passion for cockfighting. She struggles to de-center from her

own distaste in order to understand what cockfighting means to him and yet let him know how deeply disturbed she is by his aggressive passion.

> Loyd Persmooth was called up next. A rooster was delivered into his arms, smooth as a loaf of bread, as he made his way down to the pit. This time I watched. I owed him that.
>
> In the first fight I'd watched birds, but this time I watched Loyd, and soon understood that in this unapologetically brutal sport there was a vast tenderness between the handler and his bird. Loyd cradled this rooster in his arms, stroking and talking to it in a low, steady voice. At the end, he blew his own breath into its mouth to inflate a punctured lung. He did this when the bird was nigh unto death and clearly unable to win. The physical relationship between Loyd and his rooster transcended winning or losing.
>
> It lasted up to the moment of death, and not one second longer. I shivered as he tossed the feathered corpse, limp as cloth, into the back of the truck. The thought of Loyd's hands on me made the skin of my forearms recoil from my own touch.
>
> [Later, going home in the truck I asked Loyd:] 'What do they do with the dead birds?' I wanted to know. 'What?'
>
> 'What do they do with them? Does somebody eat them? *Arroz con pollo*?'

He laughed. 'Not here. In Mexico I've heard they do.'…

'What do they do with them here?'

'Why, you hungry?'

'I'm asking a question.'

'There's a dump, down that arroyo a ways. A big pit. They bury them in a mass grave. Tomb of the unknown chicken.'

I ignored his joke. 'I think I'd feel better about the whole thing if the chickens were being eaten.'

'The meat'd be tough,' Loyd said, amused. He was in a good mood. He'd lost his first fight but had won four more after that—more than anyone else that day.

'It just seems like such a pathetic waste. All the time and effort that goes into those chicken's lives, from the hatched egg to the grave of the unknown chicken. Pretty pointless.' I needed to make myself clear. 'No, it's not pointless. It's pointed in a direction that makes me uncomfortable.'

'Those roosters don't know what's happening to them. You think a fighting cock thinks its life is pointless?'

'No, I think a fighting cock is stupider than a head of lettuce.' I glanced at Loyd, hoping he'd be hurt by my assessment, but apparently he agreed. I

wanted him to defend his roosters. It frightened me that he could connect so intensely with a bird and then, in a breath, disengage.

'It's a clean sport,' he said. 'It might be hard to understand, for an outsider, but it's something I grew up with. You don't see drunks, and the betting is just a very small part of it. The crowd is nicer than at a football game.'

'I don't disagree with any of that.'

'It's a skill you have in your hands. You can go anywhere pick up any bird, even one that's not your own, a bird you've never seen before, and you can do this thing with it.'

'Like playing the piano,' I said.

'Like that,' he said, without irony.

'I could see that you're good at it. Very good.' I struggled to find my point, but could come up only with disturbing, disjointed images: A woman in the emergency room on my first night of residency, stabbed eighteen times by her lover. Curty and Glen sitting in the driveway dappled with rooster blood. Hallie in a jeep, hitting a land mine. Those three girls.

'Everything dies, Codi.'

'Oh, great. Tell me something I don't know. My mother died when I was a three-year-old baby!' I had no idea where that came from. I looked out the

window and wiped my eyes carefully with my sleeve. But the tears kept coming. For a long time I cried for those three teenage girls who were split apart from above while they picked fruit. For the first time I really believed in my heart it had happened. That someone could look down, aim a sight, pull a trigger. Feel nothing. Forget.

Loyd seemed at a loss. Finally he said gently, 'I mean animals die. They suffer in nature and they suffer in the barnyard. It's not like people. They weren't meant to live a good life and then go to heaven, or wherever we go.'

As plainly as anything then, I remembered trying to save the coyotes from the flood. My ears filled with the roars of the flooded river and my nose with the strong stench of mud. I gripped the armrest of Loyd's truck to keep the memory from drowning my senses. I heard my own high voice commanding Hallie to stay with me. And then, later, asking Doc Homer, 'Will they go to heaven?' I couldn't hear his answer, probably because he didn't have one. I hadn't wanted facts, I'd wanted salvation.

Carefully, so as not to lose anything, I brought myself back to the present and sat still, paying attention. 'I'm not talking about chicken souls. I don't believe chickens have souls,' I said slowly. 'What I believe is that humans should have more heart than that. I can't feel good about people making a spectator sport out of puncture wounds and internal hemorrhage.'

> Loyd kept his eyes on the dark air above the road. Bugs swirled in the headlights like planets cut loose from their orbits, doomed to chaos. After a full half hour he said, 'My brother Leander got killed by a drunk, about fifteen miles from here.'
>
> In another half hour he said, 'I'll quit, Codi. I'm quitting right now.'

We see in this conversation how hard two people work to de-center from their own personal orientation to appreciate the other's internal world of emotional experience. Further, Kingsolver shows us how relational experiences from the past of each character come to bear on the present relatedness moment. It is as if a third person is present in the relationship as each of them struggles to hold their own subjective position, while simultaneously de-centering and appreciating the subjective position of the other. In their conversation and in the hour of silence during the nighttime truck ride, we feel the mutual transformation taking place as each relinquishes the fixedness of their own subjective worlds and resonates emotionally with the other's—"Loyd kept his eyes on the dark air above the road. Bugs swirled in the headlights like planets cut loose from their orbits, doomed to chaos." And chaos it does so often seem as we relinquish hard-won emotional footing and attempt to join subjective worlds with another.

Psychologists speak of this process of mutually engaging each other's subjective worlds as a process of "intersubjectivity." This de-centering process differs sharply from my simply trying to understand you as an object from within my subjective point of view. This de-centering process differs from various attempts to "improve communication" or "work out compromises" in relationships.

Interpersonal/Relational Psychology now holds that the human mind is not simply a function of an isolated brain existing in between the ears of individuals. Rather, mind is conceived of a complex communal phenomenon existing between and among individual organisms—not only of our species but among all species since the beginning of time. Interpersonal/Relational Psychotherapy is committed to studying the human processes of subjectivity, intersubjectivity, and the third force (personified as the "third person") involved in the complexities of intimate human relationships.

Some Imprecise Definitions

While "trauma" has been defined and redefined many times according to different points of view, the bottom-line definition always goes back to Freud who spoke of the traumatic situation as a moment when the person's ego (sense of "I" or sense of self) is so overwhelmed by intrusive stimulation that it cannot

comfortably or effectively process what is happening at the time (Freud 1933).

The overwhelmed or overstimulated ego/self here is understood to be the fetus's, neonate's, infant's, child's, or adult's personally constructed habits of being in the world that, due to internal or external stimulation are strained, stretched, or collapsed to the point that some accommodative defensive response is required to shore up an otherwise helplessly disintegrating self in the throes of confusion, panic and terror.

"Dissociation" has in the past often been thought of as the ego's or self's (pathological, defensive) response to a traumatic intrusion. The idea has been that when the total span of the ego operative at the moment could not tolerate the overstimulation, a part of the ego would become split or separated off into a different dissociated "self-structure" or "self-state" (A. Freud 1937).

More recently, as the Interpersonal/Relational perspective in psychotherapy has emerged, dissociation has come to be understood differently as a universal and essentially normal developmental process. In this understanding, multiple, affectively-tinged self-states are thought to be present from before birth and to operate in various relational contexts. For example, one relational self-state exists in the presence of a

satisfying breast while different self-state exists in the presence of a frustrating breast.

With favorable development through good-enough parenting, these many self-states tend to be gradually brought under the umbrella of a central unified sense of self—but *multiple self-states are always potentially present, waiting to be called out in an intersubjective relational moment*.

Considered in this manner, an expectable reaction to the ego's current integration being disturbed by excessive stimulation would be to shift, to retreat or to "dissociate" into one or several already formed self-states. That is, rather than the assumption of a unitary self from birth with parts being defensively split off due to traumatic blows, the Interpersonal/Relational view holds that *multiple self-states are present from before birth and potentially present throughout a lifetime and subject to being dissociatively reawakened in various relational situations*.

The interpersonal/relational psychotherapy literature now abounds with clinical examples wherein both client and therapist during moments of intense interaction demonstrate dissociative processes as normative events in response to intensely stimulating intimate engagements (Bromberg 1998, 2008, 2011;

D.N. Stern 2004; D.B. Stern 2010, 2013; Benjamin 2017; Davies 1994; Hedges 1992, 1994a, 1994c, 1996, 2000b, 2005, 2011).

Interpersonal psychiatrist Harry Stack Sullivan (1953) first described the dissociative split between the "good me," the "bad me," and the "not-me." These are simple but handy terms to describe the parts of me that I am pleased with, the parts of me that I know about but I'm not pleased with, and the parts of me that I have chosen through my history of dissociating not to accept as a part of me—though from time to time I am abruptly confronted with responses in myself that I do not wish to or cannot own as belonging to me.

I mention this simplified Sullivanian conceptualization in order to illustrate how dissociation may operate in a relational context—how a dissociated not-me self-state may suddenly appear unbidden that either I or my relating partner, or both of us may be forced to deal with.

At this point in our psychological history, we realize that there are an infinite number of potential me's with different affective colorings that become elicited in different relational contexts. In keeping with the contemporary Interpersonal/Relational Psychotherapy slant on multiple (dissociated) self-states as being the universal normative condition of infancy and later life, it stands to reason that many

of those self-states generated in relational contexts are ones produced by traumatically overstimulating moments brought about by events as simple as a child being moved when she doesn't want to be moved or an intractable teething pain or fever that she unrealistically expects mother to soothe (or possibly brought about by much more intense abusive and/or intrusive stimulation).

Self-states generated by normal or not so normal "primary" developmental traumas may be relegated to the realm of bad me or not-me and thus remain invisible or unknown until a later in life incident or "secondary trauma" re-activates these earlier developmental traumatic self-states.[2]

(Later I will tell you how I observed traumas stimulated by 9/11 events (secondary trauma) trigger countless primary traumas from early childhood in different people.)

As Shubs (2020) and other somatic and psychodynamic relational therapists are quick to point out, simply addressing the current or secondary trauma—that is, the focal or the narrational event or the post-traumatic symptoms—does not get to the bottom of the matter. In practice, however, the choice of simply treating the current incident or troubling traumatic symptoms as opposed to working on unraveling prior primary traumas in an intimate safe relationship may be a matter of limited resources

being available, various resistances being operative, and/or the skill sets and preferences of the listening partner being limited.

I offer the following vignette to illustrate the way relational therapy with a couple has helped them distinguish between some of the primary and secondary traumas in their lives.

Joan and Matt sought me out when they were considering having a second child—this time with a surrogate mother. Because of necessary radiation and a hysterectomy following the aftermath of breast cancer, doctors recommended that they freeze some fertilized eggs while they still could in case they ever wanted more children—which they did.

They are a strikingly good-looking couple who are highly intelligent, thoughtful, mutually respectful and very much in love. In the beginning there had been extremely strong chemistry between them and their marriage started off wonderfully. Their now 3 ½-year old-son, Sean, is developing well, and both parents are invested in Sean's physical and emotional care. Unfortunately, in all of the trauma they have endured with the recurring cancer and the odds of treatment failure, emotional distance slowly developed between them and sexual intimacy came to a complete stand-still—much to their mutual distress.

They want another child and a friend has offered to be the surrogate mother. New drugs have provided a "total cure" for the

cancer but due to the exact nature of the cancer there will be a lifetime of medications required. Joan is justifiably proud of her courageous fight and her sense of victory over the disease. Matt admires her achievements but is very much afraid for her, for himself, and for Sean should there be a recurrence—they are not past the five-year safety mark yet.

Joan is frightened because when she was so overwhelmed with her treatment regimen there were times when she experienced Matt's emotionally withdrawing and times when his preoccupations with work left the burden of household and child-rearing responsibilities to her. Will this happen again if they undertake having a second child? Matt reluctantly admits that this indeed did happen and that emotional withdrawal in response to stress is a lifelong pattern for him, dating to severe emotional and physical abuse from his parents, especially his father.

Now is the right time to have a baby—the eggs are there, the surrogate is ready, the cure is in effect, Sean is of an age a sibling would be good, they want another child…but…? Both Joan and Matt are frozen with desire and fear—towards each other, toward the relationship, and toward the possibility of family expansion. Could I help them decide what to do and how to do it? After all this trauma how can they get back to their

loving intimate relationship that they enjoyed so much? How can they be assured of a satisfying and enduring future family life?

Oh, the life of a psychotherapist! Just when we think we know what we're doing, just when we think we know how to help people with their problems—along comes something new that we have no idea whatsoever how to deal with! I said I wasn't sure how or if I might be able to help them—especially since they had already been to two counselors who turned out not to be of much help. But let's meet for a few sessions and see if we can get a conversation going that might be useful. I had no idea what that might look like.

Joan and Matt each wanted to tell me something about their families of origin and how each other's in-laws affected them. They were overjoyed to share their child-rearing experiences of Sean with me and I did some coaching around some issues that were coming up at pre-school lately. Unaccountably, Sean was being more aggressive with other children and had had a few accidents in his pants lately. We talked about how sensitive young kids are to stresses parents are experiencing and to conflicts that naturally arise when parents are considering more children that will change the love structure that exists in the family.

