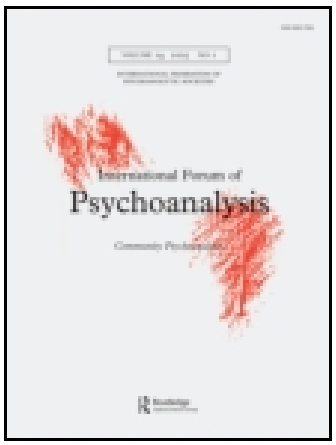

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Dialogue of unconsciouses: conversations we have without our knowledge

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Following Ferenczi's tradition of examining the dynamics between analyst and analysand, I will explore aspects of this relationship particularly around issues of mutuality versus inequality, all occurring without the conscious involvement of either participant. I propose that these issues of attachment can be further illuminated by examining the underlying neuropsychobiological processes. Case examples will be offered to illustrate these points.

Key words: Affect regulation, attachment, developmental neuro-psychobiology

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My patient's face is red, her eyes at half-mast and wet tears are rolling in torrents down her cheeks, creating blotches on her thin white T-shirt. Her shoulders heave with her deep and mournful sighs. The intensity of her pain seems to fill every inch of the room and in some ways feels like a massive storm from which there is no escape. What is my patient trying to tell me? What feelings and perspectives are inside this person that cause her such enormous distress that she has found her way into my consulting office asking, even pleading, for relief: relief from this internal pressure that feels nameless and frightening just because there are no simple words to adequately explain and illustrate her feelings and thoughts about her own process. Her earnestness conveys her need for me to understand her tears, for me to show that I can actually care.

Studying Sandor Ferenczi's therapeutic explorations, I have a keen interest in the process of communication between the analysand and the analyst. Ferenczi proposed the existence of "a dialogue of unconsciouses" (1) as an ongoing part of the therapeutic process. I will further expand on this concept of the dialogue with emphasis on the transmission of affect from an attachment perspective. Transmission refers to the sending and receiving of emotionally based material, while attachment refers to the primary connection that forms between two people who provide security and comfort for each other. This perspective includes findings from the emerging field of developmental neuropsychobiology which describes the process of affect transmission between the analyst and analysand as it affects the brain and body even when there is no conscious awareness. All of this relates to the analysand's efforts to communicate a deeply felt need for a stabilizing relationship, a longing that must often be camouflaged because of fears of the impossibility of this desire.

What does it mean to think about the dialogue of our unconsciouses? How do we actually speak to each other if we do not use words? Are we in communication at all times or only when we are speaking? Sandor Ferenczi thought about this dilemma when he began writing about technique in his efforts to understand what happens in the therapeutic processes. He was well aware that he and his patients were conversing on multiple levels simultaneously. He was fascinated by what he called this form of "receptivity" (1), or "thought-transference" (1). Ferenczi laid the foundation for an early interest in this intense form of non-verbal communication, giving it legitimacy by poetically describing the presence of this phenomenon between himself and his patients. But that was just the beginning, and it is now time to develop a further appreciation for the magnitude and complexity of this process.

Let us start by considering the dialogue and the analysand/analyst relationship. My patients, wanting to engage my attention, describe in exquisite detail the conditions, and the circumstances, that

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have caused so much psychic pain. Understanding that this communication is for a purpose, I know that I must make sense of what the patient is trying to convey that may not even be part of their own conscious consideration. What is communicated through the dynamics of the therapeutic process may be more revealing than the content of actual words. Implicit in this communication, at all times, are the patient's feelings about the nature of their therapeutic relationship. Ferenczi was concerned about the inherent inequality in all analytic relationships. Because of the actual condition of inequality, patients need to feel safe and trusting that the analyst will not use his or her position without regard for the patient himself.

