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## TALKING WITH “ME” AND “NOT-ME”

A DIALOGUE

*Abstract:* This article explores the interface between the respective contributions of Richard A. Chefetz and Philip M. Bromberg in the area of trauma, dissociation, dissociative disorders, and clinical process. The viewpoint is offered that clinicians need an experience-near language that respects a multiple self-state model and is acceptable both to psychoanalysis and traumatology. Sharing with Sullivan the belief that we are all much more alike than we are different, Chefetz and Bromberg suggest that our theories and practices must be powerful enough to address both the conflictual pathology of everyday life and the self-pathology created by trauma and neglect. “Knowing feeling” is a prerequisite for interpreting lived experience. If affect is the centerpiece of human experience—at the core of memory and motivation—then affect-consciousness is a requirement for understanding self. Through the use of verbatim clinical material presented by Chefetz and their cross-commentary on it the authors explore the negotiation of an affective language for understanding and talking with “me” and “not-me”—self-states separated, protectively, by dissociation—and what modifications in theory and technique may be necessary to support this process of negotiation as part of every treatment.

*Keywords:* Dissociation, Affect, Self, Enactment, Subjectivity, Shame, Trauma

WHAT FOLLOWS is a revised transcript of what was originally an oral presentation. The event was prepared as a dialogue, with each of our offerings serving both as a means to present our own point of view and a response to what the other had just presented about his. The material appears in the order in which it was originally presented. In “Speaking for Myself,” we each outline our own clinical perspective on our common theme, “Talking with ‘Me’ and ‘Not-Me,’” a phrase we chose to indicate the central importance of working with dissociative processes as a routine aspect of every treatment. Next comes clinical

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material selected by Chefetz from his own work—a verbatim record, transcribed from an audiotape (originally played aloud to the audience) of a therapy session. The dialogue concludes with Bromberg’s commentary on Chefetz’s clinical material, followed by Chefetz’s reflections on Bromberg’s commentary. Chefetz’s final response also includes his own later reactions to his work.

Structuring this material as a dialogue came naturally. The two of us became acquainted by the accidental discovery (through a patient of one of us, who had heard the other speak at a conference and brought in the tape of the talk) that our sensibilities were remarkably similar to one another—so similar, in fact, that it took a little while for us to recognize that the languages we each used were not the same. The words come from different conceptual systems—Bromberg’s primarily from psychoanalysis, Chefetz’s more often from the field of trauma. Even when we recognized these differences, they gradually faded into a single larger and more meaningful context. That is, even though we were raised in different “families,” there is a unique commonality in the way we think about patients, about the mind, about human relatedness, and about what we do as therapists. The rising of that commonality out of what might otherwise appear to be difference is what we hoped to demonstrate by structuring the original presentation as a dialogue. The fields of trauma and psychoanalysis are inextricably linked through the concept and clinical process of dissociation, and the time is ripe for both fields to recognize this. This presentation was just such a recognition, underlined by the fact that the meeting was jointly sponsored by the William Alanson White Institute and The International Society for the Study of Dissociation (ISSD). As far as we know, this event marked the first time the White Institute has shared sponsorship with a “not-me” organization—a society of nonpsychoanalyst clinicians and researchers committed to a theoretical and clinical perspective with its own roots, its own frame of reference, and its own rightful claim to center stage.

**SPEAKING FOR MYSELF: PHILIP BROMBERG**

**The Therapeutic Action of “Safe Surprises”**

How is it that I, as a psychoanalyst, am so involved with something as traditionally “unpsychoanalytic” as dissociation, and have been for more than twenty years. The obvious reason is not the only one—that I was

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at least for a period of time, the most powerful source of growth for most patients came about through working *in* the field, as long as the patient's level of affective safety could be sustained well enough to permit it. For the deepest growth to take place, patients needed to allow themselves to be a "mess" *within* our relationship, and in order for me to truly know them, I had to become a part of the mess in a way that I could experience internally. During certain periods, Sullivan's stance was indeed therapeutic, but over the long haul it did not lead to what seemed most central to a patient feeling recognized. Patients seemed to need attention focussed on their state of mind *itself*, as a part of what went on between themselves and others. They needed something that approached what Sullivan advocated as an exquisite attention to detail, but where the details were experiential rather than objective events. These patients, at these times, did not need to be understood; they needed to be "known," to be "recognized." And most to the point, each self-state needed to be known and recognized in its own terms. My expression "standing in the spaces" eventually emerged as my shorthand way of formulating what many contemporary clinicians are, in their own metaphors, coming to frame as the essence of therapeutic action in any given treatment—a physical as well as psychological developmental process that helps bridge psyche and soma, affect and thought, and self-states that have been isolated through dissociation (Bromberg, 1998, 2003b).

**"Me and Not-Me" in Everyday Life**

Thinking about therapeutic action as a facilitation of the patient's capacity to stand in the spaces between "me" and "not-me" states of consciousness speaks to an aspect of the therapeutic relationship that powerfully echoes Sullivan's (1954) method of "detailed inquiry" in its effort to reconstruct reported events so precisely that "forgotten" interpersonal details of the patient's story will emerge, bringing with them a reexperiencing of the affectively distressing self-experience that often will have been dissociated. The difference is that Sullivan's attention was focused on the interpersonal field between the patient and some external other, whereas my own approach requires that this be contained within an *overarching* attunement to the ever-shifting intersubjective field between himself and his patient—their respective "me and not-me" activity. The goal is a dyadic, here-and-now reconstruction of this activity in such subjective detail that the patient's dissociated self-states, being affectively

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*enacted* as “not-me” elements in their relationship, become symbolically processed as part of “me.”

The way I work with dreams is an example. Most analysts know that in order for an “interpretation” of a dream to have more than cosmetic value, there has to be at least some self-state link between patient and “dreamer”—referring here to the affective reality that was the patient’s self while asleep. In other words, “associations” to a dream are valuable only to the degree they are affectively alive. It is from this vantage point that I look at the “reported” dream as a living event that can be potentially *reentered* during a session, rather than as a story told *about* an experience that happened when asleep. In this regard, I treat it in the same way that Sullivan’s traditional detailed inquiry enters waking life events by helping to reconstruct them in such experiential detail that the dissociated affect will be reexperienced in the here and now. The moments when such experiential linking of patient and dreamer become possible can’t be planned, but they can be encouraged. This way of working with dreams makes use of natural hypnoid processes, processes that are the foundation of dissociative mental structure (both in dreams and as a response to trauma).

I don’t attempt, as a rule, to do an explicit hypnotic induction, because I feel it important that my way of working with dreams is not inconsistent with the way I work in general with a given patient. If done with careful attention to the patient’s experience of what it feels like *while* we are engaged in dreamwork, the patient is often able to bring “the dreamer” into waking consciousness and into the room with relative safety.<sup>1</sup> By “bringing in the dreamer” (Bromberg, 2000)—a self-state different than that of the patient who “reports” the dream—the dream can be reentered by the “dreamer” as it is being told by the “patient.” Because the “dreamer” self-state is experientially very close to the way the dreamer existed while asleep, it facilitates the patient’s ability to stand in the spaces between self-states that include even those *normally* isolated dissociatively as part of the natural process through which waking consciousness is kept separate from dreaming consciousness.

I want to now share a story with you—a story I recently heard from a patient—that I think will serve well in bringing to life the phenomenon

<sup>1</sup> I am particularly indebted to Robert Bosnak whose 1996 book, *Tracks in the Wilderness of Dreaming*, provided me with the inspiration and courage to adapt his thinking to my own style of working. (Also see Bosnak, 2003; Bromberg, 2003c.)

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of “me and not-me” as it exists in all of us. My patient was about to get remarried in a few weeks and was driving his fiancée, a somewhat difficult lady who was in an even more anxious state than usual, to pick up her wedding dress. He entered an intersection just as the light was changing from yellow to red, and made one of those judgment calls. Bad move. A cop pulled him over and told him he went through a red light. He, naturally, said to the cop, “No I didn’t. It wasn’t red yet. Also,” he said, “we’re just about to get married. If you can give me a break, I’d really appreciate it.”

At that moment, his fiancée took over. “How can you say that? Of course the light was red! You know you went through a red light. How can you lie like that? How can you lie to a policeman?” As she went on and on, he was getting more and more enraged, but didn’t say anything.

When she paused for breath, the cop, who was listening to all this, leaned over to him and said, “I’m not going to give you a ticket. . . . if you’re marrying *her*, you already have enough trouble.”

As they drove off he said, still furious, “How could you have done that? How could you have been so mean to me?”

“You didn’t get a ticket, did you?” she replied.

He, in a state of total consternation, could barely get his words out: “You . . . you . . . you mean you did that on purpose?”

“Well . . . I’m not sure . . . Sort of,” she mumbled.

“Sort of.” If I had been a fly on the wall, my guess is she would have been looking into space as she said “sort of.” And though I don’t know what *he* looked like at that moment, I could easily imagine his eyeballs spinning. Eventually, when she was back to “herself,” she acknowledged that she was terribly sorry and ashamed at what she had done, and that she hadn’t done it on purpose. She also revealed that since childhood she has always been terrified of cops and “wasn’t herself” whenever she was around one.

For our purposes, the most interesting question is this: At the moment she was berating my patient in front of the cop, did her behavior come from what was felt as “me,” as opposed to “sort of?” I think so! Once the threat of the cop was gone and she was saying to her irate husband-to-be, “You didn’t get a ticket, did you?” the vituperous “me” of a few moments earlier became “not me” in this new state of mind. Clearly, she experienced no conflict at either point—a hallmark of dissociation. At each point, she experienced what she did as “right,” but in different ways. The one place she might have felt conflict was when he asked her

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if she did it on purpose. Her mind, however, couldn't contain the complexity of trying to bring the two self-states together long enough to reflect on their disjunction, so again she dissociated to avoid what was too much for her mind, this time to avoid the mental confusion created by a question that required her to reflect on the possibility that *both* were “me.” In response to “You mean you did it on *purpose?*” all she could do was offer a nonreflective, “sort of.”

I'm sharing this story to put it on record early that I see dissociation as a normal function of the human mind and ubiquitous in every human relationship.<sup>2</sup> Stimulated by Putnam's (1988, 1992) research findings, much of which supported my own clinical experience, I proposed (Bromberg, 1993) that

self-experience originates in relatively unlinked self-states, each coherent in its own right, and the experience of being a unitary self is an acquired, developmentally adaptive illusion. It is when this illusion of unity is traumatically threatened with unavoidable, precipitous disruption that it becomes in itself a liability, because it is in jeopardy of being overwhelmed by input it cannot process symbolically and deal with as a state of conflict. [p. 182]

In such situations of trauma, the mind, if able, will enlist its ability for normal dissociation as a protective solution to assure self-continuity. It suspends linkages between cohesive self-states, preventing certain aspects of self (along with their respective constellations of affects, memories, values, and cognitive capacities) from achieving access to the personality within the same state of consciousness.

Here's another story, arguably less dramatic but, in another way, more powerful because the subject is *me*. While writing the preceding vignette, I recalled a moment that took place in my late teens with a girlfriend I was seeing at the time. She would frequently complain that I never told her I loved her, my response to which was to find myself hundreds of miles away and speechless. One day, in the midst of our having a particularly great time together, she looked at me and said, “Tell me you love me. *Lie* a little.”

<sup>2</sup> Daniel J. Siegel (1999), in a powerful and lucid synthesis of subjective experience, neuroscience, and the interpersonal context of self-development, dramatically supports this view of the mind as a multiplicity of internally cohesive self-states that in any given individual defines its own pathology by its relative inability to access its full range of relational flexibility (pp. 229–230; 237–238).

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At that moment, something totally unexpected happened. I *felt* love, and I told her so. It was as if I was released from a dissociative paralysis created by a “not-me” state whose function was to wave a danger flag to keep me from being trapped by something I might not see until it was too late. This time it was different. I’m sure it was because when she said, with humor, “Lie a little,” this “protector” part of me felt validated—as if she spoke to me with the part that felt *entitled* to have serious reservations in mind. I remember this incident because it not only improved my relationship with that girl, but it helped me in all the relationships that followed. Right! It didn’t lead to our getting married and living happily ever after.

**The Mind, the Brain, and the Self**

To best understand how these stories are relevant to the topic of this conference—talking with “me and not-me” in clinical practice—it might be helpful for me to make a few observations about the development of human communication and the relational context that facilitates its more-or-less normal outcome.

Let me start with a brief overview of what seems to take place at the brain level in relation to a person’s subjective experience of “self” and “other.” Research by cognitive science and neuroscience points more and more convincingly toward the fact that there are parallel, but functionally dissimilar, information processing modes in the brain that have implications for understanding the complexity of subjective self-experience. For example, LeDoux (2002), in neurobiological terms, suggests that the enigma underlying multiple selfhood reflects a parallel enigma in comprehending brain processes. He states, “different components of the self reflect the operation of different brain systems, which can be but are not always in sync . . . allowing for many aspects of the self to coexist” (p. 31). The first processing system, mediated by the brainstem and the limbic system, primarily the amygdala and hippocampus, is responsible for nonverbal encoding of emotion. The second, mediated by the neocortex, is in charge of verbal and representational symbolization of experience. How to get the two systems to collaborate when they don’t want to is the neuroscience version of the clinical question: How do we, as clinicians, talk with “me and not-me” so as to enable them to increasingly talk with each other as an internal process?

