The Clinical Uses of Therapeutic Disjunctions

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[abstract] Disjunctions are subtle blocks to therapeutic progress. At any moment analysis can be derailed as the analyst and patient work at cross-purposes. Disjunctions may arise from internal conflict dealt with, for example, through repression coupled with projection, splitting, or dissociation, from surface incongruities such as differences between the therapist's and patient's styles and cultural dissimilarities, or from harder to classify factors separating therapist and patient. The concept disjunction is descriptive. Disjunction refers strictly to the restricted capacity of the analyst and patient to work together therapeutically. Conceptualizing therapeutic impasses as disjunctions, rather than, primarily manifestations of transference-countertransference, adds depth and texture to the analytic operation. It encourages partners to work cooperatively, as they resolve analytic blocks regardless of their nature.

Disruptions in the analytic process go by many names. Included are: resistance to full analytic participation, impasses (Goldberg and Grusky, unpublished; Slavin and Kriegman, 1968) hindering the analytic couple's progress, or disjunctions (Frankel, 2000), a term I use to encompass all forms of analytic or therapeutic slowing. I will first review traditional approaches to describing blocks in psychoanalysis and psychotherapy. Then I will take on the subject in a broader, more descriptive way using the concept of disjunction leading to its bilateral therapeutic solution, conjunction.

First, consider disjunction as I use the concept (Frankel, 2000), that is as a non specific term to describe a failure of interpersonal engagement, one that forecloses therapeutic understanding. Therapeutic disjunctions are arrests in the progress and depth of work in psychotherapy and psychoanalysis. While a disjunction can be experienced primarily as cognitive, a lack of consensus, or as affective, manifest as discord or disaffection, most often it consists of a mixture of both, with the disagreement thought and felt. Disjunction is not a term that refers to the particular psychology or psychopathology of either therapeutic partner. It is a practical term, always pointing to an impediment in therapeutic engagement and progress. The concept disjunction does refer to the character of the interpersonal exchange, while it does not describe the psychological configurations involved. It is important to underscore that the psychology of one or both participants in a disjunction may be relatively problem-free. The existence of a disjunction in that case demonstrates that shared understanding between the two has simply not yet been achieved. The disjunction, then, may reflect an innocent misunderstanding, cultural, or experiential differences.

The concept disjunction is atheoretical; it is descriptive. It can be used when working in most psychodynamic systems. Disjunction refers strictly to the capacity of therapist and patient to work together. Recognizing and grappling with disjunctions often requires both partners to embrace confusion and not knowing. Productively resolving disjunctions compels a collaboration

between therapist and patient that is mutually authentic and judiciously self-revealing, resulting in a unity of purpose I call therapeutic conjunction.

At any moment, therapy or analysis can be derailed through ways that include internal conflict dealt with through repression coupled with projection (observable in treatment as transference-countertransference), splitting, or dissociation, differences in how therapist and patient manage thoughts and feelings, cultural dissimilarities, and affective misattunements resulting from discrepancies between therapist's and patient's temperaments or moods. Elusive and impermanent, disjunctions are as much a fact of dynamic therapy as of relationships in general. In therapy or analysis, the data - understanding one's self and one's therapeutic partner - is always subjective; it slips away as soon as you begin to feel you understand it. A fact becomes an opinion, an observation an impression. As soon as they can be recognized as confusing and disrupting treatment, disjunctions need to be understood. But, ironically, disjunctions are usually too fluid to be fully comprehended or completely resolved. Further, as one disjunction is contained and rapport reestablished, focus shifts and another disjunction, or a different version of the original disjunction lurking in the background, fills the space.

Living in and tolerating the personal agendas introduced by the therapist and patient, as well as collaborating with one's therapy partner, as enactments of internal scripts are experienced and interpersonally revised, may be therapeutic in itself, conscious comprehension not a requirement for therapeutic change to occur. Remarkable changes may occur silently, in the background, quite unrelated to the formal agenda in therapy or analysis. The essential question I ask in this paper is what conditions need to prevail in order for a therapeutic disjunction to be productive of desirable change, that is, for it to be the basis of a therapeutic conjunction? In making this statement I am including instances where change through therapy is mainly a product of a constructive interaction between therapist and patient, not clearly facilitated by insight.

Traditional Approaches - Repression, splitting, and dissociation, are the three most widely used traditional psychodynamic concepts to describe how therapeutic impasses occur. While not inclusive, they are clarifying as descriptions of the intrapsychic operations implicated. The distinction between impasses such as these, whether predicated mainly on the psychology of one or both therapy partners, and those arising as a result of stylistic, cultural or temperamental differences, or all combined, is clinically useful, deliberate effort in therapy directed differently for each.

