SYSTEMS OF PATHOLOGICAL ACCOMMODATION AND CHANGE IN ANALYSIS

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This paper is an attempt to investigate certain structures of subjectivity laid down in development by processes of pathological accommodation. These emerge when the child is required preemptively to adhere to the needs of its primary objects at the expense of its own psychological distinctness. By repetitive patterning of the child’s first reality, an immutable product is created and emerges in the form of fixed belief systems. Systems of pathological accommodation are responses to the trauma of archaic object loss and designed to protect against intolerable pain and existential anxiety. These structures are reactivated in analysis in the context of reciprocal, mutually influencing structures operating unrecognized in both patient and analyst. When they are not addressed, they represent a formidable source of resistance to the analytic process.

A review of pathological accommodation in the history of psychoanalysis itself is provided.

Keywords: psychoanalysis, subjectivity, pathology, analytic change

“But the mortallest enemy unto Knowledge, and that which hath been done the greatest execution upon truth, hath been a preemptory adhesion unto Authority, and more especially, the establishing of our belief upon the dictates of Antiquity”

Sir Thomas Browne; “Enquiries into Vulgar and Common Errors: Of Adherence Unto Antiquity” – quoted in Bion (1977, preface).

The history of psychoanalysis is, in large part, a record of continuing reexamination and reassessment of the factors that promote or obstruct change in psychoanalysis and in life. This paper falls within that tradition. It is an attempt to investigate certain structures of subjectivity laid down in development by a “preemptory adhesion to the dictates of Antiquity.” It describes a profound and fateful obstruction in the development of the personality, especially to self-differentiation and authenticity and, thus, to the quality of

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Man’s adaptation to the world is dependent both on the learning acquired in the transmission of culture from one generation to the next, and his ability to challenge the limits of accepted wisdom. Thomas Kuhn wrote that the successful scientist must simultaneously display the characteristics of the traditionalist and of the iconoclast (Bion, 1977). When the child is required preemptively to adhere to an inflexible personality organization that caregivers bring to its needs for psychological distinctness, these earliest attachments exclude or marginalize spontaneous experience and second thought metacognitive processes of self-reflection. The child’s ability to process new information and, accordingly, to self-correct and grow are impaired as its emerging sense of self is usurped. By repetitive process, the child’s first reality becomes patterned into a set of immutable belief systems. These subsequently find their place in retrograde social systems in which authoritative first truths remain absolute. Transgenerational transmission results here in the natural selection and preservation of entrenched characteristics impervious to changing need and evolving circumstance. The ensuing pathological accommodation continues to operate as an entrenched system beyond awareness, to preserve life by imprisoning it in archaic bonds.

That is the route by which so many individuals in our culture become isolated from a vitalizing essence of their own. In their subjective world, awareness of inner (distinctive) experience does not occupy, and is not allowed to occupy, an expanding central role in the co-construction or rehabilitation of the sense of self and in generating behavior (Sander, 1988). The sense of self established within this system is defined and appraised by alien referents, their origins buried in an antiquity that shapes experience by continuing to inform and deform. It is not subject to the rules of ordinary thought. The control system that emerges constitutes an area of common focal psychopathology that underlies nosological distinctions. Automatic, invariant, unexamined and unquestioned, it presents a major impediment to learning from experience. It constitutes a formidable source of resistance to change not only in analysis, but in the larger culture as well.

Psychoanalytic investigation into the domain of pathological accommodation also has profound implications for psychoanalytic group relationships and the transgenerational transmission of psychoanalytic knowledge in training facilities (Kirsner, 2000) and from there into the analyst-patient relationship. For the subterranean world structured in this manner to be revealed, a determined effort is needed to understand the processes in which understanding itself, our own and that of our patients, is contextually constituted and communicated.

The subject, pathological accommodation, has been approached phenomenologically during the past half-century (e.g., as-if personalities, identification with the aggressor, bad and persecutory internal objects, and especially Winnicott’s contributions on false and true self structures). Nevertheless, I believe the operation of these structures has been insufficiently recognized and understood. Analytic access to the not-experienced subjective field of force has been restricted because such investigation itself has remained under the influence of basic belief systems when these had already entered into the realm of “dictates of Antiquity.”

The metapsychological theories upon which a theoretical and international institutional hegemony had been founded continued to be staunchly defended, while the intrinsic impact of the observer and his own psychological reality on the processes being observed remained largely unrecognized (Bowlby, 1940, 1958; Kohut, 1977; McLaughlin, 1987; Winnicott, 1965). Gill (1994) has termed Freud’s discovery that he had been mistaken in believing that his patients’ tales of childhood sexual seduction had actually taken place, “the single most fateful event in the history of psychoanalysis” (p. 140). At a crucial point,
a massive shift in emphasis, theoretical and clinical, turned, at the expense of the lived interactive experience of the patient, to the isolated impact of the biological and innate on psychological life. What had begun as the investigation of complex contextual factors and their psychological elaboration turned to the isolated impact of the biological and innate on psychological life. The new course occupied the center of psychoanalytic discourse and transgenerational transmission in training facilities for much of the succeeding century. Its influence continues to the present day, infiltrating many of the new theoretical constructs and clinical practices that have evolved (Stolorow, Atwood, & Orange, 2002): “The continuing influence of Freud’s writing is remarkably constant. . . It is a voice in which no other analyst has written because no other analyst has had the right to do so. The voice Freud creates is that of a founding father of a new discipline” (Ogden, 2002, p. 769).

However seemingly diverse the new developmental and clinical theories and however seemingly removed from the founding doctrines (Fonagy, 2001), none is free of the potential for recruitment into the silent service of pathological accommodation. New developments have been assimilated into new theoretical and institutional hegemonies, each with its own set of constricting fundamental assumptions. The extent to which any particular analyst, at any particular moment, is freed from the imprisoning attachments of his own development to think for himself is the decisive factor. Such observations reflect the extent to which enduring structures mirror the continuing influence of attachments to primitive objects, and the statements apply to both patient and analyst. The transfer from object tie to unconscious and depersonalized organizing principles (“internalization”) retains the quality of those archaic attachments. The structures of pathological accommodation, like the original ties, can be seen to regulate the first and only reliable cohesion that the individual has known. In this manner, they protect against the unbearable terror of early object loss and the dissolution of selfhood whenever fundamental differentiating change might occur. In the process, repetition is inexorably substituted for change while in this addictive-like process self-regulation remains the property of another.

This paper will maintain that there is a specific context within which pathological accommodation emerges, and that the context is better illuminated when approached from an intersubjective perspective. In such an approach, the awareness of the continuing reciprocal impact of analyst and analyzand remains never far from the center of attention. In contrast to the position of intrapsychic determinism, it permits radically different understandings to emerge and these clarify the distinction between the contextual and the intrapsychic and their complex interconnection. Clearer recognition of false and true self structuring as their positions instantaneously oscillate, together with the triggering context in which these shifts take place, provides a richer latticework for the recognition and an effective approach to the treatment of the structures of pathological accommodation.

