Temporality 2: The relevance of the Heideggerian concept of time to the treatment of borderline conditions

Paul Cammell[1]
Department of Psychiatry

Abstract

In this article I attempt to demonstrate the relevance of the philosophy of time to psychiatric, psychological and psychoanalytic theories of development and therapeutic action. In an accompanying article I established a range of relevant temporal concepts, emerging from the philosophy of Martin Heidegger, with links made to Freudian concepts of time, in particular *Nachträglichkeit*, developed in the writings of psychoanalyst André Green and philosopher Jacques Derrida. In this article I proceed to explore this philosophy of time through a consideration of the developmental theories and clinical approaches of Donald Winnicott, Jean Laplanche, André Green and Hans Loewald. I conclude by establishing that the *temporalizing* function of therapeutic action can be seen to be a core or essential element of work with patients presenting with so-called borderline conditions. I demonstrate how a range of problems or ambiguities that coalesce around this condition (including dissociation, traumatization, self harm and brief reactive psychosis) can be understood in *temporal* terms.

Introduction

During therapeutic dialogue and interaction, both patient and clinicians are drawn to look back at questions of origin, cause and developmental formulation, at the same time as look forward to a future in terms of progress, outcome, resolution and so forth. In this article, I will seek to explore how a Heideggerian conceptualization of temporality can inform us about these notions of understanding *time* in terms of developmental origins and working with time in the clinic. I will draw particular reference to the understanding and treatment of borderline conditions. I have chosen this field of clinical work because, I will argue, the "borderline" concept as it is adopted in notions of "borderline phenomena", "borderline personality organization" and "borderline personality disorder", is ambiguous and problematic for the clinician because the prevailing theories of psychopathology that adopt it are excessively individualistic, categorical, intrapsychic and *atemporal*. I will begin by contextualising the "borderline" concept in terms of very specific cultural and historical determinants, and then attempt to describe developmental

[1] Correspondence concerning this article should be addressed to Dr. Paul Cammell, Department of Psychiatry, Flinders Medical Centre, Bedford Park, South Australia, 5152, Australia. E-mail: paul.cammell@health.sa.gov.au

origins and clinical approaches that are fundamentally temporal, and relate to the Heideggerian philosophical orientation I have elucidated.

In the previous article I arrived at a thinking of time that began with Heidegger's hermeneutic ontological orientation, where I elucidated concepts of Care, *Geworfenheit* (thrownness), *Entwurfen* (project) *Umsicht* (sight or practical circumspection) and being-towards-death before extending this thinking via Green's and Derrida's reading of Freud's oeuvre, in which *Nachträglichkeit*, *re-presentation*, bidirectional time, heterochronicity and, finally, *différance*, could be seen to permit a fuller understanding of historicity, facticity and potentiality that arguably remained consistent with the Heideggerian orientation.

We saw that Heidegger described the temporality of existence in terms of its futurity, its embeddedness in projects in which there is an intuitive understanding of motivation and purpose, the goals of which often defy explicit definition or representation in an objective or algorithmic sense. This temporal trajectory of existence fits within the broader horizon of mortality, worldhood and sociality from which we can only, in a derivative and secondary sense, extract ourselves to theorise or conceptualise our-selves as timeless, separate, knowable individuals. We saw that Green developed ideas about time in Freudian psychoanalytic theory to uphold the complexity of development and background, the double action of the repetition of past in the present and the present reconstruction of the past in therapeutic work. Here, the historical or temporal unconscious background is an active field of both of the psychopathology and of potentiation in the patient's therapeutic future. And then we saw that Derrida's deconstructive analysis of Freudian time showed that the unconscious field or background that is worked with therapeutically is ineliminable, always to an extent beyond us and always reduced or inextricably altered through our use of technical metaphors of interpretation.

In this article I will firstly attempt to explore *developmental* notions of temporality further, where the conceptualizations of Jean Laplanche (otherness and the enigmatic signifier) and Donald Winnicott (unintegration and disintegration) introduce fundamentally *temporal* notions of developmental origins and temporality. These notions will be seen to be in a sense originary or foundational limits that pervade infantile, child and adult experience, and will thus be relevant to the clinical approach to time and temporality in the final part of this article, where a developmental orientation will be maintained and extended. This clinical approach will explore issues that seem to coalesce around so-called borderline conditions, including issues of "trauma", "abuse", "dissociation", "self harm", "suicidality", "impulsivity" and "somatization".

