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Reading dissociation of the experience of relational trauma: Psychotherapy from the constructivist intersubjective perspective

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Dissociative processes are common for all people and do not necessarily have "clinical value". Nonetheless, in the presence of *early relational experiences of trauma* (absence of affective attunement, serious forms of negligence, psychological violence, physical violence, sexual abuse by a caregiver) they take on a protective function that lead to the creation of dissociated self-states that are multiple and cannot be integrated, each with its "own sense of truth" and own independent way to access awareness. Evolutionary trauma and dissociation are always present in the developmental history of each person and differ, from one individual story to another, only in terms of degree. In this sense we can assume that those who ask for psychotherapeutic help present dissociative phenomena of a different scope and that the work model illustrated here can be utilized for almost any patient. Through clinical examples and psychotherapy transcripts, this article describes the possible methods for using therapeutic conversation and the therapeutic relationship to read the dissociative processes and help the person find a new experience of self and of self with other.

Keywords: *early relational trauma, dissociation, multiple self-states, intersubjectivity, therapeutic relationship.*

Filippo, aged 30, in psychotherapy with one of us for approximately nine months, in the assessment phase[1] presented a story of multiple early relational experiences of trauma. A few sessions past, reflecting on himself, Filippo said:

> "***Something happens that touches me****... a part of me evaluates it, but if I don't live it within me,* ***and I look at it like an outside observer,*** *I don't enter inside of it. It is as if I didn't have the possibility of living it, it doesn't touch me,* ***I recount it in a***

[1] In our work method the assessment procedure usually lasts three sessions. Following the first interview aimed at analysing the request for psychotherapy, we ask the person to recount what he/she remembers of his/her own life experiences (from the earliest memories to the present day) and serves to help the therapist to try to construct an image of the person and the problem that has brought him/her to ask for help. The patient is not given any feedback.

> ***rational way and after a bit I don't live it anymore.*** *It closes itself behind a secret door and stays there and I only have the possibility of seeing what it was... but* ***I see it only from the outside as if I were looking at it through a window*** *and I never live it, I never live it. Maybe when there's* ***an emotional peak*** *I live it, I feel it a bit, but then later I close it inside, I close it inside. Mario (*a colleague) *is... what he says he is.* ***I cannot be there like that, there's something that protects me****... it protects me* ***from a combination of shame and guilt****... it's closed inside and doesn't connect to my part."*

We were profoundly struck as we listened to these words. It seemed almost as if Filippo had read some of the notes on trauma and dissociation that we had recently given to our students at the School of Specialization in Psychotherapy, or as if he had listened to the lecture given recently at the FIAP Conference in Ischia (Cionini, 2016) on this subject. It is almost unbelievable the way in which Filippo describes, from within himself, and in such a "clear" manner, the phenomenology of dissociation in many of its aspects.

Rereading this transcript we can find many of the elements that are typically described as effects of dissociation:

- loss of credibility of the "first-person" experience both past and present, with the possibility of reflecting on the self only as an outside observer of one's self, as a "third-person" (*Something happens that touches me... and I look at it like an outside observer);*
- removal of the emotional content from traumatic experiences and memories (*I recount it in a rational way and after a bit I don't live it anymore);*
- depersonalization and the sensation of detachment from reality: "to be inside a bubble incapable of interacting with the world", "to be separated from the world as if by a frosted window" etc. (*I see it only from the outside as if I were looking at it through a window);*
- sensation of "non-existence", in the eyes of others and of one's self *(I cannot be there);*
- sensation of personal fault, and/or sense of shame regarding traumatic experiences (*a combination of shame and guilt).*

Dissociation as a process has been studied, by most of the authors who have addressed it, in relation to trauma (Albasi, 2006; Bromberg, 1998, 2006, 2011; Janet, 1889; Ogden, Kekuni & Pain, 2006; Stern, 2003; van der Hart, Nijenhuis & Steele, 2006; van der Kolk, McFarlane & Weisaeth, 1996) and has been read as a way of protecting oneself from the memories of these experiences (Filippo, in this regard, affirms that "*there's something that protects me").* It is a phenomenon that protects the person from the risk that that pain could come back, establishing safer boundaries between the states of self that allow for decent functioning in daily life and those states related to the implicit memories of the traumatic experiences.

Dissociation, however, does not necessarily have "clinical value"[2]. It is a part of life: in normal life and neurotic life, as well as in psychotic life (Borgna, 2015). Even if the caregiving by the attachment figures was "good enough", situations of various levels of seriousness deriving from the lack of affective attunement between the child and the caregivers are necessarily present in the development history of any person. Even Shore (2011, p. 1) affirms that "dissociation is intrinsic to the development of what is normal as well as pathological in being

[2] Others would say "psychopathological", but we prefer to avoid using this term that, even if indirectly, refers to the dichotomy of normal/pathological and to the use of nosographic categories.

human" in as much as it represents an efficient short-term strategy, even if, in the long term, it undermines trust in one's self and in others and makes it difficult to involve oneself in intimate or close relationships. That which varies from one developmental history to another – regarding the experiences that we can define as traumatic and consequently regarding dissociation – is only, as Bromberg writes, *a matter of degree*.

> If we look at trauma not as a special situation but as a continuum that commands our attention only when it disrupts or threatens to disrupt the continuity of self-experience […] If we accept that developmental trauma is a core phenomenon in the shaping of personality then we also accept that it exists for everyone and is always a matter of degree. If that is so, then the stability achieved by even secure attachment is also a matter of degree. (2011, pp. 13-14)

Furthermore, a momentary loss of the conscience's associative links can occur in many circumstances in daily life for example in various types of automatisms such as when one is absorbed by watching a movie or reading a book, in states of self or hetero-induced trance, in daydream, etc.

Dissociation takes on clinical significance, however, when it becomes a modality that is rigidly activated to deal with states of suffering that are felt to be intolerable, protecting the person from coming (back) into contact with the *reality of their own experience*, when this experience has characteristics that are more intensely traumatic. Considerable relevance is attributed to the experiences of repeated relational trauma, lived during the first phases of development, frequently referred to in scholarly publications as "early traumatic events" (Bromberg, 2011; Liotti & Farina, 2011; Shore, 2003; van der Kolk, McFarlane & Weisaeth, 1996) but that we prefer to define as *multiple early traumatic relational experiences* to emphasize that it is not the events in and of themselves, but rather the way in which they are subjectively constructed that leads to certain consequences. We are referring, in this case, not only to single stressful events of a violent nature, but to early situations of serious and repeated lack of affective attunement, physical violence, psychological negligence, sexual abuse (in particular, intrafamilial abuse).

For the development of an integrated sense of self it is necessary that the intersubjective interactions between the child and the attachment figures be understandable and that the child feel recognized in his/her specificity and subjectivity, so that his/her emotional and affective experiences can be constructed within a perception of fundamental unity and coherence of self.

> A person's core self – the self that is shaped by early attachment patterns – is defined by who the parental objects both perceive him to be. That is, through relating to their child as though he is "such and such" and ignoring other aspects of him as if they don't exist, the parents "disconfirm" the relational existence of those aspects of the child's self relationally nonnegotiable because the subjective experience that organize those self-states can't be shared and compared, communicatively, with how they appear to another mind (Bromberg, 2011, p.57).