The recognition of development as a function of the infant-caregiver system (Bowlby, 1988; Emde, 1988a, 1988b; Sander, 1988; Stern, 1985; Winnicott, 1965) and the subsequent emphasis on the intersubjective developmental context of nuclear conflict within which pathological accommodative structures come to be constituted (Atwood & Stolorow, 1984; Stolorow, Brandchaft, & Atwood, 1987) has cast a new light on the problems of adaptation to reality, conceived earlier in terms of the intrapsychic movement from the pleasure principle to the reality principle. In the disorders I am describing, the reality that dominates is that of the caregiver in her/his impingement on or exclusion of whole domains of the subjective reality of the child. The expanding discipline of child observation in the past half-century has yielded findings that have contradicted prevailing notions about the quality of what had been regarded as average expectable environment. These studies have resulted in an awareness of the widespread extent to which real-life
trauma, especially in very early development, is a primary etiological factor in what earlier had been ascribed to instinctual trauma or constitutional defect. In these disorders, the breakdown factors are embedded in the total infant-caregiving system. They are inexorably reactivated within succeeding attachment systems, including the analytic transference, when the child has remained totally dependent upon its ties to an attachment figure in order to sustain a belief in the continuity of his own existence.

Pathological Accommodation and Cure in the History of Psychoanalysis

There is only one power that can remove the resistances, the transference. The patient is compelled (emphasis added) to give up his resistances to please us. Our cures are cures of love. There would thus remain for us only the task of removing the personal resistances (those against the transference). To the extent that transference exists - to that extent can we bring about cures; the analogy with hypnotic cures is striking (Hoffer, 1965, p. 381).

From its start, problems around pathological accommodation have been a continuing part of the developmental fabric of psychoanalysis itself. Recognizing the role of unconscious structures in shaping mental life, Freud first turned to the techniques of hypnosis. Soon realizing that the process was dominated by the suggestive influence of the analyst and accommodative inclination of the patient, he attempted to get around that obstacle by turning his quest for purer truth to the process of free association. Nevertheless, conceptualizations of the nature of cure in psychoanalysis continued to show the hypnotic-like influence of the analyst.

It may be remarked, by the way, that outside hypnosis and in real life, credulity such as the subject has in his relation to the hypnotist is shown only by a child toward his beloved parent, and that an attitude of similar subjection on the part of one person toward another has only one parallel, though a complete one - in certain love relationships where there is extreme devotion. A combination of exclusive attachment and credulous obedience is in general among the characteristics of love (Jones, 1955, p. 288).

There is a basic conflation here in that no distinction is drawn between compulsive attitudes of accommodative submission and voluntary wishes to please, and these are being indiscriminately regarded as characteristic of “love.” Accommodation out of love, with a respect for the legitimate needs of one’s partner, is the successful outcome of healthy development and remains the sine qua non of any wholesome relationship. Pathological accommodation shows the continuing influence of traumatic developmental attachment experience and is marked by its essentially compulsive quality. The conflation, rooted perhaps in Freud’s ideological preference for love-hate as primary motivational factors, serves to obscure the primary and underlying role of unbearable terror of early object loss that drives attachments characterized by “credulous obedience.” Jones’ remarks also illustrate the crucial impact of the observer and his theories and the extent to which masochistic self-surrender can be underestimated, confused with normal human experience, and idealized as exalted, when these characteristics are given sanction by an authoritative attachment figure. To the intractable qualities of such attachments, attesting to the continuing life and death nature of the experiences they mediate, Freud wrote, “Even in normal development, transformation is never complete and residues of earlier libidinal fixations may be retained in the final configurations. One feels inclined,” he continued “to doubt sometimes whether the dragons of primeval days are really extinct”
Pathological accommodation is an ever-present pathway that accompanies the formation of an attachment bond.

The problem of suggestion has not been laid to rest in psychoanalysis. The unrecognized impact of the analyst and his investigative stance of presumed neutrality and privilege continue to provide a context of coercive assumptions that shape free associative processes and are incompatible with the essential conditions for free and voluntary discourse. The introduction of new data of observation that gave rise to new paradigms has been responded to, not infrequently in psychoanalysis, as the sound of its death-knell (Kirsner, 2000). Concern with indoctrination of patients has persisted and come to be shared by supporters and critics of psychoanalysis alike. Schwaber (1983) addresses the traditional view of transference and its insistence on the dichotomy between the patient’s experience of the analyst as distortion and the analyst’s experience of himself as real. We have previously discussed the serious and insufficiently acknowledged consequences of the clinical application of this position (Brandchaft & Stolorow, 1990). We have stressed our agreement with Schwaber that the only reality relevant and accessible to psychoanalytic inquiry is subjective reality - the subjective reality of the patient, that of the analyst, and the psychological field created by the interplay between the two. “The central question,” Schwaber writes, “is how do we discover in our clinical work what we had not before considered” (1998). She describes a different mode of listening and observational stance which attempts to keep clear the delineation of whose perspective we are referring to, patient’s or analyst’s, and discusses the important conceptual, methodological, and epistemological ramifications at issue.

The problem of resistance in analysis raises to the foreground the vexing problem of what is being resisted and from whose perspective. Classical analytic theory, as it has developed following the decisive shift described by Gill (1994) and referred to earlier in this paper, regarded the resistances variously as those of narcissistic inaccessibility, hostility toward the analyst, or “the most powerful of all obstacles to recovery,” an unconscious sense of guilt (Freud, 1923/1961a, p. 49), all assigned to the realm of unconscious intrapsychic instinctual forces in the patient: “It is possible, to discover the repressed impulses which are really at the bottom of the repressed sense of guilt. Thus in this case the superego knew more than the ego about the unconscious id” (p. 51). In a previous 2001 paper, I used the example of the obsessional neuroses to show how psychoanalysis, in its unquestioning adherence to these precepts, had brought psychoanalytic investigation to a halt. Freud’s acknowledgment of his failure (Freud, 1923/1961a) and the failure of succeeding psychoanalysts (Esman, 1988; Freud, 1966), in this most pervasive and disabling of psychological disorders, contributed importantly to the protracted and ongoing “crisis in psychoanalysis” and fueled a decisive shift in the direction of pharmacological attempts to treat this and other psychological disorders. I have cited clinical examples to argue that the conflict embedded in the compromise formed by the structures of pathological accommodation, a quintessential element in the quality of superego pathology, have their origin in the caregiver-infant contextual domain within which self-differentiation and the ontogeny of the sense of self emerge (Brandchaft, 1988). The child’s development has been fatefully compromised by the compulsively selective inclusion/exclusion and dissociation of information that experience might otherwise provide, when such incremental self-mutilation is regarded as mandatory in order to preserve and protect a tie on which life itself depends. Obsessive–compulsive disorders display most convincingly the operation and imprisoning character of systems of pathological accommodation.

