

DANCING THE DANCE
WITH DISSOCIATIVES:
SOME THOUGHTS ON
COUNTERTRANSFERENCE,
PROJECTIVE IDENTIFICATION
AND ENACTMENTS IN
THE TREATMENT OF
DISSOCIATIVE DISORDERS

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ABSTRACT

Therapists working with dissociative patients, with their complex, overlapping transferences, frequently encounter countertransference conundrums. Further complications arise as the dissociative patient frequently uses the defense of projective identification, whereby the therapist is left "holding the bag," experiencing the patient's unwanted feelings or unacceptable impulses. Patient and therapist become the inevitable participants in transference enactment, each unwittingly playing a role written from the patient's past. However, projective identification and enactment may both be viewed as a powerful type of communication, allowing the therapist to understand the experience of the patient in a uniquely empathic way. By creatively welcoming inevitable enactment, the playing out of the patient's unconscious dynamics in the therapy, the therapist and patient can work through otherwise uninterpretable clinical material. This paper proposes that in the transpersonal field of therapy with dissociative patients, therapist and patient, "dancing together," can rework old patterns and arrive at new, deeper understanding and change. Case material is presented to illustrate this thesis.

The subtitle of this paper reflects the idea that this is a work in progress, a musing on the intricate "dance of therapy." It is a paper about technique and the process of making use of the patient's unconscious communications with the therapist (through transference/countertransference, projective identification, and enactments) in the psychotherapy of the dissociative disorders, dissociative identity disorder (DID) and dissociative disorder NOS (DDNOS).

Dancing – two people reacting to and moving with each other, leading or following, somehow in tune with intricate movements and nuances of the other. How alike this is to the therapy process. It is what we, as therapists, strive for, those aspects of the interaction which are beyond words and cognition, where therapist and patient may attain new levels of understanding through the "dance." This is the realm of knowing without saying, that which takes place in the countertransference through the experiencing and later under-

standing of projective identifications and enactments. Although enactments can be destructive (frequently the beginning therapist is admonished to beware of enactments), I propose that many are not only constructive, but vital to being able to be with the patient in her world (Ogden, 1982; Casement, 1985; Scharff, 1992; Sandler, 1998). Psychotherapy is a mutual (but not reciprocal) relationship, with both patient and therapist contributing to each other and to the process (Casement, 1985; Meissner, 1996; Aron, 1996; Renik, 1998).

Dissociative patients can often only communicate with authenticity in the most primitive ways, having been harmed at such an early stage of development and in such intrusive and traumatic fashions (Krystal, 1988; Fink, 1988; Putnam, 1997; Bollas, 1987). Christopher Bollas (1987) discusses the use of countertransference as a way of understanding what is not consciously available to the patient but which nevertheless influences and guides their felt experience. The mind of the dissociative disorder patient contains much that cannot be spoken, but can be known only by the shadow of the object as it falls upon the ego (Freud, 1917/1957, p. 249). Whether from an ego state which is in executive control or one that is "behind the scenes," communication of the patient's earliest memories and experiences frequently is beyond spoken language and symbolization. It is thus imperative for the therapist to be open to other means of learning of and from the patient.

What goes on in therapy with dissociative identity disorder (DID) patients? The patient comes in with certain expectations, likely having grown up in an abusive, neglecting environment and having survived through her use of dissociation and other primitive defenses (Braun & Sachs, 1985; Goodwin, Cheeves, & Connell, 1988; Putnam, 1989; Ross, 1989; Marmer, 1996). From before the moment the therapist and patient set eyes on each other, all the underlying histories and world views, unconscious phantasies, hopes and dreads come into play. While that which may be manifestly taking place in the therapy (assessing the patient, establishing the frame, teaching containment and so on) is vital and deserving of our attention and knowledge, at another level, we are two people playing out in the process that which may never be able to be communicated with words. It is this dance of which I write, the discovery of our client's world through

this interplay and of being able to dance with her in order to bring to consciousness and work through the traumata of her life.

