CONTEMPORARY PSYCHOANALYSIS – A 50 YEAR PERSPECTIVE
Sanford Shapiro, M.D.

Abstract

Contemporary Psychoanalysis arises from the confluence of two streams: one stream starts from Freud’s classical theory and progresses through Kleinian theory, object relations theory, ego psychology, self psychology, intersubjectivity theory, and social constructivism; the other stream starts from Ferenzi’s work and Harry Stack Sullivan’s Interpersonal Psychiatry and progresses through the work of Steven Mitchell, Phillip Bromberg, Jessica Benjamin, Donnel Stern, Lew Aron, and other relational analysts. Newer developments within contemporary psychoanalysis include nonlinear dynamics system theory, attachment theory and neuroscience.

In this paper I illustrate the impact these and other ideas have had in my 50 years of working with patients. I will give clinical examples of how each new idea has allowed for a creative solution to a difficult case.

Educational Objectives

At the end of this presentation the participant will:

Understand the use of the analytic relationship in the treatment of trauma.

Understand the empathic mode of investigation.

Understand the role of theory in psychoanalytic technique.

This paper is written as a tribute to Bernie Brandchaft, an ICP founding member. Bernie began as an ego psychologist, he then went to England and became a Kleinian. Subsequently he studied self psychology and, with Bob Stolorow, developed intersubjectivity theory. He then went his own way to develop his ideas on pathological accommodation. His hope for ICP was that each of us would, like him, find our own voice.

The journey to find my voice began in 1954 when I started medical school, and the professor of psychiatry was a psychoanalyst, John Dorsey, the last American to be analyzed by Freud. Dorsey revered Freud, and he recruited psychoanalysts from the Detroit community to lecture us. One of these
was Richard Sterba, a Viennese psychoanalyst who emigrated to Detroit during the war.

Sterba showed us photographs of race car drivers sitting behind the wheels of their sleek, long and rounded race cars. Sterba explained that these cars, shaped like large penises, were phallic symbols, representations of unconscious instinctual strivings, and he taught us about the Freudian unconscious.

I found out later that Sterba (1934) had written one of the first relational articles in psychoanalysis: “The Fate of the Ego in Psychoanalysis.” Sterba explained in his article that the patient’s ego splits -- he used the term “dissociation” -- into two parts: an experiencing ego and an observing ego. In classical thinking, the patient regresses and the analyst observes. But Sterba pointed out that as the patient regresses, and experiences the analyst in infantile ways, he also sees himself regressing -- his observing ego. The patient’s observing ego allies itself with the analyst’s ego. The analyst is not an objective bystander but an active participant.

Later, in my psychiatric residency, Sterba presented a weekly seminar on Freud’s cases. One of the residents would read aloud from the Standard Edition while Sterba would follow in the German text. He corrected Strachey’s English translation to show us Freud’s “true” meaning, and he brought to life the flavor and excitement of Freud’s thinking. He also described the cultural climate where, for example, some of Freud’s patients accompanied him on his vacation to Gmunden where they could continue their analyses. They had a special relationship with Freud that did not get written about.

Sterba also described how Freud learned from his experiences. Freud changed his theories to keep up with his developing clinical experience. For example, in 1923 Freud wrote “The Ego and the Id,” a paper in which he completely revised his theory of the unconscious and his theory of anxiety. Previously, in his topographical model of the mind which consisted of the conscious, the unconscious and the preconscious, anxiety resulted from the breaking through of dammed up libido that had been repressed. Now Freud saw the mind in structural terms: the id, ego and superego, and he said that anxiety was a signal of danger by the ego, not dammed up libido from the id.
Sterba, who was a candidate at the Vienna Psychoanalytic Institute at the time, told how he and his classmates sat up all night at a coffee house complaining: “How can he do this to us? Just when we understand how things work, he turns everything upside down!” I came to appreciate how progressive Freud was in his thinking. He did not hold on to ideas that were no longer useful, and he was open to new ways of thinking about clinical problems. Freud was finding his voice.