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information, which it then passes on to areas in the brainstem that regulate the autonomic and hormonal systems. It then transmits this to the hippocampus, the function of which is to integrate this information with previously existing information and with cortical input. Under ordinary conditions of amygdalic arousal, the event is then processed by the hippocampus, which transforms the experience into a thinkable event by first “filing” it (van der Kolk, 1987) within cognitive schemas to which it is linked. If all goes well, increased *cortical symbolization* increases, and a traumatic situation can more easily be distinguished perceptually from one that may contain certain similarities, but is otherwise relatively benign. As we know, however, all does *not* always go well.

One reason is that the cortical symbolization of experience is divided between a more sensory-based right-brain function, and a linguistically based left-brain function. To the degree this is accurate, then right-brain encoding, more mediated by the amygdala, tends to function most dramatically when the person is in an emotionally overwhelming state. When emotional life is calmer, the hippocampus is better able to get the information it needs, to associate it to a storehouse of knowledge in the left frontal lobes and other neocortical locations, and to assist in the creation of spoken narrative. Schore (2003) notes that “right brain attachment mechanisms are expressed within the regulating and dysregulating emotional communications of any dyad, including transference-countertransference interactions that lie at the core of the therapeutic alliance” (p. 43). He goes on to say that “any successful treatment must optimally access not ‘the trauma’ but the immature biological systems that inefficiently regulate stress, *especially the right brain survival mechanism, dissociation, that is characterologically accessed to cope with dysregulating affective states*” (p. 42, emphasis added). Along with many psychoanalytic clinicians, Schore then cites the mechanism of projective identification (a core element in the process of enactment) as a major “subsymbolic” channel of communication that, neurobiologically, represents right-hemisphere-to-right-hemisphere communication between child and parent, as well as between patient and therapist. He writes, more or less endorsing my *own* position, that this form of subsymbolic communication “may be the only way that *infants* or severely traumatized persons can communicate their stories of distress” (p. 43).

Developmentally, the course of events seems to go something like this (though this is an admittedly oversimplified account). Before the onset of speech, parent-child communication takes place through affectively

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regulated patterns of relational interchange—familiar, repetitive patterns of interpersonal experience that become known and remembered through what has come to be called “procedural memory.” These early interpersonal modes of relating form the child’s affective core of personal identity—a highly concrete, attachment-based foundation of self-experience on which more flexible self-development will be built. As Lichtenberg (2003) succinctly notes, “significant communication begins before an infant has the language for either an inner monologue or outward speech” (p. 498). The enduring power of this preverbal phase of self-development, he writes, cannot be overemphasized, because “failure to communicate the recognition of a baby’s humanness (subjectivity) and essential uniqueness will impair the development of that baby’s attachment . . . and his or her sense of self” (p. 499).

With the onset of verbal language, words become a new medium through which communication takes place, but until about age three, the use of words is itself highly concrete and does not immediately develop into the use of language symbolically. For a while, words are really just a new form of affective communication and serve primarily as carriers of personal feeling—a new medium for the child to express what he feels and what he needs. So, even though he now uses words, the child is still communicating subsymbolically (Bucci, 1997, 2003) through the relational experience—not through the content of the words, but through the emotional impact on the mental state of the parent that the child makes *while* he is speaking the words. If the parent is emotionally accessible to the child’s communication, his or her meaning is not as much “understood” as it is affectively “recognized,” though not yet symbolized by words. Through the parent’s reciprocal affective aliveness to the child’s vocal and gestural efforts to communicate his or her emerging sense of self, while simultaneously offering verbal language that is in sync with the shared affective context, a give and take develops that comes to include exchanges of verbalized symbolic meaning tied to the child’s sense of core identity.

Some parents, however, because they do not wish (or are unable) deal with the child’s subjectivity if it is not in sync with their own, are *not* emotionally accessible and dissociate their child’s here-and-now impact, if it reflects a self-state in the child that they experience as too destabilizing to their own sense of self. In other words, the parents react to their child as if his or her state of mind at that moment had *no meaning*—leading to a weakening of the child’s ability to hold and express certain

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of its own self-states as a communicable “I.” When this happens as a steady diet, there’s trouble ahead. It leads to the birth of “not-me” aspects of self: dissociated self-states (or selves) in the child that persist into adulthood and come to our attention as therapists if we are open to their presence through repetitious enactments into which we are drawn—a not unfamiliar experience for most therapists

Around age three, words normally become more than carriers of affect; they become building blocks in the construction of personal meaning through shared symbols. Developmentally, words are no longer only an emotional expression of what you feel, but can now be used symbolically. They can now convey who you *are* as part of conveying what you feel and what you need. The earlier, affectively organized modes of self-experience, however, do not die when symbolic speech is born. Subsymbolic affective communication continues to participate in meaning construction throughout life. This is why we best understand what someone *means* by what he is “saying” when we’re affectively engaged while he is saying it. We have greater access to the affective communication taking place as the words are spoken. This is why in my first vignette I imagined that if I had been a fly on the wall, I would have seen my patient’s girlfriend looking into space as she said “sort of.” My sense was that she dissociated from the highly charged here-and-now confrontation with her boyfriend and that her words “sort of” were empty of meaning, other than to convey she had “disappeared.”

For the relational construction of self-representation to take place securely, as part of the process of being socialized through language, the child must be validated as who he is in the moment and through his transitions between his self-states. If this fails to happen, then words are felt as untrustworthy and empty—both the child’s own words and those of others. Developmentally, the main reason seems to be the failure to carry symbolized self-experience through state-change transitions. If a child is confirmed as existing to a parent only in certain states, then the natural continuity of “me” from one state to another is rendered impossible, or at least is seriously disrupted.

#### Dissociation as Adaptation, Creativity, and Protection

I’ve described the self as a multiplicity of “self-states” that during the course of normal development attain a feeling of coherence that overrides the awareness of their discontinuity. I’ve argued that the human capacity for creative living is based on the intrinsic multiplicity of the self

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and the “ability to feel like one self while being many.” As an analyst, I find it delightful whenever I find this supported by people whose lives are dedicated to creativity, and I thought it might be interesting to present an excerpt from a book written by a rather well known performing artist and drama teacher, Kristin Linklater (1997). No matter how often I read this, it still has a powerful impact on me.

There is a . . . style of teaching that . . . says “you become a character and for a brief moment on stage you escape from yourself.” The notion of losing myself in a character implies that the character is bigger, more estimable, more exciting than *I* am, while the idea of *finding the character in myself* suggests that I am multi-faceted and illimitable, and that each character I play finds the roots of its truth in the fact that *I am All as well as One; that from my wholeness I can create multiplicity*; that I have the capacity to understand the natures of all people and can become any of them *by expanding the seed of my understanding until it dislodges and rearranges the ingredients of my personality and a different part of me dominates*. This temporarily dominant characteristic proceeds to rearrange my physical and vocal behavior as I develop a character that is rooted in truthful experience because it is rooted in me, and . . . is unrecognizable to my familiar self. [p. 6, emphasis added].

O.K. . . . where do these other selves “go” when we’re not noticing them? Right; you already know the answer. They don’t “go” anywhere. They are just kept from interfering with what is going on at the moment and this is a normal part of everyday mental functioning—like being free from thinking about a difficult meeting with your boss tomorrow while you are playing with your kids. They are watching and always “on call,” if needed. They are dissociated, but only temporarily, and not fundamentally as a defense against trauma. It is, however, dissociation as a defense against trauma that *is* of most interest to working clinicians.

The mind employs dissociation both as a mental *process* (a defense against destabilizing affective flooding it cannot regulate or escape) and as a mental *structure* (a proactive “early warning system” against the recurrence of an experience that exists mainly as an affective memory held by the body, that the mind is never quite sure really happened in the first place). It is this latter use of dissociation as a mental structure to which Sullivan was referring, in his own way, when he formulated the “me” and “not-me” distinction. Listen to Sullivan’s (1953) wonderful comment on the issue of where do the “not-me” parts of you go?

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Dissociation can easily be mistaken for a really quite magical business in which you fling something of you into outer darkness, where it reposes for years quite peacefully. This is a fantastic oversimplification. Dissociation works very suavely indeed as long as it works *but it isn't a matter of keeping a sleeping dog under an anaesthetic*. It works by a constant alertness or vigilance of awareness, with *certain supplementary processes* which prevent one's ever discovering the usually quite clear evidences that part of one's living is done without any awareness. [p. 318, emphasis added].

Sullivan is speaking of supplementary processes that allow a person both awareness and vigilance, without being aware of the awareness—that is, without “me” knowing about “not-me.” It is the primary nature of traumatic experience to “elude” our knowledge, except physically and affectively, because of the formation of psychic structure into “me” and “not me”—a dissociative gap, by virtue of which the mental experience of what was unbearable is relegated to a part of the self that is unlinked from what is preserved as a relatively intact “me.”

The thing is, this describes *many* people who end up in our offices, not only those diagnosed with dissociative disorders per se, but people with personality disorders, including borderline personality, schizoid disorder, obsessive-compulsive disorder, bipolar disorder, narcissistic disorder, paranoid personality, hysteric personality disorder, even schizoaffective disorder. It's my view that the one overarching clinical issue that embraces the differences in character diagnoses is that we, as clinicians, must find ways to talk with all dissociated parts of the self, so as to enable them to increasingly talk with each other as an internal process—to enable the parts to slowly collaborate, even though the person has spent a lifetime protecting his or her safety by making sure they don't.

As we know all too well, it is never simply a matter of getting a patient to “confront” dissociated self-experience, especially “memories.” Even when the effort may seem to have been successful, the emergent awareness of something from the past does not necessarily lead to a thinkable experience of what has been confronted, much less an experience available to self-reflection. What keeps unsymbolized experience so rigidly unyielding to cognitive understanding and reflection is that it is organized around elements more powerful than the evidence of reason—what the Boston Change Process Study Group refers to as “implicit relational knowing” (Lyons-Ruth et al., 2001). They offer the view, increasingly sup-

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ported by other researchers and clinicians, that it is the relational *process* of communication in a therapy session, rather than the *content* of the session, that is the foundation of a patients growth in therapy psychoanalysis included. In other words, contrary to the long-held axiom of classical analytic theory about making the unconscious conscious as a necessary condition for change, evidence is accumulating that “process leads content, so that no particular content needs to be pursued; rather the enlarging of the domain and fluency of the dialogue is primary and will lead to increasingly integrated and complex content” (p. 16). This does *not* mean that content is unimportant; rather, it is in the relational process of exploring content that the change takes place—not in the discovery of new content per se. The “content” that is traumatic, is embedded in relational experience that is itself part of the content, and this unsymbolized relational experience is relived by being enacted repeatedly between patient and therapist as an intrinsic part of their relationship. As Susan Sands (1994) has put it,

when one seems to be doing primarily “memory work,” the memories are often in the service of the transference rather than vice versa; that is, the recovery of memories may allow the patient to get closer to or more distant from the therapist, may ‘test’ the therapist’s ability to understand and respond to various need states . . . or may pose any number of other “questions” regarding the relationship. [p. 150]

What makes it possible, through a relationship, to link two functionally dissimilar information processing modes in the brain? My answer is a “safe enough” interpersonal environment to permit an enacted replaying and symbolization of early traumatic experience, without blindly reproducing the original outcome. It is through this process that I believe the dissociated ghosts of “not-me” are best persuaded, little-by-little, to cease their haunting (Bromberg, 2003b) and participate more and more actively and openly as an affectively regulatable self-expression of “me.”

What analysts call the “unconscious communication process of enactment” is, from this vantage point, the patient’s effort to negotiate unfinished business in those areas of selfhood where, because of one degree or another of traumatic experience, affect regulation was not successful enough to allow further self-development at the level of symbolic processing by thought and language. In this light, a core dimension of the

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therapeutic process is to increase competency in regulating affective states without pointlessly triggering the dread of retraumatization.

Speaking *about* a part of the patient’s self to another part is an inherent aspect of the work, but it inevitably leads to an enactment with the part of the patient’s self we are speaking about—and we are never in command of our ability to anticipate it. Of necessity, we are always most alive to the part of the patient’s self with which we are relationally engaged at the moment, until the enactment begins. There’s little doubt that enactments happen long before they reach the threshold of our awareness. I think it is safe to assume they begin at whatever point the part of the patient’s self we are speaking *about* begins to feel ignored relationally because we are not affectively alive enough to it. When we speak of a self that is listening—a “hidden observer” (cf Hilgard, 1977)—what we mean by “listening” is a part of the self that is affectively reacting to the session in a manner that is not being processed through the patient-therapist relationship as the session is taking place, and therefore cannot directly be engaged until it “comes out,” as many therapists working with D.I.D. patients call it. Not-me selves always come out, however, in ways that are discernable, even when they are not organized in the form of alter personalities as in D.I.D. They come out as a subsymbolic affective experience that is received affectively by the therapist who sooner or later notices something peculiar going on—most often in himself. The dissociated part of the patient’s self holding the unsymbolized experience is not in relationship with the therapist, and until the therapist feels its impact as an experience linked to a part of *himself* that has been dissociated, it stays *lost* and its existence remains enacted. Only when the therapist (often against his will) feels the enacted voices of his patient’s dissociated self-states as alive in himself, is there hope of those parts being found. Through being recognized by another mind that is affectively alive to it and affectively engaging it, the patient’s wordless experience of being hopelessly trapped in an internal prison begins to be raised to the level of thought.

