Ricerca Psicoanalitica | pISSN 1827-4625 | Year XXXVI, s1, 2025
doi:10.4081/rp.2025.1046

Dissociation and the analysis room: relational experience, affective presence of the therapist, and containment

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Abstract. – Dissociation represents a psychic mechanism that can manifest itself in both common, non-pathological forms – such as getting lost in one's thoughts during a walk – and in more severe modes, such as amnesia or identity fragmentation. In this paper, we will deal with cases where, in a therapeutic setting, it may emerge as emotional detachment or isolation, often as a defensive strategy in the face of overwhelming emotions. The task of the analyst, who is personally involved, is to offer a space for affective regulation that allows the patient to reconnect with their emotional world and reintegrate dissociated experiences. We will present two clinical vignettes to illustrate different manifestations of dissociation in session, highlighting the challenges posed to the analyst in clinical practice.

Key words: dissociation, affective regulation, interaction.

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The word dissociation commonly conjures up worrying scenarios or pathological situations. However, as clinicians, it is important to remember that, although it is a complex mental phenomenon that can manifest itself in many ways, its broad spectrum is highly diverse. In fact, it does not always present itself in pathological forms; on the contrary, it can be part of our daily experience more than we realize.

A simple and common example of this phenomenon is what happens when we travel a familiar route – by car or on foot – and realize that we have done so without paying attention to the road. Our mind was elsewhere, immersed in thoughts, yet we arrived at our destination without any problems. In this case, dissociation is understood as a momentary 'detachment of attention' from the surrounding environment and is considered completely normal and functional.

At the opposite end of the spectrum, we find much more intense and complex forms. Some people, under extreme stress – as can happen in military contexts – use self-hypnosis techniques to endure physical pain. Others report unusual experiences when recounting traumatic events, such as autoscopy, or the perception of leaving one's body and observing oneself from the outside. In the most severe cases, it is possible to come across phenomena described in psychopathology manuals, such as Dissociative Amnesia or fragmentation of identity, as in Dissociative Identity Disorder (DID).

This variety suggests that dissociation as a phenomenon is not in itself a sign of illness. It often represents a functional response of the mind to emotionally complex situations, a useful strategy for maintaining a certain internal balance. In many circumstances, it is an adaptive mechanism that allows a person to temporarily distance themselves from content that is too intense or difficult to process, enabling them to continue with their daily activities.

When this occurs physiologically, the dissociated experiences are not necessarily erased but simply 'set aside' for a while. They can then resurface and be integrated without particular difficulty. Even in the presence of momentary 'fractures' in the experience, the sense of self remains intact: the individual continues to feel they are a unique and coherent subject, capable of recognizing the different facets of their inner experience as their own.

However, when dissociation takes on a rigid defensive form that recurs automatically, it can hinder a person's ability to contain and reflect on different mental states within an integrated perception of self. In such cases, a sense of continuity and internal coherence is certainly at risk. It may seem paradoxical to think that this serves a beneficial effect for the subject, but even this form of extreme dissociation has a purpose: to protect the subject from the danger of more significant fragmentation of a traumatic nature, maintaining at the very least a subtle trace of stability and integrity of identity (Binet, 1892; Craparo *et al.*, 2020; Janet, 1889).

Today, dissociative phenomena and possible therapeutic interventions are

increasingly at the center of clinical reflection (Albasi, 2006; Falci & Giustino, 2023; Farina & Liotti, 2011). Our contribution can be aptly placed in this context, as we propose to closely observe dissociation as it manifests itself in the analytical space when the patient and therapist are directly and actively involved in a relationship. From this perspective, therefore, it is not just a matter of observing an individual phenomenon, but of understanding the dynamics that involve the analytical couple as a whole, in a *hic et nunc* setting that brings into play the present and lived event of the relationship, its immediate consequences, and its transformative potential.