To begin, we must define the terminology as used in this paper. It is a given that psychoanalytic terminology is particularly fraught with difficulty as each term has a variety of meanings and usages. In this paper, the definitions used are largely those influenced by the British School of Object Relations, that is, Klein (1946), Winnicott (1958), Bion (1961, 1967), Heimann (1950), Bollas (1987), Casement (1985) and others in this tradition.

COUNTERTRANSFERENCE

According to Laplanche and Pontalis (1973), countertransference is "the whole of the analyst's unconscious reactions to the individual analysand – especially to the analysand's own transference" (p. 92). In Freud's earliest formulation, countertransference was seen as a result of the patient's influence on the analyst's feelings and that this was a result of the analyst's own complexes and internal resistances. However, he also understood the communicative nature of countertransference when he said that the mind of the analyst could be turned "like a receptive organ towards the transmitting unconscious of the patient" (Freud, 1912/1958a, p. 115) that the therapist's "unconscious is able, from the derivatives of the unconscious which are communicated to him, to reconstruct the unconscious, which has determined the patient's free associations" (Freud, 1912/1958a, pp. 115-116). Unfortunately, this second understanding of countertransference did not gain favor until much later (Laplanche & Pontalis, 1973; Ellman, 1998). Since Freud, there has been much disagreement as to what is countertransference and whether it should include everything in the therapist's personality that is likely to influence the therapy, or whether it should just be restricted to those unconscious processes in the therapist that are brought about by the patient's transference (Laplanche & Pontalis, 1973). This, of course, speaks only to the "pathology" of the therapist and not at all to the interpersonal nature of the transference/countertransference matrix.

I will use the term countertransference to refer to all the reactions in the therapist during the session, including images, feelings, thoughts, impulses, sensations, and so on, whether conscious or unconscious and including dreams, fantasies, and images about the patient outside of the session time (Usher, 1993). Although some of these may be the therapist's own transference to the patient or the result of unresolved conflicts within the therapist, much countertransference can be seen as something being evoked by the patient in the therapist (Jacobs, 1986; Epstein & Feiner, 1993; Maroda, 1994). At any time, the therapist may not be seen as herself, but instead the patient's parent, friend, grandparent, sibling, spouse, child, or even the patient herself. In

the transference with DID patients the therapist may be any one of the patient's alter personalities or ego states. The "trick" is to be able to figure out what belongs to whom. What belongs to the therapist needs to be dealt with in the therapist's own therapy, analysis, or supervision. What belongs to the patient becomes part of the focus of the therapy. The therapist learns the "transference dance steps" the patient needs her to understand. This is not to say that both countertransference particular to the patient's productions and countertransference particular to the therapist's own past do not operate simultaneously, as they do, but only to clarify these two "definitions" of countertransference.

PROJECTIVE IDENTIFICATION

According to Laplanche and Pontalis (1973) the term projective identification was first coined by Melanie Klein to describe a "mechanism revealed in phantasies in which the subject inserts his or herself – in whole or in part – into the object in order to harm, possess or control it (p.356)." The mechanism of projective identification, closely associated with the paranoid/schizoid position (Klein, 1946), consists of the phantasmized projection of split off parts of the subject's self or even his whole self – into the interior of the mother's body, so as to injure or control the mother from within. It is important to differentiate between projection and projective identification. This has been the topic of much discourse, but I would simply say that projection is onto the object, without involving the object itself whereas projective identification is into the object, with the resultant experience of the object being changed. This would go further than Klein, who stresses that projective identification goes on in the primitive fantasy of the infant at a time when the child has not yet developed language and does not involve the object in reality. Klein stressed that in order to defend against the experience of the bad object, the infant engages in splitting of the object and causes a corresponding split in the ego. The bad is then gotten rid of through projective identification and with it some of the ego, leaving the person depleted. I would suggest that in our dissociative disorder patients, instead of splitting of the ego, there are creations of new ego states (through traumatic trance and dissociation), and it is into these new ego states that other ego states project the disavowed unacceptable feeling, impulse or object. It may be that within any ego state, there is also a splitting of the ego with the resultant good/bad split of which Klein talks, although this is not necessarily the case. Each ego state experiences the other ego states as "external objects," living in the inscape (the interior world as experienced by the collective ego states) (O'Neil, 1997). Within the inscape, the use of projective identification and introjective identification among the ego states serves the function of one state riding itself of undesirable affects (for instance, one ego state [alternate personality or "alter"] may use another ego state