The borderline concept has arisen with unstable, shifting meanings in the past 50 years. I have argued elsewhere (Cammell, 2014) that the borderline concept has necessarily arisen in our modern context as a simultaneously marginal and pervasive limit concept that exposes or challenges the limits of many of the contemporary schools of psychoanalytic, psychological and psychiatric theory and clinical practice. Clinically, there is the possibility that there is an open and heterogeneous range of experiences that become transformed behaviourally into a uniform and identifiable "borderline syndrome" (even if this varies subtly in type from practitioner to practitioner or model to model) when the "borderline individual" comes to interact with the modern clinical setting. Thus, at an individual and a contemporary cultural level many extreme and enduring problems

at the margins of experience, some related to aspects of gender difference, sexuality, aggression, and social disruption, may present under the guise of the "borderline" diagnosis.

Wirth-Cauchon (2001), for example, argues that the borderline construct situates itself within conflicts around gender and sexual difference, taking over from hysteria which was a related limit concept in the Victorian era. In the age of hysteria, the hysteric may have appeared out of the dynamics of the inability to express the unthinkable, the will to implicit silencing, the action of taboo, privacy and secret. In the "borderline" era, the borderline may be a fragmented, chaotic expression of the limits of our permissivism, the after-effects of our openness to explicitness (sexual, violent, graphic) and the collision of our high ambitions for individualism (individual rights and responsibilities) with frank problems of neglect, omission and maltreatment seen in the formative course of individuals' lives. The borderline individual's experience is constructed from within a symbiotic relationship with the clinical and cultural elements of the organization of self experience. These individual and cultural elements reflect the terrain of the failed reach of our civility in terms of the purported control of the law and human services. This is the terrain of the brutal, the savage, the rough, the bad and inhumane ways we treat each other, our children, a terrain which is then related to by means of clinical sterilization, *clinicalization*, *medicalization or technologization*. Here, therapies could be seen as forms of (substitutive) care and in pursuing such forms of care, there is a risk of dehumanization, stigmatization and disenfranchisement of the individual. In contrast to this, I would want to articulate a therapeutic stance in which the therapist is aware of their complicity in the creation of the borderline diagnosis or identity, and maintains something of a knowing and critical stance toward it in their interactions and relationships with individuals designated as "borderline". The position of the therapist is to respect the uniqueness, complexity, autonomy, and "otherness" of the person presenting for therapeutic work. And in what follows, I will seek to establish that this stance can be best established through an awareness of and sensitivity to the types of temporal issues I will elucidate. To begin, then, I will first explore *developmental* notions of temporality further, where the conceptualizations of Jean Laplanche and Donald Winnicott introduce fundamentally *temporal* notions of developmental origins for any individual.

Laplanche: Nachträglichkeit, Translation, the Enigmatic Signifier and the Theory of General Seduction in Development

One of the central themes in Laplanche's (1987, 1990, 1992) writings is his attempt to retrieve elements of Freud's early writings about traumatic seduction and expand these into a general theory of seduction where seduction is seen as foundational and universal in the development of the unconscious. As such, Laplanche is attempting to overcome the rupture in Freud's work following his abandonment of the seduction theory by universalizing the processes of seduction and sexualisation (as a form of traumatic process). This is something that will become relevant to the clinical discussion below, when concepts of abuse and trauma are analysed critically. In his theory, Laplanche suggests that repression is a "failure of translation", occurring because of the asymmetry between the child and caring adult. In the transactions between adult and child, there is a surplus (of meaning or understanding) which is nevertheless retained by the child, where repression is a form of implantation and deferral. This surplus originating from the adult can be conscious or unconscious, but for the infant or child the remnants or traces are

very much residually unconscious but reappear, in need of translation. Laplanche (1987, 1990, 1992) refers to these remnants as enigmatic signifiers or messages, the unconscious representing a surplus of untranslated communication.

For Laplanche, the small child is dependent upon the care of the adult, and has limited capacity to communicate, reliant upon the attentive, receptive and projective capacities of the carer. For the child, the primitive communication received by the carer is related to survival, adjustment and adaptation; whereas from the carer, usually the maternal figure, there is a surplus of communication, verbally and non-verbally, consciously and unconsciously, where other key elements are present such as the sexual and love components of the carer's communication (the erotics of breastfeeding and physical nurturance, the love component of maternal investment and care) that the small child passively receives. Laplanche argues that at the broadest level this is a form of primal seduction.

Thus, Laplanche's project is to formulate a generalized theory of primal seduction which is cast in terms of foreign, enigmatic elements that the child is universally exposed to, beyond the more narrow focus of the abused child or the perverse patient, that were Freud's more specific psychopathological foci and beyond a normative sequence of psychosexual development where there is an interrelationship between sexual drive/excitement and self-preservative biological needs cast in a normative, intrapsychic development sequence. Laplanche would argue that Freud's radical discovery of infantile sexuality omits the relational components of otherness and differentiality at a primal or foundational level (presuming these emerge more significantly later in Freud's Oedipal complex). Seduction, as such, is no longer an aberrant or "abusive" event, but a universal, primal one:

I am, then, using the term primal seduction to describe a fundamental situation in which an adult proffers to a child verbal, nonverbal and even behavioural signifiers which are pregnant with unconscious sexual significations (1987, p. 126).