> Analytic guilt consists of the doctor not being able to offer full maternal care, goodness, self-sacrifice; and consequently he again exposes the people under his care, who just barely managed to save themselves before, to the same danger, by not providing adequate help. (1: 52–53)

From reading how he explores his own process in the *Clinical Diary*, I now believe that my attitudes and subjective perspectives, whether critical of the patient or not, whether fully examined or not, will be transmitted to my patients, regardless of my intentions and whether or not these perspectives are actually spoken about in words. In addition, the patient is not just a passive recipient but is actively engaged and trying to make sense of his feelings about the therapeutic relationship even when he is not aware of trying to do this. This stance compels me to conscientiously consider how I can be more sensitive to what my patients may be trying to convey regarding our relationship, especially because of the possible aversion to recognizing their negative feelings due to their inherent dependency on me. The paradox of this therapeutic relationship is that dependency, while rarely acknowledged, to some degree is always present. Trying to grapple with this problem, D.L. Smith developed an approach which he calls "communicative psychoanalysis" (2). Smith states that we must be aware that our patients are constantly evaluating our behavior as therapists. By getting underneath the spoken word, it is possible to begin understanding more about how the patient holds the idea of the therapy as well as the nature of the attachment or the lack of it between patient and therapist. It is almost as if the patient's presentation, worded and unworded is like pieces of an enormous jigsaw puzzle that must be carefully reconstructed in order to see the larger picture. Smith believes that because of the inherent inequity in the patient–therapist relationship, inevitably the patient will try to signal the therapist regarding the difficulty of dealing with this unacknowledged control and dominance. He advocates listening to the patient's narrative for the themes having to do with connection and attachment, recognizing that these themes can then be linked back into the current therapeutic relationship.

Moving from this exploration of inequality, I would like to address the area where inequality is embedded but quite illusive. I am proposing that this inequality is a frequent component of the unconscious dialogue, the dialogue that is not spoken but which is communicated between analyst and patient. I do this out of the belief that as analysts we must develop a more attuned sensibility to the tone, nuance, cadence and choice of spoken word, as well as noting the body posture and facial expressions as a means of understanding what patients are trying to communicate about themselves and their feelings about their relationship with us as analysts. There is no question that we can learn from our patients about aspects of ourselves which are revealed through the complex interaction of attunement, disruption and possibly repair. The latter refers to the possibility of an emotionally healing experience where a process of disruption is turned into one of mutuality and regard (3). While I describe my patient's contribution to this process, my main interest is the examination of what these transactions evoke in me and the ways I have handled these experiences that have been beneficial in some instances and disastrous in others. The examples that follow examine these processes in more detail.

Some patients make a profound impression even at the time of the initial contact. Meeting Mary was exactly that kind of experience. Her pale skin and blond hair made her seem as if she was all one tone. Upon entering my consulting room she opted for the sofa against the window rather than a view of the open sky, explaining that she did not want to be distracted. I was struck by her quiet intensity as she spoke about her childhood of trauma and neglect. But what stood out most was the way she watched and followed my every movement. It

definitely electrified the room. I was not aware of being uncomfortable, but I knew that it must be affecting me because I was increasingly tense. I wondered how this dynamic would be played out between us? It was as if the figures and experiences of her difficult past seemed to exist in some plane ever present and interfering in Mary's experience. It did not take long to find this out. Mary brought in the following dream on her fifth session: "It's about you and me. Do you want to hear it?"

I came to your office wearing shorts. You looked at me and made some kind of critical comment. Then you gave me breakfast of toast and jam. I was very confused since I didn't know when the actual session began. I wondered was it when we began eating or after we finished? And why did you give me breakfast anyways? Then we began to talk and you got a phone call which you took. I was getting upset that you did this and finally told you so. You said that you had to talk to a suicidal patient. But I was so mad that I took my clothes which were there although I don't know why and I left. I told you that I wanted my money back although we had had some of the session and you had given me breakfast. I wanted to go back and see you to talk some more and to get a jacket that I left. But I felt that it would never work so I can't go back.