to contain all the anger); or to control another (for instance, the projection of the experience of helplessness from a persecutor state to a child state, leaving the child feeling helpless and vulnerable to the persecutor state and the persecutor state rid of the feeling of helplessness).

Hinschelwood (1989) discussed Bion's notion (Bion, 1959) that the concept of projective identification could be categorized into normal and abnormal projective identification. The aim of pathological projective identification is to rid the self of a painful state of mind by forcibly entering an object, in phantasy, both for immediate relief, and frequently with the aim of an intimidating control of the object. In contrast, the aim of normal projective identification is to introduce into the object a state of mind, as a means of communicating with it about this mental state (Hinschelwood, 1989). Introjective identification is the mechanism by which the object of the projection takes into him/herself the identification. With our dissociative disorder patients both pathological and normal projective identification may be operating within the therapy and we may introject these projective identifications.

Herbert Rosenfeld (1983) began to catalogue the kinds of phantasies involved in projective identification. These are particularly important in looking at our patients and include:

1. Projective identification for defensive purposes such as getting rid of unwanted parts of the self via:
 - omnipotent intrusion leading to fusion or confusion with the object;
 - the concrete phantasy of passively living inside the object;
 - the belief in a oneness of feeling with the object;
 - expulsion of tension by someone who has been traumatized as a child by violent intrusions.
2. Projective identification used for communication:
 - a method of getting through to an object believed to be aloof;
 - reversal of the child/parent paradigm;
 - identifying with similarities in the object for narcissistic purposes.
3. projective identification in order to recognize objects and to identify with them (empathy).

Furthermore, since projective identification is a phantasy function used in the construction of the self and of objects, there are important consequences for the individual. According to Rosenfeld, these include:

- a) the underlying splitting gives the sense of being in pieces;
- b) the experience of a depleted and weakened ego leads to complaints of having no feelings or drives and a sense of futility;

- c) the loss of ego can be experienced as a sense of not being a person at all;
- d) the identification with the object leads to a confusion with someone else;
- e) the ego may feel that parts of itself have been forcibly removed, imprisoned and controlled;
- f) the identification may result in a peculiarly tenacious clinging to the object in which parts of the self are located;
- g) anxieties arise about damage to the object as a result of the intrusion and control;
- h) there may be severe anxieties about retaliation by the object for violent intrusions; and
- i) the fate of the object in pathological projective identification is the fate of the lost self, which may come to be felt as alien and persecuting.

So why is all this important? Rosenfeld's work has been with severely disturbed patients, those he considers to be borderline, manic-depressive or psychotic. When we look at his list of consequences to the development of the self as a result of projective identification, and we make the paradigm shift to ego states rather than internal objects, we begin to see something of our dissociative disorder patients. Certainly our patients experience themselves to be in pieces, they may feel numb and without desire and the "host" frequently may be experienced by the therapist or the patient as an "empty shell." They suffer from depersonalization and have trouble at times telling the "me" from the "not-me" and one ego state may feel persecuted by, be confined by, or be cast aside by another. The patient often seems inordinately tied to the abuser, even while feeling controlled by him. There are fears of both being damaged by him and destroying him.

Rosenfeld's insights describe both the internal world of our dissociative clients and their object relations. In the context of our clinical work we observe that ego states can "take over" the patient, and experience the world from an "I" point of view. For Rosenfeld's patients, internal objects are in relation to the single ego and do not experience independent agency within the external world nor within the intrapsychic world of the patient. In projective identification, in object relations terms, it is part of the internal object along with part of the self which is projected into the external object. In dissociative theory, an ego state may partly function to contain the internal projective identification of another ego state, or may project part or all of herself into the external object and more than one additional ego state at the same time. For example, an angry ego state, which holds the unacceptable rage of another (say needy child state), may project into the therapist their rage, while the child state may be projecting their helplessness. There may be more than one projective identification operating at any given time. The therapist may introjectively identify with these conflicting aspects of diverse ego states.