The lack of confirmation by the attachment figures of the child's emotional and affective states, especially if they are particularly intense, can make him/her feel as if some parts of him/herself are unacceptable in as much as they are not approved of and represented in the mind of the other, leading him/her to disown them, to distrust them, and to not represent the reality of his/her own experience. The capacity of the child, and then of the adult, to give meaning to his/her own affective states, to reflect on them, to feel them belonging to him/herself can thus be significantly compromised, leading him/her to dissociate the self-states that are not recognized and confirmed. In this way dissociated self-states (*me* and *not-me*

states)[3] are formed; they are multiple and not integrated, they have their own independent route to access awareness, they cannot be activated simultaneously, and they cannot come into explicit conflict with one another in as much as conflict would presume the concurrent presence of both states in question.

Dissociation does not implicate an elimination of the memory of the disconfirmed experiences, but an emptying of their emotional content and/or a "non-possibility", more or less temporary, of their reactivation on a conscious level. The emotional content remains nonetheless in the implicit memory, orienting behavior and modalities of constructing the experience in the present, in the absence of awareness. (Donnel Stern, 2003).

Each of the different selves is thus enclosed within a rigid modality of coming into contact with the others, *each with their own sense of truth.* Personal identity is thus placed, each time, inside the self-state that is present in the consciousness in that specific moment.

Multiple traumatic relational experiences limit self-reflection (which can be reserved for certain aspects of one's experience) and lead one to distrust one's own capacity to construct meaning for emotionally-charged events that cannot be remembered nor recounted, or when they are verbally expressed, they lack the recognition of their affective state. The quality of memories of early traumatic experiences, when they exist, is characterized by a sense of irreality that often leads one to doubt the memory itself (Caretti & Craparo, 2008) and to believe that it could have been "invented".

Most (if not all) people who ask for psychotherapeutic help present some level or kind of dissociation. In this sense, any type of symptom of psychological distress can be read using, among other things, the dissociation model.

The therapeutic relationship and change

In relation to the therapist, as an attachment figure, the patient reactivates the expectations constructed in primary relationships as they developed over time. For this reason, the therapeutic relationship is a potential playing ground, an open space, within which it becomes possible for the patient to share new intersubjective experiences (Cionini, 2014a) and where, in "moments of change" (The Boston Change Process Study Group, 2010), the feelings of the self-states lived as *not-me* can be reconnected and implicitly legitimated and "confirmed" through a "shared affective communication".

Considering, as we have said, that both "traumatic" experiences and dissociation are always a *matter of degree,* this work model can be used for practically any psychotherapeutic process, albeit with differences resulting from the *degree* at hand.

In the more extreme cases, in which early experiences are characterized by the feeling that the attachment figure, who should protect, is the same figure that endangers, the child creates two distinct representations of the care-giver. These representations cannot be activated simultaneously and cannot come into conflict with one another in as much as the conflict would pre-

[3] The "*not me*" self-states are those to which the possibility of existing has been denied, in as much as they have been disowned and not legitimized in primary experiences. The *not-me* parts contain the feelings that there is something wrong in oneself as a person. Memories of the *not-me* parts are felt as not belonging to oneself since they are present only as "illegitimate" feelings, sources of shame, not translatable in declarative terms. The secrets of the *not-me* parts are without words and cannot be said since they are felt to be "lies". Vice versa, the self-states felt as "*me"* are those that are recognized and legitimized in primary experiences and to which the "right" of existing is conceded within the relationship with a significant other.

sume the concurrent presence of both; when one is present, the other does not exist and vice versa. Dissociation functions in the same way also for the different parts of self; one that relates to the "good" part of the care-giver, and the other to the "bad" part, so that the two experiences do not come into contact, thus preserving a sense of coherence of the self (it wasn't her, it wasn't me). The possibility of trusting/entrusting the other is thus widely compromised from within a paradox in which the desire for nearness coexists with the feeling of danger in that same nearness, together with a continuous oscillation between wanting and fearing nearness with affectively significant figures (Cionini, 2014b). The person thus finds himself in a continuous state of "alert", like when hearing noises in a dark room. Experience quickly teaches that it is a good idea to never get distracted because danger is always around the corner. "Calm" situations, even if desired, are perceived as charged with an intrinsic "threateningness"; they distract from alertness, trick you into feeling safe, and thus falling into a trap (like in the metaphor of "living in a horror movie"[4]).

The therapist, in his/her relationship with the patient, finds his/herself within this same paradox from the moment in which the setting, for its characteristics of intimacy, suggests a nearness that is easily perceivable as "threatening". To reduce this threat and build trust and security, the therapist should behave like a naturalist who, wanting to come close to a wild animal, does so very slowly and, while observing, allows the other to be observed for the time needed to feel safe. The naturalist's success depends on his/her capacity to remain within the animal's habitat long enough to not only observe it, but most of all to let itself be observed, as long as the animal is able to decide what it should expect from that potentially dangerous human (Miller, 1994).

This interpretation is useful even when the experiences of a lack of confirmation and affective attunement with attachment figures, no matter how extreme, can be linked to the discomfort of the patient, in as much as the construction of reciprocal trust and security in their relationship is an essential prerequisite for any type of psychotherapeutic process.

[4] In most horror movies the moments of greatest tension are when the protagonists are unaware of the pending danger. With a children's song in the background we can watch them enjoy a day in the countryside on a bright and sunny day, joking with friends, relaxing. All happy and beautiful as long as the spectator doesn't know it is a horror movie; the spectator is tense when he/she knows that if the monster were to arrive in that moment, the protagonists would be defenseless. Rather, he/she thinks that it is very likely that the monster will arrive at exactly that time and cannot stand that joyous state of mind in the face of looming danger. When the monster arrives, the heart skips a beat, he/she wants to cover his/her eyes and scream out "I knew!" ... but he/she also feels a little relieved, because from now on they will all be more careful. And so the emotional activation that is hardest to bear is when the mood is *still* calm. If it were not a horror movie it would be a glorious day, but it is a horror movie, and so things cannot stay nice for long.
Some individuals live in a horror movie. Experience quickly teaches them that the best way to optimize the possibility of survival is to never get distracted from possible threats. They are sensitive to changes in "atmosphere", acutely attentive to micro-expressions, equipped with a strong "sixth sense". What is this sense? It is a sort of "threat detector" that is always activated. What's the sense of this? It protects them. The situations that are potentially "calm" bring with them an intrinsic threateningness because they push them to feel "safe", and thus to fall into a trap: "And what if something were to happen just now? I'm almost defenseless!". Serenity is thus frightening because it distracts from being alert. And thus the necessity to continuously search for a problem to resolve that allows them to never fully relax, as if it served the purpose of "keeping in shape" considering that soon – *from any direction,* they are sure – they will soon have to jump back into action to save themselves again. (Casini, 2015).

Observing dissociation in the conversational flow

In therapeutic conversation, when listening to the narrative of events past and present, it is sometimes possible to observe sudden changes in the perspective of the narration and in the emotional activation of the patient, with the appearance of incongruities that make it seem absurd. It is important to emphasize that the sensation of absurdity belongs to the listener, the therapist, to the extent to which he/she doesn't understand or is not able to understand – in that phase of the process – the *sense* of the incongruity. But logical absurdity, the lack of formal coherence in reasoning, always has foundation within the *internal logic of the person.* Actually, the greater the *apparent logical absurdity* is in the narrative (from the point of view of the outside observer), greater will be the relevance of its implicit meaning for the patient (Cionini, 2016). We are presumably faced with contents that belong to dissociated parts of the self, that emerge suddenly and automatically, each with its own *status of experiential truth.* Even when the same things are presented to us with double meanings that are apparently incompatible, rather than asking ourselves what is right and what is wrong, we must consider that for the person each of the versions (no matter how opposed they may be) corresponds to the *experiential truth* of one of the self-states.