Seduction and enigmatic signification lay the foundations for future sexuality and other unconsciously driven activity in terms of untranslated signifiers that have as their origins the otherness and differentiality of the adult world of the carer—otherness and differentiality encapsulating the horizon, what is "bigger and beyond" the infant in terms of the conscious and unconscious, verbal and nonverbal, affective and behavioural world and repetoir of the adult, featuresof which are enigmatically implanted within the future-driven, drive-based developmental trajectory of the small child. Now, in this, *Nachträglichkeit* becomes the key concept in Laplanche's theory of primal seduction Laplanche posits that Freud's concept of *Nachträglichkeit*:

> contains both great richness and great ambiguity between a retrogressive and progressive directions. I want to account for this problem of the directional to and fro by arguing that, right at the start, there is something that goes in the direction from the past to the future, and in the direction from the adult to the baby, which I call the

> implantation of the enigmatic message. This message is then retranslated following a temporal direction which is sometimes progressive and sometimes retrogressive (according to my general model of translation) (p. 222).

Here, translation refers to a passive form of repression where undifferentiated, unassimilated "enigmatic messages" are retained and constitute the drive from without, sexual or otherwise. This radical reconceptualization of the drive is not in some essentialist, biological account being related to an originary somatic source so much as necessarily formed by implantations by the other. Every act of translation involves an incorporation or binding integration of the enigmatic signifier into the ego and its internal objects, where any untranslated remainder remains unconscious. In fact, Laplanche holds that there is always an unconscious surplus or excess, which he terms the *source-object*, an object that collapses the Freudian distinction between an external *object* of the drive (an external object that enables the drive to achieve cathexis and satisfaction) and its *source* (a stimulus or excitement in an erotogenic zone). Laplanche's *source-object* is a repressed, internalized fragment that becomes the source of the exciting, traumatizing drives pressing toward discharge, impinging the homeostatic body-ego from within. These drives are a combination of exogenous by-products of implantations that are residual secondary to the infants failed attempts at translation and binding leading to repression. The translation process partially alleviates repression as a process of sublimation.

As such Laplanche's revision of Freudian metapsychology involves the seductive-traumatic action of the other as the foundational origin of the drive in infant development, as well as the defensive, metabolizing process of translation and binding of the other's implantations by the subject through processes of repression and sublimation, which are ego processes that bind and integrate. By linking translation and *Nachträglichkeit*, Laplanche conceptualizes a matrix of origins that are relational but also temporal, destined to be repressed and worked through, remaining residual as unconscious enigmatic signifiers and source-objects. This process of translation, and the temporal function of *nachträglichkeit* in Laplanche's model of primary seduction, fits the descriptions of temporality derived in the preceding accompanying article, referring to bidirectional time, *re-presentation* and *différance* (deferral, excess).

Also of significance, are Laplanche's descriptions of pathological forms of implantation, which will come to be of relevance in the clinical discussion of borderline experience below. In contrast with everyday, normal implantation, Laplanche (1990) postulates a violent, pathological form he calls *intromission*:

> Implantation is a process which is common, everyday, normal or neurotic. Beside it, as its violent variant, a place must be given to *intromission*. While implantation allows the individual to take things up actively, at once translating and repressing, one must try to conceive of a process which blocks this, short circuits the differentiation of the agencies in the process of their formation, and puts into the interior an element resistant to all metabolisation (1990, p. 136)

Intromission results in elements that cannot be subject to normal processes of repression-translation—Laplanche (1990) refers to these elements as *psychotic enclaves* of untranslatable parental elements (conscious and unconscious, actions, relations, wishes, fantasies) that persist as untranslatable, foreign, unmetabolisable. Interestingly, at points Laplanche does allude to the possiblity of the superego, universally, as such a psychotic enclave which acts on the ego, while at other times he is referring to psychotic enclaves as a specifically pathological form of disturbance. In the following clinical discussion, Lapanche's ideas on psychopathology will be explored further insofar as such untranslatable elements can be seen to play a role in borderline experience, and how a notion of intromission can be expanded beyond early development and be seen to become an element of borderline and dissociative phenomena.

Ultimately, Laplanche's conceptualizations of the enigmatic signifier, repression-translation and *Nachträglichkeit* form part of a renewed, more encompassing theory of generalized seduction which includes the action of the other, unconsciously driven, on the origins of self or ego, in a form that develops the origins of the drive, in a relational and temporal situation that Laplanche refers to as the *fundamental anthropological situation*. And most importantly, Laplanche develops an understanding of the originary action of temporality in functions of *Nachträglichkeit* as bidirectional, involving *différance* and *re-presentation* through the action of repression-translation, an action which can be extended to thinking about trauma and psychopathology at a relational and temporal level, something that will be advanced in the clinical section. What will be taken up now is some related thinking Winnicott (1971, 1974) developed in his thought around impingement, breakdown, unintegration, integration and disintegration, all of which has a fundamentally temporal character.