Furthermore, the patient, when a child, was likely the object of the projective identifications of the perpetrator or perpetrators. To contain these projective identifications and to find an outlet for their expression, the dissociative child may have developed a new ego state, as in the following vignette.

CLINICAL VIGNETTE NUMBER ONE: CHARLES

A thirty-year-old man, with Dissociative Disorder Not Otherwise Specified (DDNOS), in a five-year-old ego state, tells me of being sexually abused by his grandfather and seeing the "black stuff" in the eyes "of the bad man." He is afraid of this, afraid to look into the eyes of the grandfather, because he knows that if he meets his grandfather's eyes, the black stuff will go into him and will be inside him. This session took place some years after the host, who had been unaware of this ego state, talked of feeling a "black goo" inside him, one that he felt he needed to get rid of and for which he would injure himself in hopes of letting out the blackness.

I believe that this was the experience of the child (at about three years of age) of the projective identification of the grandfather who saw the boy as bad (he also beat him) and into whom he projected his own badness, feelings of disgust, and shame. The grandfather needed to control the boy and the child feared looking into the eyes of the grandfather, becoming paralyzed by the look and actually feeling the badness going into him (the sexual abuse was not penetrative). The sense of badness was reinforced by the child's experience of pleasure at times when the sexual stimulation did not overwhelm him. The fragile ego boundaries of the young boy were unable to defend against the grandfather's need to be rid of an aspect of himself and were breached, resulting in the introjection of the badness of the grandfather. This projective identification forms part of the core identity of "the angry one," an ego state who is generally locked away in the patient's internal world. There is some evidence that in early adolescence, this ego state was preoccupied with sexual fantasies toward younger children. Cutting and other self injuries would allow the release of the bad part of the angry ego state, without it having to harm another person.

Much of the trauma our patients have experienced has not been symbolized through language. It is no wonder that the dissociative patient unconsciously uses the preverbal defense of projective identification (whether into the internal ego state or into the external object) to protect herself against a world experienced as threatening and persecutory. The use of the projective identifications and enactments in the course of the therapy helps us to untangle that which frequently cannot be known in thought. But projective identification can also be used as a bridge between our patients and ourselves, a way to empathically experience the patient and her internal state. This is like the refrain of the folk song, *Pack Up Your Sorrows* (Fariña & Marden, 1965):

If somehow you could pack up your sorrows,
And give them all to me,
You would lose them, I know how to use them,
Give them all to me.

Projective identification in the countertransference is the experience of having a disowned part of the patient's self or part of an ego state come to reside in the therapist, be experienced as alien by the therapist, and be "metabolized" and contained by the therapist's "thoughtful feelingness" so that the patient gets the experience of the therapist as now containing the unwanted part of the self. Bion (1961) states: "the experience of countertransference appears to me to have a quite distinct quality that should enable the analyst to differentiate the occasion when he is the object of a projective identification from the occasion when he is not. The analyst feels he is being manipulated so as to be playing a part, no matter how difficult to recognize, in someone else's phantasy – or he would do it if it were not for what in recollection I can only call a temporary loss of insight, a sense of experiencing strong feelings and at the same time a belief that their existence is quite adequately justified by the objective situation." Although Bion here refers to the most destructive aspects of projective identification, I believe that even in benign projective identification we feel drawn into the dance by our patients, becoming their partners.