#### Safe Surprises

At the 2002 Division 39 conference in New York City, I shared a panel with a cognitive researcher (Wilma Bucci) and a neuroscientist (Joseph LeDoux). The concepts of dissociation and the multiplicity of self, and the implications of these ideas for psychoanalytic theory and practice,

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were explored at length. Bucci, at this meeting, discussed the clinical ramifications of her research findings (Bucci, 2002), which led her to the conclusion that Freud's repression-based conception of the therapeutic action of psychoanalysis was in need of serious reconsideration. Bucci writes that "the goal of psychoanalytic treatment is integration of dissociated schemas" (p. 766), and "it follows that concepts such as regression and resistance need to be revised as well" (p. 788). Bucci offered the view that the goal of psychoanalytic treatment depends on the connection of components of emotion schemas that have been *dissociated*, and this requires activation of subsymbolic bodily experience in the session itself in relation to *present interpersonal experience* and memories of the past. Resulting from this panel, Bucci and I have recently published papers (Bromberg, 2003a; Bucci, 2003) focussing from different vantage points on the clinical fact that in order for what is dissociated to *become* symbolized and available to participate with other self-states in internal conflict resolution, a link must be made in the here and now between the mental representation of an event that resides in short-term or working memory and a mental representation of the self as the agent or experiencer. In therapy, the more intense the fear of triggering unprocessed traumatic affect, the more powerful are the dissociative forces, and the harder it is for episodic or "working" memory to cognitively represent the here-and-now event that (in the therapy itself) is "triggering" the affect, or to access long-term memories associated with it.

Even in routine analytic work, telling "about" oneself leads surprisingly frequently to a dissociated reliving of frozen self-experience that was too much for the mind to contain, and remained unprocessed as affective or somatic memory. To use this therapeutically requires sufficient relational safety to free working memory while the activation of painful dissociated experience is taking place. The issue of a patient's affective "safety" is a complicated one, and a source of much debate and discussion in the trauma literature. I've proposed that safety and growth are part of the ongoing negotiation of the analytic relationship itself, and that the basic principle involves what a given patient and analyst do in an unanticipated way that is *safe but not too safe*—an analytic approach that works at the interface of stability and change, through a replaying of the relational failures of a patient's past as *safe surprises*.

"Not-me" is engaged when the experience reaches the threshold of our awareness. But, for a while it is *dis-engaged*—dissociated by us—to

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keep it from becoming disruptive to the "work." Ironically, our patient helps us dissociate her "not-me" voice. She hates that part of herself more than *we* come to hate it when we access our own "not-me" feelings, but we hope we eventually stay long enough with those feelings to recognize that they are private, but that does not make them our "private property." Our own "not-me" feelings are at the heart of the work providing we allow them to be, but using them relationally is neither easy nor neat. Rather, it is a process of typically messy, nonlinear spurts, closer to "lurching ahead" than to the more euphemistic term "growth." During this process, the source of therapeutic action is in the therapist's ability to relate fully to whatever aspect of self the patient is experiencing and presenting as "the real me," while not forgetting to let the other, more dissociated parts know he is aware that they too exist and are listening.

The challenge for the analyst is to make what is enacted useful analytic material, and as this happens, both analyst and patient derive more and more of their knowledge from verbal and nonverbal sources simultaneously. As words are found and negotiated between them, the traumas of the past become "safe surprises" in the present, and facilitate the patient's growing ability to symbolize and express in language what she has had no voice to say. The goal is for the patient to move, slowly and safely, from a mental structure in which self-narratives are organized primarily dissociatively, to one in which she is able to cognitively and emotionally stand in the spaces between self-states, experience them conflictually, and find new and more flexible ways of being simply human.

#### SPEAKING FOR MYSELF: RICHARD CHEFETZ

##### "Diss-ing" the Self

We are going to talk a lot about Diss-ing today, though not the kind that New Yorkers usually think about. And we also talk about Self. Actually, few people in psychoanalysis seem to be able to agree on a definition of Self. There is a lot of heat, but not a lot of light about the overarching concept of Self. That probably has some meaning, but it may be more a reflection on psychoanalytic theory than on Self. Whether or not we can agree on technical definitions, we must still figure out how to talk to our patients about their Selfhood, Self. Our patients are people who are not so tortured as we are about the definition of what everyday

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people would call Obvious: “My Self. You know, Me, the Person I am.” The *Oxford Dictionary* says “Self: a person’s own individuality or essence.” My very own essence. My Self.

A fundamental belief regarding me and my essence is that I will do anything I need to do, consciously or unconsciously, to protect and maintain the safety of my essence. Would you do any differently? Of course, my thoughts are of those things I would consciously do to protect myself; or should I say “my Self?” I wonder what I would have done to protect my Self before I knew I had a Self and before I knew I was an “I?” How would I know what my essence was before I knew how to spell “essence,” or before I knew that there was a thing called “spelling?”

Just like the two- or three-year-old child who learns, for the first time to say “No,” we may get more mileage in considering Self if we allow ourselves both the convenience of not fully understanding what my Self is, and at the same time assert with conviction what Self isn’t. That’s not who I am. That’s not me. Not-Me! I am not jealous, envious, sarcastic, hurt, intimidated, controlled, humiliated, disrupted, annihilated. . . . Not-Me! Not-I! Then who am I? I don’t know, but I know That is “Not-Me!”

I disavow and disown. I deny and dismiss. I ignore and avoid. I even pretend and distract. Sometimes I do these things without realizing I do. And when the chips are down, and these other things fail to keep my Self safe, then I diss-ociate; I depersonalize, derealize, and forget, or I confuse, and alter my identity to such an extent that I (or should I say, Me, My Self, and I?) become unrecognizable to Me. I become Not-Me! And it is a real loss to then lose track of Me, but at least my Self is safe, wherever or however or whoever I (should I say “It,” in the depersonal sense?), my essence may be.

When I am Diss-ed via Dissociation, then “I” am safe in my lostness, my safe numb protected-ness. And this is true until I grow much older and there is not so much need for lostness and nothingness of being. Then I may find myself in pain over my numbness, and long to be alive, fully alive, essence-ially speaking, that is.

And so, when our patients come to us with their problems for us to shrink, to make their problems smaller and more manageable, we must learn to talk to each Me who comes for a visit, and to attend to all the Not-Me aspects of those Selves who crowd the room, dissociatively and disavowedly, and push the conversation to and fro (should we call this “transference?”). We hope, between those Me’s and Not-Me’s “I” bring to

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the session (should we call this "countertransference?"), and those Me's and Not-Me's of my patient, there will be room for all of Us.

Having gone without defining "self," can we afford to avoid defining "state?" But what are we talking about, state? It seems like we are talking about a "state of mind," "state," for short. Siegel (1999) writes, "A state of mind can be proposed to be a pattern of activation of recruited systems within the brain responsible for (1) perceptual bias, (2) emotional tone and regulation, (3) memory processes, (4) mental models, and (5) behavioral response patterns" (p. 211). Beyond the need of a definition of a state of mind is the need to move from the neurological perceptual level to that of the personal and interpersonal. What Siegel calls "specialized selves" is the closest I have come to finding a theoretician who writes about what a relational psychoanalyst or traumatologist would call a self-state:

The proposal here is that *basic states of mind are clustered into specialized selves, which are enduring states of mind that have a repeating pattern of activity across time.* . . . Each person has many such interdependent and yet distinct processes, which exist over time with a sense of continuity that creates the experience of mind. [p. 231]

If Siegel had gone just a little bit further, he might even have written, "that creates the experience of Mind, or Self." I think, however, he was too wise to do that.

Wise or not, we are stuck with the clinical observations that arise when we become sensitized to the presence of unintegrated Not-Me thoughts and feelings in our patients. These Not-Me self-states contain essences like unspeakable terror from physical abuse, unknowable crushing humiliation from chronic emotional dismissals, and unthinkable thoughts from murderous rage or jealousy. We can see the trajectory of these presences streak across our field of vision in cloud chambers with names like eating disorders, substance abuse, sexual addiction, sadomasochism, and many others. These action filled lives are conducted as if there were often no "driver" in the body of the person sitting with us and telling their story. Disavowal, denial, confusion, amnesias, despair, shame, and humiliation slowly and relentlessly beat the fragile, nearly nonexistent self-esteem of these patients within an inch of suicide, routinely. Often, beneath this symphony of negativism and obfuscation rests a layer of

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dissociative processes that guard terrifying, essence-threatening, Not-Me thoughts, feelings, behaviors, and physical sensations. We have to be willing to talk with the Not-Me self-states in our patients, and we have to help these self-states to become part of consciousness, part of what is consciously considered during moments of reflective awareness and decision making. Unless we ask our patients about dissociative experience, we are as lost as our patients. And we must challenge ourselves to become conscious of the Not-Me's in each of us that resonate and respond to the Not-Me's in our patients.

I would like to make a plea here for specificity in understanding these processes, many of which rely on dissociative mechanisms. To me, saying that someone "dissociates" is not clinically useful unless it is used in the broad generic sense, such as "she is so dissociative" or "his dissociative symptoms became more prominent." To say someone "is dissociating" is to know little about a person. To say that the intensity of depersonalization experience increased, or she experienced herself drifting away from the room as a fog closed in, or she entered a spontaneous trance state, or she became confused about her identity, moves closer to the patient's actual experience. It also helps a person to understand the meaning of her experience as a marker of inner distress. We do well to track the extent of feelings of disorganization or disorientation as a result of provocative levels of emotional distress, and to use the specificity of words like "depersonalization" or "derealization."

I do not want to give you the impression that I have been talking only about persons with dissociative identity disorder. Yes, it is true, I could be doing that, and doing that accurately. The truth is that I am talking about processes that always exist in all of us. We all have Not-Me self-states. Isn't that a basic premise of relational psychology? I am suggesting that states of mind are the building blocks of self-states. The association of states of mind into larger aggregations called self-states provides us a feeling of Self-ness, and a sense of coherence of this aggregate of self-states called "Me." This very personal assessment relies on appraisals of the continuity, consistency, congruence, and cohesion of our identities over time. I come back to this later.

How do you recognize the presence of a self-state in a patient who hides this Not-Me-ness from his or her consciousness in the first place? Stop, look, and listen. What do we see if we stop, and focus our attention on looking at our patients? We see that shifting from one set of thoughts and feelings to another is accompanied by a physiologic change of state

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that parallels the thoughts and feelings. Like the musical score of a movie, the memory of a thought or a feeling is encoded with contextual physiologic accompaniment. If we want to know about unconscious process, then we need to become keen observers of our patient’s physiology and the associated bodily changes. Typical representative changes are: change in body position, shift in facial expression, shift in eye gaze, eye closure, swallowing, and skin flush. I include tears that flow onto cheeks and tears that well up but do not flow, finger, ankle, or other repetitive movement (both onset, and ending), rooms that suddenly get too hot or too cold, and so on. All of these are often readily observable, especially if you can see your patient. If you can’t see your patient, then you won’t see these icons of state change. You may be lucky, from time to time, to catch a change in the quality of your patient’s voice or speech cadence. But you will never hear her “goose bumps” stand up and say “look at me!” You may never notice that their yawn is dysphoric and representative of involuntary motor activity in response to terror. Your patient will have to report these things to you. You have to look at and see your patient’s whole body to catch this information. If we are to observe the parade of self-states in our patients, then we must do more than rely on time-honored linguistic signs of intrapsychic conflict, beyond such events as “slips of the tongue.” But even with more sophisticated attention to verbal double meanings, dream analysis, and so on, you will fail to bring into view a lot of Not-Me’s if you ignore the basics of the experience of affect, bodily state, and facial expression. The language of the body is the basis for speech. Most recently, Damasio (1999) has written compellingly about the neurologic basis of conscious awareness and its reliance on the soma for its organization. So, the first step in discerning Not-Me states is to engage in a “close-process” observation of your patient’s bodily state.

If you do sit behind your patients, there is one other source of their physiologic state that you might notice: your own previously unconscious physiologic reaction. Call it the “physiologic countertransference,” if you like. If you can tolerate such scrutiny, then take the changes in the experience of your body as indicating that something in your thoughts and feelings has shifted in response to something happening in your patient—something about your Not-Me and their Not-Me. Would you be more comfortable thinking about projective identificatory processes? I can accept that. Be careful to remember that nothing was put into you, it was already there. Your own Not-Me simply became active in reso-

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nance with the unconscious recognition of a “fellow” Not-Me in an Other. Get to know your Not-Me’s. Some of my own Not-Me’s have become very close friends, over time.