Even in the midst of the session, as described above in everyday life, dissociative phenomena can take on different meanings: from representing the phenotypic expression of a specific personality structure, to indicating a way of temporarily coping with change, or representing a defense, particularly with regard to content (of emotional significance) that emerges at that moment. The analyst, as an active and involved participant (both witnessing the process and taking part in it), has the task of recognizing the emerging mode, while also reflecting on the personal experience of what is unfolding and the significance of this involvement in order to make use of its potential to full advantage. More specifically, we refer to situations in which dissociation represents an attempt by the patient to distance themselves from overly intense emotions arising during interaction with the analyst, and the way in which the analyst responds to them, by deciding to do something about them. These are often difficult experiences to process and can reactivate previous conflictual relational dynamics, resurfacing precisely because of the presence of the other, specifically within the therapeutic relationship, in both members of the couple.

This also poses a challenge of primary importance, involving affective regulation. The analyst's intervention should offer a relational space capable of *containing* and modulating the emotions that emerge during the session. However, containment, in this sense, is not only a cognitive or interpretative act, but encompasses a shared experience that passes through the emotional channel. When the analyst manages to understand and give shape to what is being felt by both analyst and patient – whether fear, anger, shame, pain, guilt, or hyperarousal – this active engagement contributes to the patient's affective regulation, promoting the reintegration of dissociated parts (Fonagy *et al.*, 2002; Hill, 2015; Jurist, 2018), opening up new areas of meaning with the patient, and offering the analyst the opportunity to discover new aspects of the self through that shared experience.

For this adjustment, which is far from simple, to take place, the analyst must be truly present, able to tune in profoundly to what is happening in the relationship, monitoring and modulating the emotional intensity in the field. In this way, the patient can reclaim the emotional parts that had to be isolated to avoid being disintegrated, thus managing to be present in the therapeutic

relationship without having to give up their authentic participation. Both the cases we are presenting explicitly illustrate, in different ways, what has been stated above.

Human beings are biologically predisposed to tune in to the other, in a process of mutual regulation, both to develop their own resources and to expand and reaffirm their way of being (Ammaniti & Gallese, 2014; Castiello *et al.*, 2010; Gallese & Morelli, 2024). In therapy, this capacity and need for emotional harmonizing becomes a fundamental tool, restoring the patient's emotional stability and promoting the emergence of a new, more flexible and articulated affective organization, relying primarily on rational or explanatory understanding rather than on a shared 'feeling' that paves the way for an intimate comprehension with transformative potential. Only in lived experience, in confrontation with the other, is space created to explore new ways of being, to access new perspectives of oneself and one's emotions.

The therapist's hands-on approach

It is not surprising that when faced with a patient who dissociates, the analyst finds it difficult to comprehend or accept their profound suffering. This can happen for various reasons, often described as incomprehension, anguish, or a blank mind. As a matter of fact, managing dissociative behavior and the accompanying anxiety leads the therapist to experience feelings of detachment, or even dissociation, from the situation at hand, which, we would like to emphasize, is characterized by being relational. It is important to emphasize that the difficulty encountered in the session involves the patient as well as the therapist, and that it is the therapist's duty and absolute necessity, when faced with the patient's dissociation, even at a later time, to ask themselves what to do with this experience and how to do it.

This consideration highlights how, in the clinical setting, the intersubjective relationship – identified as a shared tool of symbolic and affective meaning – represents a dynamic process in which two subjects, through co-observation of their own and each other's feelings, promote the discovery of new meanings and lay the foundations for a redefinition of the relationship and emotional regulation.

A brief clinical overview will help us translate what has been said so far into practical terms.