I listened to this dream feeling an unsettling kind of tension, realizing that she had to put me on notice about just how wary she is about the person that I am and the way I do treatment, the way I move, the way I look, the profound fear that I will breech boundaries obvious and subtle. She looked distressed and her body was slouched and listless. Her words confirmed this and thus I felt a nameless kind of fright. Corroborating this, Mary explained that she is concerned about rules and what she can expect and that this is a constant preoccupation, thereby keeping her in a frightened and tense state, probably even when she is not aware of this obsession. Previous to this treatment, she had been in analysis with a woman whom she saw for seven years three times a week. The analysis was interrupted when Mary moved to the West Coast to pursue a career. This interruption has been extremely hard on Mary because she had bonded significantly with her analyst. While she intellectually understood what this move stirred up in her, she is terrified about having to relate to another person As she explained it, "I had developed a degree of safety with Beth because I knew what to expect. Now, with you, my alarm button is going off all the time." So when I first met Mary and was trying to be welcoming, I could feel her discomfort generated by everything that was new, different and unknown about our therapy which had to replace an experience that had become securing and familiar. By relating the dream, we were able to begin the complex process of examining the myriad symbols and gestures that Mary processes as alarming. For example, my idiosyncratic habit of lowering my eyes when I am thinking and talking, was interpreted as evidence of my being overloaded and wanting to not be involved. This became a point of discussion when I noticed that Mary was shifting from being present to being in a more withdrawn state. Mary was surprised that I had noticed something that she was not even aware of doing but went on to explain how she constantly reads my behavior, looking for signs that there is some danger, even though she knows intellectually that I do not want to hurt her. I asked Mary to talk about how this process was for her internally. She explained that she sees something like my lowered eyes and then she starts feeling she wants to get away from me. Before putting this experience into words, she would have just assumed that she was correct in her assumptions. She expressed surprise that she did not feel quite so desperate now that we were exploring this mutual process together. I inquired if this meant that she felt somewhat calmer? She actually smiled and seemed to visibly relax in her chair which I again pointed out, suggesting that perhaps she was feeling relieved that we could actually talk together about what was going on between us in the therapy: "I can't believe I can actually tell you I have a problem with something you're doing and you didn't get defensive and hurt." I asked her if perhaps she thought I felt compelled to keep her from feeling upset. Thinking about this she began exploring how she believed this happened in her former treatment, which kept her feeling how dangerous and hideous her emotions must be. Relief came once more because she felt willing to consider that I could take care of myself and was not so fragile that I needed her to always be concerned about me. What would life feel like if she didn't feel this burden? From my perspective, this dream and conversation about her departure marked the beginning our highly active dialogue of unconsciouses.

This exploration was soon tested when we had to

discuss our financial arrangement changing as a result of Mary's adding an additional day of treatment. Mary's insurance paid for a portion of her therapy. When she wanted to increase to twice a week, she called the insurance company and was told she was covered. However, when I called to obtain authorization for the second day of treatment, I was told that it could only be authorized for a brief time, justified if she was facing imminent psychiatric hospitalization. I reacted to this news with dread, recognizing that I felt caught in the middle between Mary and her insurance company. When I saw Mary, I explained the loophole. Immediately, I noticed her quizzical expression as she expressed confusion that she had been given different information. I recognized that I was feeling terribly ineffective, since I wanted to provide for her, which included not causing her to feel unduly strained about the issue of money as I knew that paying for the second visit was going to be a stretch for her. At the same time, I did not want to hold her in a fragile place in my mind, so that ultimately I would handicap her by being inappropriately protective. I recognized the confusion of knowing that these opposing thoughts were going on simultaneously. But Mary had already dissociated. I talked softly to her. Why had she gone away? Gradually she began explaining that she was afraid I was "mad" and blaming her for the way things were. Whenever there is a problem, Mary automatically concludes that she will be seen as the problem, the one who caused things to go "bad". Mary went on to explain how these psychic links are now part of her, why she constructs things in a punitive manner. She talked about a time when she was in college, and even though she was living over 500 miles from her family, she was blamed whenever something went wrong As a result, Mary does not announce her departure, she just checks out as a means of protecting herself.

Wanting to understand more about the transmission process between myself and my patients, I have been studying developmental neuropsychoanalysis which offers an interpersonal perspective as a means of explaining how our brains processes emotion and thoughts. I find this perspective extremely helpful in understanding how emotional experiences become part of a person's being, leaving deeply imprinted scars which emerge whether bidden or not in moments that have personal resonance. The perspective starts with the assumption that we humans are social beings and as such we are constantly affecting each other emotionally. Actually, all mammals seek resonance with each other in order to feel safe and not threatened (4: 201–69). In order to verify this safety, mammals read each other through visual, auditory, tactile and other non-verbal cues. If there is resonance, then the participants relax and are in a non-aggressive state. But, without resonance, the signals are read as signifying danger, immediately setting off the automatic physiological process known as fight or flight. This physiological process is without thought or intention, being about basic survival either through direct aggression or by moving into a disassociative state.