In 1962 I moved to San Diego, and in 1967 I began psychoanalytic training at LAPSI in Los Angeles. There I came in contact with a group of analysts who had studied Melanie Klein. I tried immersing myself in Kleinian thinking where the Kleinian patient splits off unacceptable parts of himself, like aggression, and projects them into the analyst for the purpose of safekeeping and control, the concept of projective-identification. I also learned that when in conflict, a patient may retreat from the more mature depressive position -- a position of integration, to the more primitive paranoid-schizoid position -- a position characterized by splitting. These concepts helped me connect better with my primitively organized patients, who then started to come more often and make better progress. It was cost effective!

A supervisor introduced me to the work of Winnicott, and such ideas as: “There is no such thing as a baby -- only an infant and maternal care,” and “The capacity to be alone in a relationship.” I began to consider that there is no such thing as a patient, only a patient-analyst unit, and to appreciate the significance of the analytic relationship.

A revolution in my thinking occurred in 1977 when Bernard Brandchaft came to San Diego for a series of seminars. Ten years earlier I knew Brandchaft as a Kleinian, but now he talked about the work of Heinz Kohut, which I had read but hadn't understood. Brandchaft explained Kohut’s introspective-empathic mode of investigation, where analysts decenter from their perspectives and listen from their within their patients’ perspectives, and he explained the concept of selfobject functioning, an aspect of the relationship that helps the patient grow and develop.
Kohut's Introspective-Empathic Mode of Investigation

To decenter from my perspective and immerse myself into a patient's perspective revolutionized my work. An example is a young woman, a graduate student who was in an abusive relationship. One day her boyfriend intercepted her on her way to class and wanted to talk. She did not want to miss her class, but he was depressed and begged her not to leave him. She felt sorry for him, talked to him, and missed all her classes that day.

In the analysis we explored her belief that if she took care of herself and went to class, she would be hurting her boyfriend. She believed that taking care of herself was “selfish.”

Over time this boyfriend became more demanding and controlling to the point where she had to go to a girlfriend’s house to study. But he watched her apartment, followed her, forced his way into the friend’s house and berated her for leaving him. On one occasion he attacked her, tried to smother her with a pillow, and her friend called the police. The boyfriend ran away before the police arrived, and the police advised her to get a court restraining order.

In the analysis my patient worried that if she got a restraining order, her boyfriend would be humiliated and enraged. She wanted him to leave her alone, but she didn’t want to embarrass him. Also, she said, he was always very sorry after his attacks, and at those moments, she felt close to him.

I felt frustrated that the analysis was not helping her to extricate herself from this abusive relationship, and I feared she would be seriously hurt or killed. I told her I was worried about her safety, but she remained helpless to change.

I needed to change my thinking in which she was being masochistic or self destructive, and to immerse myself into her experience, to understand how, from her point of view, staying with this man was helping her. Thinking this way, I explored her experience, that she was away from home, alone, and felt overwhelmed by her school work. She had already failed one class and was on probation -- she did not know if she would graduate. She felt vulnerable and fragile. But when she was with her
boyfriend, she felt strong and complete. I thought of a small child feeling small, weak and helpless who, when holding her father's hand, feels strong and invincible.

Now I could say: “Of course you want to reconcile, to make up with him. It’s only when you feel connected to him that you believe you can do your work -- that you can survive. The abuse is the price you feel you have to pay to survive.”

She felt deeply understood, our alliance became stronger and her confidence grew. She could now explore other ways to get comfort and security, to reach out to people who could care about her without causing her pain. Now feeling stronger, unconscious guilt feelings came into awareness. She told me how her mother had always relied on her, and when the patient started feeling more independent and self sufficient, her mother became anxious. Her developing independence hurt her mother, and she felt that she did not have a right to have a better life than her mother. She now felt less guilty and more deserving, and she went to court for a restraining order. In time she broke up with the boyfriend.

She and I each had very different subjective perspectives, and it was only when I could understand her perspective from within her experience that she could then understand my perspective. Stolorow calls the interface between two differing subjective perspectives the intersubjective space.