If during the conversation the therapist does not concentrate exclusively on the explicit content of narration, but gives particular attention also, and above all, to the words or the phrases that appear "strange" or "absurd", to the way in which the person constructs the phrases, to the way in which they are formulated (to the prosody of verbal expression), to the tone of voice, to the micro and macro changes in body language that accompany the spoken words (Cionini, 2015), he/she can tune into the moments that signal the "intrusion" of other and different self-states on the state that was present immediately before.

The Metaphor of the Polygraph

If we try to imagine the spoken word as a relatively steady undulating line traced by a polygraph, a high or low "peak"[5] (signifying a word or phrase that is "apparently absurd" within its context, or a sudden emotional-physical reaction) can be considered the indicator, the entry way, to a dissociated state of self, felt as *not-me*, upon which it is important to linger. Adopting this visual metaphor (Cionini & Mantovani, 2016), we can presume that that which seems strange or absurd (sometimes even to the patient him/herself) corresponds nonetheless to an *area of truth of the subjective experience* of that particular self-state, even if this appears to be incoherent with the *truths of subjective experience* of other self-states.

At the moment in which a "peak" is perceived, the therapist, resorting to a phenomenological conversation mode (Cionini, 2011) can:

- mirror the patient's words/phrases and/or explain what he/she observed in his/her body language, to help him/her maintain contact, in the first person, with the feelings of the *not-me* self that appear and are active in that *present moment* (as Daniel Stern would say, 2004);
- through pausing, and making the person linger on the sensations that he/she is feeling, avoid/block (in a direct and explicit way) potential attempts by the patient to explain/reason;

[5] Filippo used this same term when, referring to his own emotional states, he said: "Maybe when there's an emotional peak I live it, I feel it a bit, but then later I close it inside, I close it inside".

- help the person to maintain/develop contact with the sensations that emerged by: a) requests of an associative type that can facilitate the resurfacing of links between these and other "traumatic" memories of the past, and b) interventions of a metaphorical, fantastical or imaginative kind, possibly aided by a request to close his/her eyes, to facilitate the immersion of the imagination in the reactivated situations/feelings;
- *confirm*, in a mainly implicit way, the *experiential truth* of the feelings of the *not-me* state that has emerged, whatever its content may be; this is the inverse operation of what happened as a child with the attachment figures when they, perceptually dissociating the feelings and desires of the child, relationally disconfirmed him/her.

In this phase of the process, even the therapist should put his/her search for explanations on hold and thus allow his/herself to "work in the void" [6] (Cionini, 2013); with self-awareness, the therapist, by entering into contact with and participating with the feelings and the affective state that the patient is living in that moment, can thus give feedback to the patient (verbal and/or body language) on the feelings that he/she is experiencing and that appear syntonic with what the other is feeling as well. In doing this:

> the therapist must be well aware of the fact that she is not, and cannot be, a "neutral observer" of that which happens in the relationship, but that she participates in it, and she co-determines it, with her own subjectivity. As a participating observer, she must analyse her own interaction with the patient, in the same moment in which she is participating, giving constant attention both to the feelings and the inclinations to action that are evoked in her by the patient in that moment, and to the effect that these can have on the interactive regulation of the relationship (Safran, Muran, 2000). She must be in contact with herself also by availing to sufficient self-awareness of her own modalities of cognitive functioning, and most of all affective-emotional functioning, and therefore be capable of determining how much that which she is feeling can be chiefly attributed to her own stereotypical modes of interpreting and reacting, in certain circumstances interpersonal, and how much it can be attributed to that which is occurring in the "Us" of the relationship. (Cionini, 2013, pp. 182-183)

The fact that the therapist receives in the first person the patient's dissociated parts of self, and presents them back to the patient mainly in an implicit way, allows them to be recognized, makes them "alive and real within the relationship", thus allowing them to be "mentalized" by the person.

The process of entering into contact with the dissociated feelings of the *not-me* state, in addition to having the effect of confirming them, often also, in an "automatic" way, leads to the emergence of links to episodic memories and sensations related to early traumatic events that may have already been addressed/narrated on a descriptive-semantic level in the earlier phases of therapy, but that now have the possibility of being recognized and received in their subjective reality and in their emotional-affective meaningfulness.

As the therapeutic process continues, when some dissociated states of self (felt as *not-me*) begin to be recognized and legitimated, thus becoming more clearly representable as parts of self, the slow process of the transition from dissociation to conflict may begin (Bromberg, 1998), or rather the possibility arises for the person to simultaneously observe states that were

[6] For the therapist, working in the void means not only abandoning the presuppositions of needing to "provide a service", "be good" and "solve problems", but most of all to suspend his/her search for explanations, to "let him/herself be touched" by that which is coming from that patient and to allow him/herself to live in the confusion of the moment of him/herself and the other; this also helps the patient to be temporarily "freed" from explanations of him/herself (that have become a part of his/her *common sense*) and to try to explore in a new way, together with the therapist, an "apparently void" territory in as much as it has been emptied of the prior constructions that have proven to not be viable.

previously dissociated and reflect upon them without being required to decide which is "true" or "more true".

The confirmation of the *truth of the subjective experience* of the *not-me* states becomes the main goal of the therapy in this phase of the process, and allows the person, often through associations that come to the forefront unexpectedly, to reconnect ways of being and feeling in the present to episodic memories and feelings related to traumatic experiences of the past, thus recognizing their affective-emotional meaningfulness and being able to receive them in their subjective reality.

A clinical example

Caterina, aged 54, has been in therapy for many years and came to us complaining about discomfort that was described in terms of panic attacks that had been occurring for a long time, and that impeded her from doing things by herself outside of the home-work routine. The first three sessions, following the initial interview, that are usually dedicated to recounting one's life experience, were particularly problematic. After the first session, in which she had great difficulty recuperating memories from her first six years of life, she came back and was very angry with the therapist, stating that she felt strongly "forced" by the therapist's questions and declaring that she was not willing to answer any more questions that had to do with her own story. We therefore agreed, considering the focus she put on the "questions", to proceed over the next two sessions that were foreseen for this preliminary work, in a way that left her totally free: she would continue to talk about what she felt like, without asking her any questions.

And that is what we did. But in fact, her personal narration was particularly void of information regarding her relationship with her parents and with her three brothers, and also regarding the successive periods of her life. She only made vague reference to a single affective relationship with another person when she was around age 20, about which the therapist was not able to understand, nor ask about, the duration (in any case, short) and its affective meaningfulness.

During the period of late-adolescence she had had a group of friends (with whom, at a certain point, she had abruptly cut all ties, "feeling mistreated" and abandoned), she had been living alone for many years with hardly any social life at all: only one female friend and one gay friend (like all of the other – few – men that she would ever be friends with).

She had already done psychotherapy for a few years, an experience that was concluded by the therapist in a way that she described as being unexpected and traumatic.