This process relates directly to my analytic work since, as an analyst, my mind and body being in close proximity to those of my patient acts as an intense source of stimulus and connection even when I am not fully aware of the effect I am having on the other. Neuropsychoanalysts are now attempting to identify the pathway of this dialogue of unconsciouses which includes the processing of non-verbal cues and non-declarative/implicit memory, memories that are taken in without conscious awareness. This means that if either analyst or patient suffered from early exposure to chronic conditions that were overly arousing and frightening, then the state of heightened arousal and fear will be permanently ingrained in the brain. Neuropsychoanalysts believe that shifts in emotions and body states are actually the basis of transference and countertransference. It is as if the brain is being trained to be on red alert, ready to process danger. This is the condition that becomes transferential in the therapeutic process, where both patient and analyst are continuously being stimulated emotionally in each and every transaction. This is the crux of why this neuropsychobiological perspective expands our understanding of the therapeutic process: it explains transmission of affects both inside myself and my patient as well as what is going on between us. The neurobiological perspective provides me with a window or a way of illuminating the deeply embedded painful moments in both my own and my patient's past.

How does chronic trauma become part of a person's responses? This link is important in understanding just how deeply entrenched are the scars of the past. Why is there such a difference in our levels of interpersonal responsiveness? Fer-

enczi struggled with this question and the current neuropsychoanalysts are attempting to understand these vast differences. We know that the developing infant is highly vulnerable to stressors in both the physical and interpersonal environment. But, of the two, the greater trauma seems to be transmitted relationally, often without any actual awareness. This trauma may not be a single profound episode, but rather is embedded in the daily conflictual interactions that are part of the surround. This is called ambient trauma (5) because it is both cumulative and inescapable. Consider the level of suffering that a child must endure, when because of dependency he must remain in his family even if it is in a chronically disrupted state. The exposure to this unremitting conflict is likely to affect the child's stability and belief in the world and people as providing a secure base (6). Allan Schore and other developmental neuropsychoanalysts explain in detail how the early experiences are essentially imprinted on neurobiological structures that are maturing in the brain during the first two years of life (7). Deep within our brain is the limbic system which mediates our ability to process emotion and affect regulation. There is significant evidence that detrimental interpersonal experiences can significantly limit the development of this part of the brain. Schore calls this the evidence of "experience-dependent maturation" of the brain (7). The outcome of this failure of maturation is the impaired ability to cope with stress, which presents as a kind of rigid inflexibility. It is as if these early developmental experiences destroy connections in our brains, leaving us handicapped in later life to deal with life's inevitable stressful situations. The history of our unique relational development is embedded in the structure and complexities of our brains. The presence of this structure becomes evident in looking at the individual's capacity to handle emotionally demanding transactions. Looking at Mary, her vigilance and negative appraisal of the cues is a strong indicator of her earlier traumatizing experiences. Her brain signaled her that I was dangerous and she had the dream that concretized some of these concerns in symbolic ways. But through our therapeutic process, through our conscious dialogue, we were able to question this disruption. This is the pathway in treatment that can be reparative.

I have been explaining how understanding neuropsychobiological processes helps me to do a better job recognizing the possibility of the unconscious dialogue. I would like to present a case where I was unable to work at this minute level. In effect, the unconscious dialogue did not take place. It was as if my patient was trying to speak to me and I to her, but we were transmitting on entirely different frequencies. Randi was a thirty-year-old single woman who came to treatment because she was no longer feeling close to her girlfriends of many years. She complained bitterly about the way her former friends were treating her, believing that they were no longer interested in her or in what she was doing. She described in great detail how these relationships ended and how much this upset her. I watched her speak and was struck how she rarely looked at me. Even when describing painful moments, she spoke in a rote, remote tone. Rarely did she ever make eye contact. Time passed but her feelings of being unwanted and uncared for did not abate. In fact, her sense of not fitting in anywhere and of not belonging dominated her whole experience. She used psychological words, but expressed primarily annoyance, irritability and disdain. During our twice-weekly appointments, I would sit with her wondering what I could do to help her feel more connected. I asked her to be curious about how she felt about our relationship but she was vague and noncommittal. These feelings felt reciprocal because I did not feel much towards her, with the exception of foreboding. This kind of blankness is unusual for me. I knew that I was uncomfortable with the level of hopelessness. Feeling I was not managing well, I sought consultation in order to understand the root of my discomfort. I had to face that I had been unable to engage her sufficiently for her to feel any kind of positive emotion. I could only conclude that the experience of being in therapy was so shaming that she felt a sense of nonexistence. The words we shared together felt pointless. And still I did not find a way to read her subtle cues that might have helped me understand what she was feeling, yet unable to have the words to say. One day she left the message on my voice mail that she was not coming to treatment any more. While the timing of this took me by surprise, in some ways it made sense. I hung up the telephone with my heart racing and that hot, desperate feeling that I know is a sign of my most extreme anxiety. I wanted to wait until I was calmed down, but I was torn because I also wanted