Enactments

The concept of enactment is somewhat new to analytic thinking (Chused, 1991; McLaughlin, 1991; Basseches, 1998; McLaughlin, 1998). Freud made no mention of the term itself, although he did refer to acting out in ways which we might now consider to be enactment (Freud, 1914/1985b). Laplanche and Pontalis (1973), in their comprehensive, *The Language of Psychoanalysis*, have no listing for the term. It is still in some dispute as to when the term came into psychoanalytic parlance and who introduced it. The dispute continues as to what constitutes enactments in the therapy and to what use they can be put. However, for purposes of this paper, the term enactment refers to "any action occurring during the psychotherapy or psychoanalysis that repeats an earlier similar experience or fantasy and communicates feeling from such an experience or fantasy by non-verbal means in a way that will draw the therapist or analyst into a non-verbal communication" (Helm, 1998, p. 157). Furthermore, Renik (1998) draws our attention to the very ubiquitous nature of countertransference enactments in all psychotherapy or psychoanalysis. He contends that the enactment necessarily precedes countertransference awareness, the rich source of understanding our patient's compromise formations. Thus, we may conceptualize "the dance" as, in part, a mutual enactment in the therapy which bring us a richer and closer understanding of our dissociative patients.

Frequently, these enactments go on over a very long time, unfolding gradually and insidiously. We may be completely unaware of them, in their subtlety. On the other hand, we may be acutely aware, especially when we find ourselves acting uncharacteristically with a certain patient, as in the following example.

CLINICAL VIGNETTE NUMBER TWO: CHRISTINE

Christine, a 35-year-old woman with Dissociative Identity Disorder (DID,) can evoke tremendous rage in me. During the session, I have fantasies of screaming at her, of throwing her out of my office, and of generally being abusive towards her. This is very unlike me, as I tend to be fairly tolerant and accepting. I find myself making what I would call "mean interpretations," those interpretations which while essentially correct, are worded in such a way that they can be hurtful. On one occasion, after several of these interpretations, I caught myself in this and asked, reflectively, what was going on. A quick self-examination brought up some personal issues, but not sufficient to explain the depth of my rage. Finally, I calmed down enough to say something without such anger, and commented that we seemed to be playing out something. She continued by complaining of her mother's general verbal abuse of her, calling her names, and being mean. I pointed out that maybe I had said something to her that sounded mean, as if I were being her mother. She denied this, and I continued, saying that perhaps she could not admit this because she was worried that I would take it as a criticism and abandon her. She said that she "loves me" and would not want to upset me. I responded that she loved her mother and that as a child she feared that she could not say anything critical to her mother for fear of the mother's retaliation and the possible loss of the mother. I told her that I thought we were playing this out in the therapy. She began to cry and there was a partial emergence of the little Christy (a four-year-old ego state), forlorn and wanting hugs and reassurance that I still loved her. I did not give in to these demands from little Christy. Instead using empathy, I told her how scary and sad it must have been to be needing mother so much and getting mostly anger and abuse from her. The adult part then took over and she talked more of mother and began to express her anger towards her. Had I not taken part in the enactment, at first unwittingly and then catching myself and using the understanding I was getting, we might not have been able to get to the expression of affect in both the adult and the child ego states.

In this vignette, the enactment preceded the understanding and was immediately available to interpretation and further understanding. However, it is more likely with our patients that the enactments go on over a period of time before being accessible to awareness, self analysis, and eventual analysis and interpretation with the patient. The following vignette demonstrates that the long enactments in

the therapy must play out over many sessions before beginning to make sense and allow for the unfolding of new material.

CLINICAL VIGNETTE NUMBER THREE: TINA

Tina is a 32-year-old woman diagnosed with Dissociative Disorder Not Otherwise Specified (DDNOS), who has perhaps been my most challenging patient. What makes her so difficult is that she rarely talks at all, never speaks spontaneously, and frequently cannot be engaged. At the same time, she cannot tolerate much silence in the therapy and so the therapy has taken a very peculiar form. She comes in, says nothing. I make a comment, either reflecting her look, her movement, or I ask how she is, and she may or may not respond with one-word answers or, occasionally, with a couple of sentences. Sometimes she will answer direct questions, generally ones to do with what autobiographical history she can remember or something in her current life which may not be too threatening. Sometimes, under the influence of her little girl ego state, she can be somewhat playful, but this is rare. The therapy has gone on like this for several years. Sometimes I have tried to interpret the lack of communication, but this appears to have little impact. Much of the time I have felt that my interpretations and even my questions were invading her space, or violating or intruding upon her. However, the alliance has grown. Over the past year there have been significant changes, if not in her mode of communication, then in our understanding of it.