Winnicott: The temporal action of integration and impingement in development

Winnicott's (1971) model of transitional phenomena highlights an understanding of early development as being primarily relational prior to any sense of a differentiated ego with boundaries between inner and outer, self and other, and so forth. Importantly, Winnicott also developed fundamentally temporal notions in his model of transitional experience. In Winnicott's (1971) *facilitating environment*, the infant fluctuates between states of primitive anxiety and feelings of omnipotence where there is no sense of inner or outer. Impingements or failures of the environment that the infant may experience as milder primitive anxiety (if gentle enough), lead to an engagement with the world in which transitional states emerge with the development of a sense of projective intentionality and subjective objecthood (the classical example being self soothing with the transitional object). Progressively, play in the transitional space culminates in mature object relating (a mature sense of unitary self and world, self and others) but where there is still, for Winnicott, a privileging of play and transitional phenomena as being at the heart of mature health, creativity and vitality (aesthetic sensibility, intellectual endeavours, religious faith, other mature forms of pleasure and transcendence). As such, two notions of developmental time operate can be seen to operate here: linear, progressive developmental time and regressive, unconscious time insofar as the self has a capacity to progress through different self states—mature objecthood, play/creativity in the transitional space, primary narcissistic states (e.g., narcosis) and profound impingement and environmental failure creating primitive anxieties. At the broadest level, the transitional object and transitional phenomena may be conceived of in three ways: firstly,

as typifying a phase in the child's normal emotional development in which processes of individuation are acted out in the process of play; secondly, where this play is used as a defense against separation anxiety (analogous with but considerably developing Freud's discussions of the *Fort-Da* game, for example); and, lastly, as an articulation of a more universal sphere of agency and creativity that is intrinsic to our sense of engagement, dwelling and agency in the world.

These Winnicottian conceptualizations illustrate a developmental component to the bidirectional temporality I have described. Here, temporality is constitutive of infant-caregiver interactional patterns where there is an unfolding of processes of identity and differentiation, continuity and change, mutuality and intersubjectivity leading to an integrated sense of self in the world of others and objects. Thus, even though Winnicott did not conceptually advance a broader notion of *Nachträglichkeit* or temporality, he certainly emphasized the importance of continuity in time, of the self and other, in ego integration and a sense of self and reality. Another key contribution, here, is his distinction between unintegration, integration and disintegration.

For Winnicott, unintegration represents a timeless, primal originary state that is immediately influenced by the facilitating environment in terms of environmental failures and impingements, leading to processes of transitional experience, potential space and ego integration. As such, unintegration could be seen to be an abstract or illusory origin for which there is a sense of nostalgia. In Winnicott's theory temporal processes become active and understood in relation to absence and frustration: in *Playing and Reality* (1971) Winnicott lists at least three aspects of the ego sense of time: the experience of a time limit to frustration; a growing sense of process and remembering; and the capacity to integrate past, present and future. An important instance of the failure of ego to integrate experience in time is seen in the clinical "fear of breakdown" (1974). Clinically, the fear of breakdown is experienced as the fear of a "breakdown that has already been experienced" although developmentally it relates to an "unthinkable anxiety" that could never be integrated in time as a transitory event in the present and then, contained within temporal ego function, so continues to be experienced as the trace of a futural prospect of annihilation. This relates to other self-states Winnicott describes under the rubric of *disintegration* where there is a loss of continuity in space and time, and the self is experienced as fragmented, annihilated, depersonalized or subjected to the most primitive anxieties such as a fear of falling forever. Experiences of disintegration and fear of breakdown relate to severe or cumulative environmental failures and Winnicott (1962) described the development of a *false self* structure to overcome disintegration, breakdown and other instabilities of self. These forms of psychopathology, as well as the notions of integration and disintegration, will be relevant to my subsequent clinical discussion of borderline experience. What is of significance here, is the elucidation of the temporal qualities of Winnicottian concepts of *integration*, which relate to a differentiated, bound sense of time as an ego function; *unintegration*, as some form of illusory, atemporal origin for which there is idealization and nostalgia;, and *disintegration*, as a form of unbinding and loss of self in which past experience seems immediately present or futural in fragmentary states of primitive anxiety.

Concluding Comments about Temporality, Development and Developmental Psychopathology

In the previous accompanying article, I advanced notions of *Nachträglichkeit*, *re-presentation*, bidirectional time, heterochronicity and, finally, *différance*, that could be seen to permit a fuller understanding of historicity, facticity and potentiality that arguably remained consistent with the Heideggerian orientation to temporality. Here, I have sought to expand upon this in the developmental context more fully: origins of seduction (Laplanche) and primary narcissism/dependence (Winnicott) permit the action of the other to occur over time with ineffable temporal rhythms (presence/absence, frustration/relief, unconscious implantation) where ego or self integration processes are developed that are temporal in nature in keeping with our understanding of *Nachträglichkeit* and bidirectional time—processes of translation-repression and movements between integration and disintegration. We saw that drives, as a form of project, are inextricably linked to this developmental context even if our understanding of them is enigmatic or supplementary.