After several sessions in which we three had established some basic comfort with each other, Joan let out a string of discontents about Matt's emotionally withdrawn behaviors, trying her best to be understanding and not critical—but she was now recovered and wanted a restoration of their former interactions and intimacy. Matt did some tearful work on his knee-jerk emotional withdrawals and re-arranged his professional work to be more present for Joan and Sean. He pledged not to let work get in the way of his family again and took some effective steps to make sure this would be so. But his sex simply wasn't working since all of this began, and he hated to begin something only to disappoint her and to feel humiliated himself. He's always been quite potent but now he has no sexual desire at all for her or anybody else, he doesn't even masturbate. She's impatient. He's apologetic. They love each other. Neither wants to break up. They're in a pickle.

As the weeks passed by Joan relates a childhood of non-recognition by her parents and her having developed a strong, aggressive, no-nonsense, self-sufficient attitude toward life and problem solving. She had become a highly successful business woman with her own thriving firm and a number of competent employees to help her run it. Matt's being soundly criticized and squelched by both parents throughout childhood left him with less than full ambition at several unsatisfying jobs until he found

his present work which was exhilarating, but time and energy consuming.

I had several times posed the question to Joan of what it had been like for her after she was diagnosed and while she was going through protracted painful treatments. I got inspirational answers of how she had always put faith in herself, how she was determined, how good it felt to know she was on top of things, and a plethora of details about doctors, medications, procedures, etc.

Then came the night of trauma revisited. Joan got caught by one of my questions and her voice started cracking, she had never intended to say this to anyone, ever—and she started shaking and sobbing uncontrollably relating the utter helplessness, hopelessness, aloneness, and defeat she had experienced repeatedly during the whole ordeal—feelings she was too ashamed to tell anyone, even Matthew. She had always been ashamed of any vulnerability and had worked a lifetime to cover up any sign of weakness or insecurity. Needless to say, both Matt and I were deeply moved with compassion to witness Joan's drop into traumatic re-experiencing before our very eyes. We were relieved and pleased that Joan at last could speak her truth—like some sort of boil was popping. We all three understood that this deep emotional outpouring wasn't just about the cancer (i.e., the secondary trauma) but about her whole life of

emotional aloneness, struggle, and determination to get on top of overwhelming circumstances no matter what (i.e., cumulative primary traumas). And on top her terror of failure and humiliation. In the case of the cancer she had had to surrender to humiliating defeat by a powerful force greater than herself. But her good old spirit of determination did kick in like it always did and she had achieved the best possible outcome.

In response, the following week Matt dropped into his own shaking and sobbing and the humiliation and defeat he had suffered repeatedly as a child from his abusive parents and how the only place that was safe was to hide, to become emotionally withdrawn, isolated and invisible but terribly alone. He had found Joan and for the first time in his life had a safe companion until the diagnosis when he found himself re-traumatized and once again very much alone with the prospects of losing her. Matt knows she's "cured" but he's terrified something else might happen and he'll be all alone with two children and no support. The cancer experience had thrown him back to a terrible sense of failure and a lack of confidence in himself. Joan and I resonated deeply with his life-long trauma and fear of more re-traumatization and failure.

From this brief account we can see that Joan and Matthew were hell-bent on doing the work they had to do to come clean with themselves and with each other about how the cancer

trauma (i.e., the sets of secondary traumas) had affected them. They needed to know for themselves and for each other how this life circumstance tapped into the worst of their growing up experiences and how as children they had each learned to close off to fear of defeat, aloneness, and shame—she by active, aggressive, competence and he by withdrawal and isolation (i.e., their primary traumas).

The following sessions featured a cascade of painful childhood memories and more elucidation of the fears they were experiencing in their present life situation. How were they going to get things back together? How could they ever feel safe in love again? And if they couldn't restore the intimacy of their marital relationship, how were they going to be good parents? Should they risk having another child?

I end the story here, with my main point about the importance of breaking through the current or secondary trauma to re-*experience* the original or primary traumas in order to establish more truth and intimacy in the present relational situation having been made. This brief story also illustrates *the importance of experiencing a retraumatization in the here-and-now with committed and emotionally involved others*.

Joan and Matt were so relieved to restore honesty and to be once again working together as a team that, even with much

relationship work yet to accomplish in order to regain lost territory, they felt confident to go ahead with having another child—hopefully this time a girl, but another boy would be great too!

We all know this experience. Some life circumstance traumatically triggers an emotional overload that needs to be ventilated with a relating partner. Usually when the conversation begins neither has the slightest idea what is about to happen but both sense some kind of highly-charged pressure present. And then, almost without warning something starts to erupt—a deep energy impelling the overloaded person forward. It may start with an outpouring of frustration or rage over the realities of the triggering situation (secondary trauma). But comes the emotional eruption and both people know something much greater is at stake, that something deep is emerging in the rapid-fire jumbled and irrational thoughts that tumble out. “Thank God this is private and confidential—I’m so humiliated and ashamed at what I’m saying, I don’t even know if it’s all true, but it seems important. I’m so confused, I don’t even know where all of this is coming from.” A good listener remains low-key but facilitating and encouraging. “Keep going. No, you’re not upsetting me. No, it doesn’t yet all make sense but let it fly! You have to get this out. You have to get to the bottom of whatever’s happening for you.” And then the cascade of jumbled memories

of similar past horrors and frustrations and how helpless, alone, frightened and defeated we felt at those times and in those circumstances (primary traumas). "Now what's going on for me in the present begins to make more sense." This sense of trauma isn't about just now but about a lifetime of similar traumatic humiliations. And so it goes.

The most important and relieving experiences of our lives have proceeded this way with someone we trusted or needed to trust with our burden. Often, for example in therapy, it goes on for long periods of time with someone to witness our actual re-living in the present the dreadful cumulative traumatic experiences of the past.

If you happen to be one of those rare people who has never trusted enough to open up deep pockets of emotional trauma from the past for re-experiencing with someone you can trust in the present, then you of all people probably are in sore need of doing so. We all have a history of traumatic moments that we have handled in various ways and then done our best to cover up and move on. The dissociations run deep. But the inhibitions necessarily involved in emotional and physical trauma and dissociation nonetheless live on in our minds and bodies with ominous consequences for our health, wellbeing, and longevity.

On a final note, I had the listener above saying, “No, this isn’t disturbing me.” Of course, many times this is not true and only the truth should be spoken. In fact, as I will demonstrate later, as the therapy deepens the therapist is rarely personally okay with what’s happening. The primitive and dissociative experiences of the client necessarily impinge upon the therapist’s own psychological functioning and well-being and the two together often have to struggle through mutual dissociations and enactments as well as mutual “chase and dodge” as well as “rupture and repair” experiences in order to experience the deep work of trauma recovery.

Listening to Cascading Traumatic Experiences: September 11, 2001

Over forty years as a practicing psychotherapist and psychoanalyst experiencing my own clients and myself working through traumatic experiences and serving as a consultant to literally hundreds of therapists in Southern California and elsewhere dealing with traumatic experiences they and their clients are experiencing, I can safely say that the cascading effects of cumulative developmental trauma manifest at every turn. The most telling of these cases are reported in a series of books produced under my authorship by therapists at the Listening Perspectives Study Center and the Newport

Psychoanalytic Institute located in Orange County, California (Hedges 1983, 1992, 1994a,b,c, 1996, 2000a,b, 2005, 2013e).

But the events that stand out in my memory as illustrating most clearly how current traumas trigger previous traumas happened in wake of the 9/11 disaster. I have told the story in my free download book, *Overcoming Relationship Fears* (2013c) and have summarized it in the accompanying *Workbook for Overcoming Relationship Fears* (2013d). Here's my version of those events.

On Tuesday morning, September 11, 2001 my daughter Breta called in frantic, heaving sobs to tell me of the terrorist attack on the World Trade Center. Telephone gripped in hand, I raced to the TV in time to witness live the second tower hit and to hear Breta's terrified screaming through the receiver. Not only was I stricken by what I was witnessing on the television, but I was paralyzed with another kind of fear—the fear of being utterly helpless, of being completely unable to do anything to buffer the terror that was shattering my beloved daughter. I yearned to hold Breta, to take her into my arms and quell the fear like when she was a little girl with the forest next to our home going up in giant flames—I held her tightly then, both of us shaking in helpless horror watching the fire fighters struggling to quench the blaze threatening to destroy our home.

But on 9/11 I was utterly helpless. There was absolutely nothing I could to do to restore the World Trade Center or my daughter's fragmenting sense of safety and peace of mind—nor my own.

We all experienced the paralyzing effects of fear on that fateful day—eyes wide open, hearts racing, lungs tight, guts wrenched, muscles tight, and a total body weakness and body-mind numbness that lasted for weeks and that will never leave us completely.

In the wake of the attack, one of my therapy clients spent two days curled up in the bottom of her closet, like she used to do as a small child after her alcoholic father had abused her. Another client re-lived a tragic teenage freeway accident in which his four closest friends had been instantly killed while he, the driver and sole survivor, had lived on in helpless loneliness and guilt. One woman re-agonized the prolonged cancer death of her mother when she was four years old, remembering feeling that her bad behavior was killing her mother. After 9/11 she had again heard her mother's screams of intractable pain and terror of dying. No matter how good she was, no matter how hard she tried, it was not enough to keep mother from leaving her forever.

I asked each client the week of 9/11 where the attack had taken them. Everyone recalled horrifying memories from earlier

in life that had resurfaced in response to that terrible moment. When asked where in their bodies they were feeling the pain, the agony, the terror—everyone knew exactly what parts of their body had taken the hit. Some had chest or abdominal pain, others had headaches, tight jaws, back pain, joint pains, asthma attacks, muscle spasms, or whatever—the list went on.

What became absolutely clear to me after 9/11 was that each of us has our own unique ways of experiencing fear. And that our individual patterns of fear live on as destructive hangovers from childhood relationship experiences to impact our minds and bodies in highly specific ways.

People in therapy had long ago shown me how childhood trauma interferes with later intimate relationships. But the 9/11 terrorist attacks revealed that all of us have deeply buried personal patterns of fear left over from earlier experiences that can be reactivated on a moment's notice—relationship fears that are physical as well as mental.

Airplanes being down, I made the 12-hour drive to Albuquerque to keep my Saturday speaking commitment with the New Mexico Psychoanalytic Society on my new book, *Terrifying Transferences: Aftershocks of Childhood Trauma*. The topic could not have been more timely—we were all in aftershock. Therapists flocked in from all over the state crowding

the large auditorium to talk about the shattering experiences we had just been through. We had all heard story after story of childhood trauma revisited—not to mention having our own traumatic reactions and re-experiencing our own childhood horrors.

Given the emotionally-charged circumstances that day, I opened the floor first thing in the morning for venting about our trying week. I listened carefully as therapist after therapist told of traumatic reactions they had been witness to in their consulting rooms following the Tuesday disaster.

As I listened to the stories therapists told that day, one more critical thing about fear and trauma emerged—we have more power over our fears than we think! We have the power to re-experience past traumas and to get some resolution in the context of current safe and intimate relationships. The New Mexico therapists were well-experienced in how to intervene to help people re-experience long-buried fear reactions being revived in the present. They knew how to encourage people to tell stories, to create pictures and to tune into body reactions from the past that had been stimulated by the terrifying events in the present. The New Mexico therapists told me how, depending on each client's unique fears and physical reactions, they were able to show their clients how to release the terrifying grip that habitual fear holds over mind, body, and relationship. Some people

needed to be encouraged to breathe deeply while remembering some long-forgotten horror. Others needed to sob, to rage, to pace the room, to lie on the floor in numbed silence, to hold hands, to hug, to pray.

The realities of 9/11 were bad enough to have to experience as a current reality, but the human tendency to layer new realities on top of old unresolved past terrors was making life utterly unbearable for clients and therapists alike that week. An enlightened therapeutic approach had much release and relief to offer. The New Mexico conference room was electrified that day as we shared our week's experiences and as therapists allowed themselves an opportunity to rage, to sigh, to sob or to cringe in helpless fear. Who could imagine what might happen next?

What I had learned that week in my consulting room and that day with the New Mexico therapists had to be shared with others. I had to find a way to show people how our individual childhood patterns of fear live on in our minds and bodies ready to be reactivated in response to impacting experiences at any time. And that our long-established fear reflexes are deeply enmeshed in our body-mind-relationship (BMR) selves.

Clients I've worked with over the years had taught me about the kinds of early relational experiences that children find frightening. Body workers and health professionals who

specialize in locating and releasing body tensions had taught me how to tune into our moment-by-moment somatic experiences. The New Mexico therapists made clear to me how we can put those hangover fear reflexes into stories, pictures, memories, and body sensations that can be emotionally re-experienced in a present intimate relationship. They clarified for me the interpersonal process required to release ourselves from the paralyzing effects of longstanding patterns of mental anguish and physical fear. That is, long-standing fears can be encouraged to re-emerge in an intimate relationship setting. When two emotionally involved people experience together long-suppressed trauma there is hope of at last finding ways to release the grip that fear has over our body-mind-relationship (BMR) connections.