to call her and try to get her to at least come and talk with me about what was so terribly wrong that she was unable to see me any more. And then, as I sat with this, I realized that I had been blinded by my own need for attachment and had failed to recognize the meaning of her distancing and self-protective behavior. In thinking about what had happened between us, I feel great pain for how desperate she must have been to have had to resort to such an extreme action to convey what was going on inside of her. Several weeks before she had told me that her boss had not listened to her and that she felt quite misunderstood. It now seemed evident that I too, like the "boss", had not recognized or been attuned to her. In her family of origin, she had to care for her parents psychologically and in some way she apparently felt that she had to accommodate to me as well. What was I transmitting to this woman? Did I become lost in my own discomfort rather than understanding why Randi felt so hopeless about her life? Had I become like her mother and father, people who needed to see her as alright rather than being able to hear and hold her sadness. Unfortunately I will never know. Whatever she was transmitting, I was unable to read it. It was as if we lived in a well of silence on two separate planes. I felt despair for us both, and especially because I could not talk this over with her. I felt as if I had truly become the soul murderer, in Ferenczi's words, the perpetrator (1).

And so, as I have begun to lay out, this process of therapeutic exploration occurs on many levels simultaneously. The patient and analyst are engaged in an unconscious as well as a conscious dialogue. What seems obvious is often not the core issue for the patient. As these clinical examples suggest, the ever-present transmission of affect in both directions between myself and the analysand seems to be a key factor in tracking the presence of this unspoken communication. It seems imperative to consider the presence of this secondary dialogue as it allows us to be much closer to the deepest feelings, the truths of the person, to recognize the trauma that the therapeutic process may be creating. Can a patient express their hurt, fright or sense of dismissal which may be evoked by the therapist's words and/or actions? Are these experiences always worded or does the patient even know that they are feeling traumatized? Decades ago, Ferenczi began the work of questioning the analyst's responsibility in potentially retraumatizing his patients. Because of my keen interest in these disjunctions, I have found that I understand patient's process much better by using neuropsychobiological principles. Looking beyond words, as analysts we must recognize that we transmit our emotions every moment of contact as part of our dialogue of unconsciouses.

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Summaries in German and Spanish

Thau NS Dialog unbewusster Konversation, die wir ohne unser Wissen haben

Ferenczis Tradition folgend, die Dynamik zwischen Analytiker und Analysand zu untersuchen, will ich Aspekte dieser Beziehung besonders um Fragen der Gegenseitigkeit versus der Ungleichheit explorieren. All das geschieht ohne bewusste Verwicklung beider Teilnehmer. Ich schlage vor, daß diese Fragen der Bindung weiter erhellt werden können, indem die zugrundeliegenden neuropsychologischen Prozesse untersucht werden. Es werden Fallbeispiele gebracht, die diese Punkte illustrieren.

Thau NS. Dialogo de inconscientes: conversaciones que tenemos sin nuestro conocimiento.

Siguiendo la tradición de Ferenczi de examinar las dinámicas entre analista y paciente, exploraré aspectos de esta relación particularmente alrededor de los problemas de mutualidad versus desigualdad, todo lo ocurrido sin el compromiso consciente de cada participante. Propongo que estas cuestiones de apego pueden ser aclaradas examinando los procesos neuropsicobiologicos subyacentes. Se ofrecerán casos ejemplo para ilustrar estos puntos.