Luigi,[1] a young patient, asks for a meeting and requests to be helped with a series of difficulties he has noticed when he is in relationships with others. This condition, which is very painful and fragmented in Luigi's account, is in

[1] Names of patients appearing in the text are purely fictitious names assigned by the authors of this work.

contrast with what happens to him one afternoon when, after making love to a girl (currently his girlfriend), he notices that for the first time he is *present*, present and connected, and not uncomfortable. Normally, in fact, anything that involves a strong intimate or emotional impact produces in him a state of profound detachment and leaves him feeling uncomfortable; a bond (intimacy-emotions-detachment) that, thanks to psychotherapy, he is able to identify and define, over time, as protective in itself, but which comes at the cost of intense suffering and of never being able to fully experience a relationship. Indeed, the analytical couple tries to make sense of this experience: detachment allows for a condition that, although not psychotic in his case and a guarantee of being separated and protected, does not allow him to perceive himself as *real and touchable*. In this regard, in fact, Luigi describes himself as if he were in a situation of *real unreality*, in which, as if behind a glass that muffles sounds, he hears words but cannot speak; he loses himself in his thoughts or in the absence of them, and in which, in a highly artificial way, he tries to analyze everything he perceives in order to reestablish connections with the reality shared by others.

Since its origins, the analysis of dissociative syndrome has had various definitions, including types and subtypes (*e.g.*, depersonalization, derealization, splitting, dipsychism, *etc.*) (Bleuler, 1911; Foschi, 2003). In Luigi's case, we prefer to speak of detachment (Albasi *et al.*, 2022; Liotti & Farina, 2011).

A strategy of detachment adopted in order not to lose oneself is therefore salvific, but at the same time a 'costly' strategy, the price of which is necessarily having to give up a part of oneself related to one's authentic relationality, as well as the experience of an Other who is authentically interested and, indeed, in a relationship.

If we follow this hypothesis, which suggests that one of the purposes of dissociation in general is to exclude emotions from consciousness, we can understand how it may be difficult for the clinician, who is normally intent on being attuned and involved, to understand what is happening both to the patient and in the analytical field. This is the case with Luigi's therapist.

During one session, however, something changes. Luigi talks about the group of friends he met with over the weekend, but as he is talking, his face gradually darkens, and he becomes detached from the reality around him until he is silent, while tears run down his face: a quiet weeping, without any looks or words. The therapist thinks she would like to get up and hug Luigi and feels extremely close to him as she becomes aware of this experience, and a long time passes. There were other similar occasions when the therapist terminated the session, which had reached an end, while Luigi, completely disconnected from time and the idea of time passing, remained on the couch, absorbed and enraptured by this condition. As she continues to think about this wish to hug him, the therapist decides to ask, "Luigi, is there anything I can do to help you now?". After a little while, Luigi speaks

up and says, “Maybe I would have liked to be hugged, but at the same time I wouldn’t want you to”. This sentence marks Luigi’s re-entry into contact with the real space and time of the session.

Let us try to read what happened between Luigi and the therapist, where one cannot help but be struck by the coincidence of the therapist’s experience (I would like to hug him) and what the patient then states, “Maybe I would have liked to be hugged”. However, the second part of Luigi’s statement opens up a further space “(...) but at the same time I wouldn’t want that.” What does Luigi not want? Contact? The emotions this might arouse? The dependence? The being cared for and the fear of not being able to tolerate it or losing oneself in it? The therapist’s verbalization, that she keeps perfectly clear the experience she feels, but asks Luigi to take a stand in this shared space (“Is there anything I can do to help you now?”), creates a potential space between the two members of the couple, a space of agentivity and co-construction, where Luigi brings for the first time an additional, emotional element with which both can return/remain in touch, even in difficulty. A bridge between the possibility of stopping in two possible states of self, conflicting and fearful, from which one wishes to escape or to scotomize, but absolutely co-present, is often one of the ‘prices’ of dissociation (Bromberg, 2011). In this case, however, both of them experience in the here and now a contrast between opposing tendencies, which can be recognized, tolerated, and utilized. From this, in fact, the analyst promotes an experience of sharing and co-construction, which we might call an analytic ‘acting-in’, which is not an acting-out, but an action with words (linguistic action).

Alternatively, the analyst could have provided an interpretation, combining what had been talked about – the friends being together and the pain of not being able to access it, which now leads to crying – with what was happening in the session. But in this way, that is, using a cognitive and explanatory channel, assuming the proposed association was correct, it would not have been possible to stay close to Luigi while keeping in mind their separate lived experiences and bringing the transformative perspective to life.