When Breta and I got together the week after 9/11, we re-experienced the frightening fire that affected us both when she was three years old, a frightening car accident that we were involved in when she was seven, and a number of other frightening circumstances from both of our lives. Her mother and I had separated just before Breta turned three. Judy and I had both maintained a close parenting relationship with Breta throughout her growing up years so that sharing emotional experiences together had always been a part of our lives. Breta

and I certainly found our sharing our 9/11 experience, and all that it brought up for us, to be both relieving and integrating.

My experiences with Breta on 9/11 and with the New Mexico psychoanalysts and psychotherapists shortly after illustrate what we already know about fear—that it is a *body-mind-relationship* experience. Connecting to our deepest selves is a matter of locating our body-mind-relationship connection. For convenience, a new term emerges, *the BMR connection* (pronounced "Beam-er"). I will use the term BMR connection to designate that central place in our selves where body, mind, and relationship are one. Once you get used to thinking in terms of your BMR connections you will find the term useful shorthand. It is helpful to think of a deep-seated body-mind-relationship connection that instinctively contracts in reflexive response to intrusive stimulation. The particular and idiosyncratic body-mind-relationship contraction is held in memory and predetermines later reactions to traumatic intrusions. Needless to say, chronically held contractions threaten well-being and longevity.

Note

←2 The terms "primary trauma" and "secondary trauma" have been used in different ways by different researchers, but here I follow the usage of Shubs (2020).

Lecture 10

THE CALL OF DARKNESS: LISTENING TO SUICIDALITY

Since the beginning of recorded time, all cultural groups have had to come to grips with suicide in one way or another. Suicide has interested philosophers, theologians, judges, poets, and artists for thousands of years—only to be followed in recent centuries by sociologists, anthropologists, and psychologists.

Shockingly, after all this scholarly and artistic attention, no widely agreed-upon theories of suicide have emerged, and virtually all efforts to predict and prevent suicide have yielded results no better than chance, and suicide is rapidly coming to be seen as a global crisis of epidemic proportions.

However, some groups of practicing therapists have recently developed various approaches that seem to point to a hopeful direction.

Spurred by a 2017 mandate from the California Board of Psychology that all licensed psychologists take a six-hour continuing-education course in Suicide Prevention, I reviewed literally thousands of perplexing and difficult-to-treat cases

brought to me individually and in case conference groups by professional colleagues and trainees, nationally and internationally, during my 50-year career—and was puzzled to find that collectively we have not experienced even a single suicide!

To be sure, we have worked through countless instances of suicidality—troubling threats and gestures, as well as all kinds of parasuicidal and high-risk behaviors. But with suicides escalating nationally and globally, how have we avoided this epidemic? What exactly are we doing that (so far!) has let us make it safely through?

I hope the answer to this question becomes clear as we consider suicide from a Relational Listening Perspective and review the promising work of several other groups of professional therapists who, with very different theories and techniques, are experiencing similar success.

*

In 1897, poet Edward Arlington Robinson mused on the question of suicide:

Richard Cory

Whenever Richard Cory went downtown,
We people on the pavement looked at him:

He was a gentleman from sole to crown,
Clean favored, and imperially slim.

And he was always quietly arrayed,
And he was always human when he talked;
But still he fluttered pulses when he said,
"Good-morning," and he glittered when he walked.

And he was rich—yes, richer than a king—
And admirably schooled in every grace:
In fine, we thought that he was everything
To make us wish that we were in his place.

So on we worked, and waited for the light,
And went without the meat, and cursed the bread;
And Richard Cory, one calm summer night,
Went home and put a bullet through his head.

Why did he…? What made her…?

What about the family, her children…? Who would have suspected…?

I saw him just yesterday—There was no indication…!

Not a word from her…!

Why didn't he ask for help…? I'm really hurting…

I'm really angry…! I'm totally perplexed. Why, why, why…?

These are the questions people have been asking since the beginning of time and I hope to demonstrate in this lecture that

none of these "why and wherefore" questions will help us at all in getting to the heart of what suicidality is all about.

At this point in time we have to step back and carefully reconsider suicidality in light of recent advances in infant research, neuroscience, anthropology, sociology, and psychotherapy on the relational nature of our species and the ways our human minds are formed, transformed, and passed on to our children.

Ten Statements Regarding Suicidality

There are ten, and only ten, definitive statements that can be made about suicide that most experts around the world can agree upon. I will elaborate on each of these key statements.

1. Suicidality is complex, idiosyncratic, and relational. It is not a singularity—a something to be clearly defined and categorized. Nor is suicidality a pathological dimension that can be rated from mild to moderate to severe. Despite the frequent appearance of being isolated and alone, suicidality invariably includes an implicit or explicit relationship or set of relationships.

2. Ambivalence is detectable in all forms of suicidality—No matter how apparently resolute the suicide act appears. Further, in a "suicide autopsy" there are always indications, clues, and pointers that constitute "a cry for help" or "a cry of pain"—clues that were missed at the time.

3. All social and cultural groups since the beginning of time have known and have had to deal with suicide—with radically different results depending on the specific era and the cultural context.

4. Suicide is an exclusively human behavior and is therefore an activity of the human *mind*—with significant psychosomatic consequences. There are no established suicide genes, neurons, or neurotransmitters.

5. "Psycheache" is the mind/body agony associated with suicidal experiences. The intervention questions are: "Tell me where it hurts?" and "How can I help you." Both of these questions open up an intersubjective, collaborative search for the personal meanings involved in the psycheache.

6. *The population of people who complete suicide is decidedly different from the populations of attempters and ideationers—though accidents sometimes make for a small overlap. Therefore, ideas taken from the populations of attempters and ideationers cannot be used to understand those fully intent on suicide, the completers—other formulations are necessary.*

7. All completed suiciders and many attempters and ideationists have been or could have been at one time diagnosed with a severe or borderline mental disorder—major depression, bipolar, schizophrenia, and anxiety disorder as well as PTSD, borderline, schizoid, sociopathic and narcissistic character disorders.

8. *Massive scientific research over more than a century has produced no widely agreed upon theories of suicidality.*

9. There are no consistently reliable and empirically validated ways to predict or treat suicide.

10. Over time, groups of psychotherapists have developed some ways of working with suicidality that seem promising.

My thesis: A Relational Listening approach that explains how past relational traumas impact current relational contexts can shed fresh light on the many issues surrounding suicidality.

Throughout the suicide literature countless experts and suicidality experiencers repeatedly point to the earliest eras of life as having somehow been formative in how suicidality manifests later in life. Losses, rejections, abandonments, and abuse in early in life are usually seen as the culprits—but since all people have experienced loss, rejection, and abandonment, what kinds of experiences—in what contexts and at what developmental junctures—may pave the way for serious suicidality later in life? And how do traumas in later life "telescope" or collapse downward the magnitude of their impact to early infant trauma?

Furthermore, since the countless consciously and socially constructed narratives of suicidal behavior attesting to various causes and motives—such as a cry for help or pain or a friend or loved one's manipulation—seem to offer little or no help to those in the throes of suicidal anguish, observers are inclined to invoke the idea of unconscious and unformulated motives based on

traumatic experiences that happened too early in life to be remembered in ordinary ways.

Here the psychoanalysts may have something to offer. Sigmund Freud was the first to assert that traumatic experience that cannot be consciously remembered must be enacted in later relational situations. His notion of unconscious experience that was retrievable in therapy was based on a 5-year-old's capacity to narrate, to symbolize and to repressively self-instruct ideas and experiences to disappear from consciousness.

It was psychoanalyst Christopher Bollas who first pointed to the unconscious of the "unthought known"—memories that have been stored in pre-verbal somatic and affective interactional modes that had never been subjected to thought until in the therapy relationship the enactments can be lived, experienced and framed in conscious thought.

The Interpersonal/Relational psychoanalysts Edgar Levenson, Philip Bromberg, and Donnel Stern, basing their work on Harry Stack Sullivan's insights from his work with schizophrenics, came to speak of "unformulated experience" that is, somatic and affective memories formed in earliest relationships that are repeatedly enacted in relationships until in a therapeutic relationship the dissociation from consciousness could be bridged and two could come to talk about the mutual

enactments that stem from early pre-verbal and pre-symbolic experience.

Intersubjective psychoanalyst Robert Stolorow and his colleagues speak of the "pre-reflective unconscious" as an aspect of relational experience that can become known in an intersubjectively-oriented therapy. The Listening Perspectives group I am a part of has devised a series of Relational Listening Perspectives for framing different developmental forms of unconscious experience—whether repressed, dissociated, unformulated or unintegrated.

The Relational Perspectives Approach

I would like to begin our adventure into the complex labyrinth of suicidality by introducing the Relational Listening approach that was not originally devised to deal with suicidality, but rather evolved to help therapists and their clients tune into life's earliest traumatic experiences.

It was only as I turned my research spotlight on suicidality that I came to realize that the Relational Listening approach that targets and allows a here-and-now therapeutic unpacking or re-living of primal emotional relatedness experience can provide the theory and intersubjective approach that suicidologists have been searching so long for.

Since I will be utilizing a Relational Listening way of considering suicidality and interventions to be used with people who declare themselves in one way or another to be suicidal, I will briefly review the Relational Listening approach that has been the central subject of these ten lectures.

A century of psychoanalytic research has yielded four main watersheds of relational development—each with its own relational fears. [Note: A summary chart from Lecture 7 is reprinted below.] Anyone subjected to overwhelming neglect, abuse, terror, intimidation, or shame during any one of the earliest phases of life is vulnerable to having similar overwhelming levels of fear, constriction, and/or fragmentation triggered by intimate relationships and/or perceived interpersonal demands later in life.

A person could experience focal or cumulative trauma in relationships at any stage of life and need to re-experience that trauma in a later therapeutic relationship in order to work through the post-traumatic experiences that are still creating problems.

That is, *relational traumas from the past tend to re-assert themselves—transfer into—the context of current intimate relationships and perceived interpersonal demands*.

But truly terrifying and deeply traumatic experiences that impact the fundamental ways the personality organizes itself are more characteristic of the earliest stages of development—the "Organizing" and the "Symbiotic" relational experiences.

Table 1 (reprinted)
Four Developmental Listening Perspectives and Seven Relational Fears

I. The Organizing experience (approximately +/- 4 months after birth)

1. The fear of being alone
2. The fear of making connections

II. The Symbiotic experience (4-24 months)

3. The fear of abandonment
4. The fear of self-assertion

III. The Selfother experience (24 to 36 months)

5. The fear of being unacceptable

IV. The Independent experience (36 months through adolescence)

6. The fear of failure and success
7. The fear of being fully alive

The Relational Listening point of view predicts that *seriously intentional suicides are re-enactments from trauma experienced at the Organizing level of experience*, while *most other suicide attempts and self-harm behaviors derive from trauma at the Symbiotic level of experience*. Various suicidal

ideations and high-risk behaviors are attributable to the higher "Selfother" and "Independent" or "neurotic/normal" relational experience, which may call for interpersonal empathy but no serious intervention.

Since most of our concern with suicidality and interventions revolves around traumas in the first two levels of relational development—levels that are preverbal and pre-symbolic—I will focus in this lecture mostly on issues at these levels of relational complexity and only briefly attend to the levels of greater relational complexity involving suicide ideation, parasuicidal behaviors, and high-risk behaviors. It is important at this point for you to spend a few minutes getting the idea of each of these early experiences and fears clear in your mind because the illustrative cases throughout these lectures will be analyzed mostly in terms of these first two Relational Listening experiences and fears.

I feel it important to clarify here that these experiences and fears—while presented as almost developmental stages are more properly thought of as *metaphors* based on relational development and are first and foremost definitions of Listening Perspectives—that is, ways that we can listen to someone's life experiences. These categories are thus properly understood as a dimension of human relatedness potentials—potentials that we all engage in in various ways throughout our days—that can be

“listened to” in the broadest possible sense while engaged in an intimate relationship. When used as perspectives from which a person in an interpersonal relational situation can momentarily grasp the kinds of relatedness currently in play, they can be immensely helpful as the many case studies authored by many different therapists in my books demonstrate. That is, all of my work specifically eschews the idea that we can ever definitively know what is going on in the human mind since mind is interactional, culturally and linguistically determined, ever-changing, and replete with infinite possibilities. Theories that define or name mental structures or purport stages of development are still participating in an outmoded “modernist” epistemology of 17th-century objectively-oriented science. In contrast, the Listening Perspective schema offers a “postmodern” approach with perspectives constructed to organize in one’s mind an infinity of relational possibilities. [These relational possibilities are elaborated in detail in Lecture 2 (pp.27-28).]

In Relational forms of psychotherapy we expect that it will be only a matter of time before the scars of preverbal, pre-symbolic, unformulated traumas of early childhood will re-assert themselves, that is, be repeated in the therapeutic relationship. Let’s consider how the Organizing and Symbiotic experiences can transfer and become manifest in various forms of suicidality.