The second step in discerning a Not-Me state is to ask your patients about your observation of them. Ask things like: “Something just went by on your face. Did you notice that too? Check in your body for sensation. What do you notice? Look with your Mind’s sensing your Mind’s eye. Is there an image, a sound, a sense of something different—a thought, an idea? What do you notice?” You don’t need fancy techniques to do this, just a willingness to inquire. These kinds of questions are at the core of much of the cognitive technique in EMDR and hypnosis. You don’t need fancy technical knowledge to ask about experience. If the patient is receptive to your question, if there is a good alliance, these questions are likely to be productive.

The third step takes place over many sessions. Fill in the narrative that goes along with the sensations, thoughts, affects, behaviors, and aggregate of states of mind that are consistent with the self-state. The only problem you will have is that the better you get at this with your patient, the more quickly the dis-aggregate becomes an aggregate. That makes it harder to recognize the separateness of the self-state, which is not a terrible problem because that is a sought-after goal.

The fourth step in discerning a Not-Me state is to develop reflective awareness for its appearance in everyday life. The self-state experience needs to be framed as it is, an important, useful, though perhaps antiquated aspect of self, relying on old, potentially inaccurate perceptions and conclusions about the world. Yes, this is a cognitive-psychoanalytic view. It does not preclude the analysis of transference or countertransference, and in many ways relies on this understanding to proceed.

The fifth step is to bring together the full context of the self-state, the physiologic sensation, emotion, knowledge, and behavior that describes the constellation of this part of the dis-aggregate Self. Patients who report their experience in a detached manner have not reached this step. Fear of affect may be a prominent impediment. Affects used as tools to avoid, distract, or preoccupy often block this achievement. This use of affect may be conscious or unconscious, and in any event, needs to be understood and appreciated for its self-defeating, creative protection from deeper states of intense, feared affect.

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this has on living a life. Appreciating the change, and noticing the effect, cements the previously disparate self-state to the rest of conscious awareness and self-identity. Not-Me has become Me.

Parallel to this experience in the patient is the experience, in the clinician, of change in Self in relation to the patient. What has this patient taught me about my Not-Me states? Do I feel differently now as I wait for them to attend their session? Do I negotiate my work with other patients differently because of what has happened with this patient? To be unaffected by our patients is not to have met them.

### Isolated Subjectivity

I want to add one more idea, so that those of you who like consistency of terminology will have something to take home with you that fits in your psychological tool kit. I simply want to notice that what we have been talking about, to a large extent, is alteration in subjectivity, Me and Not-Me. This is immediately obvious at face value. What is not so obvious is that when we use a word like subjectivity, we are thinking at a level of abstraction that involves the confluence of multiple self-states. When a self-state is in a Not-Me relation to Me, then just like affect that is isolated, the self-state(s) has(ve) a quality of not being known. This is what I mean by isolated subjectivity.

If you can accept this idea of isolated subjectivity, then maybe you can also consider that this is what we see in the more extreme cases of robust dissociative processes: isolated subjectivity, personified. The personification is intensified by dissociative experience of depersonalization, derealization, and amnesia. With this reinforcement there is not any experiential doubt about the Not-Me quality of Self, for instance, cutting the dissociatively numb arm of a Not-me self-state (which raises the important point that there is always a *multiplicity* of Not-me self-states)

When there is isolated subjectivity, then just like the situation of isolated affect, the essence of Self is kept hidden, and the aggregate of self-states and subjectivities is less coherent. This incoherence is a fabulous unconscious tool for obscuring thoughts, feelings, sensations, and behaviors! The mind becomes a repository for seemingly disparate parts of life's experience, a desperately rigid maze of hedges filled with psychic thorns that unconsciously poke, prod, and consume so much mental energy that there is little left over for living each day. How sad. How exhausting!

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We can understand the ways in which isolated subjectivity contributes to impairing our ability to live by looking at some qualities of experience mentioned earlier: continuity, consistency, congruence, and cohesion. Each of these qualities is associated with its opposite, as in “congruent-incongruent.” But we have a problem: “cohesion” has no opposite, there is no “incohesion.” This is more than a linguistic issue. “Cohesion” actually describes a continuum, more or less cohesion. Some people use the word “fragmentation” to explicate the lack of cohesion. But what fragments? This presupposes a “wholeness.” If something lacks cohesion, then what are the elements that are separated? We have no good definition of a whole Self and no evidence for it, even though we have a wish to think of ourselves as whole. There is, however, a lot of evidence for states, leading me to suggest the term “aggregation-disaggregation” as a much more parsimonious choice of language. This word-pairing, which emphasizes an active dialectic between states more than it does stasis and breakage, evokes imagery that Pierre Janet would find appealing. After all, it was Janet (1889, cited in Erdelyi, 1994, p. 5) who originally described the appearance of dissociative states as a disaggregation of the personality—a description that has clear implications for the essence of Self being a lumpy, bumpy aggregate, rather than a cohesive, orderly entity.

The feeling of “getting myself together” aggregation, is accomplished when I have a memory that I am the same self I was yesterday: the same memories, thoughts, feelings, and behaviors. With continuity and consistency for these elements of experience over time, there is a sense of being Me, having “gotten myself together,” congruence. Most importantly, because I no longer use dissociative or other “diss-ing” operations (disavowal, distraction, disorder, denial, avoidance) to protect myself from the unspeakable, unthinkable, and unknowable experiences of my life, my perceptions and the narrative of Me that results is coherent. Only after I achieve coherence can there be a sense of being the Me I know. The bottom line is the ability to make experience coherent. Processes that destroy coherence lead to a tendency to maintain disaggregation of whatever self-states might have otherwise gelled into a Self. We strive, in any psychotherapy, for understanding, coherence. But that is not enough. We must become coherent in Relation, or we are not truly human. It is this language of Relationship, so impaired by Diss-ing, that we negotiate anew, with each and every person we know, therapy or not.

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Read the words of a patient who is discovering she is a more complex

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person than she thought. See how she strives for coherence, checks on continuity and consistency. Once she establishes her orientation, she feels relieved, even though a listener with less isolated affect and subjectivity is left wondering how she can tolerate her situation.

I have spent the last several hours as not-J——. I don't know if I've ever felt exactly like I do right now. I just know I'm not me. I don't know who I might be, though. I feel like there's a tape player going on inside my head. Very noisy in there. Can't seem to stop it long enough to concentrate on anything at all. But not like I usually describe "my head is going to explode." No, different. More like, shut up shut up in there."

I'm trying to pull back, to ask inside where all of the energy is coming from. I ate ice cream for dinner tonight, which is only surprising since I am heavily dieting right now. Very uncharacteristic. Obviously someone wanted ice cream. I didn't have a bad day or anything like that. I got a ton of work done."

This is really scaring me. I don't have any control. It's like part of me is not happy I'm writing to you. Actually, when I ask about that I hear, "Tell him to fuck off." "Sorry."

I'm thinking of taking a second Klonopin. Right now I feel like I will never be able to go to sleep because there is so much activity.

Earlier I had this strange visual of me slapping myself in the face repeatedly. Came out of nowhere. Or I just have to figure out where."

I want to bang my head up against a wall to make the noise stop. I want to jump up and down and shout, "no no no no no." Like a little kid. Okay, took a second Klonopin. Thinking about a third and a fourth. Thinking about taking the whole goddamn bottle.

Now I know where I am. I am in the space where I was when I was in the outpatient program at the hospital and the sheriff took me away. That's how I'm feeling. Have to ask myself about suicidal feelings. Okay, let's see . . . where am I . . . the part of me that's active is around an 8, pretty darned bad . . . but I still feel that I, J——, have enough control to stop the part of me that wants to kill me. So, no real cause for concern.

Okay, I think I'm done now.

*From another time, six months earlier in her treatment:*

Did you see this coming? Did you know this would happen? Or were you just sure that the happy period of contentment wouldn't last. You knew! I knew! You saw my body language change toward you as soon as you brought up E's name. I was praying that you wouldn't but you did. Why did you do it? I was doing okay. We were having a good conversa-

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tion. At least I think we were, because now I can't remember a goddamn thing that happened prior to E coming out. Nothing! Do you know how frustrating that is? I don't have a fucking clue as to what we talked about for forty minutes. I'm just sitting here running my hands through my hair in complete disbelief. I don't believe this.

*And from another session:*

You know, what's happening to me is really quite incredible. I am really getting stronger. Thanks so much.

"I still have marks in my fingers where I was digging my nails into my hand. How did you know that's what I was doing? How come I stopped when you asked me to? What was that whole thing about?"

While E was . . . out? . . . I had severe burning pain in my vaginal area. Haven't figured this out yet. I'll let you know when I do.

**Principles of Treatment of Isolated Subjectivity (Not-Me Self States)**

The treatment of the person who has isolated subjectivity and demonstrates Not-Me affect, knowledge, sensation, and behavior (dissociated elements of experience) rests on an appreciation of five principles:

- (1) affect: consciousness, tolerance, and integrity.
- (2) sadomasochism and other self-harming behaviors
- (3) self as a flexible and resilient aggregation of self-states
- (4) self as agent, object, and locus
- (5) self as capable negotiator with other.

*Affect:* "Affect consciousness" and "affect tolerance" are self-evident terms, and the clinical work that leads to increasing competence in these areas is illustrated in the striving toward reflective awareness that is a major part of the clinical material presented below. *Affect integrity* simply describes the notion that the emotions that are felt are understood in context, integrally, with the other elements of experience.

*Sadomasochism:* this is best defined as the use of one pain to muffle another. Understood in this context it explains the constellations of cutting, burning, bingeing, purging, head-banging, and other behaviors that are designed to preserve self and regulate affect. There is a triumphant moment in the omnipotent fantasies associated with these behaviors as

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self hurts itself in a manner of its own choosing, preempting the possibility of another self doing the damage that is not so much anticipated or expected, but is a kind of given, a condition of living. Of course, self does not always recognize itself. Diss-ing achieves that level of incoherence, and aids in achieving the goal of relieving intense painful affect. The use of the pain is paradoxical. Pain induces a trancelike state, which relieves pain, a *petit morte*, a little death, a dissociation. As treatment proceeds, bold statements of enjoyment of cutting are replaced by an appreciation of the desperate need to see the self as an "agent," even if it means competence at destroying the depersonalized body. The competence of Not-Me states to regulate affect paradoxically needs to be admired by the therapist and the Me state, if the Not-Me is going to feel respected rather than accused. The main objection to this therapeutic stance will come from the Me state of the patient, who will think of this strategy as a ploy to allow the Not-Me to control the Me. It is not.

For example, the patient J, has a Not-Me state that uses knifelike abdominal pain in a multiply determined and affect-regulatory manner. The pain causes dissociation of affect when it is intense, just like bingeing. The knife pain is related to a dream of the patient knifing her parents and killing them. The pain is used by the Not-Me state to control the Me state and force her to recognize what the Not-Me state feels is valid hatred of the parents. The Me state hates the Not-Me for causing her pain, controlling her, and harboring hate for the parents, an unacceptable feeling. The therapist talked about the desperateness of the Not-Me state to be recognized and accepted and its creativity in doing whatever it could to get Me's attention. While not supporting her methods, the therapist supported the effort and invited the patient to appreciate the Not-Me's longing for truth and openness, an admirable goal.

*Self as Aggregate:* In successful treatments, this frame, in the form of the therapist's expectations, is applied long before the patient has achieved self as aggregation, and can be applied long before there is a fully coherent aggregate. It is an expectation that therapists keep in mind and is unconsciously communicated to their patients. It is also a matter of therapists understanding the activity of self-states in their own experience and modeling that level of reflective awareness for the patient with language that fits the experience. For example, a patient recently criticized me for saying something she believed was rude. After my initial silent denials and defensiveness, and my obvious lack of confirmation of the patient's point of view, the patient persisted. I finally discovered, with

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“mixed feelings,” how I had denied how frustrating the patient had been in her open defiance and disavowal of my observations of her. The “mix” was in my concern over what felt like a need to disclose this to the patient rather than explore the patient’s fantasies of what had happened, and not reveal my feelings to her—something that is often viewed as unacceptable in a psychoanalytically informed therapy. When I did decide to tell her that, on further reflection, she was correct, I told her I had not wanted to know how frustrated I was with her, and in disavowing and denying my own anger, I had diss’d my own angry Not-Me. I wondered out loud how I could expect her angry Not-Me to come to therapy, if I would not let mine. Her reply was simple: “That’s the smartest thing you’ve said in a while. Thanks.”

*Self as Agent, Object, and Locus:* No discussion of Self would be complete without including Schafer’s (1968) idea of self-identity as consisting of the experience of a person as an agent (doer), object (in relation to others), and a locus (occupying space, having a location). In the extreme, the patient who experiences depersonalization loses much self-identity. The out-of-body experience means giving up agency. It may feel safer not to occupy the same space as my body, and exist to the side of others, so to speak, rather than directly in relation. Dissociative processes destroy selfhood. Disavowal and related psychic tools do similar damage to the potential for maintaining integrity of self.