When I first started seeing Tina, she said that she had been sexually abused by her step-father. This emerged in an incomplete memory she had recovered spontaneously some years earlier. Her step-father had come into her life when she was about three years old and died when she was fourteen. Her mother was a severe alcoholic from before her birth to the time she was about thirteen. Her mother had neglected her to an extreme, leaving her care, from infancy on, to a neighborhood woman and to Tina's sister, who is seven years her senior. It seemed that mostly Tina was left on her own. Her isolation was interspersed with the abuse from her step-father, who paid more attention to her than mother, involving her in sports but also abusing her. She refused to consider that her current problems had anything to do with the step-father's abuse, but did admit that her relationship with mother might have had some bearing on her current situation.

More recently we had identified several ego states. These were previously well hidden from me (while not necessarily from her), although I had periodically assessed her for dissociated states and phenomena, which she had not confirmed. Through these states, Tina became able to have more access to memory of the abuse. Interestingly, the most vivid memory of abuse had to do with her sitting in the living room watching television, with her mother drunk in

another room. Her step-father, who had been reading the newspaper, wordlessly walked over to her, sat beside her, and without any verbal interaction whatever, put his hands into her pants and fondled her genitals. She tried to stop him by pressing her legs together. She could not resist, and he continued. After the abuse was over, he went back to his chair and resumed reading the paper. Tina related this to me at one session, in a somewhat dissociated state, without any affect but with some physical sensations upon which she would not elaborate.

After telling me the story, she became completely "spaced out" and wanted to injure herself. A few weeks later, she became intransigently silent session after session; she left one session after 20 minutes. She would allow no contact with any of the ego states, especially the child part of her. Session after session I privately reviewed the process, especially my internal experiences and fantasies.

After some weeks of this, I commented: "You come to the sessions and say as little as possible and I find myself in a difficult situation. Some of the time when I don't say anything, I feel as though I'm your mother, allowing something to happen to you but being partly oblivious. At other times, I feel like your step-father, intruding on you, with my words, while you are silently suffering. And at other times, I feel totally paralyzed, the way you must have felt when you lived through all this." At this point, there erupted all sorts of twitching (the way that the child state usually made her presence known) and she looked at me in silence, but instead of conveying hostility or boredom, she seemed both interested and sad. I commented that it must have been a horrid situation and that she needed me to know just how impossible it was and how much she still felt this way. Although she did not become more overtly verbal in that session, it was clear that she had felt understood in a way that was different from the past.

I am certain that there was projective identification going on here from several different ego states. Instead of continuing to play out one of the roles of the ego states, I had been able to let her know that I too had felt in the roles of these ego states. Holding parts of her and then verbalizing my experience allowed her, in future sessions, to explore some of them. One ego state called the "Presence" brought up overwhelming feelings of fear, an ego-state probably based on the introject of the step-father. In the sessions, there had been times when I found myself asking more and more questions, anything to try to engage her. I felt almost compelled to do this. My interpretation was that the "Presence" ego state, who haunted and tormented her, took the form of my needing to "go after her," yet not in silence as did her step-father but with words to which she could not respond. They were beyond her, just as the sexual probing was beyond her understanding. There was a long and involved enactment, over several years, which needed to be experienced by us together in order to reach an understanding of what could not be spoken, a

silent painful suffering, of which I had to be part. The unbearably long time reenacted the child's experience of being unbearably alone, seemingly forever, unheard and unheeded. It was only when I could put the shared dramatic dance into words, that I could connect with that child, deeply hidden.