Without ever working directly on the symptoms of the panic, the difficulties in moving around by herself gradually faded away until they totally disappeared, over the course of about a year and a half. What continued to remain in a significant way was the difficulty in investing in any kind or relationship. In the few that she continued to have over the years, the relational schema was always the same: "feeling mistreated", with alternating feelings of anger (hardly ever communicated to the other) and passivity (rarely taking the initiative to contact the other, and when contacted waiting until the last second to respond to any invitation). A couple relationship was out of the question, for what she declared was a fear of becoming extremely dependent and of the delusion, anticipated as being certain, that she would feel when the relationship came to an end.

The therapeutic relationship had been experienced, in the first phase, in "double" terms: on one hand the session was lived as the "most important" moment of the week, and on the other hand with an evident fear of traumatic abandonment. During the first months, she brought up

dreams in which the therapist was represented as a "sadistic doctor"; in other dreams brought up in successive periods, the session was interrupted without warning and without motive either because strangers came into the room or because the therapist left the setting and was substituted by someone else, clearly leaving her with a sense of abandonment. Over the last five to six years these doubles disappeared and, though she kept it at a distance, the relationship has developed to be a good one. A clear indication of this is the management of space during the session. Early on the setting used was a vis-a-vis with a desk in the middle, and initially she would sit at a good distance; over time the distance was gradually reduced. A critical moment for her was when the therapist decided to change the work setting and get rid of the desk, opting for a vis-a-vis with an armchair and sofa. In the beginning, she not only sat on the farthest corner of the sofa, but she also needed to keep a large cushion on her lap, as if it were a sort of protection. Gradually the cushion was put to the side, and then not used at all. After that, with slow successive steps, she changed the part of the sofa she sat upon, eventually sitting in front of the therapist, on the closest point possible. Needless to say, the frequency of sessions, except in the event of illness, was always constant and regular.

For a long time the therapeutic process went forward very slowly, though in a relatively constant way (notwithstanding alternating moments of acceleration and stasis, and even of temporary regression) and most of all, in the beginning, without any direct recognition of the changes that had taken place. On more than one occasion, when the therapist had tried to focus on the changes that had occurred, the initial response was that nothing had changed, though she then agreed on a number of differences in the ways she felt and moved regarding some of her more important themes, from the beginning of the process compared to the moment in which this was discussed.

About one year ago there was a particularly significant change, considering the weightiness of the topic, when she was able to make the decision to move, choosing a new home that, for the first time, she was able to feel like something she chose, a place felt to be very much her own. About ten months before the session that will soon be discussed, she had another dream, a dream that she talked about only after four months, that focused for the first time ever on her family relationships (as per our joint interpretation). From that moment onward the therapist utilized, for the first time, the work methods that we described above, resulting in notably accelerated progress. The theme of family relationships had become, though with great difficulty, more accessible. Caterina had begun to remember, and to bring to the sessions, some (few) episodes – of a traumatic nature – from her early childhood and early adolescence that she had never talked about before. Several times after a session that was particularly "intense" both for the content and for the emotional activation, the patient came back at the next session affirming that she didn't remember anything about what we had talked about the last time. Sometimes one meeting was not enough for her to be able to retrieve what had been talked about before, and to come back into contact with the content and feelings experienced.

The following passages are transcripts of a part of a recent session in which the past-present connection emerges in a particularly vivid and clear way. From the beginning, the therapist, after evaluating the need of the patient to talk about something else, suggests reconnecting with the theme discussed at their last meeting:

> *T. "Is there anything new, or should we start directly where we left off?"*
> *P. "Let's start!"* (smiles).
> *T. "Let's start. Ok* (smiling)*... with... I can't let myself, right?!..... You said... home-office isn't enough for me... and then: I can't let myself give in to a simple desire"*
> *P. "Hm"*

*T. "...I was thinking, for example, also about... (*he indicates the patient's handbag, using body language)"
P. "The bag" (laughing)

The "I can't let myself" that the therapist brings up at the beginning was the theme they had addressed through all of the last session after Caterina had made a statement in which she said she was fed up with a life circumscribed to her home and workplace, without friendships and with her inability to get involved with potential "interests" (even theoretically defined, for the first time). This "double" was reconceptualized in terms of two parts of self: one, *more reassuring,* that led her to *settle* with home-workplace, and a second that, though she desired more, impeded her from making different choices, based on a sensation that she described in these terms: *I can't let myself give in to desire.* With the premise that both parts had their own logic, the session ended with the mutual intention to try to better understand the meaning of this second part that appeared, in terms of third-person logic, incomprehensible.

The reference to the patient's handbag, suggested by the therapist only through body language, was immediately picked up on by Caterina because that bag had been the focus of many sessions the year before, in which they talked about her difficulty – defined as *absurd* by the patient herself – in deciding whether or not to buy it. She had seen it in a shop window and it cost slightly more than what she usually spent on a bag. Caterina had stated that she did not feel authorized to buy it, to *not be able to allow herself this gift,* even if the extra cost was not that much. She was able to "allow herself" the bag only a month later saying that, after discussing it more than once in their therapy sessions, she felt implicitly legitimated by the therapist.

T. "That's also when... it came up...: I can't let myself!"
P. "Because it cost too much, mmhm"
T. "Um... yes, but it is still an I can't let myself give in to desire, regardless... one time it's the cost, the next time it will be, um, I don't know... and, but... but maybe it isn't... this isn't the point... because when you let yourself buy it the cost wasn't any less. It was still the same, right?!"
P. "Yes, but when I went to get it, afterward I felt guilty, I gave myself a real talking down for..."
T. "Hm"
[…]
*P. "I don't- I don't know, maybe yeah, it's true, maybe I can't, um (*coughs) *can't allow myself things that... um... aren't indispensable" (*lowers tone of voice).

The therapist's implicit validation that was, in this case, in her words, enough to allow her to put into action a desired behavior, did not however substantially modify her sense of guilt, belonging to the *not-me* state, that continues to come to the surface in the present.

T. "Yes, but is the not-indispensable because of the cost, of the price, I mean, it leads you to some pseudo-explanations, right?!... But... um... how did... how did this come to be... this... this internal feeling... that we're summarizing here... in... in the phrase: I can't let myself?"
P. (18 sec. - sigh - 13 sec.)

In the way, the question was formulated (*how did this come to be...),* by slowing the pace of speech, and by lowering the tone of the voice, the therapist provides the patient with a way of not having to search for "explanations" for the feelings that belong to an implicit domain that is

difficult to translate semantically. The question suggests a connection between the feelings in the present and historical-personal memories. The long silence, interrupted by a sigh and then continued, together with Caterina's posture, signals that she is starting to reconnect with images of the past and demonstrates how emotionally "heavy" this is for her.

> *T. "If we take this-this phrase, right? And try to not ask ourselves why, but... so we can move more freely in terms of... associations, images... memories... wha-what could this take us back to...?"*

After waiting long enough to respect Caterina's "full" silence, the therapist again proposed, even more explicitly, the request to avoid looking for explanations through a deductive process (*to not ask ourselves why)*, inviting her to use the feelings that were emerging in an associative/imaginative way.