The belief that failures in life, reenacted on the stage of psychoanalysis, were the result of a primary sense of guilt operating from a punitive superego, remained at the center of therapeutic attempts following Freud’s elaboration of his tripartite structural theory of the
mind. That belief all but completely bypassed a deeper investigation for a considerable period. Freud himself, however, was too astute an observer to ignore completely a radical departure from his most advanced revision of theory in which his biological orientation led him to attribute the deadening characteristics of a punitive superego to a “death instinct.” “One has a special opportunity,” he wrote in a footnote in a return to a perspective he had so long ago abandoned, “to influence it when this Unconscious sense of guilt is a ‘borrowed one’—when it is the product of an identification with some other person who has been the object of an erotic cathexis. A sense of guilt that has been adopted in this way is often the sole remaining trace of the abandoned love-relation and not at all easy to recognize as such. If one can unmask this former object-cathexis behind the Unc sense of guilt, the therapeutic success is sometimes brilliant, but otherwise the outcome of one’s efforts is by no means certain” (Freud, 1923/1961a, p. 50). In 1930, however, he wrote, “In all that follows, I adopt the standpoint that the inclination to aggression is an original, self-subsisting instinctual disposition in man, and I return to my view that it constitutes the greatest impediment to civilization” (1930/1961b, p. 122). Profound questions are raised by this unqualified support for the position of intrapsychic instinctual determination which, after a lifetime, Freud had come to recognize as inadequate, and his neglect of the contextual factor which earlier he had found to offer sometimes brilliant results. Juxtaposition of these comments point to a route by which “dictates of Antiquity” have unwittingly contributed substantively to accommodative influence in analysis. Serious consideration needs to be given to the implications of an understanding that, in the treatment of obsessional neuroses, not only does, as Freud wrote, “The patient cling(s) to what had lost its value for him,” but so, similarly, does the analyst.

As it has been necessary to reconceptualize the psychological forces at work in obsessional disorders, so also with the whole range of psychopathological syndromes. The proposition that all self-experience, growth-enhancing and growth-obstructing, is embedded in a constitutive and sustaining intersubjective matrix, facilitates the emergence of radical new understandings into areas from which it has been previously excluded. It enables psychoanalytic understanding to be extended to the full range of psychopathological disorders, including psychotic and borderline states (Stolorow et al., 1987, pp. 132–179), grasped as byproducts of a pathogenic developmental system. Intersubjectivity theory constitutes a radical departure from the tendency to place the origins or continuance of psychopathology solely within the patient (Orange, Atwood, & Stolorow, 1997).

Trauma and Pathological

A vast literature has begun to stress the role of trauma, incurring from the dawning of consciousness itself (Bowlby, 1969, 1973, 1980; Cicchetti & Greenberg, 1991; Crittenden, 1994, 1995; Main, 1995; Meares, 1998; Stolorow, 1999) that initiates the cocreation of complex systems of pathological accommodation (Brandchaft, 1991). These come to crystallize and occupy central experiential pathways in personality formation. The course and goals of a psychoanalytic treatment of developmental disorders must be based on bringing these Traumatic Attachment Systems to light and addressing them therapeutically. An understanding, in depth, of the effect of unresolved trauma requires a recognition of the ways it is contextually constituted and repeated in psychoanalysis.

It has come to be widely recognized that real life trauma constitutes an assault on nuclear formations of the personality at their onset. Winnicott defined trauma as an
impingement from the environment and from the individual’s reaction to the environment that occurs prior to the individual’s development of the mechanisms that make the unpredictable predictable. He maintained that trauma at the beginning of life relates to the threat of annihilation. Subsequently, attachment studies show that its effect is felt on biological and behavioral systems at many levels and that the child’s ability to negotiate developmental tasks is severely challenged.

Where such developmental trauma has become the average expectable environment, it has a pervasive impact on the primary relationship, playing a determining role in the subsequent course of development (Crittenden, 1994; Fonagy, 2001; Main, 1995). Here, the child’s first efforts are turned toward the task of dealing with pain and the encroaching experience of the extinction of life, commensurate in its massive impact with the infant’s total dependence upon its objects. An attachment system of complex interweaving between self and object occupies the center of the child’s attention and shapes initiative. Occurring at the dawning of consciousness, processes of pathological accommodation become the context within which translocation (“internalization”) occurs in the automatic processing of experience. From a bedrock position, they continue to exert an enduring influence on the formation of the child’s personality, the complex relationships of its experiential world, basic feelings about itself and life, and its expectations and subsequent relationship with objects. Systems of pathological accommodation, as prototypical forms of self and object reciprocal attachment, operate powerfully at preverbal and procedural levels.

Those pathways, which otherwise might have addressed phase-appropriate tasks, are preempted or stunted, and the corresponding crucial structures fail to emerge. These observational data became the basis, earlier, for classical ego psychology’s theory of ego deficit and subsequently for those of a deficit psychology of missing structures (Kohut, 1977). A radically different self-object system, however, has been created, and this system plays a greater, not a lesser, central and constitutive role than a responsive caregiving attachment might have played. This new system remains exquisitely context-sensitive and context-dependent with traumatic memory traces and ever-present proximity of life-threatening trauma at the core of the reality it attempts to organize. The harsh set of tasks involves preoccupation with strategies for maintaining attachment to the object, while simultaneously coping with the complex effects of relational trauma as development proceeds. The preoccupying mental state may well attain the proportions of an “attention-deficit” disorder, especially when the caregiver’s attention continues in its fixation on what is “missing” in the child while that of the child remains focused on the lack of the object’s aware/responsiveness to the toxic state that is preoccupying child.

Trauma such as that which accompanies a serious mismatch of the caregiver’s experience and response with that of the infant can be observed to result in a shock-like “toxic” state. In the instantaneous tsunami-like reaction, the time-space dimension of experience undergoes collapse while the fragile structures supporting a continuing sense of self are crushed. The state, as it can be observed in the therapeutic interaction, brings together a cognitive/affective montage in which are indissolubly fused unconscious memories of life-endangering archaic experience and the shroud-like expectation of future threats of extinction. In this process, damage keeps being inflicted on the quality of one’s personal experience and entire spectrum of one’s relationships. The hole created will be filled in by a combination of compensatory enactments and distancing structures together with those of pathological accommodation, which “heal” the breach. From infancy, a preternatural sensitivity has been retained. A rigid template is formed through which all experience comes to be filtered. A patient so traumatized will frequently display a
knowledge of the analyst’s unconscious intentions before the analyst knows about them (however reductionistic or distorted from the analyst’s point of view). Embedded at the sound-bite level of experience is the patterned belief that such knowledge must be disavowed and disposed of because unwelcome or damaging to the analyst. What remains may be only the briefest pause and an all-but imperceptible shift in affect state, microscopic elements, easily ignored in the search for familiar macroscopic themes. Also in place in such experience is the patient’s unquestioned belief that the analyst’s appraisal of her, and of himself, will be based at every stage on how well or poorly she is able to please and affirm the analyst by showing progress in the program on which he rests his claims for progress and the patient’s well-being. The making of a hypnotic-like cure of love is in progress. Transgenerational transmission of accommodative pathology is making its contribution “to keep maladjustment in good repair” (Bion, 1977, p. 99).