USING PROJECTIVE IDENTIFICATION AND ENACTMENTS

How then are we to make sense of what we are experiencing within ourselves in relation to our patients? What are the questions that we need to ask ourselves in order to sort out this process, in order to learn the dance? First, when we feel that we are invaded or drawn in, where something is being powerfully evoked in us as therapists, we need to ask "to whom do these evocations belong?" If we understand that these are partially arising from some of our issues then this would suggest that we need to be aware of and manage our own transference issues, perhaps with supervision or our own therapy. It is when we first say, that this is a not-me experience, or when we find ourselves reacting in uncharacteristic ways that we are in the realm of projective and introjective identification. It is here that we need to ask further questions of ourselves. Bollas (1987) moves through the development of the specific questions one might ask as noted by various analysts. He cites Paula Heimann (1950) as asking the questions: "Who is speaking?" "To whom is this person speaking?" This implies that at any time during a session there are shifts among the internal objects; that the patients may be speaking "with the voice of the mother, or the mood of the father, or some fragmented voice of a child-self either lived or withheld from life" (Bollas, 1987, p. 1). Later in the 50s, Margaret Little (1951) added the questions that the analyst asks herself: "What am I feeling?" "Why am I feeling this?" and "Why now?" These questions make the link between the patient and the therapist, bringing the therapy into the realm of interplay, of dancing together. To these questions, I would add: "Who am I being with this patient?" "What part of the patient do I hold?" "What does this interaction mean to the patient?" "Why do we need to engage in this dance?" Keeping in mind that projective and introjective identification may serve many functions, it may be necessary to return to these questions again and again in order to begin to put the dance steps into words.

Some of the time we may be containers for unacceptable affect. Sometimes we are being controlled or harmed by the intense rage and desire to destroy the loved object. At times we learn what it is "like" to live our patients' lives; at other times, to be the abuser or unavailable, neglecting parent. Whatever our role, we can often only truly understand by engaging in the dance.

Patrick Casement (1991) suggests the use of two devices in helping with the understanding of the transference-coun-

tertransference experience in order to be able to make an appropriate interpretation: using the "internal supervisor" (a process whereby the observing ego of the therapist can supervise the experiencing therapist's experiencing ego in situ) and "trial identification" (hearing an impending interpretation through the patient's ears). I find both of these very helpful; however, how might we do this if we do not allow ourselves to dance with the patient? It is only when the dance becomes second nature to us, that we may be able to put into words what was previously unspeakable.

More recently, writers in the trauma field (Wilson & Lindy, 1994; Pearlman & Saakvitne, 1995) have discussed secondary traumatization as a special type of countertransference stemming from introjective identification with traumatized or dissociative patients. Still others (Kluft, 1994; Gabbard & Wilkinson, 1994; Davies & Frawley, 1994) identify some of the transference-countertransference positions commonly experienced by therapists treating borderline and DID patients or sexual abuse survivors and discuss ways in which to understand the experiences and to make use of them in the therapy. Being able to stay with these countertransference experiences and to transform them for our dissociative patients is an essential part of our therapeutic work.

The last vignette demonstrates the process of dancing the dance with a complex DID patient. Here the therapist comes to connect affectively and empathically, and also to understand and interpret the enactments in the therapy.

CLINICAL VIGNETTE NUMBER FOUR: LIZ

When I first began to see Liz, some ten years ago, she was an 18-year-old student, very emaciated, but smiling and pleasant – a very incongruous sight. At the time, her diagnosis was anorexia nervosa and borderline personality disorder. She presented with a history of sexual abuse which she had only recently disclosed to her previous therapist. The case was transferred to me as that therapist had taken a sabbatical. The diagnosis of DID was made about a year and a half into therapy with me and was my first diagnosed DID case.