Early trauma is experienced in the context of an infant reaching out for satisfaction—and instead experiencing traumatic emptiness or hurt. When the potentially satisfying connection is somehow painfully thwarted, the infant learns that to connect—to long for competence in connecting to others, to oneself, and to the interpersonal world—is dangerous.

The transfer from an Organizing experience trauma is recognizable in a shutting down, a blocking, or a switching of attention at moments when empathic connection between therapist and client are about to be or have been successfully made. The refusal, blocking, or backing away from connections in intimate and trust relationships points to the nature of the original scar. And when the nature of the original contact is actually abusive or injurious, all the more reason to "never reach that way again." At moments of helplessness, hopelessness, and despair in later life others may experience the person as depressed, bipolar, anxious, autistic or whatever.

It is my belief that intentionally completed suicides are rooted in this kind of transfer from a traumatic infancy experience into a current interpersonally demanding or potentially rewarding relationship or social situation—no matter how otherwise well developed, intelligent or creative the individual may be.

Said differently, just at the point that some potentially powerful and affirming connection arises in a relationship or interpersonal social situation, the person—transferring an Organizing experience fear—will experience an inner retreat or collapse of some sort through backing away from or thwarting full affective connection through "psychotic symptoms" of one sort or another. Metaphorically, one turns from the light of consciousness (i.e., knowing together) toward the call of darkness of safe retreat, of rest, of the peace to be found in the unconsciousness of sleep and death.

This is certainly the call of darkness. Note that people with active or chronic diagnosable serious mental illnesses are perennially experiencing this level of relatedness experience with an array of ways of avoiding, thwarting, or withdrawing from interpersonal connections (so-called "symptoms"). On the other hand, many deeply traumatized individuals may move forward into normal and even extraordinary adult life experiences and achievements, but when some relational experience is over-stimulating (i.e., potentially fulfilling or successful in certain ways) it can easily trigger the inner retreat or collapse into darkness. Certainly at that moment a psychotic failure of ordinary consensual reality testing is operating.

Alternatively, the transfer from the Symbiotic experience manifests in therapy when prior connecting or attaching

experiences have been reliably successful, and an infant is able to engage in a certain set of relationship scenarios involving mutual affect regulation and mutual instrumental manipulations with caregivers so that a bonding or attachment style becomes possible. Those infants and toddlers that form "secure" attachments are able to move toward individuation and more complex levels of relational possibilities (i.e., the Selfother and Independent forms of relating). However, those infants and toddlers that develop "insecure" attachments form enduring bonding patterns that either cling too closely to mother or conversely withdraw from closeness with her.

Every bonding couple has its own "mommy and me are one" set of satisfactions and frustrations according to a certain style or engagement mode that is unique to each couple. This uniqueness is why "borderline" or "character" pathology is always idiosyncratic and—despite diagnostic attempts—cannot be clearly specified in advance as to what exactly it looks like.

If all goes well in the second year of life and a "secure" attachment or bonding set of experiences has been established, then a separation-individuation from the established bonding pattern is set to occur with the infant refusing Mommy's way and the Mother allowing (or not) the tantrums and opposition to free the child from symbiotic bondage. But often enough in "insecure" forms of attachment this psychological differentiation

fails to occur or may only partially occur. The person may continue to develop well in many ways, but the person remains stuck with a somewhat restricted or rigid character style (so-called “borderline,” “sociopathic,” “narcissistic,” etc.).

Later in life, and re-enacted in therapy, this restrictive or instrumental character style may be experienced by others as manipulative, coercive, demanding, constricting, alienating, or self-limiting. That is, the person who did not achieve a “secure” attachment followed by personal individuation may be experienced by others as needing or demanding relatedness that is (unconsciously) intended to be instrumental in molding relationships into his/her accustomed relatedness needs and styles irrespective of the other’s boundaries and needs.

Suicide threats and gestures as well as “parasuicidal” (self-injury) behaviors may be engaged in with the (usually unconscious) hope of somehow impacting others so that one’s conscious or unconscious symbiotic relatedness (dependency) needs and habits can be met.

Preverbal Relatedness Potentials

These first two levels of relatedness potentials—Organizing and Symbiotic—arise in the earliest months and years of life before verbal symbolism and narrational skills develop and

therefore are not rememberable in words or stories, but rather in body sensations and emotional-interactional habits.

This fact has crucial implications for suicide interventions. That is, if it is true (as I am contending) that intentional suicides and instrumental gestures and attempted suicides all have their unconscious origins in these earliest developmental epochs, then it follows that there are no words or stories to express the re-enactments of primordial traumatic experiences.

Therefore, answers to questions as to the why and wherefore of an individual's suicidal behaviors simply cannot be answered—cannot be put into words or stories. Rather, people tend to point to triggering events or to make up reasons that appear to hold water but in fact fail to represent the deep mind-body anguish involved.

The bottom line: *People cannot tell us why they attempted or gestured or succeeded in the suicidal impulse*.

Speech and stories only become coherent by the third year of life and memories and reports representing those later experiences are more reliable though various forms of unconsciousness are always at play. But since traumas of the Organizing and Symbiotic era hold the key to understanding suicidality there is no way for suicidal people to tell us what their deep unconscious experience and needs are at the moment.

Instead, the memories that are being enacted are marked with the body/mind agony of Psycheache.

In the third year, Selfother experience, the self-relatedness mode feeds off of the praise and admiration of others to bolster an otherwise weak or not yet stabilized sense of self. The transfer to therapy is a re-enactment of the need for affirmation or twinning from the therapist-other. It's not that suicide might not become accidentally triggered by events, but so long as one is feeling adequately affirmed in life suicide is not an option. My favorite example is Gustav Flaubert's *Madam Bovary* who uses everyone and everything to bolster her fragile self-esteem—until she is at last publicly exposed in her adulterous treachery and fragments into cyanide—the call of darkness with relief from her mad self-aggrandizing frenzy. Businessmen who have had a calamitous turn of fortune may leap from buildings or shoot themselves because their self-worth and pride has been based on what they were able to amass and control. However, often enough the grandiose self of the narcissist tends to ignore or move right past humiliation or injury. So it would seem that actual suicides resulting from *Self-other* failures of affirmation are relatively rare, impulsive, and desperate.

In the *Independent experience*, i.e., "normal"/"neurotic" relating, most everyone from time to time hits a deep discouragement or humiliating embarrassment and feels like

"maybe it's time to throw in the towel" or "life just isn't worth it." But while the ideations may reflect a depressive moment, they are seldom long-lasting, manipulative, or instrumental and pass when the situation passes. We usually "can get by with a little help from our friends." In therapy the meaning of the discouragement or defeat is free associated to until it dissipates or the conflict is resolved.

High-risk behaviors may be frequent with some people at either of these two more complex levels of relatedness experience. When and if the person is ready to examine them, they will likely be revealed to be related to some self-esteem issues (Selfother) or some triangular (Independent) relatedness conflict.

In considering completed and attempted suicides our interest will be mainly in the first two pre-verbal kinds of infantile trauma that may appear in adult life when triggered by some relational situation.

Review

- **Organizing transfer** is some kind of avoidance or rupture of connectedness or competence in order to avoid anticipated traumatizing over- or under-stimulating relational situations.

- **Symbiotic transfer** is behavior (unconsciously) designed to be instrumental in getting one's early relatedness needs met according to a certain restrictive but familiar pattern or style.

- **Selfother transfer** represents enactments aimed to get responses from the other to bolster self-esteem.

- **Independent transfer** is a re-enactment of competitive and cooperative triangular conflicts from childhood in current relational settings.

Why the Call to "Darkness"?

There is a simple answer to this question and a more complex theoretical one. But in either case, to those vulnerable to occasional or frequent bouts of depression and suicidality the call of darkness is no mere metaphor, but a compelling and terrifying reality.

The simple answer rests on early life experiences—the rhythm of waking and sleeping activity of a fetus and neonate and the earliest emergence of consciousness out of non-consciousness. In waking activity both before and after birth the earliest sense of agency is deployed into encounters with sustained sensorimotor experiences of otherness that alternate with lapses into sleep—darkness. By the fourth month in ordinary and expectable development the forays into otherness experience take on a definite intentional seeking quality

involving expectation so that the processes of developing human consciousness and mutual affect regulation truly get off the ground. Thus, during the third trimester and during what infant researchers are now calling the fourth trimester, the infant is *organizing* channels of connection to her world—both physical and mental until moments of anticipatory and sustained seeking reliably begin.

The pediatrician-psychoanalyst Donald Winnicott speaks of the baby's "going on being" in the first three months and the importance of the mother's "total maternal preoccupation" during this time so that the organizing efforts are reinforced in a timely manner and are not thwarted by unnecessary intrusions or delays—so that the infant is not forced to begin "thinking," that is, trying to figure things out before she is ready.

But we know that many things can and do go wrong to impinge on these early organizing activities—alcohol fetal syndrome, premature birth, adoption at birth, incubators, surgeries, illnesses, depressed or crazy mothers, raging and alcoholic fathers, marital strife, environmental stresses, hostile siblings, invasive toxins, neglectful or abusive caregivers, pets, or even rats in the crib. Impingements disrupt baby's reaching forays midstream in baby's deployment of her perceptual-motor explorations resulting in under- or over-stimulating experiences and the "never reach that way again" becomes established.

Babies vigorously protest intrusions into their need space and may kick, scream, cry, arch their backs, hold their breaths, bang their heads or flail wildly in pain and angst until exhausted and then fall into sleep—the peaceful retreat of "darkness", the relief of unconsciousness. Vulnerable individuals later in life may have this early retreat to peace and darkness triggered in situations of extreme hopelessness, helplessness, despair and psychic pain. Or, conversely and paradoxically, in otherwise positive situations that are anticipated to bring successful connection with another. That is, *the anticipation of an otherwise satisfying interpersonal (or social) situation may trigger retreat or collapse into the relief of darkness because in infancy the original reaching experience resulted in a traumatic disaster*.

The more complex answer to the question "Why darkness?" relates to an issue Sigmund Freud worked over during his entire professional career from his earliest papers in the 1890s to his final papers in the late 1930s, a phenomenon he referred to as "the splitting of the ego." By this Freud meant that the earliest sense of agency, "the I," necessarily becomes split as it deals with the world. That is, while one part of "the I" reaches explorationally into the world, another part of "the I" maps what it finds—that is, *actively creates and in some sense then becomes an internal representation* of what is out there.

Hungarian psychoanalyst Alice Balint in an illuminating 1943 paper, "Identification," expands Freud's thinking on the ego, "the I," creating a perceptual-motor-affect identity inside that mirrors an object-affect identity on the outside—through the process of "identification." One might say there is a "me-self" and an "other-self" both in the ego, "the I." Psychoanalyst Otto Kernberg speaks of the building blocks of personality being comprised of "a representation of self, a representation of other, and an affect linking them—so that there is always a "split I" but in ordinary development the split becomes smoothly integrated into a developmental building block. But when in infancy the "other-self" is experienced as traumatizing then the interactional-narrational quality of the internalized other is likewise traumatizing. That is, the sequence and affect quality of the perceptual-motor reaching out to contact "otherness" comes to take on a negative or traumatizing *internalized* narrational quality.

In the *Organizing* experience the internalized narrational quality requires a shutdown, a retreat toward or into darkness—a loss of consciousness. In the Symbiotic experience the internalized narrational quality is that of creating compelling mutual affect regulation or interactional scenarios. That is, the unique mother-child symbiotic (attachment or mutual affect regulation) scenarios are of an *instrumental* nature—each person

behaves in a way designed to get her needs in the relationship met. These internalized instrumental scenarios reappear in later life as (usually unconscious) interactional efforts to compel the other to meet my psychological needs according to my internalized expectations. Said differently, when the Organizing experience is re-activated in later life there is psychic pain and the call of darkness. When the Symbiotic experience is activated in later life, there is anxiety and pressure to get the other to "do it my way." It seems, then, that completed suicides are most likely derived from Organizing experience while various kinds of suicide attempts and gestures are more likely derived from the internalized instrumental scenarios of the Symbiotic experience.

But however one chooses to think of this basic process of creating or internalizing a subjective world based on the ways one *experiences* the external objective world, in the earliest months of life the early external world may offer some hard knocks. For example, French psychoanalyst Andre Green speaks of the "dead mother" as an internal under-stimulating representation of a blank, white, empty, dead but nevertheless present early maternal environment that colors one's subsequent experiences of emptiness in the world. Conversely, *when a child is forced by traumatic over-stimulation to retreat into the peace and darkness of unconsciousness and sleep, blackness and darkness is internalized as a refuge against reaching in some*

way that has intolerably and painfully failed. In later life idiosyncratic forms of interpersonal or social reaching in anticipation of success and fulfillment may paradoxically trigger the other side of the split ego into experiencing either white, blank emptiness or a painful collapse into darkness.