*Self as Negotiator:* If in the relationship with the therapist, the patient is not a real partner, who negotiates the course of the treatment and the therapeutically idiosyncratic “language of significance” in the relationship with the therapist (language that only the two of them might understand in the context of their relatedness), then there is little hope for the patient’s real growth. The therapist must be a real person who can engage the patient in an affectively alive conversation, achieving a mutuality in relationship. While brilliance in the therapist is not to be dissuaded, its appearance in conversation with patients may be threatening and destructive. Therapists need to find a way to be smart enough in their work, and also to recognize, admire, and make use of the intelligence in their patients. Psychoanalytically informed treatments must contend with the observations of Not-Me aspects of self in patients and therapists. Therapists must model a reflective awareness of their Not-Me’s if patients are to do the same. Respect for the essence of what it means to be human is to appreciate the organization of Mind as an aggregate of self-states that defines the experience of our subjectivity. Experience that is incoher-

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ent, inconsistent with expectation, incongruent with past experience, and lacks continuity with the rest of our lives provokes organizations of states of mind that need to be experienced as Not-Me. The incoherence is intolerable for a Me. The creation of a Not-Me is requisite in the psychological survival of the Me until it gains the strength to tolerate intense affects that have been unbearable. The sacrifice of self, in the service of the preservation of self, is routinely observable. The central role of affect—its obligatory association with physiologic activity and its discernment through careful observation—is essential in working effectively with our patients. The isolation of subjectivity is an understandable adaptation in the service of the preservation of self. The construction of new narratives inclusive of behavior, bodily sensation, autobiographical knowledge, and intense affect bring healing to our patients when this is accompanied by the working through that occurs in the analysis of a transference-countertransference constellation. The negotiation of the relationship between patient and therapist must include a model of reflective awareness in the therapist for the presence of both Me and Not-Me elements of self in the therapist too.

To live in relation to others is to be truly alive. While we are indeed all much more alike than we are different, the extent to which we tolerate our own internal “different thoughts and feelings” predicts the extent to which we either live with ourselves peacefully or at constant threat of war—a conflict that can lead to suicide. Whether our Not-Me’s represent a different aspect of Self, or are projected onto different people, in a different culture, in another part of the world, we may all suffer greatly when we “Diss” them.

**VERBATIM TRANSCRIPT OF SEGMENTS OF A THERAPY SESSION  
WITH A PATIENT WITH DISSOCIATIVE IDENTITY DISORDER**

Richard Chefetz

**Preface**

The following material is taken from a single session in which the conversation preceding this material had been about the degree of the patient’s consciousness about her dissociative processes during the course of her life. Though the first and second segments of material are out of order, from the third segment on, the material appears in the same (un-

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broken) sequence in which it took place. Chefetz, the therapist, has inserted clarifications and brief explanatory comments meant to orient the reader and contextualize the “surface action” of the material. Interpretation and understanding of clinical process are taken up in the commentaries that follow. The patient’s words are italicized.

*“I understand that it’s all just me. With different aspects, or whatever the hell you want to call it, whatever you want to label it. But when you’re from the inside looking out, it isn’t me. That’s somebody else. I’m not that person, I’m not this person, I’m not that person. IT’S NOT THE SAME! And that’s where it’s hard to. . . .”*

“Yes”

*“Go out and do whatever you want to do with your life, because I never finish anything, I never accomplish anything, you know, it’s like, all half started here, here, here, and eventually things get done, but you know, it’s a hell of a route to get to everything. Okay.”*

“Well, I’m looking forward to a time where you understand, you can count on yourself. Cause I know that’s been missing for you.”

*“Count on myself. That’s like [made a sound conveying a not quite contemptuous dismissal of the idea and returned quickly to her previous tone], thank you, yeah. I don’t know. I think I trust that statement about as much as I trust counting on someone else. You know what I mean? It’s like the inside doesn’t have any more trust for the inside world than the outside world.”*

“Well, before you knew there was an inside, before you had consciousness for there being an inner world, in which a lot of these ways in which you feel like you’re not you exist . . . waiting for an opportunity to take over, or do what needs to be done to get you through the day. Even before you knew that.”

*“I understand that. But, and I might not have understood that’s what it was. But I did know something was wrong. I mean, basically it was my sanity that I questioned.”*

*Dr. Chefetz comments:* When I say that “I am looking forward to a time,” I am setting an expectation for a future possibility. I am also acknowledging the current situation of disarray and lack of self-trust. This is a debilitating experience for our patients. I don’t expect that she will agree that it’s possible for her to achieve this state of confidence now, but I do let her know I believe it is possible. She confirms the gravity of the meaning of her lack of self-confidence, and of her switching behaviors, by indicating that it has caused her to question her sanity.

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I want to emphasize here that part of our job is to help our patients figure out what their experience of themselves actually is, to achieve a consciousness of being. In a typically dissociative, non-self-reflective person, this is quite an achievement. It is important that the language that describes this experience be as close to the patient's own language as possible, without the therapist imposing his own terminology. This language is often negotiated, so that both participants in the conversation know what they are talking about. The therapist assists the patient's inquiry and joins her quest for self-definition.

### Segment 2

“Does it feel like it was you who did all these things? Or do you just sort of know the history of the week?”

*“I was there. But sometimes, it was like, how do I explain it? It's like, while I was doing something, I know, I switched, and the Perfectionist came out and fixed something that I did, with the patch, the drywall patch around the marble, cause it was like, you know, I remember standing back going: Yeah, that looks better. That's what I was trying to do. Whatever. You know. But, it was like, I knew what was going on, you know, it's like all of a sudden, like Nancy said this, this big sigh like, you know, [whooshing sound indicating transformation] and then switched hands and [same sound again] did it. Nancy goes like, in her mind: What just happened? So I know there was a switching there, cause, ya know, I got it better left-handed then I did right-handed. Which was kind of awkward, considering I was working on the right-hand side of the window. So I had to stand over to the side and you know its hard to work in a right-sided corner with your left hand.”*

“Oh, yeah.”

*“So, yeah. Stuff like that. And then it was like, I wasn't going to patch every hole in the room. And then boom [another whooshing transformation sound, magical in quality] everything was done. You know. Like all of a sudden there were spots all over the room going like: What color are you painting? What did you do? You had holes in the wall. So, um, hole painting today. [patient and therapist both laughing]. Anyway, you know, stuff like that.”*

“Had to! Had to!”

*“Yeah. Yeah. Oh yeah.”*

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*Dr. Chefetz comments:* Here the patient is talking about what it is like to notice the effects of her switching from one Not-Me state to another.

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Her laughter is anxious. I am trying to draw her out, to encourage her reflection. I stay away from interpretation or clarification. My emphasis is on matching her affect. Just like Beatrice Beebe (1997) matches the affective state of infants to calm them, I am matching her state of excited engagement. My spontaneous utterance of "Had to! Had to!" is exactly the energy I must have been tracking. It is not the linguistic content, but the emotional content that teaches her she is understood. It is probably equivalent to Beebe cooing to one of her infants. The patient's "Yeah. Yeah. Oh, yeah" reflects this attunement, a mutual pacing that is part of intimacy and builds trust. She knows I am "with" her.

Segment 3

*"Then there's the frustration of going to therapy and not knowing you've been in therapy for however long I've been coming here."*

*"So, it's been a while."*

"I guess so. How long have you been coming here?"

*"I guess. What year is this? 2000? 2002? Okay. Um, late 90s somewhere. So, you know, 97, 98, 99, 98, 97?"*

*"Somewhere in there."*

*"Somewhere in there. So it's been a long time. Doesn't seem like it. Isn't that weird?"*

*"Umhumm."*

*"It doesn't seem like that."*

"It seems like we just met yesterday?"

*"Well, not really, but kind of. Do you know what I mean? It's like all of a sudden I realize I am in therapy and it's me. Before that, it was like, the shell was going into this room and the shell was going out of the room. Do you understand what I mean?"*

"You're conscious in a way that you weren't before."

*"Oh, yeah."*

*"Really aware."*

*"Oh, yeah. . . . And I was conscious that I was like going to therapy but not conscious as to what happened. And then there was that spell where, it's like, I don't know what that guy thinks, but, I know, that's not what's wrong with me. I just talk to myself. I don't know why you think this is, you know, whatever, but . . . then that kind of like changed. And then I go, reality sunk in."*

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"You became conscious."

*"Well I, kind of."*

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"In a different way."

*"In a different way. And then sometimes, it's like, I just stepped out of a boxing ring and, you know, it's like Heaven help me if I gotta slam the brakes on the way home because I don't think my legs would be actually strong enough to actually do that. I'm that weak."*

"Yeah."

*"Um, and then there's still the reluctance of uh, that, that little gut feeling that one of these days I'm going to have to say something I really don't want to talk about, knowing that it's a part of all of this. Probably a big part of all of this. And it's like, if I never say it, I don't know. Ay, ay, I, ay I. Anyhow, that's a subject that's not approachable."*

"Whatever that was. Was there something you were talking about even? I don't think so. Right?"

*"I don't know. There is something I don't want to talk about."*

"What's it like for you to be conscious in this way?"

*"What's it like?"*

"Yeah, I mean how is it?"

*"Well, you know, I guess this is where I get my progress report. Gotta check in once in a while and see how everything's going."*

*Dr. Chefetz comments:* I continue to try and have her explore her awareness of her Mind. As she describes the change in her experience of working in therapy, she momentarily realizes that in a previous recent session she was severely distressed as she confronted thoughts and feelings that overwhelmed her then, and that she has still not openly spoken about. She has been increasingly suicidal, and I am not about to push her to talk about what she wants to hide. I join her by saying "Whatever that was. Was there something you were talking about even?" Paradoxically, this gives her room to acknowledge that there is something that she doesn't want to talk about. I stay focused on the general, and avoid the specific, while aiming for increased self-reflection as I ask, "What's it like to be conscious in this way?" The question is a "fishing" question. I don't know what "this way" is. I am hoping she will tell me.

The particular language of the words above need some explanation: "And it's like, if I never say it, I don't know. Ay, ay, I, ay I. Anyhow, that's a subject that's not approachable." For you, the reader, it is probably difficult, not being able to hear the words or to see the person uttering them, to grasp the quick succession of self-states that took place in this sentence. First the voice tones of a person feeling somewhat baffled about what she was trying to communicate, then the suggestion that she

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was about to say something pithy, and finally, all in the same sentence, a person who acts as if she is being stopped from speaking by being yanked off the stage with a vaudevillian stage hook! People with dissociative disorders may exhibit what is called "interference phenomena." In this experience, patients report feeling as if their voices were suddenly controlled by someone else, or their thoughts "stolen" from their minds. This hypnotic experience is similar to what is described in the hypnosis literature as "made thoughts" or "made feelings." A good resource for understanding these kinds of experiences is Loewenstein (1991).

Segment 4 (continuous)

"We've been talking a little bit about how your life has changed in terms of like the church and stuff."

*"I'm a different person. There's no doubt about it. I mean everyone around me notices it. And it's like. . . . And the people I let around me now, it's like, you know, if it's a hassle or whatever, Bye. I don't want any part of it. Instead of just . . . I guess I'm strong enough to know what I'm comfortable with or what I'm not comfortable with, or saying. Before, it would have been like, who am I to say? But it makes, you know, I don't tolerate, and I'm not even sure what it is I don't tolerate. If you know, I'm around someone who yells a lot, I won't go round them any more, I don't want to bear it. If someone's yelling a lot and I have no choice, I'm like, you know, making sure they understand they're not acceptable or whatever. Or, I have this habit of shutting out things around me that I'm not into or something, I don't know. Or. . . ."*

"How do you shut it out? What do you do?"

*"I don't know. But I don't bear it. I don't see it. I'm in, you know . . . I'll go through whatever I'm doing in whatever situation it is, it's like listening to my father scream at me. You know. Turn the switch down, and finally turn it off. I could have been in the same room with him while he went on for an hour and never heard a word he said. I can still do that."*

"But would you feel something of it?"

*"Do I feel something of it?"*

"Yeah. I mean you might not have heard the words, but was there something?"

*"Oh . . . yeah. Look around and there he is. His mouth is still moving and you could tell that he was getting madder and madder, but I didn't bear."*

"Would you feel the threat?"

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“No. Nope.”

“Would you know about the threat?”

“Yes.”

“You’d kind of know about it.”

“Yeab.”

“Like a headline, but it wasn’t about you?”

*“Even if attack was imminent, it was like go ahead, it doesn’t affect me. I’m just going to sit just exactly what I’m doing, where I’m at, doesn’t matter. I still have that ability to just put myself, staying in one position, but put myself totally away from what’s going on around me. If I don’t like what I’m seeing or hearing or what’s going on, I don’t participate, maybe that’s what it is. I check out. Then it becomes a foggy memory. And then sometimes it’s like . . . most of the time I walk around, it’s like there’s no hap- happy sad, unhappy, whatever, and then sometimes the emotions and stuff are so raw, I can’t handle listening to the news, watching a commercial, read a book. I can’t do anything.”*

“What do you think about?”

“What do I think about?”

“Yeah. What do you think is happening?”

*“What do I think has happened? I don’t know. I’m not DOING your job.”*

“You want me to do my job?”