Intersubjectivity Theory

Stolorow and Brandchaft collaborated on the development of intersubjectivity theory where analysts focus on the impact their personalities have on their patients’ transferences. (Stolorow, R. Brandchaft, B. and Atwood, G., 1987). Even if a patient’s transference is 99% distortion and one percent reality, the analyst focuses first on the one percent reality -- the analyst’s contribution to the patient’s response -- before looking at any distortions.

Relational Theory

At one of our Self Psychology conferences around 1900, I heard Steve Mitchell, a Relational
Analyst and an explicator of Harry Stack Sullivan, discuss a presentation by Robert Stolorow. Mitchell offered a strong, but respectful, critique of Stolorow’s paper. Stolorow said this was the first critique he had heard from someone who understood what he was talking about, and he learned something from Mitchell.

Mitchell's critique was that while Stolorow appreciated the analyst's impact on the patient's transference, he was not appreciating the patient's impact on the analyst's functioning. Stolorow did not disagree. Analysts also have transference reactions to their patients’ personalities. Patients sense their analysts reactions to them, and relational analysts often will acknowledge what their patients already know.

It was around that time that Mitchell started a new psychoanalytic journal: “Psychoanalytic Dialogues: A Journal of Relational Perspectives.” His article, “Contemporary Perspectives on Self: Toward an Integration” (1991) showed some overlap between the ideas of Harry Stack Sullivan and of Heinz Kohut. Mitchell was invited to Los Angeles to present a paper at an ICP conference. This time Stolorow was the friendly critic. Thus began a series of dialogues between interpersonal psychoanalysis and self psychology. The two groups cross-fertilized each others thinking, incorporated each others ideas, and for me this was the birth of Contemporary Psychoanalysis.

New Perspectives on Resistance

Coming from ego psychology, I saw resistance as arising from instinctual wishes within the patient. In this model -- a one person psychology -- the patient is motivated to avoid facing forbidden strivings. The task of the analyst is to confront the resistances and to interpret the defenses.

In a contemporary two person model, the patients are resistant when they anticipate a painful response from their analysts. Now the task of the analyst is to investigate what, if any, contributions the analyst might be making to the patient’s fears. An example is the case of Bennett.

Bennett, a 38 year old attorney, began his analysis with complaints each day that I never said
good morning to him. I knew I said good morning, but I wanted to stay with his experience and not confront what I perceived as his distortion. Each day, accommodating myself to his point of view, I tried saying "good morning" a little louder. But he continued to complain: "It drives me crazy that you never say good morning when I come in."

I felt like telling him: "I said good morning! Didn't you hear me?" I felt this must be a resistance. I wondered to myself: "Does he have some unconscious need to disavow my greeting -- to keep me at a distance?" I kept my mouth shut and thought about our two differing subjectivities.

I then wondered: "Could there be some subjective truth encoded in his perception of me?"

Could I be somehow contributing to his experience?

I explored the feelings triggered by me when he came in each morning and did not experience a greeting.

"It feels awful," he said. "It reminds me of when I was little and waited each morning outside my father's room -- for hours -- until he would get up and come out." His father, who was depressed, worked late and slept late, and stayed isolated in his room for hours. When his father finally emerged, he showed no eagerness to see his son. The little boy looked in vain for some spark -- some sign of recognition -- only to be disappointed.

I realized that -- seeing him at an early hour -- I was not fully awake when I greeted him. Although I said good morning, there was no spark of pleasure or excitement in my greeting. I explored the impact my lack of enthusiasm was having and he revealed that -- not only was he disappointed -- he also felt ashamed. He had believed that his father's lack of response was his fault, was his failure as a son. After recalling -- and talking about his feelings of shame and failure, he was able to acknowledge my greeting and to see things from my vantage point. He said good morning to me, too.

Coming Late to Appointments

In contemporary psychoanalysis our thinking about a patient's motivation has also changed. I no
longer see patients as motivated by incestuous and aggressive strivings that must be resisted but see them instead as motivated to grow and to develop. My task in this model is not to confront resistances but to infer how patients need to use me in their process of getting better. An example of this change in thinking is my approach to patients who come late to their appointments.