Internal disjunctions: intrapsychic disjunctions re-represented as disjunctions between patient and therapist or between dissociated self-states

(1) Repression and resistance: In traditional psychodynamic theory, the culprit in disrupting the flow of psychotherapy and psychoanalysis is "resistance," that is, intrapsychic conflict expressed as transference in the clinical setting. The therapist is seen as critical or dangerous, malevolent or seductive, for example, as a result of the patient transferring to him or her some characteristic from his or her internalized objects, the therapist is invested with the patient's self-criticism or experienced as the embodiment of a repudiated wish. In the traditional Freudian scheme at issue is a derivative of an instinctual wish perceived as threatening by the subject. In other systems the threat is conceived of differently. For example, in Fairbairn's object relations based system the perceived danger is of loosing a critical personal connection.

Transference and resistance are mostly unappreciated, unconscious to the person experiencing them. In traditional Freudian psychology they represent attitudes and wishes, states of mind that have been made unconscious through the mechanism of repression. The fundamental disjunction resulting from repression is presumably within the subject, that is,

intrapsychic: involving opposing poles of an internal conflict, dissonance between incompatible states of mind. Repression keeps the subject from being one with him or herself by automatically relegating unacceptable thoughts and feelings to deep storage, within the unconscious, outside the knowledge and control of the ego.

(2) Splitting - For Klein and her successors within the British Object Relations tradition, the term splitting refers to the defensive disavowal of unacceptable, degraded aspects of one's self and/or one's internal objects, recreating them in another person through projective identification or in a split-off version of one's self within one's self-experience (Grotstein, 1993, pp. 131 - 138; Odgen, 1986, pp. 43-52, 57-59). Disjunctions, in this frame, develop when a person experiences his or her problematic attitudes as foreign, belonging to another person. Clinically, splitting and repression coupled with projection become blurred in that in both mechanisms the offending agent, whether a repudiated self-aspect or unacceptable need, appears to belong to the other person. For the sake of convenience, splitting is the more total process, generally associated with defense mechanisms such as omnipotent control over others seen as threatening and primitive idealization of people enlisted to protect, rendering the subject's world into blacks and whites and precluding introspection (Kernberg, 1976), as well as the schizoid defenses so ubiquitous in the work of authors from the British Middle school such as Fairbarn (1958), Guntrip (1971), and Winnicott (1963).

(3) Dissociation: Some relational thinkers like Bromberg (1998), while acknowledging the place of repression and splitting, focus on dissociated self-states, some of which are pathological and others reflecting the way the mind is organized, some clearly recognized by the subject and others hardly acknowledged. From this perspective, problems in therapy and life may come from difficulty with encountering and trying on new or uncomfortable versions of self and other. In fact, Mitchell (1997) views therapeutic work as the making of more options for how to be, new ways of "participating" (p. 52), available to the patient.

While related to one another conceptually, repression, splitting, and dissociation belong to different psychodynamic models of how the mind is structured and works. They also differ, (a) in their locus of operation: dissociation occurs strictly within the subject's personality and not between two people as is the case in splitting with projective identification and repression associated with projection, (b) in the emphasis on the pathological: the greedy, hateful, perverse, nature of the mental configurations necessitating splitting and pathological repression contrast with the incompatible states of mind, not necessarily in need of such forceful repudiation, found in milder forms of dissociation, (c) and in the way, and extent to which, the repudiated state is kept out of consciousness: repressed material being for the most part conceived of as unconscious, split-off aspects of one's self visible to the subject but not recognized as his or her own, and dissociated states of mind consciously perceived by the subject but not really owned, often on the edge of consciousness. Through different means, projection in the case of repression, and externalization in splitting, one side the conflict may be displaced to another person, or, as in dissociation, to another place within the subject's mind. In these cases the disjunction is of an internal type, and reflects a psychological conflict that has been relocated through repression or splitting.

All said, the notion of an internal disjunction is a simplification and in part a relic of one-person psychologies. Therapeutic operations are, as is the case with all interpersonal phenomena, co-created. Each one of the two people engaged therapeutically is influenced by the other, at times in profound, deep-reaching ways. Still, separating internal disjunctions into a separate category has descriptive advantages. It is useful to break any disjunctive occurrence into its component parts so one knows, as exactly, as possible, what forces are at work in the therapy and can formulate a plan for dealing with them therapeutically.

The following categories need to be added to our catalog of explanations for therapeutic disjuctions.

External disjunctions: misalignments between therapist and patient

(1) Misattunements: As with the music mothers and babies can make together (Beebe, Jaffe, Lachmann, 1992, 1997; Emde, 1988a, 1988b), adults may sense each other's emotional requirements and meet or miss them. People are always probing to see whether they will be appreciated, vitalized, or disappointed by others. Disjunctions of misattunement are ubiquitous and can stifle any relationship, including the one between therapist and patient.

(2) Cognitively based disagreements: where people, patient and therapist, misunderstand each other's intended verbal communications.

(3) Misalignments between the individual and his or her environment: Interpersonalists such as Sullivan (1953), Fromm (1947, 1970) and currently Levenson (1996, 1998) focus on the character of individual's connection to others and to whether they are at odds with the expectations of the family and community, the society, within which they live. Indeed, misalignments between a subject and his or her environment can be personally disruptive but hardly acknowledged as significant factors coloring the work of an intrapsychologically directed therapy.