*“You want me to do your job too?”*

“Come on! [laughing emphatically together]”

*Dr. Chefetz comments:* I keep pressing ahead to identify feelings. I joke with my patients about the “F” word, “feelings.” Affect consciousness is the goal. Affect provides context and meaning. Get rid of affect, and she can watch her father’s mouth move, but not appreciate any threat. Still, she somehow, implicitly rather than explicitly, is aware of a threat. I want to help her fill in the blanks, to associate. I use humor when possible. It helps me too. The last few lines of this segment might have sounded like a rehearsed comedy routine. Both she and I enjoyed the action.

#### Segment 5 (continuous)

*“What do I think has happened? I think I touched on something, or something’s triggered something like a memory or I mean a lot of times when that happened, there’s like flashbacks. You know, the flash cards or the silent movies, or something go on and off in the brain.”*

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“And do you react to those while they’re going on and off?”

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“No.”

“You don’t?”

“No. I know they exist. I know there’re happening. It’s like that’s when I don’t feel anything.”

“Is it happening to you?”

“Is it happening to me? Heck no. It’s a black-and-white movie I’m watching. You know, the old news flash in front of the movies. Sixty seconds . . . coming, next the cartoon. Steamboat Willy, I don’t know.”

“These are scenes from your past?”

“Well, I hope so. I wish they weren’t, but yeah, they are. Scenes I know. Scenes I’ve been to, and stuff. I mean. . . . know.”

“What’s it like for you to be talking about it right now?”

“As long as you don’t ask for the subtitles, I guess it’s okay [with a chuckle].”

“But when I asked you my question, if you’re faced with. . . .”

“What question?”

“What’s it like for you? Your face wrote a whole novel.”

“Did it?”

“Yeah. In about five seconds of twitching.”

“Ab.”

“A lot of movement in that face.”

“Okay, but . . .”

“A lot of feeling.”

“Okay, well, I think that, sure, I feel numb. That’s the easy answer.”

“You notice what the legs are doing?”

“Yeah. I know that. Antsy, is that the term for this?”

“So, it’s very uncomfortable talking about it?”

“Well, that’s bordering on the . . . you know it’s always like I always gotta skirt that edge of talking about what I don’t want to talk about.”

“Whatever that is.”

“Cause intellectually I know I have to.”

“Eventually.”

“Sooner or later it’s all got to be worked out. And I can skirt it all I want, and it’s not going to come out. It’s just . . . but, this is it. Okay? That’s what this is. This is that.”

“Yeah, always moving.”

“Getting toward that goal, you know, you gotta talk about this one of

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Dr. Chefetz comments: This was a convenient ending for this tran-

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script, but it was not the actual end of the session. We are still in the middle of an effort to raise consciousness for her experience. She notices the meaning and jokes about it, as if I am the one who is not sure what is real or not real. She also notices the meaning that I address: some of the things she might be expected to own as her actual life experiences are held in a Not-Me place, and rarely does she own these as part of her life. It's OK to know, if we don't add the subtitles. Translation: I can see these scenes in my mind, but it doesn't affect me when there are no words to hint at the meaning of what I see. These are just scenes in my life.

I draw attention to her face so that she becomes more aware that she has a face that has expression, conveying affect and clarifying meaning. Frontal lobe and limbic circuits that generate emotional expression receive feedback from facial sensation. When someone smiles as he talks about his anger, these feedback circuits get confused, and it is easier for someone not to know about his feelings.

In her wisdom, my patient finishes this scene by saying that she knows that at some point she needs to understand her life. She's right: after almost exactly five years, it's still going to be a while.

#### COMMENTARY ON CHEFETZ'S CLINICAL MATERIAL

Philip Bromberg

I want to thank Rich for his generosity in sharing things so private and personal. I'm particularly grateful, because I could have been left out on a very long limb. It's always risky telling someone you hear an enactment taking place in his work, because he might not have the slightest idea what you are talking about, so to hear Rich, in the next session, not only agree but describe what the enactment was *about*, is very satisfying.

As I listened to the tape of Rich's session with Nancy I heard the beginning of an enactment involving mistrust, and I'm going to try to recreate what took place inside me as I listened that led me to that formulation. I began to hear what had clearly started as a "discussion" about Nancy's dissociation subtly develop an enacted subtext. A part of Nancy seemed to be experiencing Rich's effort to give her hope about the future *at that moment*, as a way of his not having to listen to her frustration and anger—that her life continues to be just too damned hard, because all

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he gives her is insight into the fact that she has a lot of different parts. But *she's* the one that has to live with them, and still suffers from the fact that it hasn't changed.

Nancy is highly dissociative, which I obviously knew in advance of listening to the tape; the fact that she is dissociative is what the conference is about. But I also could *bear* it, not just in their discussions *about* dissociation and her multiple selves, but in the self-state shifts that seemed to be evoked by the affective complexity of her relationship with Rich—the kind of complexity that can feel suddenly destabilizing to both patient and therapist. Rich brings to a relationship a blend of personal qualities that aren't often found together in a therapist—a seriousness of purpose, a deep affective resonance with his patient's internal life, a spontaneous playfulness, and a mind that is always thinking. You've all gotten a taste of what I mean just by being with him here today. It's a blend of real qualities, not an analytic posture. As a therapist, Rich's blend of professional skill and personal relatedness makes him a dream come true, but for a dissociative patient such as Nancy, it is precisely for that reason he is also dangerous—not a dream come true, but her worst nightmare; certain parts of Nancy can easily trust Rich and start to hope there is more to life than trauma waiting to happen just when you think you are safe.

A dissociative mental structure functions essentially as an “early warning system.” It is geared to disrupt the growth of trust and hope, thus preserving the patient's vigilant readiness for disaster. Any perception that a relationship may be trustworthy compromises the vigilance a patient relies on to maintain control over the dissociative system. Each island of self has its own internally defined function, and each dissociated self becomes its own island of “truth.” If such a patient forgets, even briefly, that feeling secure and connected to her therapist can lead to unforeseen betrayal, she threatens her own hard-won “fail-safe” system. This is why there is often a bewilderingly abrupt shift in the interactional field at the very moment a dissociative patient starts to feel close—a switch to a state of consciousness in which she will find or evoke something she can use as a danger signal associated with the hope of continued closeness. And there is never a shortage of things that a patient can find in a therapist to use in derailing the hope of sustained and satisfying connection. The therapist invariably provides them, simply because no matter how much a therapist cares about his patient, he is not an empathy machine. There's always that damned fact that in any relationship,

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you have a mind of your own, anxieties of your own, and needs of your own, and that goes for therapists too. The nature of human relatedness includes one’s “otherness.” The essential core of therapeutic growth for any patient is in the negotiation between self-interest and secure attachment to an “other” in those areas of personality where this negotiation has either been compromised or has never taken place. Aspects of any therapist’s subjectivity—his own selfhood—will inevitably be disjunctive with his patient’s subjective experience at certain moments, and will be *felt* by his patient as “off,” “intrusive,” “wrong,” “threatening,” and so on, even when (perhaps *mostly* when) those parts of each person’s self that are in collision are dissociated, not represented in conscious thought by *either* person: that is, when they are “not-me.”

I became aware of a shift in Nancy’s state of consciousness to one where she seemed to find needed proof that Rich, like everyone else, has to be watched carefully. It had the feel to me of what is sometimes the start of an enactment involving mistrust.

“Trust” is not a word that is easily applied to the personality structure of patients such as Nancy. What looks like trust is often the unreflective adaptiveness of a still dissociated part of the patient’s self that cannot hold self-interest and attachment to the other in the same relational context. Other dissociated parts of the self are functioning as on-call watchdogs, vigilantly ready to intervene and protect the patient from “certain” disaster, if she seems about to place her trust in someone.

I heard some of what I’ve just described in a segment of the tape, the part where Nancy gives a little speech, beginning “I UNDERSTAND that it’s all just me . . .” and Rich says, “WELL, I’m looking forward to a time . . . etc. . . . etc. . . . etc.” I heard a “not-me” part of Nancy who reacted, not with hopefulness to what Rich said, but with mistrust, as if he were saying, “The Nancy you are *right now* is making me feel bad about *myself*, and I prefer to think about who you *will* be in the future—a time when I will feel like a great therapist.”

My own self-states were very active while I was listening to this. For example, a part of me that became responsive to what I later conjectured was a “not-me” aspect of Rich, led me to feel a vague discomfort that Rich was working too hard, and I was aware of feeling a little grouchy with Nancy. I’ve observed that when this sort of thing takes place in my own work, my dissociation is most frequently in response to shame—a warded-off blow to my momentary stability as a therapist. There have even been times with certain patients that I’ve questioned whether I *ever*

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knew what I am doing. I can remember one situation where an old *New Yorker* cartoon popped into my mind: A female patient was on the couch, and her male analyst, wearing his hat and coat and carrying a briefcase, was standing up next to her, saying "Excuse me, Mrs. Smith, but I've decided to retire." What made this drawing particularly funny is that the expression on the analyst's face was totally serious and unperturbed as he is about to give up his profession in the middle of an analytic session. You don't have to *be* an analyst to recognize that the analyst's professional-self in the cartoon had become so completely destabilized by the relationship with his patient that he didn't have a clue he had been taken over by "*not-me*." This cartoon, in less dramatic form, happens routinely in every therapist-patient relationship.

In what was going on between Rich and Nancy, I could feel the presence of a subtext that transformed what was a topic being discussed into an affective reliving of it in the here and now. A shift in my own self-state allowed a direct contact between aspects of *my* "not-me" experience and aspects of Nancy's. My attention switched from thinking *about* Nancy from the outside, to feeling Nancy's presence from within an intersubjective field of which I, momentarily, had become a part.

Had I been her therapist, and experienced in that context what I experienced listening to the tape, would I in fact have used this shift in my self-experience as "material" with that patient at that moment? If so, how? If not, why not? I don't know, and I can't know, because it would depend on what went into organizing the totality of my experience at that moment, not on a clinical choice based on the objective application of a principle of technique. Had I been her therapist, I would have my particular knowledge of Nancy and my own experience of what our relationship felt like at that point in treatment. Would using my experience of the enactment *openly* with her come as a shock, because it would be a huge departure from what she otherwise anticipates from me? If yes, wouldn't my unanticipated behavior be most likely dissociated by her, and sucked into the enactment, becoming just more proof to Nancy that she can't trust anyone? Let's imagine it did happen exactly in that way. Is it an "error?" Can the moment of her dissociation, if it is observed by the analyst, be itself used as a potential window into a therapeutic outcome? I believe that what happens at that point depends in part on the treatment model that supports an analyst's clinical approach.

S ____	Rich as an analyst is dedicated to a thoughtful and judicious concern	____ S
N ____	for his patient's affective safety and communicates this through his ongo-	____ N
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ing behavior with her. A part of Nancy knows that he cares and thinks about her emotional welfare, even at those moments when another part of her recognizes that his effort to give her “encouragement,” rather than hanging-in with her pain, is most responsive to his own needs. Some part of her knows that he cares about helping her more than he cares about preserving his self-image as a “good analyst,” even though, at that moment, his own needs have the greater priority. As long as an analyst’s responses to his patient do not represent an unreflective “anything goes” attitude, the possibility is remote that he is going to pointlessly retraumatize his patient when she is feeling most vulnerable. In other words, from the clinical vantage point that Rich and I share, we don’t believe there is a “rightness” or “wrongness” contained in one’s clinical choices, as long as the patient is not being misused. What matters is being as attuned as possible to the impact of the choices you *do* make. This means being committed to recognizing your patient’s dissociated responses to your participation as well as her more conscious responses. It doesn’t mean always being *successful* at it. Using enacted experience in this way, dissociated parts of a patient’s self, such as the part that holds mistrust of someone to whom she is attached, can come to be voiced and recognized as a healthy part of “me,” through a therapy relationship in which the past is relived in a “safe-enough” way.

I decided to organize my thoughts about Rich’s clinical material around one theme, the issue that most made us want to do this conference together: that is, there are always pieces of dissociated self-experience that have weak or nonexistent links to the experience of “me,” and with certain of these inaccessible “not-me” self-states, before they can become aspects of “me,” available to internal conflict, they must first become available to self-reflection. Until this happens, they can only be talked “about” over and over, without self-change, because they are not felt, experientially, as belonging to “me.”

I now concentrate on the final segment of Rich’s tape, because I think it provides a particularly good illustration of this issue as it develops in richness (no pun intended) through the linking of two related moments in time. My hope is to show how talking with “me and not-me” has the same basic treatment goal for Rich as it does for me—the goal of facilitating a patient’s ability to increasingly take her own mind as an object of reflection (which for most psychoanalysts, regardless of theoretical persuasion, is the signature of an analytic process).

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Let me set the stage for my commentary. When an analyst wishes to

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help a patient deepen her emotional experience of an event she is describing—for example, an event that the patient states had been upsetting, but is reported without much affective immediacy—the intervention that is most typically offered is some variation of the question “What did you feel? or “What was the upset-feeling like?” This, to me, is a great improvement over the more traditional “What comes to mind?” But an analyst can do even more, as for instance, asking “What is it like for you to feel upset?” This question addresses a more complex reality than even “What was the upset-feeling like?” (which is a request simply to describe the upset feeling). An answer to “What is it like for you to feel upset?” requires, not only accessing the experience of the (upset) feeling itself, but simultaneously trying to access the experience of the experience (a request to reflect on what being upset itself is like). Fonagy and Target (1996) refer to this as the ability to represent a mental representation, the underpinning of mentalization, and the foundation for what analysts have traditionally called “the observing ego.”