Four Psychological Formulations

1. Mark Williams's "Cry of Pain"—*In Cry of Pain: Understanding Suicide and Self-Harm* (1998), Williams recasts our thoughts about a cry for help in terms of a different intention: "Suicidal behavior is most often not a cry for help but a *cry of pain*. It is like an animal caught in a trap, which cries with pain. The cry is brought about by the pain, but in the way it communicates distress, it changes the behavior of other animals who hear it."

2. David Lester's "Instrumental" Gestures—Suicidologists have generally concluded that many attempted suicides are not actually trying to die since the gestures are weak—taking less than a lethal dose, cutting lightly and so forth. These seemingly *instrumental* gestures that are often interpreted as a cry for help or an interpersonal manipulation of some sort.

3. Ronald Maris and "Suicidal Career"—Maris (1981) maintains that virtually everyone engaged in suicidology agrees that the descriptive profiles of self-destructive behaviors of the past must give way to "dynamic developmental models": "Suicidality varies over time and among different types of individuals. It is argued here that

the suicide's biography or 'career' is always relevant to his or her self-destructive reaction to crisis...."

4. "The Fantasy of being Rescued in Suicide"—In their 1958 paper, Viggo Jensen and Thomas Petty discuss suicide as a complex psychoanalytic construction in which playing the odds with death almost always involves a test for the person who is cast in the role of potential rescuer. "Suicide is dyadic; fusion fantasies and self-object confusion lie at its heart, and in almost all instances, a warning is given before the deadly chance is taken."

The Major Psychological Perspectives on Suicide

The Freudian Approach

Any survey of the psychoanalytic tradition necessarily begins with Sigmund Freud's 1917 paper "Mouring and Melancholia," in which he contrasts normal and ordinary grief reactions to loss (mourning) with chronic and debilitating mental preoccupations (melancholia). According to Freud, in ordinary mourning the normally functioning ego has suffered a loss with grief and, *after having painfully accepted the reality of that loss, matures—expands its purview—through locating and identifying with others in order to repair or replace that loss*.

Freud's formulation reads that the ego turns aggression against itself—that is, the primary ego discharges its aggression toward the identificatory ego resulting in a debilitating

depressive reaction often defended against by manic activity that works as a defense against depressive despair.

In 1920 Freud again considers suicide in the context of a case study of an 18-year-old girl after she made a suicide attempt: "Analysis has explained the enigma of suicide in the following way: Probably no one finds the mental energy required to kill himself unless, in the first place, in doing so, he is at the same time killing an object with whom he has identified himself and, in the second place, is turning against himself a death wish which had been directed against someone else" (p. 147)

Following Freud's "Mourning and Melancholia," the next major addition to psychoanalytic thinking on suicide was an emphasis on unconscious motivations made by Karl Menninger in 1933:

> The conception of self-destruction as a flight from reality, from ill-health, disgrace, poverty and the like, is seductive because of its simplicity.… Its essential fallacy is one of *incompleteness*; it lies in the implied assumption that the forces impelling the regression come *wholly from without*.… From the standpoint of analytical psychology the push is more important than the pull, i.e. the ego is driven by more powerful internal forces than external reality. The paramount factors in determining behaviour are *the impulses from within*, the motives originating in the individual which express his attempt at adjustment to reality.…

> We know that the individual always, in a measure, creates his own environment, and thus the suicidal person must help to create the very thing from which, in suicide, he takes flight. If we are to explain the act dynamically, therefore, we are compelled to seek an explanation for the wish to put oneself in a predicament from which one cannot, except by suicide, escape.

The Jungian Approach

The Jungian Analytic perspective centers around what life, and death as a part of life, has meant to people from all cultures throughout time, as well as how those meanings have been expressed in archetypal forms—notably in sleep and death.

In *Suicide and the Soul* (2011), Jungian analyst James Hillman makes clear that death is an important aspect of life and that the question of how one lives or dies—by fate or by choice is a crucial one everyone must consider:

> Any careful consideration of life entails reflections of death, and the confrontation with reality means facing mortality. We never come fully to grips with life until we are willing to wrestle with death.... We need not postulate a death drive nor need we speculate about death and its place in the scheme of things to make a simple point: every deep and complex concern, whether in oneself or with another, has in it the problem of death. And the problem of death is posed most vividly in suicide. Nowhere else

> is death so near. If we want to move towards self-knowledge and the experience of reality, then an enquiry into suicide becomes the first step. The concern of an analyst is to maintain connection with the inside of experience and not to surrender to the pressures of the outside…. *If an analyst wants to understand something going on in the soul he may never proceed in an attitude of prevention*….Not prevention, but confirmation, is the analyst's approach to experience…. His desire is to give recognition to the states of the soul which the person concerned is undergoing, so that they may become realized in the personality and be lived consciously. He is there to confirm what is going on—*whatever* is going on. *Ideally, he is not there to approve, to blame, to alter, or to prevent. He may search for meaning, but this is to explore the given, not to lead away from the experience as it is*. (p. 61)

Hillman specifies the ideal position of the analyst: "Without dread, without the prejudices of prepared positions, without a pathological bias, suicide becomes 'natural.' It is natural because it is a possibility of our nature, a choice open to each human psyche. The analyst's concern is less with the suicidal choice as such, than it is with helping the other person to understand the meaning of this choice, *the only one which asks directly for the death experience*."

The therapeutic action or transformation, says Hillman, "begins at this point where there is no hope. Despair produces

the cry for salvation, for which hope would be too optimistic, too confident.... My only certainty is my suffering which I ask to be taken from me by dying. An animal awareness of suffering, and full identification with it, becomes the humiliating ground of transformation" (p. 62).

The Shneidman Approach

By 1998 Edwin Shneidman, through numerous publications and the establishment of many suicide-prevention centers and national and international organizations, had made a major impact on the field of suicidology and had grasped the folly of many of the earlier approaches.

According to Shneidman (2004), "Our best route to understanding suicide is *not* through the study of the structure of the brain, nor the study of social statistics, nor the study of mental diseases, but *directly through the study of human emotions described in plain English, in the words of the suicidal person*. The most important questions to a potentially suicidal person is not an inquiry about family history or laboratory tests of blood or spinal fluid, but '*Where do you hurt?*' and '*How can I help you?*'"

Here are Shneidman's (1998) widely acclaimed "Ten Commonalities Found in Suicide":

1. *The common purpose of suicide is to seek a solution*. Suicide is not a random act. It is never done without purpose.

2. *The common goal of suicide is cessation of consciousness*. Suicide is best understood as moving toward the complete stopping of one's consciousness and unendurable pain, especially when cessation is seen by the suffering person as the solution, indeed the perfect solution of life's painful and pressing problems.

3. *The common stimulus in suicide is psychological pain*. If cessation is what the suicidal person is moving toward, psychological pain (or Psycheache) is what the person is seeking to escape.

4. *The common stressor in suicide is frustrated psychological needs*. In general, human acts are intended to satisfy a variety of human needs.

5. *The common emotion in suicide is hopelessness-helplessness*. At the beginning of life, the infant experiences a number of emotions (rage, bliss) that quickly become differentiated. In the adolescent or adult suicidal state, the pervasive feeling is that of helplessness-hopelessness.

6. *The common cognitive state in suicide is ambivalence*. Freud brought to our unforgettable attention the psychological truth that transcends the surface appearance of neatness of logic by asserting that something can be both A and not A at the same time.

7. *The common perceptual state in suicide is constriction*. I am one who believes that suicide is not best understood as a psychosis, a neurosis, or a character disorder. I believe that

suicide is more accurately seen as a more-or-less transient psychological constriction, involving our emotions and intellect.

8. *The common action in suicide is escape or egression*. Egression is a person's intended departure from a region, often a region of distress.

9. *The common interpersonal act in suicide is communication of intention*. One of the most interesting things we have found from the psychological autopsies of unequivocal suicidal deaths done at the Los Angeles Center was that there were clues to the impending lethal event in the vast majority of cases.

10. *The common pattern in suicide is consistent with lifelong styles of coping*. [all emphasis added]

Shneidman (1996) advises us:

> We must look to previous episodes of disturbance, dark times in that life, to assess the individual's capacity to endure psychological pain. We need to see whether or not there is a penchant for constriction and dichotomous thinking, a tendency to throw in the towel, for earlier paradigms of escape and egression. Information would be in the details and nuances of how jobs were quit, how spouses were divorced, and how psychological pain was managed.
>
> The implications: *Reduce the pain; remove the blinders; lighten the pressure*—all three, even just a little bit. If you address the individual's perturbation

(the sense of things being wrong), that person's lethality (the pressure to get out of it by suicide) will decrease as the perturbation is reduced. That is the goal of therapy with a suicidal person.

Shneidman believes that *suicidality springs from psychological assaults* "very early in childhood," and that likely

> *the pains that drive suicide relate primarily not to the precipitous absence of equanimity or happiness in adulthood, but to the haunting losses of childhood's special joys*.
>
> In part, the treatment of suicide is the satisfaction of the unmet needs. One does this not only in the consultation room but also in the real world. This means that one talks to the significant others, contacts social agencies, and is concerned about practical items such as job, rent, and food.
>
> The way to save a suicidal person is to cater to that individual's infantile and realistic idiosyncratic needs.
>
> With a highly lethal suicidal person the main goal is, of course, to reduce the elevated lethality.
>
> *The most important rule to follow is that high lethality is reduced by reducing the person's sense of perturbation*. One way to do this is by addressing in a practical way those in-the-world things that can be changed if ever so slightly.

> A psychotherapist can try to decrease the elevated perturbation of a highly suicidal person by doing almost everything possible to cater to the infantile idiosyncrasies, the dependency needs, the sense of pressure and futility, and the feelings of hopelessness and helplessness that the individual is experiencing.
>
> In order to help a highly lethal person, one should involve others and create activity around the person; do what he or she wants done; and, if that cannot be accomplished, at least move in the direction of the desired goals to some substitute goals that approximate those which have been lost. [emphasis added]

The Attachment Approach

Jeremy Holmes, a long-time attachment researcher, turns his attention to the process of mentalizing the suicidal experience. He makes the point that the paradox of mentalization is that being able to think about suicide makes its occurrence less likely and conversely, not being able to mentalize the suicidal choice increases the likelihood of it happening.

Holmes has defined mentalization as the ability “to see oneself from the outside, and others from the inside” (2011, p. 152), and he sees suicidality as triggered by a collapse in one’s attachment network leaving suicide as a viable option.

Considered developmentally, such a person has never internalized a secure base which allows a secure self in adult life. Without having established in infancy reliable mutual affect regulation with caregivers there is no internal other to turn to for support in despairing moments.

Konrad Michel and Ladislav Valach (2011) speak to the importance of attachment in therapy:

> From an attachment perspective, a secure relationship is not merely instrumental in helping the patient to do the work of therapy, it is intrinsic to the benefit: Patients come to experience the painful emotions associated with their suicidal state in the context of an attachment relationship in which they are no longer alone but rather have the sense of their mind being held in mind by the therapist….
>
> This experience, in turn, *enhances their capacity to mentalize in the midst of emotional states rather than being emotionally overwhelmed* in a nonmentalizing suicidal state that is characterized as *cognitive disorientation. Hence a mentalizing connection is the foundation for treating suicidal patients*. (p. 87)

Holmes (2011) holds that

> [m]entalizing is a means by which separation and loss are endured, a bridge across the inevitable fractures and ruptures that are intrinsic to intimacy,

> and it is only on the basis of secure attachment that the insecurity of detachments can he borne.…
>
> Unmentalizing, the suicidal person knows that death is the answer. He cannot or will not consider other possibilities—that this too shall pass. It is the job of a therapy team to build or rebuild the visualizing of a life that could be lived—and/or to keep the patient alive until that becomes feasible. (p. 166)

The Transference Focused Psychotherapy (TFP) Approach

A group of researchers and clinicians led by Otto Kernberg at the Personality Disorders Institute at Cornell University has developed Transference Focused Psychotherapy (TFP) as a manualized and empirically validated psychoanalytic psychotherapy.

The specific objective of TFP is the modification of the personality structure of patients with severe personality disorders, particularly borderline personality disorder, but also narcissistic, paranoid, schizoid and schizotypal personality disorders. Such integration leads to improvements in the capacity for genuine friendships as well as investment in creative and cultural pursuits. The main strategy in the treatment of patients with borderline personality organization consists in the facilitation of, the (re)activation of, split-off internalized object

relations of contrasting persecutory and idealized natures that are then observed and interpreted in the transference. TFP is carried out in face-to-face sessions, with a minimum of two and usually not more than three sessions a week. The patient is instructed to carry out free association while the therapist restricts his or her role to careful listening and observation of the activation of regressive, split-off relations in the transference and to help identify them and interpret their segregation in the light of these patients' enormous difficulty in reflecting on their own behavior and often on the maladaptive, turbulent interpersonal interactions in which they find themselves. The interpretation of these split-off object relations is based upon the assumption that each reflects a dyadic unit comprised of a self-representation, an object representation, and a dominant affect linking them, and that *the activation of these dyadic relationships determines the patient's perception of the therapist*.