Within a secure developmental attachment system, sensitive caregiver responses form harmonious sequences with the child’s distinctive experience. Where repeated trauma prevails, the child’s natural rhythms and psychological states do not initiate harmonious interaction responses. Instead, the attachments serve as pathways for responses centered in the caregiver’s own insecure attachment patterns. In place of letting the child take the lead in the playful interaction, for example, the anxious mother, like the anxious therapist later, will direct the child, thus beginning the extinction of any center of initiative in the child. The obsessive caregiver will keep scrutinizing the child for flaws and defects, and they then become enmeshed into a ritualistic system of “fixing.” The center of the developmental stage is shifted from the child’s vitalizing expressions to the caregiver’s deadening, impinging, frightened, or abusive mismatch. Ever afterward, this sequencing will occur automatically beyond the influence of self-reflective awareness. Occurring at split-second intervals, the process results cumulatively in an “overburdening” exhaustion. If its triggering contextual origins go unnoticed, it may seem unexplainable and intractable as a characterological “volatility” in the patient, impervious to cognitive learning, and an analyst may well conclude that understanding doesn’t work and that something more is needed. A specific individual system failure, however common, has been universalized.

Well-being and happiness cannot be sustained within this system. Feelings of attractiveness come systematically to be extinguished and replaced by those of repulsiveness, aliveness by malaise. The repetitive sequencing of such states of mind takes the form of obsessive brooding and self-reproach from which patients cannot free themselves when they are alone. These states are frequently not clearly recognized as discrete states of mind and as reactive to psychologically complex triggering interactions. They tend to be seen as characterological, and latterly to purely chemical or bipolar reactions inherent in the isolated nature of the experiencing person, and predictive of dire prognostic consequences. Terror has been unleashed in the subjective world, and, as on the larger geopolitical stage of our contemporary world so dramatically, terror requires immediate preventive or preemptive intervention. However, in analysis, it is imperative that these states are clearly identified, and the analyst’s reflective power restored if he is to avoid becoming entangled in a reifying ruminative process or in action/interpretation designed to terminate the offending state.

Within traumatic attachment systems, the child develops a lasting hatred of reality and may spend a lifetime attempting to evade it or, “born again,” to superimpose a more acceptable substitute upon it. The hated reality is one has been imposed and has come to crush spontaneity and individual joyfulness. At its center, the traumatized child has come to feel itself as bad. Its experience has been interlaced with threats and episodes of abandonment, physical and psychological, and first belief in causality establishes that it
has done something egregiously, malignantly, and selfishly “wrong.” The child has been forced to adopt or embrace, this alien impinging referent as not-to-be questioned Truth because such threats leave it helpless. Intense anxiety is aroused, and the anger generated is the only means the child possesses to attempt to prevent the caregiver from carrying out or continuing the threat. Subsequently, when its anger is ignored or thrown back and the child blamed for the difficulty, a dysfunctional hermetic feedback circuitry has been firmly established. Chronic rage and revenge follow, laying the foundation for sadomasochistic character formations. This child carries the stigma of badness driven into his selfhood and will never able to put the torment to rest: “Like damn little men pounding at my brain with picks and axes and chisels” (Stevenson, 1998, p. 36).

Patterns of reciprocal interaction in infant-caregiver systems that become conduits for pathological accommodation cover a vast area of dispositions. Where the child’s distinctive experience regularly triggers an aversive response, a traumatic pattern will be automatized and mediated at a cellular level. The incremental bits of spontaneity will no longer be available for conscious processing and will be absorbed into a resulting blanket of lifelessness, despair, and/or synthetic and cliché-ridden “as-ifness.” This dynamism makes the individual approach to sustained and sustaining microscopic investigation, reflection, and understanding imperative. It is intrinsic to an appreciation of the intersubjective context of all human experience that both participants in the analytic dialogue are vulnerable to the activation, each of his own, developmental traumatic system.

Template Formation – Transmitter of Pathological Accommodation

Words dry and riderless
the indefatigable hoof-taps
While
From the bottom of the pool, fixed stars
Govern a life.

Sylvia Plath, “Ariel”

In this context of repetitive/cumulative trauma, the child’s acute sensitivity will serve as an advance warning system, and his development will have to be patterned around a program of matching the caregiver’s mental state with a system of “shoulds” and “shouldn’ts.” An enduring template comes into being under wide areas of the child’s cognitive, emotional, behavioral and neurophysiological functioning, just as similarly had happened in the caregiver’s own childhood. This metasystem is established before symbolization has developed, and it will continue to operate largely beyond the corrective influence of subsequent relational experience or self-reflective awareness. Acting like a DNA-inherited pattern into which subsequent experience will be silently synthesized, it serves as a conveyor belt for future transgenerational transmission. Once established, “it filters experience in such a way that minimizes the likelihood of spontaneous change” (Sroufe, 1996).

At the very foundations of personality formation, traumatic sequences (“schemata-of-a-way-of-being-with” Stern, 1985) are established in which the child’s connections with self and caregiver are repeatedly broken into by mismatching. These temporal segments
of mental life will form the underarching *templates* that come to organize behavior in all significant relations, including, eventually, the relationship with one’s own child. The mismatch trauma will unleash a spiraling of intolerable affects, as an evolutionary system responds automatically to the signal of encoded primeval threats to survival. The state of distress is brought to an end with the compulsive rematching of the child’s mental organization to that of the caregiver. The process takes place in milliseconds. Its hierarchical position is rooted in the procedural level of experience before the capacity for the representation of internal working models has developed. It is subsequently incorporated into such models acting as a compulsion in statu nascendi. Attachment observation yields conclusive evidence that infants attached to maltreating figures are not less attached - indeed they are likely to remain the more rigidly so by reason of their continuing insecurity and that of their attachment objects. Winnicott has traced the adult fear of a future mental breakdown to one that has already occurred so early in life that it cannot be remembered.