We now also have the temporal foundations of an understanding of trauma, seen within a universal phenomenon of seduction as the imposition of the other upon the small child within the context of differential relating, which can in some way become excessive in the process of intromission of unassimilable, unmetabolisable experiences which will reside as unintegrated, psychosis-inducing fragments; as well as the notion of an excessive or cumulative experience of impingements (both as environmental failures and excessively active input from the care giver) that lead to self pathologies in terms of disintegration and defensive false self structures.

What I will turn to, now, is an application of these philosophical and developmental principles concerning temporality, to the clinical treatment of borderline conditions.

Winnicott, Green and Laplanche on the Temporality of Clinical Work

In Winnicott's (1971) thinking around the transitional, potential space of psychoanalysis, he describes elements of the *temporality of play*:

> I make my idea of play concrete by claiming that playing has a place and time. It is not inside by any use of the word (and it is unfortunately true that the word inside has very many and various uses in psychoanalytic discussion). Nor is it outside, that is to say, it is not part of the repudiated world, the not-me, that which the individual has decided to recognize (with whatever difficulty and even pain) as truly external, which is outside magical control. To control what is outside one has to do things, not simply think or wish, and doing things takes time. Playing is doing (p. 41).

Within the Winnicottian metaphorics of the clinical encounter, play occurs both within a relational and a *temporal* field. We are reminded of Winnicott's (1971) developmental ideas about the timing of presences and absences, senses of integration and disintegration, effects of failure and impingement, leading to traumatic effects (impingements, loss of a sense of self and the real, false self structures and so on). Green (2002, pp. 110-130) extends the notions of the symbolization of play, reflecting on Freud's ideas about the *Fort/Da* game, traumatic enactment and symbolization, expanding these ideas to a much broader field of "traumatic play" that occurs within the therapeutic space, in all manner of performative and narrative based expression and symbolization.

Winnicott and Green: Traumatic Play in the Therapeutic Encounter

Green (2002) develops a sophisticated theory of drive and object relations (the *drive-object*, "objectalizing") based upon many of the ideas Freud (1920-1922) develops in *Beyond the Pleasure Principle*, simultaneously linking and relating the Freudian conceptualizations of the pleasure and reality principle, *Eros* and *Thanatos*, *Binding* and *Unbinding* with more Winnicottian conceptualizations of play and trauma. Underlying this is a commitment to reinstate a drive theory, a commitment I do not necessarily share in the form it takes in Green's (2002) theoretical elaboration, where I would see that there remains a risk of maintaining some form of deterministic, essentialistic or reductionistic system of energetics. Ricoeur's (1965) work *Freud and Philosophy* conducts a careful analysis of the Freudian hermeneutic realm where the causal energetics of the drive become inextricably linked to the domain of symbolic interpretation for the analyst, a hermeneutic link between energetics and meaning. In this work Ricoeur (1965) does repeatedly note the significance of Freud's assertions of the timelessness of the unconscious and the Id, but Ricoeur does not undertake a broader analysis of Freudian time or temporality within this project.

What is relevant for us, here, is the temporal element to traumatic play that Green develops from Winnicott's work. This can be melded with the broader field of relational, somatic, affective and technical elements I have elaborated upon within my hermeneutic ontological framework. If we adhere to ideas of traumatic elements re-emerging repetitively, seemingly in an unthinking, compulsive sense, we can use notions of temporal rhythmicity (binding/unbinding, discontinuities/fragmentation) and the idea of these elements being somehow dissociated, unintegrated or outside time, in order to understand the requirement of a *temporal* quality to therapeutic action. Here, therapeutic work may relate to the "temporalizing" of traumatic elements as they are constructed, contextualized and worked through in the therapeutic relationship. Green (2002), aptly describes the challenges of work with borderline cases, or even defines borderline cases, in temporal terms:

> With borderline cases, the compulsion to repeat has revealed a psychic vocation whose purpose is *anti-time*. Everything has to return to the point where it began; it is not possible to consider any conflict with the minimum degree of suspension required for

> it to be elaborated, and then, perhaps, overcome. Everything has to be actualized and exhausted on the spot; not only to prevent any progression, but also to prevent anything new from emerging (p. 121).