(4) Differences in temperament, and cognitive and affective style, including ways people regulate affect internally and in relationships with others, also create subtle, often hard to characterize disjunctions (Goldsmith and Campas, 1982; Thomas and Chess, 1980).

C. Subjectivity, Hermeneutics

Missing from this list of explanations of how external disjunctions arise in therapy or analysis is the topic of subjectivity. So much of contemporary thinking about dynamic theory is predicated on putting subjectivity and co-construction in the center of the therapeutic model (Aron, 1996; Hoffman, 1992). People can never know one another, or even themselves, with any sense of certainty. Understanding another is based on inferences, many of which represent projections of one's own experience. Self-states also constantly shift, even according to one's biological rhythms and situationally determined moods. Disjunctions, from this vantage point, are then based on the highly personalized, and invariably inaccurate ways people understand or misunderstand one another. Add to this statement the complexity of any therapy situation, the variety of personal, interpersonal, and environmental influences alive in a therapy field at any one time. The best patient and therapist can do is to truly work together to arrive at a series of imperfect agreements, each a consensus.

Making an effort to disentangle a therapeutic disjunction, with the therapist concentrating on any of the determining factors I have named, may lead to an additional artifact, skewing how the patient and therapist understand their work. Often missed or minimized are the more silent collaborative, synchronistic features of the experience resulting in interactional, therapeutic change. Therapist and patient may be tempted to accord too much significance to their deliberate efforts, the two convinced that their psychological formulations and associated therapeutic tactics are responsible for the most profound changes observed. Sharon, the patient I describe later, progressed only when I made it clear that I understood her requirement that I be affectively present. Arriving at a dynamic understanding, emphasizing guilt at her having missed work for a week, had little impact.

Conflicting with the view that subjectivity fatally separates people, is the observation that much of what people find out about each other is mediated non-verbally (La Barre, 2001; Knoblauch, 1997; Donnel Stern, 1997). My opinion is that this communication is often more accurate than one might imagine. It is interesting to think about two people consciously disagreeing with one another, while on a nonverbal level they are in tune. In the case illustration, Sharon brings this dilemma home to me as she becomes progressively withholding while never dropping her affable demeanor. Sharon wants me to recognize her need for my greater presence, while ostensibly she and I act as if all is well in our work.

Given the complexity of the therapy experience, with intrapsychic, surface elements, and subjectivity implicated to different degrees from one therapeutic moment to another, I believe that an overriding term like disjunction provides a non-reductionistic, clinically useful framework for reference. Being sensitive to these failures in therapeutic rapport can guide the therapy couple toward action that is predicated on shared responsibility for understanding and finding useful solutions to these breaches, new creative ways to discover and achieve the patient's goals for therapy.

How the Notion of disjunction has been used

Conceptualizing lapses in therapeutic rapport interactionally, whatever their individual makeup, is not new. Disjunction and its antidote conjunction, structured around the disruption and repair of personal connection, are written about explicitly (Greenberg, 1995), or alluded to elsewhere (Ehrenberg, 1992; Goldberg and Grusky unpublished; Slavin and Kriegman, 1968) . The self psychology and child development literature refers to similar developments between mother and child (Beebe and Lachmann, 2002; Lichtenberg, Lachmann and Fasshage, 2002; Stolorow, 1995; Stolorow and Atwood, 1992; Wolf, 1993), as well as to the inevitable separations and joinings, disruptions and repairs (Beebe and Lachmann,1992), between therapist and patient, the loss and recovery of empathy and attunement between them (Beebe and Lachmann, 2002; Stolorow, 1995; Stolorow and Atwood, 1992). In this framework, the therapist is for the most part a developmental object (Settlage, 1992), an incubation medium for the patient's arrested self development.

A similarly, interactional but essentially unidirectional view of the therapy process (Stolorow, Atwood and Orange, 2002, pp. 19-39) burdens the otherwise strikingly creative contributions of other thinkers who advocate careful, empathic listening for the therapist. Some examples include Theodore Reik (1948), Evelyn Schwaber (1998), and Darlene Ehrenberg (1992). Reik's fix for psychoanalytic disconnection is careful, unbiased listening. His and Schwaber's analyst tunes into unconscious themes by focusing sensitively on the nuances of the patient's communication, with Schwaber placing more emphasis on the analyst's use of patient feedback and Ehrenberg the patient's and therapist's impact on each other. R.D. Laings (1959) enriches the concept by focusing on perspective, with the patient's report, even when he or she is considered psychotic, valid when understood from his or her unique point of view. However, with each of these authors for the most part it is the therapist who has the last word in decoding the patient's incoming communication.