> *P. "....Well, earlier I suddenly had* (clearing her voice) *this memory of... mm mm (*coughs) *of my mother who mm in fact told me that… uh... there were a number of times when, you know, that hm hm* (clearing her voice)*... who told me that, well, that there wasn't... how-how can I say this?! That nothing... no obviously she didn't tell me that... I can't let myself, so, she told me... that mm...* (sigh) *that so noth-nothing in the house was mine"*
> *T. "Um"*
> […]
> *P. "I recall that so... um... this funny thing, I don't know... I saw a dress... I don't know how old I was... maybe 12-13... ya know, I saw this dress that I um... that I would have liked and then it di-didn't get bought because you know there wasn't-wasn't any money, you know."*
> *T. "And this happened for your brothers too?"*
> *P.* (14 sec. - sigh – 5 sec.) *"Um um... I-I don't know, maybe not, but it's not... maybe it's not fair to say: to the others yes, and to me no... ya know maybe a li-little bit, yeah, a little bit, to the others a bit more."*
> *T. "It is really hard to say, isn't it?!"*

The memories that emerge are not easy to translate into words to the degree that they reactivate the "pain" of these experiences. There are clear signs: the continuous disfluencies, the many intervals of silence, the attempts to minimize the emotional weight of the memories. By picking up on this and sharing the struggle and difficulty of this process, the therapist recognizes Caterina's "pain" (*It is really hard to say, isn't it?!*), and thus increases the possibility that she can stay in contact with her own memories and develop them further.

> *P. "But... I-I remember that particular dress because... I remember that I cried and... maybe… may-maybe because that dre-... was… the first and last time. […] But, more than this, it's my mother's attitude towards me, it was... it was always… um...: Here in this house nothing is yours... um...: You don't have, you know, you don't have rights, you don't have..."*

In the successive conversational turns, that are not included here, other memories from her adolescence resurfaced. As she reactivated them, Caterina oscillated between attempts to exonerate her mother and increasingly powerful feelings of "having been treated badly" (a feeling that repeatedly emerged regarding relational situations in her present life). In a similar way,

when talking about her anger from that time, she describes alternating moments in which it emerged violently and moments in which it was pushed aside when she "gave up" or "let it go", as if she was making the idea of "not having rights" her own. It seems that this description does in fact correspond to an alternating activation of dissociated parts of Caterina that resurface even in the present.

T. "It's as if... in the absence of your mother... there's this part... this part of you that took her place […] It seems like... this role... that you took on... regarding yourself... by saying that... that your needs don't count, that your desires don't count"
P. "... Hm"
T. "But I rebelled so much in the past against someone else... an-and now who do we rebel against?" (using "I language"[7] and gradually lowering the tone of voice)
P. "(Takes a breath)*"... I don't have an enemy anymore?!"*
T. "No, no, you still have an enemy! And it's worse than before... depending on the point of view..."
P. "(sigh)
T. ".... You!!" (said in a decisive manner)

In a crescendo, during which the message is formulated in an increasingly explicit way (leading up to that final "*You"*), the therapist points out and emphasizes the sensation that now, in the absence of her mother (who passed away a few years ago), it is as if the *not-me* part of Caterina has taken on the role of her mother, continuing to deny herself the right and the possibility to be, to exist with her own needs. The very long silence that followed (more than a minute), together with changes in her posture, demonstrate the impact this had on her and the fact that Caterina is again reliving (reconnecting to) images from the past, difficult to translate into words for the pain that they bring with them.

P. (68 sec.) *"I was thinking that... um... my mother didn't... e-ev-ever-ever encourage me, for anything. I was thinking... at school, right? I don't have any memories... and... but there... but there was never a time… but-but really never.. that she said to me... good, well done, you know... never... and... and, a part from that I believe that there just wasn't any... how would you say it? Um... trust, right? Trust"* (13 sec.)
T. "If I'm not mistaken, you would have also liked to go to college, right?!"
P. "Yes, yes […] well I remember that once my mother asked me: But you... uh... what do you want to do? And I never told my-my mother what I would have liked to do, instead, I remember that day I-I told her: Well, no, I don't know and she told me: Ah, you're really... you're really without any... ambition. But... I did not-not-not... (takes a breath) *tell her because I was afraid... that... she would make fun of me. Yeah! No-but, actually I never told this to anyone because I was afraid that but, you know, my mother that... she would make fun of me...*

[7] For "I language" (Cionini, 2005) we intend the conversational passages in which the therapist speaks as if he were the patient. This is a modality that can be useful, on one hand, to help the patient maintain contact with herself in the first person, and on the other, even to facilitate the therapist himself in staying within the dimension of comprehension, in trying to momentarily make the other's feelings her own.

anyway... and would say... yeah, that um she would make fun of my desire you know" (lowering tone of voice and slowing pace of speech)
T. "Hm"
P "And (11sec.) *that's why um…"* (clearing her voice)

Paraphrasing Bromberg we could say: that which couldn't even be thought of before, now can be said. The statement that Caterina is now able to formulate, though with evident difficulty (*I was afraid that my mother would make fun of my desire*), can be seen as a sort of "summary" of the traumatic experiences of a lack of confirmation perceived in relation to her attachment figures (in this case in particular with mother). Feelings that she herself says she had never revealed to anyone, presumably not even to herself, and that have been dissociated in a *not-me* part.

T. "That she would make fun of my desire! Hm... that is a strong, um, way to put it!... afraid that she would make fun of my desire…" (words clearly articulated, low tone of voice)

The patient's statement hits the therapist like a "bomb", and by repeating the statement twice in a slow and punctuated way, the therapist tries to give her a sense of what the therapist is feeling, even in the first person, to help her maintain contact with the feelings that have emerged that are active in that moment and "confirm" them. Feelings that can be capable of recognizing, more than any theoretical explanation, the origin and the meaning of the affirmation that the session started with: *I can't let myself give in to a simple desire.* In the very next turn of the conversation it is clear, however, that Caterina still needs to keep them at a distance, continuing to dissociate that part of self. The contact made with her self and her life story is evidently too powerful to hold on to emotionally, at least in this moment (she will need another two sessions before she can really let herself do this).

P. "But... you think it's strong? I don't find it that strong like... because maybe at home there was a bit, this was the climate, right?"
T. "Ah!"
P. "That's why for me maybe it's a bit... Nor-nor-normal, almost, this... (takes a breath) *this..."*

In fact, after she came into contact with the feelings of her *not-me* part, the need to relativize them, to deny their affective value, strongly emerges. The dissociative process once again comes powerfully into play; it's as if it were another person who said what she said. It's as if before the therapist two different people had rapidly taken each other's place. The *not-me* part is substituted by the part that, to protect against an inundation of unbearable pain, denies – thus normalizing – her own experience as if it had never existed.

Given Caterina's difficulty, the therapist then tries to present her story again by slowly narrating it, as if referring to another person, to help her maintain contact with her feelings but trying to imagine them through the experience of a different person.

T. "So, if you think... about a little girl, about a teenager... who... feels inside... a fear like this, so that... the people who... who should be taking care of her and... people who obviously every child would want to be seen, to be observed, to be

considered. *and this girl is afraid to talk because... she's afraid that... her parents or other people close to her... will make fun of her desires... Shit!!"*

P. "Ah!!... But I don't see it like that... I don't know, I-I, I mean, it seems like something nor-normal... Really, it's not... it's nothing that..."