I would add, here, further Winnicottian elements to the atemporal traumatic elements: features such as severe unthinkable acute psychic pain (as a form of archaic disintegration experience), suicidal thinking, other overwhelming states described as affective (pain, anxiety, horror, despair) or dissociative (depersonalized, derealized, disavowed, absent and so forth), experiences of psychic death that are also performatively expressed and thus highly dangerous insofar as they entail self harming or suicidal impulses. These elements, which seem so immediate and overwhelming, are difficult to work with, *play* with (saying this, in itself, seems glib or antithetical), re-temporalize or contextualize. All of the contextual, constructive work therapeutically (the relationship developed, the concern, the boundaries and limits, the empathic gestures) might have at their heart an attempt at establishing an enduring and intact temporal continuity in the therapeutic relationship. In Winnicott's terms, the good-enough mother survives. In broader terms, the therapist maintains the context of the work, the good will and attempt to meet and engage in a working, constructive dialogue and interaction where it is necessary for the patient to see how he or she is held in mind, thought about, related to, responded to over time. All of this work has a temporal quality (the rhythm/regularity of the work, the reliable presence and absence of the therapist), all of the temporal elements to distinguish boundaries and borders around me and not-me, related to in terms of actions, utterances and discourse. The broader theoretical, conceptual or technical aspects to this therapeutic endeavour could be considered supplementary in Derridean terms.

We can add to this a consideration of our earlier discussion of Laplanche's (1990, 1992) formulation of a general theory of seduction, where his theorization of the formative impact of enigmatic signifiers, the impact of the other in the differential relationship as universally seductive and traumatic, and the ongoing temporal modes of translation-repression, all fit within a theory of bidirectional developmental time. In the clinical setting, this enigmatic otherness constitutes an invitation to seduce or be seduced (with all of the "sexual", "aggressive", abusive", "traumatic" or other overtones this may engender) both directed toward the patient and the therapist alike. It constitutes the general field of traumatic enactment and play that is relationally based and constituted by the therapist and patient alike. To maintain a differential orientation, the therapist must maintain a thoughtful stance giving him or herself the opportunity ("giving him or herself *time*") to think temporally from within the field, with and for the patient so that the patient can come to do this more so with and for themselves. And this process is not merely a past-focussed, reconstructive, insight-forming process. It is a process of potentiation and becoming that hopefully facilitates broader growth and change for the patient.

Loewald and the Therapist's Sicht

Loewald (1980), in papers such as "The Experience of Time" and "On the Therapeutic Action of Psychoanalysis" was keenly interested in the futural focus of the psychoanalyst in what he termed the "teleological" aspects of psychoanalysis. In his view, the process is always guided by the analyst's awareness of the patient's true form or "emerging core". The analyst must hold this in trust to steer the process: "It is this core, rudimentary and vague as it may be, to which the analyst has reference when he interprets transferences and defences, and not some abstract concept of reality or normality" (p. 229).

In a broader field than the traditional analytic field of one-person interpretation what does this mean? The therapist somehow maintains a temporal focus, working with the patient within a space of potentiation to construct, contextualize, constitute and understand the therapeutic process in a temporal sense: a broad field of discussing, reflecting upon, differing about "what you're doing", "what I'm doing", "what we're doing" where "doing", in the broadest sense of *play*, refers to a whole experiential-relational field of narrative and performative expression. It fits into and melds with the context, what the therapist does and says, what can and can't be offered and so forth. The therapist thinks about those alteritous, enigmatic elements that impact upon the space. In a traumatic sense, these are important to think about and this requires some restraint and maintenance of a space for the patient to articulate, work on and play with these elements, and for the therapist to think about and respond to them from within a differential relationship. The therapist must be mindful of this, and this requires an awareness of and cultivation of a differential setting within which this can occur (a setting of thought, observation, consideration and deliberate responsiveness). As such, this is not just a therapeutic process of therapist and patient meeting in the here and now, where the therapist attempts to attune to and connect with their patient without a sensibility to temporal elements. Although this kind of present-focused process is important, and it is articulated well by Daniel Stern (2004) describing moments of meeting, attunement, and implicit relational processes that assist in the development of a sense of relational self, even Stern (2004, pp. 197-218) does not hold to ignoring the action of the past on the present in the therapeutic processes he describes in his own work and the work described by the Boston Process Change Study Group.

The therapist does and must take up the opportunity to engage with, play with and change with their patient in the present moment, but also, at the same time, in an enigmatic way influence their patient where a significant part of this influence involves a number of temporal actions with and for the patient: *reflection upon*, *coming to terms with*, *working through*, *anticipating*, *projecting* and so forth. In the sense of trauma, this temporalizing action may take the form of restoring elements to their place in the past, or it may be an attempt at restoring a futural focus. If this refers to understandable, discrete, traumatic events it can be a sense of the balance between "getting over" something and "getting on with life" in a process of restoring some sense of temporal balance alongside balance in the other aspects of being described in my hermeneutic ontological framework. However many elements are more enigmatic, less understandable in that literally traumatic sense, and the therapist cannot claim to arbitrate and interpret all of these with an objective or omniscient stance. Chronologically, the earlier the "events", the more implicitly, enigmatically retained or understood they may be. There is no sense that one can reliably attempt to reconstruct a reality or an insight in this. In spite of the many vacillations and

complex statements Freud made about actual trauma, intrapsychic trauma, seduction, phantasy and wish, which have become a core element of the controversial heritage and contestability of his body of work, Freud (1917) did hold to the ambiguity between truth and falsehood in "traumatic experience":