I do not mean to exclude from this list theorists such as: Bugental, 1987; Ferenczi, 1950; Frank, 1993 and 1997; Safran and Muran, 2000; Renik, 1995; or Searles, 1975, who, like myself, see the patient as a full and equal partner in engagement and change process. In these writings, failures in therapeutic rapport are managed in a way that is fully bilateral and collaborative. My interest is in exploring this reciprocated experience, assuming that when applied judiciously, with proper caution taken by both partners to respect each others' personal boundaries (Gabbard, 1994), this approach can significantly enhance the depth and richness of psychotherapy,

improving its reach. A disjunction in this case, whether originating as an incompatibility between partners or the replaying of one or more enacted interpersonal scenarios, may be the basis of an enriching shared experience, bringing both partners to greater depths of comprehension and initiating profound, unprecedented, that is, creative, change in both.

Why bother with disjunctions?

How does the concept *disjunction* enhance our clinical thinking? Probably the key *clinical* concept I have to offer is that attending to disjunctions in a therapy or analysis mitigates the temptation to see a therapeutic stalemate through one's personal and theoretical assumptions. The interpersonal complexity of the therapy interaction is kept accessible, exposed to both partners. When you become aware of *not knowing* in a clinical interaction, or you can compel yourself to look for what you are fuzzy about (Wolstein, 1994), you are most likely to consider genuinely new possibilities, clinical and theoretical, most particularly ones that go beyond the edge of the plausible. As therapist, you are in the best position discover a breach, a disjunction within yourself, or between yourself and your patient, and then to find out what it is about. When you can share your disorientation with your therapy partner and enlist him or her in making sense of it, you are more likely to arrive at something like the truth about that clinical situation. This perspective, I believe, mandates an authentically collaborative series of exchanges with the best resource you have in the therapy outside your self-reflection for generating truly new ideas: the other consciousness in the room with you, the patient's. When you are lost in your own subjective haze or countertransference, she is often the one that has the best chance of clearly seeing your part in an analytic stalemate. Also, except when she is being defensive, she also likely to be the one who knows herself best, at least as far as her own subjective experience is concerned.

The problem with relying on the conventional explanations, such as resistance, splitting, and dissociation for explaining obstruction in the flow of therapy or analysis is that each taken alone tends to emphasize pathology, and most particularly the patient's pathology, as opposed to incongruence between states within the patient or between the patient and the therapist, or even the patient and society (Safran and Muran, 2000; Frank, 1999; Levenson, 1998). They tend to support the fiction that the therapist is consistently clear seeing and authoritative, and they reduce the patient's vitally needed authority and perspicacity. They also make the therapy field seem too simple, removing its bidirectionality. Cultural, thematic, situational, intersubjective and subjective (based on mood, at times with roots in biology, for example), stylistic, and other interpersonal sources of disjunction tend to get overlooked. Also, there are always multiple disjunctions at work, some obstructing and others bending the couples' attention toward progress. There is everything to like about concepts like intrapsychic conflict re-represented in transference–countertransference involving reenactments, splitting, and dissociation when applied to the patient's mental life, each certainly has its place in our metapsychological repertory and in organizing particular clinical moments. Taken alone, however, each often misses the flesh and blood of the clinical situation. Disjunctions are multiple, and are always complex with contributions by both therapy partners. They, as all interpersonal experiences, also derive in part from difficult to articulate sources that include but also transcend the patient's defenses, style, and temperament and are configured bilaterally.

The picture of therapeutic breaches and their resolution I want to create seizes on the intrinsic value to the therapy process of recognizing and struggling to resolve disjunctions, enabling deep-reaching, bilateral change. Disjunctions, tolerated and thoughtfully managed, can be used to unpack the nature of a therapy interaction and harness its energy so the two can rise to new, often unanticipated, interpersonal heights, at times enabling intrapsychic change of remarkable proportions. Before illustrating disjunction, and its utility in creating therapeutic

conjunction, a word about identifying and negotiating disjunctions.

Identifying and Resolving Disjunctions

How are disjunctions recognized clinically and, once identified, how are they resolved? Between identifying and resolving disjunctions, identifying is generally the easier part, though disjunctions can hide for long periods of time disguised as areas of consensus, protected by illusion. Also, smaller, apparently benign, disjunctions can deflect from deeper more insidious ones.

Signs that a paralytic disjunction is afoot are apparent in a slowing of the pace or vitality of the therapy or analysis (Frankel, 2000). This decay can sometimes be detected within a single session. Patient, therapist, or both, get lazy, bored, repetitive. Ironically, at a point like this they may produce more polished “insights” since their thinking may be less disrupted by the powerful emotional forces that characterize more authentic engagement.

Figuring out how to get useful information about the structure of a disjunction, and what to do to resolve the disjunction, generally involves *going out on a therapeutic limb* in ways that often seem strange and potentially disruptive to therapist and patient. At times, for example, the therapist will have to guess about themes he or she only vaguely, intuitively senses might be lurking beneath the surface. Of course, at moments like this he will need to label what he is doing as a response to his intuition (Slavin and Kriegman, 1992), and ask the patient's for confirmation and guidance. As they work to understand and resolve disjunctions, authority and control shifts between the patient and therapist. Intermittently, the patient becomes the expert, the clearest seeing member of the duo. At these points, especially, the therapist listens even more intently, soliciting feedback from the patient. Then, reoriented the therapist temporarily takes over, but with more accuracy.