This *traumatic attachment system* is the “reciprocal primal relatedness that will form the archaic substrate of the analytic situation” (Kumin, 1996, pp. 8). The analyst’s ongoing and scrupulous introspection will be a critical ingredient enabling him to recognize the continuing intrusion of his own predetermined contribution. An analyst’s fixed beliefs as to what the patient should and should not believe as well as what would be “best for the patient,” tend to concretize and move the patient’s pathological system toward intractability. The goals and processes of psychoanalysis must be based, in this view, on the recognition that this complex developmental interweaving of subjective-intersubjective patterning constitutes the nucleus of the psychopathology as it is inevitably interactivated and maintained reciprocally in analytic transferences. The analyst’s self-reflective disentanglement is a mandatory, if by no means simple, requirement.

### Analytic Process and Treatment

In previous works, a number of case illustrations have described in detail the clinical application of the principles of intersubjectivity (Atwood & Stolorow, 1984; Stolorow et al., 1987). Clinical material discussing the treatment of patients whose primary developmental disorder resides in systems of pathological accommodation may be found in Brandchaft (1983, 1991, 2001).

For my present focus, I will use as text a brief case report of a Mrs. C contained in a recent paper, “On Analytic Process,” by Ablon and Jones (2005, pp. 541–568). The report describes an important ongoing research project with extended comments by Blatt and Fonagy, and a reply by Ablon, on the research project. Recorded excerpts from the treatment of Mrs. C are contained within the report to illustrate the use of the research method in evaluating progress in psychoanalysis.

In the report, discussion of contemporary conceptualizations of “interactive dimensions inherent in the relation between analyst and patient” as mutual and reciprocal influences on the analytic process, centered around a specific interaction as “the context for therapeutic action.” (The intersubjective perspective, though not specifically referenced in the report is exactly such a conceptualization.) The analyst himself had come to label this recurring interaction sequence, “Playing Stupid.”

In this recurrent interaction, the patient’s thoughts became muddled and confused when she talks of sexual feelings and her wish to arouse me; the analyst finds himself talking more than
usual in an effort to explain matters. . . An excerpt from the fifth year of the analysis provides a clinical illustration of the interpersonal interaction (Ablon & Jones, p. 556).

Below is the excerpt from the case report exactly as it appears in the article. Comments within the excerpt that concern the ongoing research project are those of Jones and Ablon. All italicized segments in the excerpt are my own and intended for special emphasis. Numerals following a passage refer to portions of the text on which my comments will follow.

*Mrs. C*

An attractive married social worker in her late twenties, Mrs. C complained of lack of sexual responsiveness, difficulty in experiencing pleasurable feelings, and low self-esteem. Mrs. C experienced herself as emotionally constricted and inhibited, and fearful in her behavior. She was very self-critical and worried even when she made a minor mistake. She felt she was unable to hold her own opinions, and lacked the strength of her convictions; especially difficult was disagreeing with her parents or husband. She had been married for less than two years to a successful businessman when the analysis was begun.

The analysis was conducted over a 6-year period or for approximately 1,100 hours; its outcome was considered to be very good by both analyst and patient. . .Ratings. . .were then completed by at least two clinically experienced judges.

The excerpt from the transcript of a session during the fifth year of the analysis follows.

At the beginning of the hour the patient notes that she has been feeling angry all week-end because she wanted the analyst to say something during the last hour. But she is unsure specifically of what she wanted him to say.

Patient.

I don’t know it seems rather strange to me, because it isn’t as if I really don’t have any idea of what I’m thinking about. But then I muddle it all up, so I can’t think about it in any kind of straight way. (1)

Analyst.

Well, you know, what you’ve just been describing is really a very good description of the way you’ve sounded the past weeks here. You’ve been feeling - and all last week it’s true you wanted me to say something - but you were sounding as though you were feeling terribly confused, you couldn’t put anything together, and it all started with (husband) saying you were playing stupid. And I think that’s a pretty good description. The week before you talked about what does an IQ number mean? You can’t be. . .that stupid. (2) (3)

The point I’ve been trying to get at, it’s as if all week, what you have been doing - for, I think, a very particular reason - is muddling up your thoughts. You said, when I did some things that I was trying to put together, to help point you in a certain direction You find yourself not thinking about them, ignoring them. As though you were trying to maintain this very same state you were describing - feeling muddled, confused. And not because you don’t know something. Quite the contrary.

Now you see, I think what really started this was when you made love Sunday afternoon with (husband) during your daughter’s nap. (4) I think it’s been since then that increasingly you’ve felt it necessary to be in this frame of mind, where you’re sort of stupid. Playing stupid, muddling things.
The analyst goes on in a lengthy interpretation to connect this state of mind with a memory she had reported... when she was a little girl, she was supposed to be taking a nap, but wasn’t, and she saw something that troubled her. What she saw is never clarified. She was supposed to be sleeping but wasn’t, so she had to “play dumb,” to hide what she knows. The patient has trouble understanding what the analyst is saying, demonstrating in the interaction what the analyst has been interpreting... In fact the analyst is induced to repeat the interpretation later in the hour. (5)

Patient.
And I don’t know, somehow, getting into my curiosity, if... I keep thinking, you are implying that the seeing the rabbits, and then pretending I didn’t see it, well I don’t know, somehow I keep thinking, well it must be from what you are saying. And I know I’ve lost something you said... the fact that I know something that I don’t want to admit I know. And then I don’t know, then I think, well I don’t know what that is... (6)

Analyst.
It’s true you don’t know what makes it hard for you to try to get at what it is. Is this playing stupid? All last week, everything I said you sort of heard it, and then dropped it. And you even commented on how you hadn’t dealt with the things I had said I thought were related in some way... You’re finding it necessary to be stupid, to stay in this state, to not know.

Patient: (silence).
Mm, it’s not that I’m getting anywhere, and maybe I am. But I was just thinking of the fact that in not letting myself know - because I feel as if that’s what I am doing right now too - and not understanding in the way I should, what you’ve just said Or not just this last time, but before. Because I did understand what you said and it just reminds me of this tension I had all weekend. (7) (8)

This illustration captures what we have termed an interaction structure. It is clearly an interpersonal interaction that both the analyst and patient identify as repetitive and recurring. The reciprocal, mutually influencing quality of these repetitive interaction structures can be seen in how the patient’s stance evokes in the analyst his own countertransference reaction. His interpretations are lengthy, carefully explanatory, and contain some exasperation. Interaction structures are mutually created or engaged in by patient and analyst. Therapeutic action is located in the recognition and understanding of these recurrent interactions by both analyst and patient. The experience, interpretation, and comprehension of the meaning of such repetitive interactions constitute a major component of therapeutic action.