Instead, the therapeutic dialogue that took these elements into account, and consequently the analyst’s intervention, provided the tools for *affect regulation*, stabilizing the patient and helping them to emerge from dissociative isolation, and reconnect with the real space and time of the session.

In other words, what occurred within the analytic dialogue can be defined as an explicit movement of interactional complexity (Morelli & Corbelli, 2024): it is this operation that allows the experience of non-symbolization, typical of dissociation, to be transformed into thinkability.

During the clinical dialogue, not only an interpretation, but also more minimalist interventions, such as a question, a simple prompt from the analyst, a stimulus, can give rise to an intense emotional state in the patient that is difficult to manage (De Robertis, 2019), and that eludes managing and elicits,

especially in subjects with low emotional resilience, a dysregulation of emotional flows (Cassidy, 1994).[2]

Predictably, then, with respect to personal stimulus tolerance thresholds (Tronick & Gold, 2020), the outcome is disarrayment. At this point, the patient may express stress signals of varying nature and intensity, one of which may be the dissociation from the present and ongoing experience, as a form of 'disengagement'. Disengagement communicates the patient's aversive reaction to being stimulated, a reaction that may trigger dissociation as a self-defense response.

In this sense, the dissociative action, like other less severe disengagement phenomena (leaving the session or expressing the intention to leave, rocking backwards and forwards on the chair on which one is sitting, turning one's head away, staring insistently at an object or part of the room or into the void, *etc.*) can be considered a behavior that, appertaining to a communication signaling, makes us understand to what extent the patient is an active subject in relation to the signals he sends to the analyst; but also equally active in being animated by a 'precise' communicative intentionality, obviously traceable at a nonconscious and implicit level (De Robertis, 2019).

However, even in the dissociative *mode*, should the patient maintain verbal communication, traces of that initial disarray may persist, which the dissociative response has only partially circumvented: these can be identified in the sudden, and apparently almost 'unjustified', appearance of an incoherent, chaotic, but above all artificially constructed narrative, so much so as to appear simil-delusional, but which turns out, in the eyes of the analyst, to be a valuable element to be taken into account. In fact, the alteration of the narrative expresses, through the linguistic channel, a persistent quota of fragmentation at the expense of a Self, which presents itself at that precise moment as not cohesive and suffering. At this point, in the full *hic et nunc* of the session, however, the patient's 'rambling' and derealistic text become for the analyst a salient sign and trace attesting to the emotional upheaval taking place in the patient, and thus the need to proceed with an intervention aimed at the hetero-regulation of affection and the reestablishment of internal cohesion (Hill, 2015).

Therefore, knowing, recognizing, and addressing the emotional context in the *here and now* of the session, upstream from the elicited dissociative phenomenon, allows the psychotherapist to include among the goals of clinical action also the devices that are useful to achieve greater 'emotional compe-

[2] Emotions, which represent attributions of meaning to experiences (Lazarus, 1991) and index experiences, are priority factors in the development of the subject, both for the purpose of identity construction and self-organization; therefore, emotions are defined as built-in mechanisms to emphasize their usefulness for survival and adaptation (Lazarus, 1991; Scherer, 1984; Siegel, 1999, chap. IV).

tence' of the patient, regarding the *range* of resilience and the ability to recover regulation after exposure to induced dysregulation (*Ibid.*, p. 17).

A further window: the case of Elena

A reference to what happened in a session with Elena can further exemplify these theoretical references.

Elena is a young patient suffering from a variety of symptoms: self-harm, *binge eating*, depressive states, and generalized anxiety. In the sessions, Elena complains and belittles herself, certainly not for the first time, about the limitations she encounters in preparing for and sitting university exams (a situation that falls within her depressive framework) due to difficulties in concentration, poor motivation, anxiety when answering questions, *etc.* This time, however, contrary to what usually occurs, she seems to be open to a reflection on the topic of 'exams', saying, "Well, I'd like to, but I don't want to!"