Not infrequently, rapid role reversals of idealized and persecutory aspects appear in the transference providing the clinician with a vital window into the patient's internal world of object relations. Thus, the patient may identify with a primitive self-representation while projecting a corresponding object representation onto the therapist, while, ten minutes later, for example, the patient identifies with the object representation while projecting the self-representation onto the therapist.

TFP assumes that it is always *a relationship* that is activated and projected in transference and countertransference. Interpretations seek to address conscious and preconscious experiences of the patient that are in harmony with the person's sense of subjectivity.

The Dialectical Behavior Therapy (DBT) Approach

Marsha Linehan (1993) developed Dialectical Behavior Therapy to work with suicidality and the population of patients diagnosed "borderline personality disorder." DBT is a manualized approach to treatment with things for the therapist to do and not do in treatment. She established clearly that this population of character disorders required long-term treatment—a year or more—with a minimum of one individual and one group session weekly with homework in between and greater frequency when needed. DBT uses treatment strategies from behavioral, cognitive, and supportive therapies. It is known that there is a high rate of suicides in this population and Linehan has set up a set of clear protocols on how therapists are to handle suicidality.

Anthony Williams (2014) describes the approach:

> A behavioural/problem-solving component focuses on enhancing capability, generating alternative ways of coping, clarifying and managing contingencies, all with the emphasis on the "here and now."

> The 'dialectical' aspect lies in its emphasis on balancing *acceptance* of (seeing clearly) the stresses that exist in the environment on the one hand with the need to *change* them on the other.
>
> *The theme is encouraging clients to really grasp things, to understand them deeply as they are and to step back from them temporarily in order to see what might be changed*.... DBT involves an 'exhaustive description of the moment-to-moment chain of environmental and behavioural events that preceded the suicidal behaviour.... Alternative solutions that the individual could have used are explored, behavioural deficits as well as factors that interfere with more adaptive solutions are examined, and remedial procedures are applied if necessary'... all this ... is helped by training in mindfulness skills. (p. 211)

The Interpersonal Theory of Suicide Approach

A group of researchers and clinicians let by Thomas Joiner has devised an Interpersonal approach which holds that the only people capable of death by suicide are *those who have experienced enough past pain to have habituated to the fear and pain of self-injury sufficiently so that the instinct of self-preservation can be overcome*. Any strong fear and pain experiences can produce (1) the *acquired capability* to enact self-death, and (2) the *desire to end their lives*.

So the question becomes: who are the people with suicidal desire? The theory answers: those that have experienced two interpersonal states of mind, *perceived burdensomeness* and *failed belongingness*

Joiner et al.'s *The Interpersonal Theory of Suicide: A Guidance for Working with Suicidal Clients* (2009) contains a number of very useful forms and tools. Two that asks a series of penetrating questions are the Interpersonal Needs Questionnaire and the Acquired Capability Questionnaire. As exhibits the authors offer the Theory-based Assessment Form, The Commitment to Treatment Contract, A Crisis Card that reminds people of how they have decided to handle suicidal crises, A Suicidal Check List for Young Adults and Adolescents, and other clinically useful forms and assessments.

Considerations of Liability

In 2000 I first published a comprehensive text for therapists, *Facing the Challenge of Liability: Practicing Defensively*. In 2017 I published a revised and expanded edition of that book.

In the forward Bryant Welch, the attorney-psychoanalyst who first established the APA Practice Directorate, wrote: "Malpractice lawsuits and licensing board complaints are a serious threat to the welfare of psychotherapists. It is a fantasy to

think that only the culpable are brought before licensing boards or become the targets of malpractice litigation.... Being a good person and a competent therapist does not guarantee that one will not be forced to defend the profession, often with the very right to continue practicing at stake. Anyone who works with borderline patients, families, children, or very sick patients is at risk. It is that simple, and it is only at one's peril that one denies this fact."

Welch lists eight areas of ongoing concern:

1. Do an initial comprehensive suicide risk assessment of the patient and make assessment an ongoing part of treatment. Be mindful of the suicide risk factors, tapping the latest available literature on the subject.
2. Don't allow yourself to deny a suicide risk.
3. Spend adequate time with the patient—whether you get paid for all of it or not
4. If necessary, make it clear to the managed care company that a lack of treatment could be seen as negligence and result in a lawsuit against them—put this in a certified letter to the managed care representative if necessary.
5. Practice full disclosure with the family of the suicidal patient.
6. Educate the patient's family about the signs of potential suicide.
7. Employ good follow-up practices with patients.
8. Always follow good documentation procedures.

Clients who engage in chronic and intractable suicidal gestures, self-injuring activities, or other potentially self-abusive or harmful behaviors may need to be terminated and referred out of individual psychotherapy on the basis of unmanageability. The resources we have at our disposal often do not meet the client's needs.

This must be explained to the client early in therapy, and limits must be set and put into writing with consequences that are effectively followed through on.

I have seen many therapists struggle compassionately for long periods of time with clients to no avail but the therapist becomes utterly exhausted and burned out.

Therapists need to be clear in a no-fault, non-punitive fashion that they are not equipped to deal with such intense and dangerous expressions, so that these forms of communication have to be renounced in order for therapy to continue. I find that *it is usually the therapist's resistance to limit-setting and systematic follow-through that slows down the process*.

But the bottom line is that no therapist is in a personal or professional position to receive endlessly or to respond effectively to chronic life-threatening or safety-endangering communications. If it is not possible to contain the therapy work in manageable limits, the client must be referred to a more

appropriate intensive therapeutic resource or to a setting where different liability parameters exist.

Most clients confronted in this seemingly harsh way about how important their therapy work is, how crucial safe and manageable nonthreatening communications are for the sanity and well-being of the therapist, and how the client must find alternative forms of experiencing and communicating her or his concerns, in fact, do find different, creative, and contained ways of continuing their therapy work with the therapist safely.

But the therapist *has to believe* that alternate forms of communication are essential for mutual safety and that they are achievable within the creative potential of the client for the limit setting to work effectively. If the client truly cannot comply in this way your liability is simply too great to continue with her or him.

Managing Suicidality in Clinical Settings

By a wide margin, the book which gives the most concise and carefully considered approach to the current situation of risk and liability in suicidality and that contains numerous forms for assessment and treatment of suicidality is *The Assessment and Management of Suicidality* by David Rudd (2006), who has

served repeatedly as an expert witness and been up against a number of other very sharp expert witnesses.

The standards of practice with regard to suicidality tend to be fluid on a case-to-case basis and largely established *after the fact* in court or licensing board hearings by expert witnesses who will raise a series of trenchant questions designed to make any of us look quite unprofessional. *Our only option at this point in time is to take a deep breath and get serious about protecting ourselves from serious accusations of unprofessional conduct*.

Writes Rudd (2006):

> When a life is tragically lost to suicide, it is imperative that the clinician be able to provide documentation offering a clear, specific, and succinct rationale for clinical decisions. Trust me, a host of questions will be directed at the practitioner:
>
> 1. Why was a patient who was thinking about suicide or had made a suicide attempt not hospitalized?
> 2. Why was a given course of treatment followed when there were indications that the patient was not responding well or getting better?
> 3. Did you consider alternative treatment options?
> 4. Was medication considered? …
> 5. What did you do to safeguard the patient's environment?
> 6. What steps were taken in response to the identified risk level?

7. Did you make an effort to talk with and enlist the help of family and friends?
8. Did the patient have a crisis response plan in place to deal with unexpected crises? (p. 7)

There are three elements to the standard of practice in suicidality: (1) foreseeability, (2) treatment planning, and (3) follow-up. These three elements apply regardless of whether or not we see a patient one time or twenty. It is essential that we complete thorough and accurate risk assessments (foreseeability), respond appropriately (treatment planning), and make sure our plan was implemented (follow-up) even if we are not the one providing the continuing care.

Conclusions

1. Despite 200 years of widespread attention and six decades of intensive scientific study, our overall ability to predict and prevent suicide is now seen as no better than chance.

2. Research studying various populations aimed at establishing "risk factors," biological factors, familial or social factors are helpful in identifying high-risk situations but fail at targeting the individual psychodynamics of suicidal individuals

3. "Suicide crisis" therapies embarked on in the short "window of vulnerability" following a suicide attempt are often successful in reducing suicidal ideation in the short-term but do not address the long-term underlying suicidal dynamics.

4. Expert suicidologists from around the world generally endorse the Aeschi imperative that a “therapeutic alliance” must be formed with suicidal people with the goal of engaging them in long-term therapy.

5. Suicidologists generally agree that—despite the appearance of loneliness and isolation—suicidality is always dyadic in nature. The therapeutic approaches that claim clinical or empirical successes are strikingly similar in that they address the “suicidal career”—the lifelong recursive relational patterns underlying suicidality.

7. While suicidality often represents a “cry for help”, at the epicenter is unbearable “Psycheache” and a “cry of pain.”

8. Suicidologists around the world have identified trauma in early child development—especially abuse, neglect, and abandonment—as the psychodynamic sources of suicidality.

9. Suicidologists have been uniform in calling for a developmental theory to account for how the early seeds of suicidality are laid down.

10. The psychoanalysts, the Jungians, the DBT group led by Linehan, the TFP group led by Kernberg, the Relational Listening group led by Hedges, and the Austin-Riggs group have in common that they generally see *intentional completed suicides* as stemming from psychotic, mood-disordered, or autistic spectrum states that require intense psychodynamic and psychiatric treatment.

11. These same groups of treatment experts have in common that they see most *instrumental suicidal gestures and*

attempts as stemming from characterological states such as borderline, addictive, and sociopathic personality disorders.

12. All approaches—clinical and empirical—that claim long-term therapeutic success are based on forming a strong "therapeutic alliance" with an extensive "working through" that promotes significant personality transformation.

13. All therapeutic approaches to suicidality modify traditional "therapeutic neutrality" in that realistic instructions, contracts, and life interventions must be undertaken in times of suicidal crisis.

14. The *Relational Listening* approach developed over 40 years by a large group of psychodynamic therapists in Southern California targets the "Organizing" developmental relatedness mode as the psychodynamic source of most *intentional completed suicides*.

15. The *Relational Listening* approach targets the "Symbiotic" developmental relatedness mode as the psychodynamic source of most *instrumental suicidal gestures and attempts*.

16. All of the leading therapeutic approaches have in common an in-depth, detailed inquiry into the life-history and relational-history of the suicidal person.

17. The leading therapeutic approaches generally recognize that the reasons given and the narratives engaged in by the suicidal person are a conscious overlay to the deep unconscious relational sources of suicidality.

18. The *Relational Listening* approach currently offers the only clear and explicit theory of early childhood development to account for *intentional completed suicides* as well as *instrumental suicidal gestures and attempts*.

19. Finally, it would appear that any systematic therapeutic approach that allows for a long-term therapeutic alliance engaged in a detailed life inquiry focusing on relationships is likely to have the power to transform the personality so that suicidality is no longer an issue.

Afterword

I hope you have enjoyed these ten lectures. They represent the thoughts and clinical work of many patients and the therapists over many years. I hope that anything that has piqued your interest will motivate you to go to the primary sources in books and papers to expand your vision and knowledge. I have come to believe that the penetrating work of the last century is but the threshold to our understanding of the vast complexity of human mind.

References

Abraham, K. (1924). A short study of the development of the libido. In *Selected Papers of Karl Abraham,* tr. D. Bryan and A. Strachey. New York: Brunner/Mazel.

Aron, L. (2001). *A Meeting of the Minds: Mutuality in Psychoanalysis*. New York: Routledge.

Balint, A. (1943). On identification. *International Journal of Psycho-Analysis,* 24:97-107.

Balint, M. (1968). *The Basic Fault*. London: Tavistock Publications.

Beck, A. T., and Dozois, D. J. A. (2011). Cognitive therapy: Current status and future directions. *Annual Review of Medicine*, 62: 397-409.

Benjamin, J. (2017). *Beyond the Doer and the Done To*. New York: Routledge.

Bion, W. (1984). *Learning from Experience*. New York: Routledge.

Blanck, G., and Blanck, R. (1979). *Ego Psychology II: Psychoanalytic Developmental Psychology*. New York: Columbia University Press.

Bollas, C. (1983). Expressive uses of the countertransference: Notes to the client from oneself. *Contemporary Psychoanalysis*, 19(1), 1-34.

______. (1987). *The Shadow of the Object: Psychoanalysis of the Unthought Known*. New York: Columbia University Press.

Breuer, J., and Freud, S. (1893-1895). Studies on hysteria. *Standard Edition* 2.

Bromberg, P. (1998). *Standing in the Spaces: Essays on Clinical Process, Trauma, and Dissociation*. Hillsdale, NJ: The Analytic Press.

______. (2008). Shrinking the tsunami: Affect regulation, dissociation, and the shadow of the flood. *Contemporary Psychoanalysis,* 44(3).

______. (2011). *The Shadow of the Tsunami and the Growth of the Relational Mind*. New York: Routledge.

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

Erikson, E. (1959). Identity and the life cycle. In *Psychological Issues,* Monograph No. 1. New York: International Universities Press.