Comments
I stress at the outset that everything in the theoretical portion of my paper supports the conclusion reached in the final sentence quoted above (“The experience...”). The excerpt describes an “interpersonal interaction pattern that [is] repetitive and recurring.” The writers believe that the data supplied, as recorded above, supports the conclusion that the analyst’s interpretive stance and his responses were ultimately proved correct by the patient’s agreement, and that “the case of Mrs. C illustrates. the simultaneous process experiencing, recognizing and understanding the interaction.” I believe the report demonstrates the unidirectional application of this principle as it ignores an essential component in its own conclusion that “(1)nteraction structures are mutually created or engaged in by patient and analyst.” Consequently, the part played by the analyst’s interpretive stance and responses
remains unrecognized and unacknowledged in the uniform ratings of the outcome of the case as “very good” and its assessment of the interactional sequence as a model for psychoanalytic conduct. Taking the analyst’s contribution into account leads, I believe, to the conclusion that the agreement reached was the outcome of a system of pathological accommodation, coconstituted and comaintained reciprocally by the impact of the analyst’s interpretive stance and responses, and of Mrs. C’s compulsive compliance within that system.

I have chosen this brief case excerpt because of the significant epistemological problems it raises and because it provides the opportunity to distinguish between, on the one hand, a change at the psychological surface based upon a pathological accommodation that, requiring and maintaining at its core a debased and enslaved sense of self, is a perversion of an analytic process; and, on the other hand, a genuinely liberating change at the psychological depths. The latter would take into account that central in Mrs. C’s pathology is her “inability” to sustain the validity of her own perceptions and “hold her own opinions,” and that encoded in her subjective universe as organizing principle is a firm belief that a secure relationship with a man can only be maintained by her submissive compliance to his needs and opinions. These residua of her unique developmental attachments had undoubtedly already shaped her frightening experiences in the crib to which reference is made. There is ample warning that such an establishment of belief is likely to have played an essential part in the sexual difficulties Mrs. C had encountered subsequently in her marriage. Genuine transformation requires that “the reciprocal, mutually influencing structures” (of pathological accommodation) “will have been recognized by both analyst and patient.” In such a process, Mrs. C’s own experience, a developmental casualty, will have emerged and been maintained as central in her perception and in the generation of her subsequent behavior in the dyadic relations. Where pathological accommodation however enthusiastic has shaped the agreement of patient with analyst, the agreement itself is a continuing activity of the interactive relational context in which the underlying pathological structures are being maintained. It is characteristic of a false self cure as described by Winnicott and Bowlby.

I will examine the sample more carefully not for the purpose of criticism of the conduct of the case or the technique employed. I am hoping, rather, to call attention to important principles elaborated in the preceding body of my paper.

The research article discusses the stance of Mrs. C, “Playing Stupid,” as determinant in the analyst’s countertransference reaction. The codetermining impact of the analyst’s stance, verbal and attitudinal, is an intrinsic, omnipresent, reciprocal influence on Mrs. C’s experience and responses, including her “Playing Stupid.” His position is that of an observer from above and outside the intersubjective dimension of the interactive field. The significant events are described as if taking place within the essentially isolated domain of the patient’s intrapsychic world and her behavior is held to be exerting a unidirectional effect upon the analyst’s psychological structure. This isolating focus is a creation of the analyst’s own subjectivity. It reflects a crucial dimension of psychological remoteness of his own personality from its actual participation in the events he is witnessing. The unstated assumptions of objectivity and repeated assertions of privileged superiority in his knowledge of Mrs. C’s reality, to which she must finally agree, set the conditions for a repetition of the developmental trauma that has been the subject of my paper. The template that permeates the intersubjective context (what the patient should or should not feel or think, how she should or should not behave, as well as who she basically is) is a developmentally embedded pathological interaction structure. It can be recognized as taking its own particular form in her personality structure. A parallel and reciprocal
template may be organizing the analyst’s experience as it repetitively asserts itself. Such a template can take the form of a compulsive attachment to unquestioned assumptions about the events unfolding before an analyst, long after these assumptions would have required questioning and reassessment. Each of these templates represents the transfer of early attachment ties to depersonalized structures as discussed earlier in my paper; in the patient, an invariance of belief about the conditions in which a tie, and life itself, can be sustained; in the analyst an addictive attachment to idealized theoretical convictions that protects against fragmenting uncertainty. Their tenacity can be attributed to the crucial defensive function they would have required to fulfill in dealing with the developmental trauma of early object loss and the threat of psychological chaos. Careful investigation into Mrs. C’s successive responses might well disclose these primary motivational factors at work, as I will describe subsequently. The template can be made available to an analyst’s self-reflection into his “countertransference” reactions when a patient’s unyielding disaffirming responses, such as are reported here, represent a profoundly unsettling challenge to the analyst’s sense of self and the certainty that defensively supports it. Here the forceful reassertion of the analyst’s perspective brings to a halt a threatening descent into a chaotic unknown. Such templates are intersecting transgenerational transmission vehicles for the bond and bondage of pathological accommodation, the “mortallest enemy unto knowledge.” It is likely that they have profoundly and influenced affected the thematic content and course of the treatment to this point. Such templates represent essential qualities of the analytic attachment bond and are clearly functioning outside the reflective understandings reached by the analyst in the report. Never made available for attenuation in the treatment, they will nevertheless continue to live on and exert their shaping influence on life’s meaning.

The underlying thematic focus of the analysis in the previous week and for some time seems to have been on Mrs. C’s inhibited sexuality, much the same sort of behavior she is showing flagrantly in the analysis. Specifically, Mrs. C’s thoughts become muddled and confused when she speaks of her sexual feelings and her wish to arouse men. Such affect-laden cognitive symptoms, as the analyst recognizes, indicate that the patient is in the presence of an experience of acute psychological trauma, though in his eyes a trauma from any active participation in the infliction of which he has been exempted. As the weekend approached, Mrs. C had made urgent, if fearful and cautious, efforts to elicit some response from the analyst not forthcoming in their usual discourse. What she wanted him so urgently to say, or why, she is unable to bring herself to clarify. The analyst’s approach is one which would be consistent with a belief that Mrs. C’s sexual constriction and inhibitions, and presumably her low self-esteem, are importantly linked to the enduring influence of repressed traumatizing childhood sexuality, perhaps related to repressed primal scene experiences, as might be suggested in her (screen ?) memory of the rabbits. His therapeutic efforts seem to be directed to attacking and weakening defenses of denial and repression, hoping thereby to bring Mrs. C’s feelings about her disturbed sexuality and the traumatic memories, believed to be now emerging from repression in transference form, to conscious expression.