After an initial moment when, with her *Ah!!*, Caterina seems to have grasped the meaning of the therapist's "move", coming back into contact with her *not-me* part, distancing comes to the forefront again through a process of normalization.

T. "It's nothing that…?!!"

The therapist's intervention, saying *It's nothing that…?!!*, pronounced with a tone of voice matching a stunned look of disbelief, allows Caterina, after taking the time she needs, to recontact her own feelings.

P. (16 sec. - takes a breath) *"I mean, in the house there was this climate, in my opinion, of just... denigrating, right? Or still of... (*sigh- 12 sec.) *I, for example, really felt it uh... towards me, in-in-in in comparison to-to-to my brothers, right? Obviously (*lowering tone of voice)*... um... and so wh-what do you do? You-you you defend yourself! Right? You don't say anything anymore."*

T. "Yes, yes, well sure... this isn't what... I was highlighting... Of course one defends oneself... and doesn't say anything anymore... What's terrible is that... is that one doesn't feel like saying anything anymore... that I don't feel it is possible to say anything anymore (gradually lowering tone of voice and once again using "I language") (17 sec.) *I mean, I feel like saying... can I feel like existing under these conditions?"*

In these interactions we can find what Beebe and Lachmann (2002) call "heightened affective moments"[8]. The therapist, feeling intensely once again in first person Caterina's pain, tries to communicate this to her with words, with the tone and rhythm of voice, and also with body language.

P. (23 sec.) *"But, um* (coughing) *when you said those things before, right? About a girl who... who expects.. a certain behavior from... from her parents* (takes a breath)*... I, when you were saying those things"*

T. "Mm-hm"

P. "Um I thought… I thought that... (sigh) *and... listening to you I thought that what you were saying... was something... it could have been something terrible.*

[8] Beebe and Lachmann propose *three principles of salience* that establish the way in which the expectations within an interactive encounter should be organized: "the principle of *ongoing regulation,* the principle of *disruption and repair* and the principle of *heightened affective moments.*" The first is "based on the expected and characteristic ways in which an interaction unfolds. (…) Disruption and repair captures a specific sequence broken out of the broad pattern. In heightened affective moments, one dramatic instance stands out in time." (2002, p. 143). In particular, the heightened affective moments refer "to interactions that are organized when a person experiences a powerful state of transformation, either positive or negative." (2002, p. 189). They are moments that are jointly constructed within the therapeutic relationship and "can provide opportunities, refinding old loves, or, potentially, retraumatization." (2002, p. 189).

So it's as if... um (coughing)*... I would have needed to put up a wall against the things that you... were saying, right?"*

T. "Uh huh!"

P. "In the sense of... of defending myself, yeah, against what you were saying" (lowering tone of voice)

T. "Hmm.. Yes!"

P. "I don't know, maybe then I start to think that... um... that I still need to... defend myself against my past, I don't know, to... to not think too much about it... to erase it, I don't really know right now" (lowering tone of voice)

The intensity of what has been reactivated makes it so that Caterina feels the need to "put up a wall" to defend herself from feelings that, in this moment, seem "too much" to hold on to for long; feelings that she allows herself to declare and share with the therapist, together with her need to, momentarily, distance herself from the memories of her past.

T. "Uh huh... Yes, but it is a way... a certain way of erasing it, right?... I mean, I try to not think about the pa- about my past... and... erasing it... b-but then it's like I reproduced it... in the present"

In this passage, the therapist implicitly brings up what was said before when suggesting that the *not-me* part of Caterina had taken on the role of the mother by saying "her own needs and desires didn't matter".

P. (13 sec.) *"Hm"*

T. "... Because.. I know it hurts!!... And so that it's spontaneous, the need to put up a wall and to defend yourself... but maybe it hurts even more if.. if I say to myself, like you said a few minutes ago: It seems normal to me, it doesn't seem like anything... out of the ordinary... I mean, because it's not just ab-about not allowing yourself the bag or things like this... it's <u>not allowing oneself... to feel what I feel</u>!" (using "I language" again)

Maybe one could say that "the wall" put up by Caterina represents her own "resistance", connoting – as frequently happens – this term in a negative sense. In fact, when a patient "needs to resist" it means that what has happened in the therapeutic relationship has come to represent a "threat" that is too hard to bear in that moment. But, as is also affirmed by Steele (2015), the so-called resistance can be more properly re-read as the "need to protect oneself" by the patient, and should therefore be accepted as such and "confirmed" as the person's need. In effect, in the previous passage and in the successive one, the therapist declares to understand, thus confirming this need, even if at the same time the therapist mentions the "other side of the coin" (*but maybe it still hurts*).

P. (28 sec.) *"I don't know, I-I even regarding these subjects... um...* (clears her voice) *that are heavy I should um... f-fe-fee-feel bad, I don't-don't know, really I don't... don't know how to say it... I don't...* (takes a breath) *maybe because I take it as a given, is that possible?... That I take them as given, I take...?"*

T. "I would say the opposite… Because I deny them to myself! If not it wouldn't affect you this way, right!? When I was talking about a girl, I mean, like talking about someone else who is not you... if you tried even for a moment to imagine that same situation for someone else... a-and probably it struck... it struck so

hard, so hard that you felt the need to put up a wall... and and uh... I don't know, but it seems like... it seems like... (the pain)... *I felt it more than you!"*

P. (smiles)

T. "That's kind of paradoxical, isn't it?"

P. "Yes, it is paradoxical… Ha!… No, I understand it's paradoxical, I understand that it isn't, but it isn't..."

T. "But it hurts!"

P. "… No, not right now... no... I mean, I'm amazed, because may-maybe, it should, I don't know... (sigh – 34 sec.) *I don't know! It's a reaction that is so, I don't know...* (lowering tone of voice) *I was thinking that I started out justifying my parents, right?"*

Once again it seems almost as if, in a sort of "paradoxical" situation, the emotional impact of these memories are more alive and immediate for the therapist than for Caterina. By coming into contact with the feelings and the affective state that the patient is living in that moment, the therapist brings his own feelings back to her (that appear syntonic with those of her *not-me* part) affirming that it is *as if* the pain that has been reactivated by her memories (*I felt it more than you)*. A paradox that Caterina grasps and shares, almost amazed by her own reaction.

In their final exchanges, the therapist, considering that Caterina – although this time she came into direct and intense contact with memories of her own early experiences – has still needed to put up a wall *to... defend myself against my past, I don't know, to... to not think too much about it... to erase it,* and foreseeing that the wall would presumably crumble over the next few days, closed the session by saying:

T. "The next time I'll be curious to know if this sort of anesthesia tonight will continue over the next few days."

In keeping with this "premise", the next session begins with the therapist asking:

T. "How did this week go?" (with an almost joking tone of voice with a clear reference to the anticipation made at the end of the last session)

P. (openly laughs, immediately grasping the sense of the question) *"I'm ashamed to say it* (they laugh together)*... Well this is how it went. It went that... I left here feeling not bad... I didn't feel bad...* (lowering her tone of voice) *it was like to say...* (sigh), *I dunno, maybe shook up? I don't know... I needed to... anyway to go home, so I went the whole way saying: I have to go home, I have to go home. Then when I got home, I opened a bottle of wine, I drank the wine* […] *I looked for something on TV that woulddd* (laughing) *distract me... and and... so, I don't* (drastically lowering her tone of voice) (13 sec.) *I thought that maybe I don't want to think about certain things, I don't know. But I do-don't..."* (…)

P. "I needed to... uh, how do I say it, to lighten things up a bit, right? […] *It's as if I, uh, needed to... anyway to tell you that... that it sou-... sounds a bit strange, but, that I am bad too"*
[…]

P. "I mean it's a bit like saying, um, a bit like saying, I believe, uh, it's not just their fault, it isn't possible that it is just their fault, if everything happened that way… um, ya know, uh, it's also my fault, I am also responsible... um… mm hm"

[…]

P. "If I uh... start to think then that I wasn't altogether that bad, maybe the whole thing becomes a lot heavier, doesn't it?