The question that Rich asked, as you might imagine, is not an easy one for a dissociative patient to cope with. It requires her to emerge from her dissociative cocoon, at least momentarily, in order to try to answer it. This challenge to the dissociative mental structure will often evoke a switch to a different dissociated self-state or sometimes lead to a dissociative *symptom* (such as a headache, a glazed look, or a flickering of the eyelids), which can then become an object of attention in itself. The question, “what is it like at this moment to . . . blah blah blah,” is not a request to simply deal with the experience cognitively, but an invitation to the patient to try to do something that is, for her, quite complex—to access the dissociated aspect of herself that holds the perceptual experience of her own upset mind and contain it consciously as part of the here-and-now reality of talking *about* it with her therapist. Nancy is being asked to *perceive*, in the here and now, a past experiential moment, not a narrative to be described from a distance, not a “story to be told,” but a space to be reentered experientially—a nonlinear reality where past and present, linked by cognitive reflection, coexist. It is a moment such as this that links my clinical vantage point with Rich’s especially closely. I’m going to try to illustrate this through what I heard taking place between Rich and his patient in the last section of his tape—an example of what I’ve just called “the process of facilitating a patient’s ability to increasingly take her own mind as an object of reflection.” It is a way of

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expressing, in the language of clinical process, what I've described in more conceptual language as a link being made in the here and now between the mental representation of an event that resides in short-term or working memory, and a mental representation of the self as the agent or experiencer.

Rich has just asked Nancy how long she's been coming to therapy, and she starts counting, with only a vague sense of time orientation. (The patient's words are in italics; Rich's words are in capital letters).

*"What year is this? 2000? 2002? Okay. Ah, late 90's somewhere. So, you know, 97, 98, 99, 98, 97?"*

"SOMEWHERE IN THERE."

*"Somewhere in there. So it's been a long time. Doesn't seem like it. Isn't that weird?"*

"UMHUMM."

*"It doesn't seem like that."*

"IT SEEMS LIKE WE JUST MET YESTERDAY," he offers.

*"Well, not really, but kind of. Do you know what I mean? It's like all of a sudden I realize I am in therapy and it's me. Before that, it was like, the shell was going IN this room and the shell was going OUT of the room. Do you understand what I'm saying?"*

"YOU'RE CONSCIOUS IN A WAY THAT YOU WEREN'T BEFORE."

*"Oh, yeah!!"*

"REALLY AWARE."

*"Oh yeah. And I was conscious that I was going to therapy but not conscious as to what happened. And then there was that spell where, I don't know what that guy thinks, but, I know, that's not what's wrong with me. I just talk to myself. I don't know why you think this is, you know, whatever, but. . . . Then that kind of like changed. And then I go, reality sunk in."*

"YOU BECAME CONSCIOUS."

*"Well I . . . kind of . . ."* [not really agreeing]

"IN A DIFFERENT WAY" [he amends it]

*"In a different way. And then sometimes, it's like, I just stepped out of a boxing ring and, you know, it's like Heaven help me if I gotta slam the breaks on the way home because I don't think my legs would be actually strong enough to actually do that. I'm that weak. Um, and then there's still the reluctance of uh, that, that gut feeling that one of these days I'm going to have to say something I really don't want to talk about, knowing*

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*that it's a part of all of this. Probably a big part of all of this. And it's like, if I never say it, I don't know. Anyhow [laugh], that's a subject that's not approachable."*

"WHATEVER IT WAS. WAS THERE SOMETHING YOU WERE TALKING ABOUT EVEN? I DON'T THINK SO, RIGHT?"

*"I don't know. There is something I don't want to talk about."*

"WHAT'S IT LIKE FOR YOU TO BE CONSCIOUS IN THIS WAY?"

To reiterate, I believe that Rich's question, "WHAT'S IT LIKE FOR YOU TO BE CONSCIOUS IN THIS WAY?" is one of the most powerful interventions a therapist can make. It increases communication between different parts of the self by coconstructing an intersubjective space (in which the therapist's mind and the patient's can coexist) and increases her capacity for mentalization. The first part of the question enhances her capacity for self-reflectiveness ("WHAT'S IT LIKE?"), while the second part ("... TO BE CONSCIOUS IN THIS WAY") asks her to stay *in* the experience she is reflecting on. The more her mind can do that, the less she needs to dissociate. Nancy replies, puzzled,

*"What's it like?"*

"YEAH, I MEAN HOW IS IT?"

[Laugh] *"Well, you know, I guess this is where I get my progress report. Gotta check in once in a while and see how everything's going."*

I believe that what Nancy means by "check-in" is checking-in with another part of *herself*. One can see here how frightening it is for her to self-reflect with Rich in the moment, so she holds tight to her dissociative mental structure, and instead of responding to his intended meaning—"What's the EXPERIENCE like for you RIGHT NOW to be conscious in this way?—she responds (with a nervous laugh) as if he had asked her for a cognitive evaluation of her progress (How do you think you are doing?). I hear this moment between Rich and Nancy resonating with my own vignette described earlier, where my patient's girlfriend "checked out" and replied "sort of" when asked to reflect in the moment on her own mental processes. It's the kind of moment that I think often provides a great window of opportunity, if you can catch it and if there has been enough groundwork laid to work together with the experience of her checking out, right then as it is happening.

I think this is an important point, because it underlines the fact that the value of Rich's intervention doesn't depend on whether it "works" in the linear meaning of the word. By allowing some intersubjective space

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to open up *at that moment*, her shutting down and dissociating can itself become increasingly available as a shared event.

“Not-me” is a self-state that because it is dissociated, is not directly accessible to symbolization by offering new meaning to the self that exists in the here and now—a process that has been referred to over the years as “interpretation.” In order for new meaning to have “meaning,” a patient needs first to feel her “not-me” state being recognized and responded to relationally, and this can happen only through “not-me” feeling real and alive to the therapist at that moment. Unless the patient’s “not-me” state of mind is fully recognized by the therapist, any new level of meaning, no matter how significant it may appear to the therapist, is to the patient just one more fiction *about* her. Until “not-me” feels relationally alive, the patient is being asked to inhabit meaning that isn’t hers and to accept some new words or concepts as a substitute for feeling real. Okay. Let’s look at what happens next! Well, not exactly “next,” but very shortly.

Nancy has been talking about her flashbacks, but from a very removed place—as movies, cartoons, or flash cards, and Rich suddenly asks:

“THESE ARE SCENES FROM YOUR PAST?”

*“Well, I hope so. I wish they weren’t, but yeah, they are. Scenes I know. Scenes I’ve been to, and stuff.”*

Rich then does it again: “WHAT’S IT LIKE FOR YOU TO BE TALKING ABOUT IT RIGHT NOW?”

*“As long as you don’t ask for the subtitles, I guess it’s okay.”*

That’s so lovely! Nancy almost says directly that she will talk about anything as long as she doesn’t have to reflect on what she is talking about while she is experiencing it. So, this time, as distinct from the time before, she openly (but metaphorically) acknowledges her dissociative defense.

Rich continues to pursue her: “BUT WHEN I ASKED YOU MY QUESTION, IF YOU’RE FACED WITH. . . .”

*Nancy replies: “What question?”*

Here is where you will hear Rich talking *to* “not-me” (not just *about* “not-me”) at the same time he is talking *to* “me.” It is the body that holds the dissociated “not-me” experience, so listen to how he speaks *to* and *about* her body at the same time).

Rich asks, as he did earlier: “WHAT’S IT LIKE FOR YOU?” (but this time, he goes further):

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“YOUR FACE WROTE A WHOLE NOVEL.”

*“Did it?”*

“YEAH. IN ABOUT FIVE SECONDS OF TWITCHING.”

*“Ab.”*

“A LOT OF MOVEMENT IN THAT FACE.”

*“Okay, but. . . .”*

“A LOT OF FEELING.”

*“Okay, well, I think that . . . [laugh] . . . I feel numb . . . That’s the easy answer.”*

Nancy has said to Rich, “There is something I don’t want to talk about.” But Rich knows that another part of Nancy is “listening” and he wants to let her know he is aware of its presence. It’s the part holding the experience that Nancy (as “me”) doesn’t want to access, much less reflect upon—the process she calls “subtitles.” Rich, talking to both “me” and “not-me” at the same time, is in effect saying to Nancy, “I know there’s something you don’t want to talk about, and I also know that you *can’t* talk about it, because it’s not really yours to talk about yet. But there’s another part of you who I can see from your face is trying to get our attention—a part of you who probably does know what that “something” is, and doesn’t want to keep being so alone with it. Maybe she hopes you will let her speak to you, so that little by little you will know what *she* knows, and then you and I can talk about it together, so she won’t have to be so alone and you won’t have to be so afraid of her. It sure is scary, though, to have her “in your face,” and to know I see her there, and why wouldn’t it be? After all, what’s *always* most frightening is the possibility that something you’re not ready for might hit you all at once, and it could be too much for your mind.

As Rich is speaking to Nancy, he knows that the “not-me” part of her that he sees in her face is listening too, and he wants her to know that he is aware of his role in protecting Nancy’s emotional safety if she *does* share with Nancy’s mind the affective experience of the “something” that happened to her.

As a result, Nancy becomes *aware* of her numbness and is even somewhat able to reflect on it as shown by her laugh. In other words, she’s able to experience herself using dissociation to escape from the moment, and even calls it the “easy answer.”

This gradual process of making a patient aware, in the moment, of her own dissociative reactions—especially when the awareness comes about through shared processing of here-and-now experience—allows her

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thought processes to mentally represent experience that had previously been affectively unregulatable, and this, in turn, reduces her reliance on dissociation as an automatically “triggered” response.

*Until the unspoken self is engaged, speaking to the self that is already engaged eventually reaches its limit of usefulness.* How do we know when that limit is reached? We don’t actually “know,” but often we can feel or see “something else” happening while we are talking *about* the patient. The “something else” we feel or see is what alerts us to the wordless voice of a “not-me” trying to be heard—a voice that *can* be heard and eventually engaged, providing our experience of the “something else” reaches the threshold of our somatopsychic awareness.

#### SPEAKING FOR NOT-ME

Richard Chefetz

#### Preface

The reader is advised that the speaker who delivered the next commentary spoke in the Southern accent of a country doctor from the Blue Ridge Mountains of Virginia. This is not a thick accent, but it was clearly present to those in attendance. While Dr. Chefetz practiced medicine for ten years in such a locale, it was not his intention to start speaking in this tone during the presentation. It sort of just happened. You can believe what you like, but that is the truth. Yes, it surprised him, and it also kind of delighted him.

The truth is, Philip has told you only one of his reactions to this clinical material. He and Rich talked, and decided that the version you’ve read made the most sense for this discussion. But it was the second version Philip wrote, the one you didn’t read, that made the most sense to Not-Me.

I am an old friend of Rich’s, though I haven’t always been so friendly. And as long as they were talking about Not-Me, it is worth noting that there is more than one Not-Me. No surprise, huh! So, let’s get on with what Philip heard, and see what you think about it. I’ll tell you what I have figured out, and if Rich is lucky, he’ll get a chance to speak at the end, but not before I’m done. This is my time.

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Philip noted, in the other version of his response to Rich, that he

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thought he heard the beginnings of an enactment regarding mistrust. Rich wasn't aware then that *I* was active again in the background, though he is aware now. I'm a version of Rich about whom you are going to learn a lot more than *he* ever wanted to know.

Here's the text where I show up, twice no less. You have it in front of you, right from the getgo, the first line in the audiotape as Nancy spoke. Remember what I told you about her voice tones? Remember how she felt? She was making a point, wasn't she? It had to have been in response to something Rich said.

Nancy: "*I understand that it's all just me. With different aspects, or what ever the HELL you want to call it, whatever you want to label it. But when you're from the inside looking out, it isn't me. I'm not that person, I'm not this person, I'm not that person. IT'S NOT THE SAME! And that's where it's hard to . . . go out and do whatever you want to do with your life, because I never finish anything, I never accomplish anything, you know, it's like, all half started . . . and eventually things get done, but you know, it's a hell of a route to get to everything. Okay?*"

Rich: "Well, I'm looking forward to a time where you understand you can count on yourself. Cause I know that's been missing for you."

Nancy: "*Count on myself. That's like . . . thank you, yeah. . . . I think I trust that statement about as much as I trust counting on someone else. You know what I mean?*"

[Rich starts out and tries again] "Well, before you knew there was an inside. . . ."

[Nancy repeats] *I understand that. But, . . .*"

What has happened here? Philip noticed something about this exchange. He did what he does so well, he used his feelings to hear what happened. In Philip's own words: "I felt a part of Nancy needing to mistrust Rich, and in his own piece of it, I could feel Rich not wanting to be mistrusted. As in every enactment, the therapist is participating in his own dissociative process, and slowly *becomes* the person he is perceived as being."