Each maneuver in resolving a *paralytic* disjunction is likely to be painful and disruptive. Therapeutically wrestling with disjunctions of this magnitude often shakes one or both therapy partners to their very core. If this level of disruption is absent in the resolution process, the result is likely to be relatively trivial. It is the shock of finding and understanding what major disjunctions actually consist of that makes it possible to begin a process of moving therapeutic change, ideally involving revisions in the therapist’s and the patient’s sense of self and other. I call the result of this interpersonal encounter *creative change* (Frankel, 2001), leading to psychological change in both partners in directions so unique and vital, that the outcome bears little resemblance to their earlier ways of being. *Creative change* happens when therapist and patient are astonished by, thrown off track by, each other. Both partners discover new ways of being, often laboring against concerted opposition from within themselves, as old social forms reassert themselves, or from the outside, as people in the patient's life oppose the shift. Over time, they create for the two an entirely new relational experience, one that builds in the direction of the patient's latent needs and emerging goals for therapy.

Disjunctions, when experienced at their fullest, at first often throw each partner disastrously off balance. Misperceptions, blind spots, limitations, and prejudices are laid bare. Willingness to undergo stinging self-reflection is tested. Finally, both partners’ ability to collaborate, while bringing in their best introspective capabilities, is weighed. For each, recognizing and resolving disjunctions requires remarkable humility: including the ability to acknowledge one’s own flaws and to work intimately with another person to find solutions to painful, often confounding personal and interpersonal dilemmas. Embraced in this way, then, disjunctions often become the basis of reorientation and change for both patient and therapist. In the case example, Sharon compels me to recognize ways I wasn't meeting her need to be felt

and heard by me. In that experience, I, as therapist, had to radically revise my perception of the meaning and impact of my well-intentioned but misguided therapy stance on her. Recognizing and grappling with her disaffection provided the clues that enabled the treatment to get back on track. Sharon's complaint was expressed without words, requiring her to repeatedly prod me to reevaluate my view of our therapy task.

Sharon

To the extent that therapist and patient, can become chronically trapped in a therapeutic disjunction, Sharon and I were in the peculiar position of being afflicted by a state of seamless harmony. My work with Sharon is presented below in a way that emphasizes discrepancies in the history she presented to me, and the disjunctions in rapport and understanding as they developed between us. The solution to our therapeutic disjunction included the forced recognition of my contribution to Sharon's disaffection and the heart-felt response she needed from me to resolve the breach between us.

I have used Sharon as my case example because her insistence that the authenticity of my response meant so much to her. Of the many types of disjunctions encountered in psychoanalysis and psychotherapy this kind seemed most important to write about. In other cases the breach in rapport is often more straightforward, reflecting a failure of therapist and patient to understand one another. In those instances the urgency of the clinical situation is likely to be more limited, ironically allowing easier access to a more typical exploratory analytic process. The quality I am referring to is not only a measure of the extent of the patient's disjunctive alienation. It is the character of that separation that is at issue, as well. Being understood correctly is not likely to be negotiable for the patient. It is rare for a patient to tolerate a therapist's lack of comprehension for very long. Patients generally demand understanding, authentic therapeutic engagement a quality they are good at recognizing.

Sharon was adopted by her stepmother after she married Sharon's father at Sharon's age six. Her biological mother has never been willing to have anything to do with Sharon. She even refused to see Sharon when Sharon called her for the first time a few years ago. She, like the father and adoptive stepmother, are professionals.

Sharon and her three years younger brother were brought up in an historic New England village. It was a perfect community, just the place for the perfect family. The problem was that Sharon was never as perfect as the rest of them. She wasn't outstanding in school and insisted on resisting her parents' well-intentioned efforts to perfect her from the time she could assert herself. She preferred playing video games to studying, and as a teenager became an instant expert at using alcohol to screen out her parents.

Of course, Sharon was the nicest kid in the world. When her mother began to bring her to therapists at age 8, she was happy to cooperate. They were nice people and she liked playing with their toys. Only, she never knew why she went and never caught onto what they were trying to do with her. Considering her subtle non-compliance, it is telling that Sharon's therapist during high school got to like her so well that she elected to be her friend, relinquishing the job of therapist at least in its conventional sense and even accompanying her to Mexico one summer.

A nice kid like Sharon with professional parents should have been able to qualify for entrance to a competitive college, but it wasn't like that. Sharon was rejected from all colleges except a little known college in upstate New York, and then only after her counselor begged them to accept her.

What Sharon especially remembers from her otherwise "perfect" college experience are the anxiety attacks she began to have in poetry class during her junior year when she read her rather passionate poems aloud. It became so bad that she thought on a few occasions she was having a nervous breakdown.

My point here is to recreate the contrasts I encountered with Sharon: the harmony in our rapport and the ways her history and current behavior failed to support this image, or her promise in school and her hard to explain failings, or the ease with which myself and others could be drawn into a romanticized swoon with her, believing in her unconditionally, only then to be let down. -- So, then who was the real Sharon? I contend that it was closer to the idealized view, but that it was Sharon's intention not to let that view prevail for too long. The disjunctions she created in her relationships, including ours, had a purpose.