Some months after diagnosis, she began to talk of a cult abuse history and eventually I met her main "cult alter" whom I will call Deirdre. This ego state was usually very agitated when she came out. She was threatening to those around her and to other internal ego states. As a matter of fact, my first meeting with her was when she was in restraints in the intensive care unit of a psychiatric hospital. After admission she attacked several nurses and was completely out of control, trying to burn herself and verbally threatening other patients. The staff were all afraid of her. I sat with her while she struggled and screamed and cursed and threatened me while restrained in a rather airless room. I spoke with her quietly, remarking on how angry she was and scary. But then something happened to me. I noticed that my eyes had filled

with tears and that they had begun to stream down my cheeks. I felt no sadness, fear, anger, as a matter of fact I felt rather calm. But the tears were undeniably there. Puzzled, I searched myself for the sources of this sadness. I decided that they might in fact be coming from an introjective identification with this desperate part of herself, who wore the mask of the bad, frightening, and destructive ego state. I commented to Deirdre, who was looking at me with surprise and some curiosity: "I think that I am crying your tears. You cannot let yourself cry them, because then you would no longer scare away the outside world. And maybe you would also know just how sad and lonely you are." She continued to curse me and struggle, but within a few moments was able to calm down and talk, very haltingly, as though she had never really talked before. This was the beginning of a long relationship with Deirdre, in which most of her disowned feelings were projected into me, for me to name, contain or metabolize. Frequently, I have been caught off guard by these experiences, but always I have experienced them as not mine, as though something had entered me.

Here, I believe, the projective identification is not so much used in the standard Kleinian sense of control or destruction, but instead as a way for me to contain something which she finds overwhelming. This does not mean that all of Liz's projective identifications are her way of creating within me a part of her for purposes of containment or metabolizing overwhelming affect. She uses projective identification for many reasons, including to control me. However, its use both to communicate what it is like to be her and her being able to witness in me, something of herself, accepted, named, and reworked, has allowed her to reown aspects of herself that I believe would not have been able to even been allowed into awareness, were it not for the use of projective identification in the therapy.

The enactment in the intensive care unit allowed her to feel as though she were being "rescued," something that in fact her mother did not do. We can understand this aspect of the enactment as my having also taken on the role of the mother, that mother who would have held her child's pain and rescued Deirdre from the abuse. The eventual understanding and interpretation (after several similar enactments) came about because I tacitly agreed to dance with her. It was only as we observed the changes in her through working through these projective identifications that we could understand together how painful it had been for her to be abandoned by her mother, who seemingly turned her back on or turned her over to her father and his cronies who abused her.

There have been times with this client when I felt a need to block the projective identification (did not dance with her), and these came to be failures in the communications and caused disruptions in the alliance. It was only after processing these enactments themselves that we came to understand their meanings. Frequently, Deirdre had the need to

have me take on the role of the "bad" mother, who would not respond. Until we were able to unravel these complex transference-countertransference interplays, make sense of the enactment, and put them into words for further work, therapy was derailed and threatened with failure.

DISCUSSION

These clinical vignettes give some flavor of the work of experiencing the powerful projective identifications and enactments typical in the treatment of dissociative disorder patients. These patients may not be able to put into words their most traumatic and conflictual material, possibly because of (as recent research seems to indicate) biological reasons (van der Kolk, McFarlane, & Weisaeth, 1997) as well as ones which are psychodynamic. By taking part in their enactments, we may be able to appreciate more fully the patients' experiences and their meanings, and be able to provide verbal expression otherwise inaccessible to the patients.

In the past, therapists have been admonished for "getting into" enactments with the patient. This, I believe, has led many therapists to either shy away from learning from the experiences or to feel shame for having "fallen into acting out" with the patient. The rich material available through this approach is blocked from awareness or rejected. Awareness may only come about after enactment. Dismissing enactments as "mistakes in technique" means that a standard experience in the treatment of persons with dissociative disorders will not be subject to inquiry, a grievous loss for the patient and clinician alike.

We must allow these experiences to unfold, to abandon for the moment the psychic distance that we often maintain, so that we may make our patients our partners in dance. For this, we must allow the invasion of the projective identification and allow part of our patient's inner world to be within us. Through this dance, we can help the patient make sense of herself, hold and metabolize the traumas, and work toward healing. To quote T. S. Eliot (1959):

We shall not cease from exploration
And the end of all our exploring
Will be to arrive where we started
And know the place for the first time. ■

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