T. "Heavier?"

P. "Ah... exactly, because if I think that... all things considered... I have my responsibilities um... and-and... they have their reasons, then it's all so much lighter, right? It all gets very, diluted.

For the first time Caterina grasps, and explains in a very explicit and clear way, one of the typical characteristics of the dissociative process: attributing responsibilities to herself (in terms of fault, shame...) regarding what she remembers about her own childhood interactions as a way of alleviating and *diluting* the pain of reconnecting with her own experiences. It seems, as always happens, that in trying to give a sense to her own experience, the only possibility is that of attributing the "fault" to herself or to her care-givers and, within this alternation the "pendulum" always tends to swing, at the end, towards the first solution. Defining oneself as bad or at fault describes the protective function of the *not-me* part, that thus allows one to lessen the feelings of being unlovable, of not having been recognized by attachment figures, of nonexistence in their eyes (better "bad" than "nonexistent").

An important passage of the therapeutic process that can be proposed also in very explicit terms is for the therapist to highlight that it doesn't make sense, that it is useless, to search for who is "at fault", but rather that the goal is only that of trying to understand that which the person has felt and what effect this may still have on the present day. Usually in these moments we resort to the metaphor of the "court trial" to show what we do not need to do; this is not about finding this or that person innocent or guilty (also because it is impossible to know what really happened), but only about giving sense to what one feels in the present as an effect of what one felt in the past.

In fact, this is what was said in the following session:

T. "[…] *Then it's not so much about what happened as much as what, what happened then, brought about over time and what it brings about even now.."*

P. "... Hm (7 sec. - sigh - 22 sec.) *I don't know, I... I mean, you say understand what it brought about?* (sigh – 12 sec.) *I don't know what it means, I... I felt... treated badly, not loved an-and... uh... ex-excluded, that's it, excluded"*

T. "Hm"

P. "And so... I excluded my-myself"

[…]

T. "And maybe I excluded... even my own desires (21 sec.) *My desires, my feelings... I feel like saying my right to have them"*

P. (12 sec. sigh 5 sec.) *"I don't know, I don't know about this, I know that it is something that, hm... that I do even now... if I feel excluded I... I immediately exclude myself!"*

It seems that Caterina has reached the point in which she makes the therapist's proposal her own, when, two sessions prior, the therapist suggested that in the absence of her mother, her *not-me* part had taken on her role, continuing to "deny herself the right to exist with her own needs" and tending to exclude herself each time she perceived the possibility that she could be excluded by someone else.

In the successive encounters the process of change was considerably accelerated following her *affectively connoted* comprehension of how much certain feelings and constructions in the

present were connected to her past experiences. After a session in which she "needed" to talk about a totally different subject, she began to evaluate the possibility, never considered before, of being able to get involved in social activities, in which she would come into contact with other people; towards the end, the central problem of her "fear of nearness" was also briefly addressed.

In the following encounter, Caterina began to connect parts of her own historical experience with her feelings in the present. When the therapist asked her to try to see a relationship between her "fear of nearness" and her own past, for the first time, a series of memories (never recounted before) spontaneously emerged of her as a child and an adolescent, related not only to her mother but also to her father; the latter being a figure whom Caterina always avoided, over the years, lingering on. Regarding her father she talks about *vague memories of affection,* substantiated however by a few vivid images and episodic memories; an affection that she did not perceive once she was 9-10 years old when, following the birth of her youngest brother, she felt *neglected, forgotten.* It is significant that Caterina is now able to reactivate even positive memories regarding "moments of nearness" with a figure who, being blending with that of her mother, was – when she rarely came to the surface – only given negative connotations. At the beginning of the therapeutic process, touching upon the death of her father, she had stated that she didn't care one bit and that she didn't feel, and had not felt, any emotion provoked by this event. The importance of these memories lies in the fact that now it has become possible for her "to stand in the spaces" between self-states (see Conclusions), contemporaneously considering positive and negative aspects of her relationship with the paternal figure (belonging to different parts of self) and also giving sense to how the positive aspects could have been "submerged" by the disillusion deriving from her perception of having been *neglected, forgotten,* following the birth of her youngest brother.

Conclusions

What could be the most transformative element in the experience of a therapeutic process conducted from this point of view? Coming back into contact with dissociated memories from one's past is *important* but is *not sufficient* in and of itself. *Important,* because remembering feelings that led to the construction of one's self-image in terms of being bad, at fault, and ashamed, regarding not having felt accepted and confirmed by attachment figures, allows one to begin to give sense to the symptoms and the feelings experienced as "absurd" and "disturbing" in today's relationships between self and others.

Not sufficient, because the possibility of feeling that what we felt is acceptable and can shared with an "other" that feels it together with us is even more important

Therefore, that which can be most transformative is the possibility of having one's self mirrored in the eyes of an other (the therapist), of being recognized intersubjectively and of feeling confirmed (as did not happen in early relationships), so that the feelings of the *not-me* state can be legitimated and become representable as parts of self.

The authors of *The Boston Change Process Study Group* suggest quite similar concepts when they state that:

> change takes place in the implicit relationship at "the moment of meeting" through alteration in "ways of being with". It does not correct past emphatic failures through the empathic activity. It does not replace a past deficit. Rather something new is created in the relationship that alters the intersubjective environment. Past experience is recontextualized in the present such that a person operates from within a different mental

> landscape, resulting in new behaviors and experiences in the present and future. (2010, p.28)

In order for this to happen, it is necessary for the therapist to avoid working on *the apparent absurdity of incoherence*[9] (that emerges from the irreconcilability of the *truths* of dissociated self-states) and that the attention of the therapist be focused on the feelings of the *subjective reality of the not-me states* that need to be confirmed as such. The augmented capacity of the person to represent previously dissociated states and to reflect on them, now allows the person to be able to simultaneously observe them without having to decide which one is more "true", thus embarking on (as mentioned above) a slow process of transition from dissociation to conflict. This transition opens up the possibility of new experience. The patient, by giving up the protective safety of dissociation, can start to tolerate the presence of a conflict in which antithetical ideas can be simultaneously apprehended, to recognize the feelings of the *not-me* state as legitimate and negotiate between subjective truths belonging to *me* and *not-me* states that were previously dissociated (Bromberg, 2011); this means becoming capable of "standing in the spaces" of the "realities" that previously belonged to different self-states, of experiencing them contemporaneously, without losing any of them. Similar to when the background becomes foreground together with the foreground. Bromberg says:

> health is not integration. Health is the ability to stand in the spaces between realities without losing any of them (…) the capacity to feel like one self while being many (Bromberg, 1998, p. 116)

> "Standing in the spaces" is a shorthand way of describing a person's relative capacity to make room at any given moment for subjective reality that is not readily containable by the self he experiences as "me" at that moment. (Bromberg, 1998, p. 213)

Let us conclude by sharing the words of another patient, who we will call Orazio. After being in therapy for about a year, during a session in which his "resistance" to being able to let himself go was addressed, he described his own dissociation in these terms:

> *"I am a sort of monster who doesn't feel emotions when reading his own internal novel and who refuses to work and collaborate to be able to deal with the situation which is not one of the best […]. I talk about things as if they were something that happened two hundred years ago... to someone else […] It's as if I were a mere outside observer of my passions […]. The wall, the armour has ensured my survival... the crises* (panic attacks) *that I still have now and then, are like fissures, cracks that open up, and very dangerous things come out… that give news about myself […]. Yes, one part protects itself, and one wants to get out."*

References

Albasi C. (2006). *Attaccamenti traumatici* [Traumatic attachments]. Torino: UTET.