So, now I can tell you more about who Sharon is at age 29. She is one of the most delightful people I have ever worked with. She is articulate, funny, sensitive and deep. I always look forward to seeing her. She came into twice weekly treatment a year-and-a-half ago, concerned about the anxiety and feelings of unrealness she often experienced when with people. From the beginning, she anticipated that we would move to a formal psychoanalysis when her time and money permitted. Also, Sharon has become one of the nation’s best young screenwriters. Her work always receives accolades.

There are wrinkles, however. While Sharon has a sweet relationship with her parents she has made certain to settle 3,000 miles away from them. Somehow when she is with them she always feels depressed and irritable. Sometimes she also feels that way with Aaron, her fiancé. He is overly controlled, working mindlessly at a job that pays almost nothing and often unable to let go and have fun.

Sharon had just come home from a week away, visiting her fiancé’s dying stepfather. She had been nervous about going at first, had never been with someone who was dying. But it was OK; the stepfather was upbeat and talkative. Why then, Sharon asked, did she become so anxious the minute the plane landed in San Francisco, and the next day at work was a nightmare? She couldn’t help thinking her senior editor was critical of her having been away. Then, when she was assigned a 30-minute piece on the future of technology she relaxed incubating a radical new idea, at least until a visiting screenwriter from Chicago showed up and Sharon felt obliged to have a drink with him. On the one hand, it was no big deal, but the anxiety returned when the screenwriter arrived and Sharon spent the whole time feeling removed and uncomfortable.

When I asked for more information about her experiences, Sharon had nothing to offer. Earlier, she said she had several dreams just before returning but failed to tell me them. She seemed a little vacuous. Our disjunction was growing.

I went on somewhat anxiously: you mentioned something about dreams, Sharon? That's right, there were three all about something getting in my way at work, making it go slowly. The most distinct dream was about my screening a piece and the film being adulterated when it had to go through a number of devices. That's actually a metaphor for how I feel, held back.

I'm aware of that in your mood, Sharon, what do you make out of it? I don’t know, I'm just feeling irritable. I’m not sure why; but it began well before I came in today, when the plane landed and especially when I went to work this morning. -- More silence, but judging by the distressed look on Sharon's face and her tense posture, silence pressing for a response from me.

So, uncharacteristically, I felt compelled to offer a half-formed interpretive comment, reasoning that I knew enough about Sharon's ambivalence about going on this trip and possibly compromising the progress she was making at work, that I could give her return to therapy a jump start.

That makes sense Sharon. There are times when you feel guilty about indulging yourself with your creative zeal at work, this time I think you felt frustrated being away. The Chicago guy was a nuisance, just made things worse.

Yeah, that's right…but her voice became vacant.

I feel a little empty and tense. I want to reach Sharon but I'm failing. -- Strange Sharon, it looks like I'm loosing you.

Because I don't feel it. It's a good explanation, but I don't feel much.

I stare more intently at Sharon wondering what is next since she is probably right. There is some big secret and I don't have a clue what it is. Sharon is impatient, the hour is almost up, and increasingly she isn't really fun to be with. Or maybe its me, losing my credibility.

Here is the first point at which I *had to* grope for an idea about what Sharon needed, and what to do about it. She is asking for help understanding her anxiety and finding ways to curtail it in the future. But, is that all that is happening? Her surprising withdrawal, following a burdened but thoughtful conversation with me, pushed me to speculate about other agendas she might have. For example, could she be coercing me into a relationship in which we both view her as troubled and me as competent? If so, is she doing it out of guilt about feeling more competent than she thinks she should, having just taken good care of her fiancée? And what should I do, given my lack of certainty about what is troubling Sharon: respond with energy and empathy or stay relatively impassive? -- Don't mistake it, the message from me, the communication between both of us, and the results of each approach, would have been different with each formulation I created. Had Sharon been more forthcoming our dialogue would probably have been smoother. But, instead she forced a disjunction, making me labor to understand what was going wrong between us.

Sharon certainly may have needed to spoil our work in order to make me to see her as a failure. But there are many other explanations for Sharon's withdrawal, each credible, and I was forced by her to examine each exhaustively. The strained interaction between Sharon and me could have been orchestrated by other internal factors. For example, Sharon may have started to feel close to me as she wished to with her biological mother; the anxiety created forcing her to pull away. Or, perhaps the problem was with me. I might have felt close to her, excited by her secretly defiant style - irritated with Aaron and her adoptive stepfather for allegedly keeping her from her brilliant future - and uncomfortable committing myself to that stance. Just for the record, my father did what he could to keep me from being radically creative, and I find Sharon's ability to defy her parents and be unconventional titillating. In that case, to protect Sharon and myself from my own defiance I might have become slightly removed. There were other possible sources for our disjunction, as well. For example, Sharon and I are so different culturally: Sharon, Presbyterian, from a family unfriendly to emotions, and me, Jewish, from a background where feelings were the priority. I doubt that I would have considered each of these possible explanations for our growing disjunction, had I not been forced to by Sharon's holding back.