Fonagy, P., Gergely, G., Jurist, E., and Target, M. (2002). *Affect Regulation, Mentalization, and the Development of the Self*. New York: Other Press.

Fraiberg, S. (1982). Pathological defenses in infancy. *Psychoanalytic Quarterly*, 51(4), 612-35.

Freud, S. (1912). Papers on technique: The dynamics of transference. *Standard Edition of The Complete Psychological Works of Sigmund Freud,* 12:97-108.

______. (1915). Observations on transference love. *Standard Edition of The Complete Psychological Works of Sigmund Freud, 12:159-171*.

______. (1920). The psychogenesis of homosexuality in a woman. *Standard Edition of The Complete Psychological Works of Sigmund Freud*, 18:147-172.

______. (1933). New introductory lectures on psycho-analysis. Standard Edition, 22:1-184.

Freud, A. (1936). *The Ego and the Mechanisms of Defense*. New York: International Universities Press.

Giovacchini, P. L. (1979b). *Treatment of Primitive Mental States*. New York: Jason Aronson.

Green, B. (1999). *The Elegant Universe: Superstrings, Hidden Dimensions, and the Quest for the Ultimate Theory.* New York: W. W. Norton & Co.

______. (2004). *The Fabric of the Cosmos: Space, Time, and the Texture of Reality.* New York: Knopf.

Hedges, L. E. (1983). *Listening Perspectives in Psychotherapy*. Northvale, NJ: Jason Aronson.

______. (1992). *Interpreting the Countertransference*. Northvale, NJ: Jason Aronson.

______. (1994a). *In Search of the Lost Mother of Infancy*. Northvale, NJ: Jason Aronson.

______. (1994b). *Remembering, Repeating, and Working Through Childhood Trauma*. Northvale, NJ: Jason Aronson.

______. (1994c). *Working the Organizing Experience*. Northvale, NJ: Jason Aronson.

______. (1994d). Projective identification or reciprocal scripting in judicial processes..Unpublished manuscript.

_____. (1996). *Strategic Emotional Involvement*. Northvale, NJ: Jason Aronson.

_____. (2000a). *Terrifying Transferences: Aftershocks of Childhood Trauma*. Northvale. NJ: Jason Aronson.

_____. (2000b). *Facing the Challenge of Liability in Psychotherapy: Practicing Defensively.* Northvale, NJ: Jason Aronson.

_____. (2005). Listening Perspectives for emotional relatedness memory. *Psychoanalytic Inquiry*, 25:455-483.

_____. (2011). *Sex in Psychotherapy; Sexuality, Passion, Love, and Desire in the Therapeutic Encounter*. New York: Routledge.

_____. *Cross-Cultural Encounters*. International Psychotherapy Institute e-Book, freepsychotheapybooks.org.

_____. (2013c). *Overcoming Relationship Fears*. International Psychotherapy Institution e-Book, freepsychotherapybooks.org.

_____. (2013d). *Overcoming Relationship Fears Workbook*. International Psychotherapy Institution e-Book, freepsychotherapybooks.org.

Heimann, P. (1950). On countertransference. *International Journal of Psycho-Analysis,* 31:81-84.

Hendrix, H. (1988). *Getting the Love You Want: A Guide for Couples*. New York: Harper Perennial.

Hillman, J. (2011). *Suicide and the Soul*. Putnam, Ct.: Harper Perennial. (Original work published 1964).

Holmes, J. (2011). Attachment theory and the suicidal patient. In Michel, K., and Jobes, D. A. (2011). *Building a Therapeutic Alliance with the Suicidal Patient*. Washington, D.C.: American Psychological Association.

Jacobson, E. (1954). The self and object world: Vicissitudes of their infantile cathexis and their influence on ideational and affective development. *The Psychoanalytic Study of the Child, 9:*75-127. New York: International Press.

______. (1964). *The Self and Object World*. New York: International Universities Press.

Jensen, V. W., and Petty, T. A. (1958). The fantasy of being rescued in suicide. *The Psychoanalytic Quarterly*, 27:3.

Joiner Jr., T. E., Van Orden, K. A., Witte, T. K., and Rudd, M. D. (2009). *The Interpersonal Theory of Suicide: A Guidance for Working with Suicidal Clients*. Washington D.C.: The American Psychological Press.

Kaplan, L. (1978). *Oneness and Separateness: From Infant to Individual*. New York: Simon & Schuster.

Kernberg, O. F. (1975). *Borderline Conditions and Pathological Narcissism*. New York: Jason Aronson.

______. (1976). *Object-Relations Theory and Clinical Psychoanalysis*. New York: Jason Aronson.

______. (1980a). *Internal World and External Reality*. New York: Jason Aronson.

Klein, M. (1946). Notes on some schizoid mechanisms. *International Journal of Psycho-Analysis,* 24:97-107.

Kohut, H. (1971). *The Analysis of the Self*. New York: International Universities Press.

______. (1977). *The Restoration of the Self*. New York: International Universities Press.

______. (1984). *How Does Analysis Cure?* Chicago: University of Chicago Press.

Lewis, T., Amini, F., and Lannon, R. (2000). *A General Theory of Love*. New York: Random House.

Linehan, M. M. (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder.* New York: Guilford.

Little, M. (1981). *Transference Neurosis: Transference Psychosis*. New York: Jason Aronson.

Mahler, M. (1968). *On Human Symbiosis and the Vicissitudes of Individuation,* Vol I: *Infantile Psychosis*. New York: International Universities Press.

Maris, R. (1981). Pathways to Suicide: A Survey of Self-Destructive Behaviors. Baltimore: Johns Hopkins University Press.

Masterson, J. (1972). *Treatment of the Borderline Adolescent: A Developmental Approach*. New York: John Wiley and Son.

______. (1976). *Psychotherapy of the Borderline Adult: A Developmental Approach*. New York: Brunner/Mazel Publishers.

Menninger, K. (1933). Psychoanalytic Aspects of Suicide. International Journal of Psycho-Analysis, 14:376-390.

Michel, K., and Valach, L. (2011). The narrative interview with the suicidal patient. In Michel, K., and Jobes, D. A. (2011). *Building a Therapeutic Alliance with the Suicidal Patient*. Washington, D.C.: American Psychological Association.

Mitchell, S. (1997). *Influence and Autonomy in Psychoanalysis*. Hillsdale, NJ: The Analytic Press.

Norcross. J. (2002). *Psychotherapy Relationships that Work: Therapist Contributions and Responsiveness to Patients*. New York: Oxford.

Psychodynamic Diagnostic Manual (PDM 2006).

Pearce, J. C. (2002). *The Crack in the Cosmic Egg: New Constructs in Mind and Reality*. New York: Park Street Press. (Original work published in 1979.)

Poe, E. A. (1850). “The Poetic Principle.” In Leon Edel et al. *Masters of American Literature* (Vol. 1). Boston:

Houghton Mifflin, 1959, pp. 256-262.

Rossner, J. (1983). *August*. Boston: Houghton Mifflin.

Rudd, M. D. (2006). *The Assessment and Management of Suicidality*. Professional Resource Press/Professional Resource Exchange.

Schore, A. (2015). *Affect Regulation and the Origin of the Self: The Neurobiology of Emotional Development*. London and New York: Routledge. (Original work published in 1994.)

Searles, H. E. (1979). *Countertransference and Related Subjects: Selected Papers*. New York: International Universities Press.

Shneidman, E. S. (1996). *Definition of Suicide*. Oxford, England: Oxford University Press. (Original work published in 1985.)

______. (1998). *The Suicidal Mind*. New York: Oxford University Press USA.

______. (2004). *Autopsy of a Suicidal Mind*. Oxford, England: Oxford University Press.

Shubs, C. (2020). *Traumatic Experiences of Normal Development: An Intersubjective, Object Relations Listening Perspective on Self, Attachment, Trauma, and Reality*. London and New York: Routledge.

Spotnitz, H. (1976). *Psychotherapy of Preoedipal Conditions: Schizophrenia and Severe Character Disorders*. New York: Jason Aronson.

Stern, D. B. (1997). *Unformulated Experience: From Dissociation to Imagination in Psychoanalysis*. Hillsdale, NJ: The Analytic Press.

______. (2010). *Partners in Thought: Working with Unformulated Experience, Dissociation, and Enactment*.

New York: Routledge.

______. (2013, March 16). Address to the Newport Psychoanalytic Institute. Newport Beach, CA, USA.

______. (2015). *Relational Freedom: Emergent Properties of the Interpersonal Field*. New York: Routledge.

Stern, D. N. (2004). *The Present Moment*. New York: Norton.

Stolorow, R. D., and Lachman, F. J. (1980). *Psychoanalysis of Developmental Arrests*. New York: International Universities Press.

Sullivan, H. S. (1953). *The Interpersonal Theory of Psychiatry: The Collected Works* (2 Vols.). New York: W. W. Norton & Co.

Volkan, V. D. (1976). *Primitive Object Relations: A Clinical Study of Schizophrenia, Borderline and Narcissistic Patients*. New York: International Universities Press.

Wade, N. (2006). *Before the Dawn: Recovering the Lost History of Our Ancestors*. New York: Penguin Books.

______. (2009). *The Faith Instinct: How Religion Evolved and Why It Endures*. New York: Penguin Books.

______. (2014). *A Troublesome Inheritance: Genes, Race, and Human History*. New York: Penguin Books.

Williams, A. M. (2014). *Cry of Pain: Understanding Suicide and Self-Harm*. New York: Penguin Group USA. (Original work published 1998.)

Winnicott, D. W. (1949). Birth memories, birth trauma and anxiety. In *Through Paediatrics to Psycho-Analysis: Collected Papers of D. W. Winnicott,* pp. 174-193. New York: Basic Books.

______. (1974). Fear of breakdown. *International Review of Psycho-Analysis,* 1:103.

Wittgenstein, L. (1953). *Philosophical Investigations*. Trans. G. E. M. Anscombe. New York: The Macmillan Company.

About the Author

Lawrence Hedges, Ph.D., Psy.D., ABPP, began seeing patients in 1966 and completed his training in child psychoanalysis in 1973. Since that time his primary occupation has been training and supervising psycho-therapists, individually and in groups, on their most difficult cases at the Listening Perspectives Study Center in Orange, California. Dr. Hedges was the Founding Director of the Newport Psychoanalytic Institute in 1983, where he continues to serve as a supervising and training analyst. Throughout his career, Dr. Hedges has provided continuing education courses for psychotherapists throughout the

United States and abroad. He has consulted or served as expert witness on more than 400 complaints against psychotherapists in 20 states and has published 23 books on various topics of interest to psychoanalysts and psychoanalytic psychotherapists, three of which have received the Gradiva Award for the best psychoanalytic book of the year. During the 2009 centennial celebration of the International Psychoanalytic Association, his 1992 book, *Interpreting the Countertransference*, was named one of the key contributions in the relational track during the first century of psychoanalytics. In 2015 Dr. Hedges was distinguished by being awarded honorary membership in the American Psychoanalytic Association for his many contributions to psychoanalysis through the years.

Photograph courtesy Marcie Bell

Other Books Authored and Edited by Lawrence Hedges

Listening Perspectives in Psychotherapy (1983; Revised Edition 2003; 40th Anniversary Edition 2022)

In a fresh and innovative format Hedges organizes an exhaustive overview of contemporary psychoanalytic and object relations theory and clinical practice. "In studying the Listening Perspectives of therapists, the author has identified himself with the idea that one must sometimes change the Listening Perspective and also the interpreting, responding perspective." – Rudolf Ekstein, Ph.D. Contributing therapists: Mary Cook, Susan Courtney, Charles Coverdale, Arlene Dorius, David Garland, Charles Margach, Jenna Riley, and Mary E. Walker. Now available in a 40th Anniversary edition, the book has become a classic in the field.

Interpreting the Countertransference (1992)

Hedges boldly studies countertransference as a critical tool for therapeutic understanding. "Hedges clearly and beautifully delineates the components and forms of countertransference and explicates the technique of carefully proffered countertransference informed interventions … [He takes the

view] that all countertransferences, no matter how much they belong to the analyst, are unconsciously evoked by the patient." –James Grotstein, M.D. Contributing therapists: Anthony Brailow, Karen K. Redding, and Howard Rogers. During the 2009 centennial celebrations of The International Psychoanalytic Association his 1992 book, Interpreting the Countertransference, was named one of the key contributions in the relational track during the first century of psychoanalytics.

In Search of the Lost Mother of Infancy (1994)

"Organizing transferences" in psychotherapy constitute a living memory of a person's earliest relatedness experiences and failures. Infant research and psychotherapeutic studies from the past two decades now make it possible to define for therapeutic analysis the manifestations of early contact traumas. A history and summary of the Listening Perspective approach to psychotherapy introduces the book. Contributing therapists: Bill Cone, Cecile Dillon, Francie Marais, Sandra Russell, Sabrina Salayz, Jacki Singer, Sean Stewart, Ruth Wimsatt, and Marina Young.