Taking advantage of this comment, the therapist asks, "I can understand that you would like to, but what does 'I don't want to' refer to?" At this point, Elena draws back her head, looks away from the therapist, and starts talking with her eyes looking upwards (almost 'ecstatic'), saying that she is close to graduation (actually, she has fallen quite far behind in her curriculum, a recurring reason for arguments and disputes in the family), alternating work on her dissertation and preparing to sit the open exam for admission as a member of the General Secretariat of the EU Council for planning and setting up of international summits. She also mentions a Brussels official who specifically asked her to prepare for the open exam, assuring her of her support, given her background and expertise. The patient's statements were difficult to understand because they were expressed as a rather 'rambling' narrative, where characters and terms such as 'Lisbon Treaty', 'qualified majority', 'intergovernability', *etc.*, appeared in a confused and jumbled manner.

At a certain point, the therapist takes advantage of a pause to intervene with the aim of helping the patient *return to reality* and lower the *arousal* to regulate what appeared to be emotional decompensation in reaction to a question that, to the patient, had 'rightly' seemed too challenging to process or too demanding a terrain to deal with.[3] A destabilizing context from which Elena

[3] One may legitimately consider that sometimes it is the analyst who might be the source of the emotivogenic stimuli sent to the patient. These stimuli act as micro-traumas that disrupt the analytic work and the relationship – should they fall beyond the margins of one's own subjective manageability – and that situate the experience in the ranks of a 'malignant chaos', evidence of a perceived failure to master what, at a given moment, to the patient's implicit perception, turns out to be an unmanageable context. These, in our view, are the facets that concern psychoanalytic 'traumaticity' or the 'vulnology' of treatment, from which no analyst, even the most 'sufficiently good', can consider themselves to be exempt or exempted: we refer to

promptly disassociates, entering into a derealistic eloquence. At that point, the therapist says, "Perhaps we can approach together and, for now, share some of the difficulties you are facing, because we all have them...."

Elena looks around questioningly and falls silent.

And the therapist continues: "If you faced them, what do you think might happen?"

"Well, if I talked about it, I would have to deal with a mix of feelings, of emotions: sadness, shame, disappointment, yes, a jumble of these things."

The therapist then chooses to make an intervention to support the relationship: "I was thinking that since you are not talking to yourself here, but you are talking to me and with me, we can share the things you tell me. Sure, they might be challenging or burdensome, but this doesn't mean that together, little by little, they can't be addressed, or that they can't be talked about, otherwise, the alternative is giving up entirely".

During this brief closing dialogue of the session, Elena was very present with her gaze, posture, and sometimes even with a smile, an 'intentional' smile.

In conclusion, not only the theoretical assumptions, but also and especially the clinical examples mentioned, underscore how dissociative manifestation can be considered a complex phenomenon, which has the chance to manifest itself specifically in relational contexts, proving to be not only the bearer of inevitable perturbations, but also a valuable tool for verification and stabilization of therapeutic intervention.

an eventuality that can occur at any moment in the process when analytic interventions, in the broadest sense of communicating, at that juncture "create conditions (in the patient) to which the organism cannot adapt" (De Robertis, 2019, p. 245; Kardiner, 1947, p. 172).

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Conflict of interests: the authors declare no potential conflict of interests.

Ethics approval and consent to participate: not required.

Further information: this article is a revised form of the paper presented by the authors at the IFPS Forum on October 26, 2024, Bergamo, Italy. The potentially personal information that appears in this article, relating directly or indirectly to one or more persons cited as clinical cases, has been edited to conceal and safeguard the confidentiality, privacy, and data protection rights of those involved, in accordance with the journal's anonymization policy.

Received: 2 June 2025.
Accepted: 13 June 2025.

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Ricerca Psicoanalitica 2025; XXXVI(s1):1046
doi:10.4081/rp.2025.1046