The analytic relationship, as Mrs. C’s marriage, has apparently been troubled for some period, and Mrs. C’s anxieties have led to recurrent states of “terrible confusion” and incoherence, which culminated in her demand before the weekend. The session reprinted here follows the weekend in which the patient was alone with disturbing thoughts and disabling anxieties that had been triggered or exacerbated by events in the last session. On her return on Monday, Mrs. C seems to be experiencing herself as she previously described, “emotionally constricted and inhibited, and fearful,” though, for a brief moment at the very beginning of the Monday session, not completely so. For she starts with a clear
assertion that she was angry with the analyst all weekend, before retreating behind a self-critical statement about “muddling it all up.” The brief opening statement, uncharacteristically straightforward, is certain to have included importantly her reaction to being left with painful feelings for the weekend, unresponded to at all. As she continues, her affect state shifts dramatically from assertive coherence to “muddled up” confusion, thereby reproducing the anxiety-ridden, confused state that has been labeled “Playing Stupid” (a “convenient” short-hand that Mrs. C has conveniently accepted as her own). The understanding of this state of mind has been restricted by the extent to which it has conformed to the unquestioned impression of the analyst and her husband, and then obediently by Mrs. C, as being a pure and isolated product of her inner world of psychological structuring. This interpretation repeated many times in the past and with increasing irritation and forcefulness, (and by now surely anticipated by Mrs. C), preceded and triggered the noxious psychological state that is the subject of the hour.

(1) A unique moment has been introduced as Mrs. C has reported that she was angry all weekend and then her affect state instantaneously shifts. If that fleeting moment and the centrality of her psychological position in it could be held, harmonious interaction could follow on the basis of a continuing investigation from within the perspective of her reality. A shift on the part of the analyst in his listening and investigative/interpretive stance to one consistently within the patient’s subjective world of experience might help open a fresh pathway and begin to attenuate her painful feelings of being alone in the world. Such a process, if reliably sustained, might lead to a transformational change and, consistently sustained, come to include an updating of her preemptive beliefs about the nature of relationships. Continuing a consistent focus into Mrs. C’s actual moment-to-moment experience as the point of investigation and therapeutic intervention might lead to a broader understanding of Mrs. C as a person. Ultimately, a fresh view might emerge of the origins, foundations and possible survival functions of her anxiety-ridden sexuality as well as the existential anxieties that might have been involved in the states of mind labeled “playing dumb.”

(2) The analyst ignores the need to attune himself to the vivid immediacy of Mrs. C’s anger and hurt together with the shift in her affect as urgent clues to the active intersubjective context in which Mrs. C’s anxiety is propelling her rapid descent into confusion. In this way, the trauma of the weekend annihilation of Mrs. C’s subjective reality is vividly, if unwittingly, reenacted in the session. The analyst’s response pushes the dialogue into the familiar, convenient, but for Mrs. C, far-off terrain of his agenda. His stance concretizes into an authoritarian reaction to a narcissistic trauma of his own, experienced as a result of Mrs. C’s “resistance.” Similar reciprocal interactions are familiar in the difficulties encountered in troubled sexuality. As the analyst defensively confronts Mrs. C with her continuing (“shouldn’t”) behavior, his reaction is such as to crush any hope of genuine discourse, voluntary interaction, and empathically informed understanding. A reification of reciprocal pathological Traumatic Attachment Systems is taking place.

(3) The analyst aligns his experience (of Mrs. C as a troublesome dissembler) with that of her husband in what she might well experience as critical and degrading. His interpretation is framed in such a way as to leave Mrs. C compelled to accept that she is either stupid or “dumbing” herself willfully in order to evade the Truth. That he and her husband may have arrived at a subjective understanding of Mrs. C is an alternative, which, however painful, might lead to hope where now despair is closing in. Sadly, it is rendered firmly not open for consideration. In place of strengthening the bond with his patient by an empathic attempt, the analyst is compelled to align himself with Mrs. C’s husband in a desperate attempt to persuade her of his credibility. If Mrs. C’s marital difficulties have
Similarly been viewed in isolation and as purely intrapsychically determined and without reference to her husband’s contribution, such a stance on the part of the analyst will have played an important role in itself codetermining Mrs. C’s attitudes, openness or “resistance” to his analytic efforts. Safety is an essential condition for a therapeutic interaction to take place in analysis so that differences can be adjudicated without lasting damage to either party. Such conditions of safety are essential, as well, in a marital relationship in which love can be felt and sexuality experienced authentically, not on command. Although the analyst’s perspective may have precluded the investigation of the contextual factor in Mrs. C’s fearful sexual difficulties, the brief interval which I have emphasized represents a bit of spontaneous break through in which different possibilities in the analyst’s responsiveness are being tested. The episode of Mrs. C’s anger and the triggering analytic experience of which it is a part are not referred to further in the transcript or report.

(4) The analyst returns to his preoccupying interpretive theme, further endowing it with the authority of objective and preemptive Truth (“I think what really started this”). The crucial question is “What’s True and Whose Idea was It?” Ogden, (2003, pp. 591–607).

(5) The analyst refers specifically to Mrs. C’s report that she had made love Sunday afternoon with her husband during her daughter’s nap and the confusion that followed. In the opinion of the research report, the patient’s trouble in understanding is regarded as “demonstrating in the interaction what the analyst has been interpreting,” and “Playing stupid, muddling things.”

(6) The pathological circle has now been joined. Mrs. C is reproducing in the analytic process the pathogenic developmental relationship. She has “forgotten” her anger and disappointment with the analyst together with her feelings about being left and unrespon-sed to. She preserves the idealized immunity for him, which he has indicated clearly he needs as the basis for a continuing tie. She must proceed under his direction ("when. . .I was trying. . .to help point you in a certain direction"), as he is obstinately unable to respond to the direction to which she was pointing. She then responds, “Well I don’t know, somehow I keep thinking, well it must be from what you are saying.” In the disorders I have been describing the reality that dominates is that of the caregiver in its impingement on or its exclusion of whole domains of the subjective reality of the child. When the caregiver disregards the protest of the child or throws the anger back upon the child who is blamed for the disjunction, the experience has become traumatic.

(7) The template of what Mrs. C should and should not be knowing and doing that has been shaping Mrs. C’s experience in the analysis now appears openly: “I feel as if that’s what I’m doing right now too—and not understanding the way I should.” The cohesion achieved is one of accommodative submission (Crittenden & DiLalla, 1988, pp. 283–284). These observations speak to the importance of the rigorous investigation into the intersubjective patterning of the patient’s minute-to-minute experience as essential to enabling the patient to become aware affectively of the shift from “being” to “seeming to be.”

(8) To return briefly to the theme of the patient’s sexual symptomatology, it must be acknowledged that much of that story remains undisclosed. Nonetheless, there is no indication in the report of the analyst’s interest in having extended his inquiry into Mrs. C’s transference feelings and anxieties activated by the weekend break. When such feelings do come into the Monday hour, the analyst’s dismissive response is such as to discourage the patient from any further expression. The phenomenology of erotization in response to object loss, a defense against encroaching devitalization and psychic collapse, is familiar. It suggests that whatever the sexual feelings Mrs. C may have been experiencing and concealing, the context of the loss of the analyst and her urgent attempts to
compensate for, act out, or deny that painful loss would have to be taken into serious consider-ation in the investigation and any understandings reached.