Remembering, Repeating, and Working Through Childhood Trauma: The Psychodynamics of Recovered Memories, Multiple Personality, Ritual Abuse, Incest, Molest, and Abduction (1994)

Infantile focal as well as strain trauma leave deep psychological scars that show up as symptoms and memories later in life. In psychotherapy people seek to process early experiences that lack ordinary pictoral and narrational representations through a variety of forms of transference and dissociative remembering such as multiple personality, dual relating, archetypal adventures, and false accusations against therapists or other emotionally significant people. "Lawrence Hedges makes a powerful and compelling argument for why traumatic memories recovered during psychotherapy need to be taken seriously. He shows us how and why these memories must be dealt with in thoughtful and responsible ways and not simply uncritically believed and used as tools for destruction." – Elizabeth F. Loftus, Ph.D. Nominated for Gradiva Best Book of the Year Award.

Working the Organizing Experience: Transforming Psychotic, Schizoid, and Autistic States (1994)

Hedges defines in a clear and impelling manner the most fundamental and treacherous transference phenomena, the emotional experiences retained from the first few months of life.

Hedges describes the infant's attempts to reach out and form organizing connections to the interpersonal environment and how those attempts may have been ignored, thwarted, and/or rejected. He demonstrates how people live out these primitive transferences in everyday significant relationships and in the psychotherapy relationship. A critical history of psychotherapy with primitive transferences is contributed by James Grotstein and a case study is contributed by Frances Tustin.

Strategic Emotional Involvement: Using the Countertransference in Psychotherapy (1996)

Following an overview of contemporary approaches to studying countertransference responsiveness, therapists tell moving stories of how their work came to involve them deeply, emotionally, and not always safely with clients. These comprehensive, intense, and honest reports are the first of their kind ever to be collected and published. Contributing therapists: Anthony Brailow, Suzanne Buchanan, Charles Coverdale, Carolyn Crawford, Jolyn Davidson, Jacqueline Gillespie, Ronald Hirz, Virginia Hunter, Gayle Trenberth, and Sally Turner-Miller.

Therapists at Risk: Perils of the Intimacy of the Therapeutic Relationship (1997)

Lawrence E. Hedges, Robert Hilton, and Virginia Wink Hilton, long-time trainers of psychotherapists, join hands with

attorney O. Brandt Caudill in this *tour de force* which explores the multitude of personal, ethical, and legal risks involved in achieving rewarding transformative connections in psychotherapy today. Relational intimacy is explored through such issues as touching, dualities in relationship, interfacing boundaries, sexuality, countertransference, recovered memories, primitive transferences, false accusations against therapists, and the critical importance of peer support and consultation. The authors clarify the many dynamic issues involved, suggest useful ways of managing the inherent dangers, and work to restore our confidence in and natural enjoyment of the psychotherapeutic process.

Facing the Challenge of Liability in Psychotherapy: Practicing Defensively (2000, Revised 2017)

In this litigious age, all psychotherapists must protect themselves against the possibility of legal action; malpractice insurance is insufficient and does not begin to address the complexity and the enormity of this critical problem. In this book, Lawrence E. Hedges urges clinicians to practice defensively and provides a course of action that equips them to do so. After working with over a hundred psycho-therapists and attorneys who have fought unwarranted legal and ethical complaints from clients, he has made the fruits of his work available to all therapists. In addition to identifying those

patients prone to presenting legal problems, Dr. Hedges provides a series of consent forms (on the accompanying disk), a compelling rationale for using them, and a means of easily introducing them into clinical practice. This book is a wake-up call, a practical, clinically sound response to a frightening reality, and an absolute necessity for all therapists in practice today. Now available in a revised and updated edition. Gradiva Award Best Book of the Year.

Terrifying Transferences: Aftershocks of Childhood Trauma (2000)

There is a level of stark terror known to one degree or another by all human beings. It silently haunts our lives and occasionally surfaces in therapy. It is this deep-seated fear often manifest in dreams or fantasies of dismemberment, mutilation, torture, abuse, insanity, rape, or death that grips us with the terror of being lost forever in time and space or controlled by hostile forces stronger than ourselves. Whether the terror is felt by the client or by the therapist, it has a disorienting, fragmenting, crippling power. How we can look directly into the face of such terror, hold steady, and safely work it through is the subject of *Terrifying Transferences*. Contributing therapists: Linda Barnhurst, John Carter, Shirley Cox, Jolyn Davidson, Virginia Hunter, Michael Reyes, Audrey Seaton-Bacon, Sean Stewart,

Gayle Trenberth, and Cynthia Wygal. Gradiva Award Best Book of the Year.

Sex in Psychotherapy: Sexuality, Passion, Love, and Desire in the Therapeutic Encounter (2010)

This book takes a psychodynamic approach to understanding recent technological and theoretical shifts in the field of psychotherapy. Hedges provides an expert overview and analysis of a wide variety of new perspectives on sex, sexuality, gender, and identity; new theories about sex's role in therapy; and new discoveries about the human brain and how it works. Therapists will value Hedges's unique insights into the role of sexuality in therapy, which are grounded in the author's studies of neurology, the history of sexuality, transference, resistance, and countertransference. Clinicians will also appreciate his provocative analyses of influential perspectives on sex, gender, and identity, and his lucid, concrete advice on the practice of therapeutic listening. This is an explosive work of tremendous imagination and scholarship. Hedges speaks the uncomfortable truth that psychotherapy today often reinforces the very paradigms that keep patients stuck in self-defeating, frustrating behavior. He sees sexuality as a vehicle for both therapists and patients to challenge what they think they know about the nature of self and intimacy. This book is a must-read for anyone

interested in understanding 21st-century human beings—or in better understanding themselves and their sexuality.

Cross-Cultural Encounters: Bridging Worlds of Difference (2012)

This book is addressed to everyone who regularly encounters people from other cultural, ethnic, socioeconomic, linguistic, and ability groups. Its special focus, however, is aimed at counselors, therapists, and educators since their daily work so often involves highly personal cross-cultural interactive encounters. The running theme throughout the book is the importance of cultivating an attitude of tentative and curious humility and openness in the face of other cultural orientations. I owe a great debt to the many students, clients, and friends with diverse backgrounds who over the years have taught me how embedded I am in my own cultural biases. And who have helped me find ways of momentarily transcending those biases in order to bridge to an inspiring and illuminating intimate personal connection.

Overcoming Our Relationship Fears (2012)

We are all aware that chronic tension saps our energy and contributes to such modern maladies as high blood pressure and tension headaches, but few of us realize that this is caused by muscle constrictions that started as relationship fears in early

childhood and live on in our minds and bodies. Overcoming Our Relationship Fears is a user-friendly roadmap for healing our relationships by dealing with our childhood fear reflexes. It is replete with relationship stories to illustrate each fear and how we individually express them. Dr. Hedges shows how to use our own built-in "Aliveness Monitor" to gauge our body's reaction to daily interactions and how they trigger our fears. Exercises in the book will help us release these life-threatening constrictions and reclaim our aliveness with ourselves and others.

Overcoming Our Relationship Fears: WORKBOOK (2013)

Developed to accompany Hedges's Overcoming Relationship Fears, this workbook contains a general introduction to the seven relationship fears that are a part of normal human development along with a series of exercises for individuals and couples who wish to learn to how to release their Body-Mind-Relationship fear reflexes. An Aliveness Journal is provided for charting the way these fears manifest in relationships and body maps to chart their location in each person's body.

The Relationship in Psychotherapy and Supervision (2013)

The sea-change in our understanding of neurobiology, infant research, and interpersonal/relational psychology over the past two decades makes clear that we are first and foremost a

relational species. This finding has massive implications for the relational processes involved in teaching and supervising psychotherapy. Clinical theory and technique can be taught didactically. But relationship can only be learned through careful attention to the supervisory encounter itself. This advanced text surveys the psychodynamic and relational processes involved in psychotherapy and supervision.

Making Love Last: Creating and Maintaining Intimacy in Long-term Relationships (2013)

We have long known that physical and emotional intimacy diminish during the course of long-term relationships. This book deals with the questions, "Why romance fades over time?" And "What can we do about it?" Relational psychologists, neuropsychologists, and anthropologists have devoted the last two decades to the study of these questions with never before available research tools. It is now clear that we are genetically predisposed to search out intersubjective intimacy from birth but that cultural systems of child rearing seriously limit our possibilities for rewarding interpersonal relationships. Anthropological and neurological data suggests that over time we have been essentially a serially monogamous species with an extraordinary capacity for carving out new destinies for ourselves. How can we come to grips with our genetic and neurological heritage while simultaneously transcending our

relational history in order to create and sustain exciting romance and nurturing love in long-term relationships? Making Love Last surveys research and theory suggesting that indeed we have the capacity and the means of achieving the lasting love we long for in our committed relationships.

Relational Interventions: Treating Borderline, Bipolar, Schizophrenic, Psychotic, and Characterological Personality Organization (2013)

Many clinicians dread working with individuals diagnosed as borderline, bipolar, schizophrenic, psychotic, and character disordered. Often labeled as "high risk" or "difficult", these relational problems and their interpersonal manifestations often require long and intense transformative therapy. In this book Dr. Hedges explains how to address the nature of personality organization in order to flow with and eventually to enjoy working at early developmental levels. Dr. Hedges speaks to the client's engagement/disengagement needs, using a relational process-oriented approach, so the therapist can gauge how much and what kind of therapy can be achieved at any point and time.

Facing Our Cumulative Developmental Traumas (2015)

It has now become clear that Cumulative Developmental Trauma is universal. That is, there is no way to grow up and walk the planet without being repeatedly swallowed up by

emotional and relational demands from other people. When we become confused, frightened, and overwhelmed our conscious and unconscious minds seek remedies to deal with the situation. Unfortunately, many of the solutions developed in response to intrusive events turn into habitual fear reflexes that get in our way later in life, giving rise to post traumatic stress and relational inhibitions…. This book is about freeing ourselves from the cumulative effects of our life's many relational traumas and the after-effects of those traumas that continue to constrict our capacities for creative, spontaneous, and passionate living.

Relational Listening: A Handbook

Freud's singular stroke of genius can be simply stated: *When we engage with someone in an emotionally intimate relationship, the deep unconscious emotional/relational habits of both participants become interpersonally engaged and enacted thereby making them potentially available for notice, discussion, transformation, and expansion*.

This *Handbook* is the 20th book in a series edited and/or authored by Dr. Lawrence Hedges and surveys a massive clinical research project extending over 45 years and participated in by more than 400 psychotherapists in case conferences, reading groups and seminars at the Listening Perspectives Study Center and the Newport Psychoanalytic Institute in the Southern

California area. The first book in the series, *Listening Perspectives in Psychotherapy* (1983), was widely praised for its comprehensive survey of 100 years of psychoanalytic studies and a 20th anniversary edition was published in 2003. But the important aspect of the book that the studies were organized according to four different forms of relational listening according to different levels of developmental complexity went largely unnoticed. Also generally unattended was the critical epistemological shift to perspectivalism which since that time has become better understood. The subsequent books participated in by numerous therapists expand and elaborate these *Relational Listening* perspectives for working clinicians. This *Handbook* provides not only a survey of the findings of the 45-year clinical research project but, more importantly, an overview of the seven developmental levels of relational listening that have consistently been found to provide enhanced psychotherapeutic engagement.

The Call of Darkness: A Relational Listening Approach to Suicide Intervention (2018)

The White House has declared suicide to be a national and international epidemic and has mandated suicide prevention training for educational and health workers nationwide. *The Call of Darkness* was written in response to that mandate and begins with the awareness that our ability to predict suicide is little

better than chance and that at present there are no consistently reliable empirically validated treatment techniques to prevent suicide. However, in the past three decades much has been learned about the dynamics of suicide and promising treatment approaches have been advanced that are slowly yielding clinical as well as empirical results.

In this book, Dr. Hedges presents the groundbreaking work on suicidality of Freud, Jung, Menninger and Shneidman as well as the more recent work of Linehan, Kernberg, Joiner and the attachment theorists along with the features in common that these treatment approaches seem to share. He puts forth a Relational Listening approach regarding the origins of suicidality in a relational/ developmental context and will consider their implications for treating, and managing suicidality. The tendencies towards blame and self-blame on the part of survivors raise issues of professional responsibility. Dr Hedges discusses accurate assessment, thorough documentation, appropriate standards of care, and liability management.

Terror in Psychotherapy: The New Zealand Lectures (2020)

Contemporary neuroscience, infant research, and relational psychotherapy make clear that we are a relational species—that our brain and neurological systems actually organize in the first year of life depending on the relationships that are and are not

available. By the second year of life a symbiotic interaction, characterized by mutual affect regulation and mutual attachment experiences, is becoming established. In Terror in Psychotherapy, Dr. Lawrence Hedges demonstrates how trauma experienced during these “organizing” and “symbiotic” levels of relational development stimulate fear, anxiety, and terror that have consequences for later relationships—in extreme forms laying the foundation for suicide and homicide. A series of case vignettes illustrate how early relational intrusive trauma produce terror in transference and countertransference experiencing.