If infantile experiences brought to light by analysis were invariably real, we should feel that we were standing on firm ground; if they were regularly falsified and revealed as inventions, as phantasies of the patient, we should be obliged to abandon this shaky ground and look for salvation elsewhere. But neither of these things is the case: the position can be shown that the childhood experiences constructed or remembered in analysis are sometimes indisputably false and sometimes equally certainly correct, and in most cases compounded of truth and falsehood (p. 367).

Elsewhere, Freud (1900), also, described hysterical symptoms as being more than just traumatic remnants in a mnemic sense: "Hysterical symptoms are not attached to actual memories, but to phantasies erected on the basis of memories" (p. 491).

Further aspects of the Temporalizing function of Therapy with So-called Borderline Conditions

If, in my analysis, I extend this notion of "hysterical" symptoms being mediated unconsciously to all manner of processes of expression or articulation that are relationally, temporally, somatically, affectively and technically derived, it becomes evermore complex. What the therapist can hope to do is establish a sense of relatedness, dwelling and sharing in this context of limits, alterity and complexity. What the therapist can be mindful of, here, is the manner in which the temporalizing function creates room or space for this relating, for dreaming and thinking, interpreting and understanding where previously there wasn't.

Thinkers of the Intersubjective School have articulated some related ideas in their writings on trauma work. Stolorow (2011a, b; 2009), for example, elaborates his own conceptualization of relational trauma and relational work that establishes kinship-in-finitude: he uses the philosophical conceptualisations of Critchley and Derrida on death and mourning, and adapts the Heideggerian concept of *Mitsein* (and in particular, being-towards-death, solicitude and authenticity), to articulate how relational work can re-establish a sense of temporal and relational functioning after trauma. Orange (2011) describes how dialogue, in all of its metaphorical complexity, can help to understand and overcome the most complex or inarticulable elements of traumatic "experience", where creative dialogue and metaphoric play can form a part of therapeutic work. In thinking at this level, we are aware of the limits of explicit, conscious work on identifiable traumatic elements (imaginal re-exposure, integration work, and so forth): some of the work may simply be levelled at attempts at re-establishing temporal, relational, affective and somatic links. In doing this, we have an orientation for approaching unconscious work with the traumatized unconscious that is much broader, temporally and relationally attuned and able to approach the complexity of the action of trauma which may become manifest in all manner of atemporal, non-relational, unresolved, unformulated, dissociated, psychotic, unsymbolized, somatic, and affective fragments of expression or gesture.

I believe that many of the problems around understanding the temporality or historicity of what I loosely call the traumatized unconscious may be addressed using this type of relational, temporalizing therapeutic stance grounded in my hermeneutic ontological approach. This can be considered, for example, in cases of brief reactive psychosis, dissociative psychosis, or what since the mid to late nineteenth century have been known as hysterical psychoses (see van der Hart et al., 1993). In some ways, hysterical psychosis could be described as involving forms of splitting and fragmentation that lead to personal modes of expression (acting, speaking, self-interpreting) which rely on fragmentary experiences, descriptions or expressions which seem narrow and limited, often with a literal and concrete quality, which can be overcome through the kind of therapeutic work I am describing. Often these presentations seem to relate to an event of re-traumatization, sometimes with a "determined" feel to it (linked to repetition compulsion) in which the subsequent decompensation may have psychotic elements (persecutory and grandiose) as well as more dissociative elements related to a disjointed sense of self, time, others and so forth. There may be concrete and fragmentary symptoms (conversion symptoms, symptoms akin to somatoform dissociation) that seem to have a mnemic or symbolic quality that the patient cannot consciously acknowledge. The present interpersonal situation (therapeutically or extratherapeutically) can be responded to as a form of "re-traumatization" leading to a sense of fragmentation or dissociation, somatic and affective experiences that feel real and in the present, and interpretations of occurrences that meld the past and the present in a narrowed down, collapsed form of temporality as if it were all appearing in a fragmentary form in the present-day.