Philip doesn't ask who Rich becomes, but I will tell you. He becomes like all the other people in Nancy's life who didn't listen or see that she was living in Hell. She didn't know who she was, or how she was, and Rich ignores her passionate statement and sticks with his own agenda. He must not have known he wasn't listening, because it is like he is arguing with her point of view: You might feel that way, but I'm looking forward. He, in fact, says: "Well, I'm looking forward to a time where

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you understand you can count on yourself. Cause I know that’s been missing for you.” I know he’s a good therapist. So, why did he say that? He ought to know that when he uses the word “Well,” he is disagreeing and might not be listening. He wasn’t getting it. It’s kind of a mild form of Diss-ing, isn’t it? Whose reality are we in here, after all? And he also didn’t know *I* was there. He didn’t listen to me either! He just *acted* like I feel. That’s what always happens. See, I don’t want to know what living in Hell is like either. He thinks he is the good therapist, wise, thoughtful, compassionate, all that stuff. But when he starts talking like Cassandra, the immortal who could see the future, then he suffers her same fate, nobody listens to him either. Good therapists don’t necessarily need to do good things. Sometimes they need to tolerate thinking and feeling about what it is like to live in their own private hell if they are going to understand and respond to their patients. Are you still listening, Rich?

So, Philip heard a Not-Me in Rich, organized around trust. Nancy heard it too, and challenged him. She doesn’t trust Rich’s statement that she will be able to count on herself. And, as yet, she can’t trust him to listen to what she is saying, though she keeps on trying to get it across to him. I think it’s especially important when, in the final paragraph of that section, Nancy uses the word “but.” (I’ll reprint what Nancy said just below, so you can see what I mean.) She uses it twice, maybe for emphasis, after Rich asks her to reflect on the time when she wasn’t conscious of having an inside. The word “but,” just like the word “well,” heralds a contradiction, a disagreement, a challenge to another view. The view that is challenged is the view of a second Not-Me, a cousin of mine, one who’s not about trust. Listen, the theme is hidden, though not too deeply.

Nancy says: *“I understand that. But, and I might not have understood that’s what it was. But I did know something was wrong. I mean, basically it was my sanity that I questioned.”*

In response to Rich’s first Not-Me, Nancy basically tells Rich to stop dreaming about her being able to trust herself and work with the fact that she doesn’t trust. She’s living in Hell and needs some help with it. She tries to tell him that he is not listening to her, but he keeps not listening. The second Not-Me is related to Rich’s fear of feeling that he is not sane. She wants to put aside understanding dissociation and learning about dissociative mechanisms and focus on the question of what really worries her: Is Nancy insane?

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Rich has a problem in this session. His patient just spent four sessions in a row working on heavy-duty, trauma-related feelings and has gotten

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increasingly suicidal. He's not happy about that, but he's used to it, at least that's what he likes to think. Lot's of luck, Rich. How did you ever think you could get used to that? You must be the King of Wishful Thinking, you know, like the song from a few years back. So Rich, you know, as long as you maintain this view that suicidal patients don't really bother you because you are used to it, you are at risk for not listening to them, and that is risky. You *know* that. Why aren't you listening here? You had convinced yourself that you could speak in everyday hypnotic language, referencing a time in the future to which the patient could look forward. You forgot a few things. First, in the face of your patient's suicidality, you decided to solve her problems by proclamation, rather than to give her what she really needed, to be understood. That would make you a hero, but not a very good listener. Nobody ever listened to Nancy. She needs that more than she needs you to be so smart. OK, yeah Rich, I'm being pretty blunt, but if you are going to learn something from this, then you need to tolerate the truth.

Rich has another problem here, and his name is Not-Me. If he tunes into Not-Me, then he locates his own pain, and if he doesn't tune in, he is liable to repeat this scene again with this patient and others. If I can keep his attention, then maybe he can learn something from me.

All you have to do, Rich, is ask yourself a simple question: Why do you believe I might have shown up in this scene, at this time, with this patient? Now Rich, don't dump on yourself about little ole' Not-Me making you conscious again of something you prefer not to think about. Remember, I am not here to torture you, just to protect you from what you find you can't tolerate feeling, or find unknowable, or unspeakable. Ask yourself: What makes it possible for Not-Me to be active now? What do you prefer not to sense, know, or feel? Does this have anything to do with what is going on in Nancy, that she doesn't want to know or feel? Is anything going on in your life, or even with another patient, that is affecting what is going on here with Nancy? What gave me the opening, Rich, to show up in this emotional script, right now?

That's right, Rich. Make a list. It's OK to be a little obsessive.

So, before you saw Nancy, you had just finished seeing one of the two most challenging patients in your practice. Chronically suicidal, you meet with her every week, just before Nancy. Go on. OK, Nancy also has been suicidal, and she does not always trust herself to be safe, promises to call if she is in trouble, but never calls. You often find out about suicidal intent by a so-called slip on Nancy's part, after the fact. So, you must be

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anxious about her. No, you haven't forgotten about the patient who killed herself while you were in medical practice. Why would you? Suicide is not just an idea. You know all about the reality, don't you? Who could really forget? You've worked through that long ago, but it doesn't mean you have forgotten, even if you'd like to. The scar is healed, but it's still there, if you will just look and notice.

So, yes, there is a trust issue, and it's not just about whether or not you will listen. You are not sure if you can trust Nancy's safety, and you're not sure if you can trust your judgment about her safety. The thing is, Rich, in the interaction we're looking at, you don't seem to want to know that she doesn't trust what you are saying. If you did, then you would have heard her say that she understands BUT. . . . And you would have asked her about it. Sounds like you couldn't tolerate knowing. Why? Oh, O.K., you can't tolerate knowing how scared you are that she or one of your many other suicidal patients might actually kill herself. But think about your being intolerant of knowing you are scared. If you are scared that she might kill herself, then how is she likely feeling? Right, she's scared too, but hasn't said so. That's the other piece of you not listening to her concern about whether or not she is sane. People sometimes kill themselves if they think they are going insane and will never recover. Now you understand me, too, Rich. You understand Not-Me. You don't want to know those feelings in yourself. Who would? I won't hold that against you, if you won't hold it against Not-me. Deal? Remember what you know, Rich: Nancy will do best if she feels she has a connection with you, even if it is understanding her helpless despair, if that's what's cooking in her. You know you don't need to cheer her up to help her survive; she needs to make sense out of her experience, to know she is sane, coherent. If she is in Hell, acknowledge it, tune in to it. At least then she won't be confused, and she won't feel so alone because you join her when you understand. Remember what you said earlier? Coherence. Right? Even if you can't stop her pain, she is better off being understood, in pain, but not so alone.

What else is on your list, Rich? Oh. Well, why should that be a surprise? You're tired of tuning in, being empathic, you need a break? Sounds like rocket science to me! OK, if you can't change the scheduling of your patients, then maybe you could give yourself the mental space of being aware that you are tired. Remember, I'm the one who steps up to the plate when you don't want to know. I will protect you, but my kind of protection comes at a price. If you are not aware, then the fatigue will

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warp your perceptions. Yes, work on your schedule, screen your new patients well, but know how you feel.

So why do *you*, my readers, think Rich avoids dealing with Nancy's statement that her issue is about feeling sane or not? Yeah, right. All of *you* out there may be getting a little reality fatigue yourself, just reading a Not-Me's paper. Surprised? This is part of what is so challenging about listening to dissociative process. You just can't do it all the time. Nobody has the brain power to do that. Sounds pretty cut and dry, doesn't it? But then you would make the same mistake that Rich was making, being rational about this. He doesn't want to tune into feeling disoriented. He can do it, but as I am saying this, he is realizing for the first time that there is something about Nancy's story that is so painful, something about the pain in her face and body that is so compelling, that he is having a hard time with it. Rich prides himself on being thoughtful, organized, intuitive, incisive. Tuning in to the experience of feeling so distant from his actions that he could watch himself doing drywall spackling and have no control over how his body was behaving must be a little unnerving for him. How are you doing thinking about that? Yes, Nancy is not exactly comfortable with it either. You know that she didn't first depersonalize because she didn't like drywall dust. She knows that too.

After Philip heard your paper, Rich, he said that Nancy *thinks* this is not sane, so she doesn't have to *feel* it's not sane. She can use the thought to distract from the feeling. I think that you, Rich, do the same thing with suicide feelings. Rich thinks he manages the suicidality in his patients well, so that he doesn't have to feel the impact of their wish to die or his own experiences of humiliation and despair. It's not pretty, but it is what it is. This is just more of Not-Me who doesn't want to feel scared but does.

This depersonalization experience, watching yourself do things that you don't intend to do, like doing drywall patching, sounds crazy, doesn't it? It's not. It is not psychotic, it is dissociative. It is just an extension of depersonalization and derealization experience, being not in my body and seeing the world as if there is something not real about it. Add a little isolated subjectivity, and there it is, experience that is hard to make coherent, and hard to trust. Depersonalization is an experience that preserves the essence of Self.

Rich has something he is just chomping at the bit to say, and he has been listening to me, so I'm going to give him a chance to speak. Thanks for listening. That is the biggest gift to a Not-Me. I appreciate it.

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OK.

Hi. It’s nice to be back. There is only a brief time left, and I want to add some thoughts about a problem that psychoanalytic theory hasn’t been able to manage yet. It is the problem of a person like Nancy who has amnesia for things she says and does, depending on which self-state is present. The problem gets trickier when a self-state spends much of its time sitting back and observing the traffic of one self-state after another, doing their thing in the world, and doing things differently, so differently that it is as if they are different people. Sometimes that self-state keeps track of what is happening by assigning different names or other signifiers to these observable experiences—names like The Kid, the Protector, The Whore, The Dummy, Mary, Jack. If that is what our patient reports to us, then how are we to respond to that report? If I am sitting with a patient who appears to be behaving like a child, speaking like a child, and she begins to cry, wouldn’t it be natural for me to say, with some tenderness in my voice, “Nancy, what would these tears say if they could speak?” Sure. But what if my patient replies to that by saying “I’m not Nancy. She has gone away. She doesn’t like to feel sad. Now I’m all alone.” How would you respond? Would you ask, “What is your name? Who are you? Has this happened before? What happened the last time Nancy left you with the sadness? How did that work out?” If we stick with the intention of moving toward coherence, then these questions seem reasonable. What if I were to say, “Nancy has to be here, you and Nancy are the same person, you don’t understand.” How would the patient respond to your dismissal of her experience?

Philip and I have had a number of discussions about the importance of our original audience, and now our readers, thinking about multiple self-states as a normative process. Each of us believes that, and works with that view. Both of us are concerned that two outcomes might happen as you read this. First, we were worried you would think we were writing about self-states only in the context of dissociative identity disorder. Second, we worried that you would stop looking for Not-Me states in yourselves, because you might think that if this were only about DID, then it didn’t apply to you.

I think there is also some risk in raising the question about amnesia and identity alteration. One kind of risk I have noted. The other is that to not *take* (the emphasis is more effective on the word “not,” I think, than on the word “take.”), the risk of noticing would mean I’d have been untrue to myself, and my patients, in bringing to you only part of what

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they bring to me to understand. So, I am making a plea for all of us to think and learn together, to not assume that we know.

Identity alteration is a pseudodelusion. Eventually, as my patients with dissociative identity alteration come to understand the full range of their lived experience, affect, sensation, behavior, and knowledge, the opaque divisions between self-states become transparent, dissolve, and are no more. I cannot convince them that they don't experience what they experience any more than I could convince Nancy that in the future she could trust herself. Each altered identity is overflowing with a richness of meaning that must be understood before healing can take place. Winnicott admonished us not to analyze the transitional object. To me, that means avoiding statements like, "You know Nancy, that is just a regular wool blanket, there is nothing special about it, in reality, you just believe there is." If Nancy has a Not-Me associated with a childhood experience, it makes no clinical sense to me to tell that Not-Me, "Look at the size of your feet, and the rings on your fingers, you are an adult, you just believe you are a child." It does, however, make sense for me to say, "You know, I have been noticing the rings on your fingers. I've been wondering what you know about those. Why do you wear them? What does it mean that you have them on your fingers?"

Identity alteration is very important in working with suicidal thoughts and feelings in our most disturbed patients. Depersonalization and derealization are robust findings in eating disorders, borderline personality disorder, and persons with substance abuse and addiction histories. Self-destructive acts are often experienced as occurring in a Not-Me manner. "I didn't feel it. It was like I was cutting someone else." "When I cut the skin, it was numb, but when I saw the blood, I felt a sense of relief, as if this arm that seems to have no meaning for me, not even to be connected, might, after all, have some proof that something in me is alive," or "I ate, and ate, and ate. I couldn't stop myself. I watched myself eat pizza after pizza, until the pain became so big that it blocked out everything else, and then I went away. I just don't know what happened after that. The next morning I woke up on the floor of the bathroom. I don't know how I got there."

How do we understand these experiences and help our patients?

You have heard from two clinicians who bring somewhat different backgrounds together to work on problems created by dissociative processes that seem designed to protect the essence of our Selves, but when taken to excess exact a steep price. We all have multiple self-states. And

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just like all of us being equal, sometimes some self-states seem to think they are more equal than others. (Well, at least that’s how Me left Not-Me feeling. Bet you thought, just like Rich, that you might never hear from Not-Me again!)

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