Contributing could have been any one or a combination of these factors: patient, therapist, or cultural differences. These and countless other sources account for disjunctions.

Sometimes you are mainly dealing with transference (Sharon's feelings about her biological mother) or are captive to countertransference (my wish to defy authority), but at other times you are primarily dealing with mood or cultural incompatibilities. Or maybe, G-d forbid, the issue is that the therapist misperceives what the patient needs to formulate and make the changes she requires: the therapist coming up with the wrong formulation, using a technique that doesn't work, or delivering a nonverbal message that is off, maybe simply out of attunement. In that case the therapist leaves the patient stranded, without a reliable partner for therapeutic change.

In reviewing this clinical sequence, it is clear to me that my disjunction with Sharon began before I became aware of it. When I recognized it, I was dismayed, not knowing what to think or do. -- As I recall, I responded with heightened emotional intensity, an example of the added energy therapists instinctively use to keep their patient engaged. As I remember my behavior during this episode, I listened more attentively, leaning forward in my chair, and infusing everything I said with passion. In response to her sudden withdrawal, I experienced Sharon as loosing touch with me. To compensate for her distancing, I provided enthusiasm, intuitively adjusting the pitch of my voice, speaking forcefully but more sympathetically as I attempted to restore our rapport. This is an example of the nonverbal action that therapist and patient typically use to reestablish at least minimal attunement between them. However, as Sharon showed me, my response was either misguided or wasn't powerful enough to reengage her.

Actually, as far as Sharon and I could tell my interpretation was pretty close to the mark. Sharon is ambitious. She likes her work and really did not want to be away from her office for so many days concerned she would loose her place in the race toward position and fame. But, in spite of my making this observation, Sharon progressively faded and I was beginning to be as boring as the screenwriter from Chicago. Clearly, my assumptions about the basis of our disjunction were inadequate and Sharon intended to show me where I was off.

Going back to my subjective experience with Sharon, I was getting uncomfortable and that was good. My thinking became muddled. Guilt, ambition had always been the themes. I tried a few more time worn interpretations, reminding her that she had been excited, before leaving for the visit to Aaron's stepfather, about a television series she was developing about a zookeeper who found success living with his animals, and that her last documentary attracted national attention. So, I said, being away must have been hard for her. - - More uneasy silence. I struggled, at first confused, then in increments letting my mind go blank, as I realized something I had not expected was happening. Slowly I was getting the idea that I really did not understand Sharon's mood.

Sharon, this happens sometimes, things between us will seem almost perfect, and out of nowhere you will make us aware that there is a subtle breach, one I'm not at all aware of. Right, its like you're out of touch today. I just need something else; want you to be more connected somehow; more concerned. Its not that anything in particular is troubling me, apart from wanting to get back to work and not be bothered by people. I agree that issue is there. I feel uncomfortable telling everyone to take a hike so I can get back to work. But, more than that, you're off in a very subtle way today, a little too comfortable about what you think I need. I don't really feel you there. You know, my mother and father, but mother especially, would worry about me and then send me to a specialist, most often a therapist. They couldn't join me, experience with me what I needed...Left me with a peculiar kind of loneliness in the middle of all that attention.

Discussion: Clearly, Sharon and I were plagued with one or more disjunctions. They could have been based on transference, countertransference, perhaps cultural background, and maybe mood. But the most potent disjunction was in my failing to provide a fully alive emotional coupling for Sharon. As I later learned I needed to maintain a certain level of anxiety and discomfort to satisfy her that I was taking her seriously. When I stopped we lapsed into a deep sleep and Sharon's experience became bland, vitality and meaning disappearing. In a sense, then, Sharon as alive and connected vanished.

Even my heightened attentiveness when she began to fade was insufficient to reengage Sharon. She also needed to see me as upset and confused, and believe I cared enough to struggle to reestablish our connection. My response had to be heartfelt in a way her parents' never had been. Had I not been forced to listen and respond on this level, I doubt I would ever have fully understood the block in our work. I probably would have searched for a explanation and accepted a half-truth, continuing to imagine I was essentially in harmony with Sharon. Her pessimism about ever being fully understood would have remained. Inviting her to explore the disjunction with me, and providing her with feedback about my experience, made all the difference.

Of great interest to this discussion is that the authenticity of the attitude I am describing is so arduous to maintain. It is required of the therapist, as Sharon repeatedly reminded me, that he be ever vigilant for lapses of attunement. Yet, the therapist has his own life. He can't be affectively present at every moment. If he tries to, he is fated to fail at points. The trick, as I see it, is in restoration. The vigor of the patient-therapist bond needs to be continually recreated so that not just the patient's, but, more pertinently, the therapist's sense of connection is renewed as well. Not done successfully, the patient will detect the failure and be lost as a full therapy partner.