My personal analysis was conducted from a classical vantage point. I was rarely on time. No matter how hard I tried to be punctual, I was invariably late to my appointments. My analyst believed that coming on time was evidence of mature ego development and that my coming late was a regression, a reinstinctualization of what should be an autonomous ego function. I was trying to exert omnipotent control, he said, I was being manipulative—an expression of my unconscious aggressive strivings. I felt guilty—like I was doing something wrong.

My analyst did not understand that I suffered from an exaggerated sense of responsibility—something I was taught at an early age—and that I felt compelled to squeeze as much as possible into my day. If I was early for an appointment, I felt I was wasting time. I was torn between my fear of wasting time, my analyst’s need for me to be on time, and my desire to please him and be mature. Only when I arrived exactly on time did I feel safe.

Now, looking at behaviors from the patient’s point of view, I see that resistance is survival, not pathology. Coming late to my appointments was not an attempt at omnipotent control, like my analyst thought. It had, in fact, nothing to do with my analyst but was an expression of my feeling disrupted— I was taking care of everybody else and not taking care of myself. My wish was to be a good boy, to do what was expected of me. I believed that accommodating my needs to those of others was a necessary condition for survival, and, unfortunately, I had too many masters.

This insight helped resolve an impasse in the case of Esther, a 32-year-old professional woman who entered analysis because of conflicts in relationships. She was in love with two men, each of whom wanted to marry her. Esther alternated in her affections: she loved each man and debated their
individual merits. After one year of analysis, Esther, with embarrassment, told me about a third relationship. She was having an affair with her boss, a married man.

Esther was unable to make up her mind because she did not know her mind. She felt compelled to be what others expected. She was taught, and she believed, that having and pursuing needs of her own was selfish. And during this period of the analysis, Esther came punctually to her appointments.

As we explored and understood her unconscious beliefs, Esther began to feel she had a right to say no to others, including me, and to think about what she wanted. She stopped the affair with her boss, became more distant from one of the men in her life and grew closer to the other whom she eventually married.

During this period of the analysis, Esther began coming late to our appointments. Thinking in a classical mode, and doing to her what my analyst did to me, I interpreted the lateness as a resistance, as an expression of unconscious anger towards me. Esther was hurt by these interpretations, but as she tried to comply, the life went out of her, she became anxious, and our relationship become distant.

The lateness intensified; sometimes Esther did not even show up, and the analysis became stalemate. I realized that I had been trying to get Esther to see things from my perspective and had not been understanding her subjective experience. I needed to decenter from my belief that she was resisting and to immerse myself in her experience. I now understood that Esther had come on time because she felt compelled to comply with my rules. But now she was differentiating herself from me and developing a sense of personal agency. She was learning who she was and what she needed, and her coming late was her taking care of herself—it was not her anger directed at me.

Inadvertently I had been retraumatizing her with a reliving of an early relationship with her parents where she learned to automatically, and unconsciously, comply with their expectations to maintain their support. Because she assumed that that was how relationships were supposed to work, it never occurred to her to confront me or to complain about my interpretations. She did her best to
accommodate to me, and she felt imprisoned in the process, as in all her relationships. She believed that I required her to come on time to maintain my connection with her. My interpretations conveyed disapproval, put distance between us, and interfered with her developing sense of self delineation.

When I changed my thinking, my interpretations changed. Now I appreciated, and told Esther, that she was becoming able to choose what was best for her. She could decide to stay at her office and complete her work, if that seemed pressing, or she could come to her appointment and talk with me. Either way I would stay connected with her.

Esther’s vitality returned, her boldness and confidence increased, the breach in our relationship was healed, and the analytic momentum resumed. We together appreciated in a new way how she had been taught that her job was to take care of her parents, even at her expense. She believed that taking care of others was a requirement of staying connected, what Brandchaft called pathological accommodation.. From her perspective, to take care of herself required her to withdraw and be alone.

To get better she needed to have an experience of doing what she thought was best and still feel my connection. Coming late, in this case, was a developmental achievement, not a resistance. It was an expression of Esther’s developing sense of agency. My job was to appreciate, and to interpret, this new phase of Esther’s self development. When I did that she felt stronger, gained in confidence, and became more assertive in her outside relationships.