Whatever the nature of the distress Mrs. C may have suffered over the weekend, that of traumatic loss has been carried over from the weekend into the Monday session. Strikingly, not mentioned in the verbal discourse, it remained neglected throughout the hour. Such consistent neglect of Mrs. C herself results in her treatment not as a whole, feeling person, but as an assemblage of disparate parts and an object of another’s perception and purpose, as if no “she” existed apart from that purpose. Mrs. C, now in the company of her analyst, is as alone as the child in the crib of her memory. On her own, abandoned and lost, she is without a word of comfort from anyone in her world who understands her, her feelings, and her despair. No one cares enough, because once more, as in the traumatic past of her “crib memory,” everybody is busy doing his own really important thing.

The desperate feeling of being alone, the experience of alienation as it permeates Mrs. C’s experiential world beneath the thicket of pronouncements, badgering, and acts of submission in the session, might itself crucially become involved in therapeutic transfor-mation. For it touches on the deepest of dreads—the existential threat to the continuity of existence, the permanent lack of a human presence. Unresponded to, it entails a continuing hollowness at the core of one’s personal existence. For transformation to occur, however, there has to be a human presence that has been tested. In analysis, that means, above all else, someone who reliably cares enough to abandon preconceptions and really listen—not only to what is spoken but importantly what suffuses the atmosphere. Only in such a setting, I believe, can the “dragons of primeval days” come to be recognized as part of shared humanity and common heritage, faced, and their power attenuated.

A consistently contextual perspective might result in a different understanding that could impact the patient in a different way and open a fresh pathway to a transforming analysis. What follows is a different response at what I believe is an appropriate point of intervention. I will begin with the patient’s initial comments:

At the beginning of the hour, the patient notes that she has been feeling angry all weekend because she wanted the analyst to say something during the last hour. But she is unsure specifically of what she wanted him to say.

Patient.
I don’t know it seems rather strange to me, because it isn’t as if I really don’t have any idea of what I’m thinking about. But then I muddle it all up, so I can’t think about it in any kind of straight way. (1)

BB.
I can sense how confusing and disturbing this must be for you. . . . -my failure to have responded to or inquired further in the last session into your urgent request that I say something to you. . . . Could we try to sort it out a bit together. . . . Perhaps, for a start . . . let’s go back just to how you were feeling when you were anticipating coming to see me today. . . . you were telling me that you had been angry, felt disappointed, let down?. . . left with those feelings all week-end?. . . . Were you afraid that when you came in today and told me straight out how you honestly felt. . . . being disappointed and angry with me. . . . did you think - that would not be welcome to me, that I would not want to hear about that?. . . Were you afraid, or perhaps convinced?. . . . that I would not appreciate how important. . . and helpful. . . it is that you come to feel safe in holding on to your own feelings and your own experience? . . . did you believe that it would make me think the less of you or interfere with our relationship?
If what I am saying corresponds to what you are feeling...then it might help explain your so-called “muddling”...Perhaps when we began today...as perhaps now...you were frightened to tell me something about myself that I might not want to hear...straight out...fearful of its impact on me...and my reaction...then your disappointment and anger with me...gets turned to a disparaging attack upon yourself and your thoughts...In that way...as the only way...to preserve a helpful tie to me...you turn against your own feelings?...

I include pauses intended to provide the patient with the space to respond, and for the analyst to attempt to get some information as to his impact as he is proceeding. I emphasize this point because of the analyst’s long and uninterrupted interpretative response to Mrs. C’s opening communication. I have become mindful of the damaging effects of imposing additional tasks when a patient’s state of mind is already seriously stressed. Overburdening, I believe, may well have played a part in the subsequent dialogue that is presented. In the theoretical portion of this paper, I have described the subjective symptoms of the traumatic experience as constituting an assault on nuclear formations of the personality. They involve a “shock-like state” of profound disorientation together with a loss of the capacity for rational thought and reflection. The report of Mrs. C’s responses seems to fit this description. The onset of this state must be recognized by the analyst for it calls for an imperative shift in the analyst’s response together with the eventual opening of the investigation into deeper split-off levels of experience.

Here I am Reminded of an Experience of my Own

The patient, R, had also returned after a weekend absorbed in ruminative preoccupation. He was able to identify an immediate stress factor: he had had an appointment with a lady friend with whom he was having an intimate relationship. She had been out of town and called leaving a message that she wasn’t able to meet him and that she would get in touch with him later. He remarked that he had told her a thousand times not to do that to him. He then spoke of the demands being placed upon him at work and his feeling that the entire enterprise would collapse if he continued to fall behind. And he spoke of an impending “nervous breakdown.”

I was about to continue my questioning in order to get at the nature of the anxieties underlying these two circumstance and their possible interconnection, as well as the background anxieties of the week-end that might have been activated in the transference. But I paused because something in the unspoken quality of his words caught my attention.

I said, “Will you tell me honestly whether you would prefer for us to continue to work at this right now, or to just lie there and relax for a bit?” He paused, and then replied, “Since you asked, I do think I would rather just lie here quiet for awhile.” I said, “Fine,” and then fell silent. He was also silent for some minutes, after which he then shook himself and said, “I’ve just had the most amazing experience. For the first time in my life, I was absolutely clear, I knew with complete certainty, what I really wanted!”

Having recognized and aligned myself with the patient’s state of mind and his need to recover from the acute overstimulation, we were subsequently able to return to the investigative function of the analysis. Locked with this state of mind were profound archaic existential anxieties and fears of madness that had tormented the patient with every relationship from very early on. The patient became aware of a characteristic that marked every relationship, the need to make himself absolutely indispensable to his partner, including the analyst. He became able to recognize the triggering experiences “warning signs,” always the loss or prospective loss of an important object and better able to deal with the hitherto rapidly spiraling “out of control” incremental mental processes.
I am well aware that processes of pathological accommodation can accompany any perspective, including of course that I have indicated as my own. Mrs. C’s responses to such intervention might well have been similar to those actually reported. That would constitute, in principle, no obstacle, but rather call for a continuing and unweighted inquiry, at an appropriate time, into her experience of my intervention. In my paper, I have stressed that in systems of pathological accommodation, awareness of distinctive inner experience has been a defining casualty, developmentally and in analysis. Its rehabilitation is a primary objective of the analytic relationship if authenticity is to develop where accommodative submission has prevailed. The attention to minute shifts in affect state, such as those as described here, derives from the belief that such shifts indicate the fate of microunits of experience that, operating from a prereflective domain of consciousness, automatically have come to continue to shape experience. They indicate precisely the pathogenic, reciprocal interaction structures that psychoanalytic understanding of unconscious experience needs to address in order to bring transformation about.

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References