Interpretively, repetitive efforts made at linking the re-traumatizing event to the concrete psychotic state (referring to splitting and projective mechanisms) would not lead to an "ahah" moment where an insightful awareness crystallizes and the psychotic state resolves, losing its "literal realness". Rather than asserting an explanation or a causal understanding the therapist opts for exploring the experiences and events in a more open approach, dialogically, facilitating a dwelling in and reflecting upon the experiences together, describing them together and exploring them for their possibilities. The therapist actively attempts to disentangle what is past and what is present, what is attributable to the patient or to the other (which could be the therapist him or herself), defining borders and boundaries in the work, relationalizing and temporalizing the work in the manner I have already described above. In doing this, there may be a gradual restoration of a sense of self and place and time, and with this is a gradual working through of what begin to crystallize as "memories" as if from the current day viewpoint what couldn't be comprehended is now "seen".

As this process develops, the patient experiences the return of a sense of self awareness and reflectiveness, a capacity to self interpret and a gradual recovery of themselves as not overcome by two separate forms of objective presence: the event of re-traumatization and the psychotic state. They feel they can descriptively explore the complex moods and feelings—they may be senses of violation, self-loathing, shame, disgust, anger—and link these to the described past and present events and occasions which are acknowledged to be only partially apprehended or understood as memories. Here, we may be dealing with complex interpersonal experiences and events, with no objectifiable truth or understanding, and with the possibility of limits of understanding, memory or comprehensibility. There is no sense that this is fully resolved or worked through so much as a sense that the patient has somehow recovered themselves to go on with the work of the therapy in all its complexity, openness and potentiality.

This kind of case can be explored in such a way in order to elaborate upon how a therapeutic process in which the patient and therapist dwell together more openly and attempt to experience, relate to, describe and explore the hidden and concealed in what the patient experiences without the inference of causal mechanisms, definitive explanation or reference to forms of objective presence leads to the sense of a more complex self structure which is analogous in some ways to Heidegger's Care structure in its relationality and temporality. This is the case because it involves an overcoming of self-splitting which features modes of self-interpretation which have recourse to objective presence. Other modes of self-functioning, what Heidegger might call more authentic modes, are recovered and these relate to aspects of the Care structure in its temporal historicity (how thrownness and projection are implicated in a present moment that seemed seized by the past re-traumatizing event and the continuously "present" dissociative or psychotic states). This recovery is facilitated by the reciprocal process of dwelling together which facilitated mutual awareness (what Heidegger called doubling or empathy) something recovered after relational events in which doubling or empathy do not feature.

Conclusion

I have deliberately spoken about this in general and abstract terms in order to encapsulate this type of work in a way that encompasses many different iterations and forms of complexity. One can think of cases of hysterical psychosis one has seen, or even generalize this type of relational and temporalizing stance to many other forms of clinical situations or clinical work where the expression of apparently enigmatic unconscious, dissociative or psychotic elements are worked through, understood and contextualized in a relational and temporalizing therapeutic process. It can incorporate all manner of complex and fragmentary affective, somatic disturbances, relational problems and dissociative disturbances featuring discontinuity and disintegration. For example, I could refer to Bromberg's (1995, 1998) conceptualization of multiple selves, traumatisation, and the understanding of dissociative identity disorder or multiple personality disorder being seen as an extreme variant of selfhood which is universally conceptualized as multiplicitous, the norm of which involves "standing in the spaces". One can apply the temporalizing form of relational work I describe here to this domain, where stable, self-attributed identities can be seen as a developmentally appropriate but restrictive form of trauma response that require validation and empathy but also addressed with understanding and contextualisation with a view to working through and overcoming.

An important emphasis has been placed upon a broad notion of play that encapsulates more discursive and performative elements than Winnicott (1971) originally described. These elements, unconscious, enigmatic and traumatic, become temporalized in such a way as the patient is more open to the complexity of their being, less affected by the intrusive, fragmentary, disintegrating and unbound elements that had existed without a temporalizing, restorative function found in play with others. This is what is therapeutically discovered as a form of true self found in dialogue and relationship with the therapist. The temporal movement in this work helps to re-situate the individual in a space of care with the therapist, which becomes an expressive and performative *microcosm* of a broader horizon of care in life outside the consulting room. What the patient may gain is more of a sense of themselves, their own being, and authenticity in their relationship with themselves and others. The intrusive, enigmatic and fragmentary unconscious intrusions or impingements are less narrowing, alienating or destabilizing, as

these have been shared and contextualized so as to create a clearing, a space from which to consider the future as an horizon. The patient is no longer confronted by death (psychic death, suicide) as an immediate prospect or already experienced annihilation, so much as an horizon of finality and alterity that can be comported towards, related to with others within the project of life, but thankfully deferred.

Biographical Note

• Paul Cammell is a psychiatrist, academic and psychoanalytic psychotherapist who originally trained in philosophy, and is affiliated with Flinders Medical Centre and Flinders University, South Australia as a senior psychiatrist and senior lecturer. He has recently been a Visiting Fellow at the Personality Studies Institute, Cornell University, New York. He is currently the Chair of the psychotherapy training committee of the Royal Australian and New Zealand College of Psychiatry.

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