To be clear, my confusion in this case served two purposes. It provided a signal for me that I was not understanding something about Sharon and our therapeutic interaction. Yielding to, and being directed by that disorientation, eventually allowed me to understand and then join with Sharon so we could find our way again. In my interaction with Sharon, my disorientation and distress also served a powerful interactive purpose, strengthening our bond. This configuration was based on one of Sharon's transference expectations for me. It alerted her that I was indeed interested in hearing and feeling with her, differentiating me from her affectively vacant parents.

Sharon brought her historically based assumptions to therapy. For her the weight of her parents' need to eradicate untidy areas of her personal life formed the basis for her expectations of me. Yet, she was also correct in her judgment that for a long period I failed to accurately comprehend her needs, delivering my own version of what I believed she required. I focused on her transference expectations, her assumptions about my motives and others', as well as on the countertransference I introduced into the field. What I missed was that she *also* needed me to be in a real, not *just* an observing, therapeutic role. Over and above my analytic stance, my actual response, including my earnestness, my tolerance for our stalemate, my feeling and being interested in her communicated distress, was instrumental in healing our disjunctions.

Sharon needed me to accentuate and, in the end, create our disjunctions making me notice and respond to them in a way she found convincing. While she valued the harmony between us, however, fundamentally she did not want a perfect twining relationship with me. There were some obvious but relatively trivial disparities between myself and Sharon, such as those based on the dissimilarity between the starchy New England culture in which she had been raised and the one I grew up in. The most important disjunction between us, however, needed

to be cultivated, hatched out of a superficial sense of rapport. For Sharon, shared, conspiratorial illusion camouflaged the existence of a more thoroughgoing disjunction that was seriously limiting for the therapy: the ease with which Sharon could loose her sense of vitality, reflected by her impatience when she felt I was affectively off-key.

It is no wonder that patient and therapist so often collude to minimize disjunctions, since they can be so difficult to fully comprehend and painful for the therapist as well as the patient to face. I was inclined to cheer-lead Sharon into reestablishing our bond, thinking of her as compromised without noticing how much my obtuseness was contributing to her distress. It would, I imagine, have been easy for me to carry on an intelligent, upbeat therapy, even the formal aspects of a psychoanalysis, with Sharon, without ever noticing her profound but subtle detachment and how I was contributing to perpetuating it. The disjunctions, as in so many of our cases could have gone undetected for the entire therapy process. Patients often feel vaguely satisfied with their treatment, not recognizing what has been missed.

The Effect on the Therapist, Reconsidered

Most difficult to convey about my therapy experiences with Sharon is its impact on me. Note, how the authority to know and lead in the therapy moves repeatedly between therapist and patient. Sharon forcefully disoriented me with the implicit intention of informing me about her distress (Ogden, 1982). She did not relent until she was satisfied that I could understand her message and change. Instrumental in that conversion was the tedious, painful, and at times frightening experience of sharing her distress. That the experience with Sharon also required me to confide the truth of my distraction speaks to the importance of authenticity in a therapist's stance. Sharon simply would not accept me as unimpassioned

The bilateral concept disjunction, as I use it, assumes the kind of interpersonal complexity I have described and holds that for meaningful discovery and change to occur embracing disjunctions has enormous value, maximizing depth and facilitating conjunction. The notion of conjunction, patient and therapist actively joining on a new, deeper level, is typically missing - at least explicitly - from traditional psychotherapy schemes. Even in relational models, where the process is considered interpersonal and its intersubjective character is emphasized, the therapist is, in practice, often accorded a wide berth to be authoritative and to take liberties in refraining from revealing very much about him or herself. According to my model of the dynamic therapy and analysis, depth of connection, including a gripping emotional involvement by the therapist, should be emphasized and sanctioned (Frankel, in press; Safran and Muran, 2000; Slavin and Kriegman, 1998). Limits on this process are, in part, set by the patient's capacity to engage in it without becoming confused or overwhelmed.

Then, there is the problem of the therapist's needing to limit the extent of his or her immersion in the interaction with the patient. These unofficial limits are usually there and either rationalized as being therapeutically necessary, required to maintain an exploratory process, or simply unacknowledged, placing a ceiling on therapeutic reach. Authors from Reik (1948) to Ehrenberg (1992) and Renik (1995) speak articulately about the attitude and technique a therapist needs to assume to achieve full impact. Missing from these descriptions may be the personal impact of the experience on both partners, therapist included. Problematic is that the personal toll on the therapist, on a patient by patient and day by day basis, may be so great that the therapist may inadvertently need to limit the extent of his involvement (Maroda, 1999, pp. 49-64). In turn, there is usually no way that patient and therapist can easily gauge the limits the therapist places on her personal commitment to the patient and therapy, regulating its emotional depth and making sure it doesn't intrude into his personal life. In consequence, opportunities for full therapeutic involvement and maximum progress may be missed. Alternatively, as the therapy

process deepens and conjunction is approached the thrill of connection for patient and therapist alike can be exhilarating, providing a profoundly convincing impetus to carry on and experience rewards that often more than match its frequently exhausting rigor.

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