Beebe, B., & Lachmann, F. M. (2002). *Infant research and adult treatment: Co-constructing interactions*. Hillsdale: The Analytic Press.

Borgna, E. (2015). La dissociazione come forma di vita [Dissociation as a way of life]. In L. Zorzi Meneguzzo, L. Consolaro, F. Gardellin & L. Panarotto (a cura di). (2015). *Come melograni. Dialogo interdisciplinare su dissociazione e persona* (pp. 7-10). Milano: Mimesis.

[9] See the section above entitled "Observing dissociation in the conversational flow".

Bromberg, P. M. (1998). *Standing in the spaces: Essays on clinical process, trauma, and dissociation*. Hillsdale: The Analytic Press.

Bromberg, P. M. (2006). *Awakening the dreamer: Clinical Journeys*. Hillsdale: The Analytic Press.

Bromberg, P. M. (2011). *The shadow of the tsunami: And the growth of the relational mind*. Hillsdale: Routledge.

Caretti, V., & Craparo, G. (2008). La disregolazione affettiva e la dissociazione nell'esperienza traumatica [Affective disregulation and dissociation in traumatic experience]. In V. Caretti & G. Craparo (a cura di), *Trauma e psicopatologia. Un approccio evolutivo-relazionale*. Roma: Astrolabio.

Casini, C. (2015). *Vivere in un film horror* [Living in a horror movie]. Unpublished manuscript.

Cionini, L. (2005). Prefazione (seconda) [Preface (Second)]. In C. Barni, G. Galli, *La verifica di una psicoterapia cognitivo-costruttivista sui generis* (pp. 17-28). Firenze: Firenze University Press.

Cionini, L. (2011). Transfert e controtransfert: le emozioni in psicoterapia. L'ottica cognitivo-costruttivista [Transfer and counter-transfer: Emotions in psychotherapy. The cognitive-constructionist view]. In P. Moselli (a cura di), *Il nostro mare affettivo: la psicoterapia come viaggio* (pp. 15-22). Roma: Alpes.

Cionini, L. (2013). La psicoterapia cognitivo-costruttivista [Cognitive-constructivist psychotherapy]. In L. Cionini (a cura di), *Modelli di psicoterapia* (pp. 133-213). Roma: Carocci.

Cionini, L. (2014a). La persona del terapeuta come strumento del cambiamento: implicazioni per il processo formativo [The person of the therapist as an instrument of change: Implications for the training process]. *Costruttivismi, 1*, 29-33. (Retrieved from http://www.aippc.it/costruttivismi/wp-content/uploads/2016/12/2014.01.028.032.pdf)

Cionini, L. (2014b). *L'approccio costruttivista alla terapia dei disturbi post-traumatici* [The constructivist approach to therapy for post-traumatic disturbances]. Paper presented at the Symposium "Trauma, sviluppo traumatico, vulnerabilità e cura del trauma", Azienda Sanitaria Firenze, 21 novembre, Sesto Fiorentino, Italy.

Cionini, L. (2015). Il linguaggio delle parole, il linguaggio del corpo e il linguaggio delle immagini nel processo di cambiamento [The language of words, the language of body, and the language of images in the process of change]. *Costruttivismi*, *2*, 169-180. (Retrieved from http://www.aippc.it/costruttivismi/wp-content/uploads/2015/09/2015.02.169.180.pdf)

Cionini, L. (2016). *Traumi relazionali precoci multipli e dissociazione: la logica dell'assurdo* [Multiple early relational traumas and dissociation: The logic of the absurd]. Paper presented at the Symposium "Amore e Psiche: la dimensione corporea in psicoterapia", VII Congresso della Federazione Italiana delle Associazioni di Psicoterapia (FIAP), 6-9 ottobre, Ischia, Italy.

Cionini, L., & Mantovani, I. (2016). *La conversazione terapeutica* [The therapeutic conversation]. Unpublished manuscript.

Janet, P. (1889). *L'Automatisme psychologique.* Paris: Alcan.

Liotti, G., & Farina, B. (2011). *Sviluppi traumatici. Eziopatogenesi, clinica e terapia della dimensione dissociativa* [Traumatic developments: Etiopathogenesis, clinic and therapy of the dissociative dimension]. Milano, Raffaello Cortina.

Miller, D. (1994). *Women who hurt themselves.* New York: Basic Books.

Ogden, P., Kekuni, M., & Pain, C. (2006). *Trauma and the body*. New York: Norton.

Safran, J. D., & Muran, J. C. (2000). *Negotiating the therapeutic alliance. A relational treatment guide*, New York: Guilford.

Shore, A. (2011). Foreword. In P. M. Bromberg, *The shadow of the tsunami: And the growth of the relational mind*. Hillsdale: Routledge.

Steele, K. (2015). *Dalla resistenza alla comprensione. Approcci psicoterapeutici integrati con pazienti difficili* [From resistance to comprehension. Integrated psychotherapeutic approaches with difficult patients]. Paper presented at the Symposium "Attaccamento e Trauma", Istituto di Scienze Cognitive, 25-27 settembre, Roma, Italy.

Stern, D. B. (2003). *Unformulated experience: From dissociation to imagination in psychoanalysis*. Hillsdale: The Analytic Press.

Stern, D. N. (2004). *The present moment in psychotherapy and everyday life*. New York: Norton.

The Boston Change Process Study Group (2010). *Change in psychotherapy. A unifying paradigm*. New York: Norton.

Van der Hart, O., Nijenhuis, E. R. S., & Steele, K. (2006). *The haunted self: Structural dissociation and the treatment of chronic traumatization*. New York: Norton.

Van der Kolk, A. C., McFarlane, L., & Weisaeth, L. (Eds.) (1996). *Traumatic stress: The effects of overwhelming experience on mind, body, and society*. New York: Guilford.

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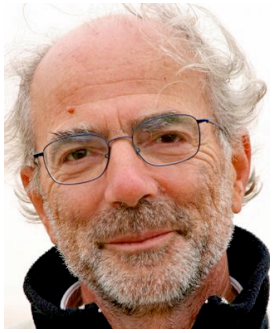

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Reference (APA)

Cionini, L., & Mantovani, I. (2016). Reading dissociation of the experience of relational trauma: Psychotherapy from the constructivist intersubjective perspective. *Costruttivismi*, *3*, 173-193. doi: 10.23826/2016.01.173.193