My philosophy of therapy was changing. I stopped seeing myself as an authority or as the expert. I began to see my role as a facilitator -- one who patients used to overcome obstacles to growth. And as I came to appreciate relational thinking, I realized that interpretations were not always necessary. Sometimes a relational experience alone is therapeutic.

An example of such a relational experience is a patient who complained that he didn’t feel connected to me. I explored his feelings and appreciated, what I thought of as being empathic, his frustration at having such a distant analyst. I understood, and interpreted, his feelings as having their
roots in early relationships with distant parents. But his complaints about me continued. I then had supervision from James Fosshage, a relational psychoanalyst. When I mentioned this complaint, that the patient did not feel connected to me, Fosshage suggested that I move my chair closer to the couch, which I did. The patient didn’t say anything, but he reported a dream where he was in a boarding house. He was having dinner and sitting at a long table with people seated on either side of him. He felt very connected to the people there.

I made no interpretation of the dream, and I heard no further complaints about my being distant. By moving physically closer to him I provided a behavioral, non verbal message -- a developmental experience -- that was more powerful than an interpretation. Much of what we communicate in an analysis, I have come to believe, is behavioral and not verbal.

Harry Stack Sullivan

In my training I had little exposure to the work of Harry Stack Sullivan. In fact, I was told that his work in Interpersonal Psychiatry was not analysis because it did not deal with intrapsychic conflict. It dealt with relationships between people – something social workers, not psychoanalysts dealt with. I have since come to believe that intrapsychic does not mean conflict between ego and id, but it means conflict between one's self representations and one's object representations, a conflict in relationships.

Relational analysis is not a theory of technique. As Lew Aron says: “Relational analysis is not . . . a unified theoretical system . . . it represents a community of psychoanalysts who share a common clinical and theoretical sensibility” (Aron, L. 1996, p.31). For me relational analysis means focusing on the impact my patient is having on me, and feeling free to share with my patient my feelings or reactions when it feels comfortable to do so. By focusing on the impact my patient is having on me, on my thoughts, fantasies, dreams and associations, not just my impact on the patient, I may get glimpses into my patient's early ways of being in relationships. Sharing my experience instead of interpreting the patient's experience often feels less intrusive and more respectful, and that too becomes part of a
new relational experience.

While I had been aware of the impact of the patient's personality on my functioning as an analyst, I never thought of it as a legitimate focus of my work. My natural tendency is to be reserved, and seeing the patient's impact on me as a legitimate focus of the analysis has freed me up.

I don't think self disclosure is unique to relational analysts, but that is where I have found the most open discussion. And I don't find any uniformity in how self disclosure is used. For me the question is not whether to self disclose or not to self disclose, the question is what is the impact on the patient when I self disclose, and what is the impact when I don't self disclose. In this way of thinking anything goes, but everything matters. The following are some examples of how I have integrated self disclosure into my work.

Ruth, a 46-year-old married graduate student, with a six year old daughter is a patient who held my feet to the fire. Ruth was working on her doctoral dissertation, and in the past had suffered severe, early abuse. She had "failed" in therapy with each of four previous analysts, and now I was her fifth analyst. In our work, she frequently complained that my way of working was "canned" and insincere, and I repeatedly had to stretch to find ways of being with her that came across as genuine.

She liked it when I made understanding comments, but she did not like it if I tried to connect a present experience with something from her past. If I suggested, for example, that some of her upset at her husband might be similar to the upset she felt toward her father when little, she felt discounted. Also she was hurt every time I did not remember some experience she had previously described. And she complained that I did not do more to help her get over upsets with people who offended her. She wanted me to be more involved in her life, to tell her how to deal with her daughter and her husband.

I felt guilty and inadequate, but I thought my reactions might reflect some sense of inadequacy on her part, and I did not disclose these feelings. I wanted to take her complaints seriously, but not be defensive. I said I would try my best but that I was limited. When she said I seemed distant and not
present enough, I told her I had heard that same complaint from others – it was one of my shortcomings (paraphrasing Brandchaft). Owning up to my limitations was helpful to her. Seeing that I didn't feel ashamed or get defensive about my limitations made it possible for her to feel she didn't have to be perfect and it was OK for her to have limitations.

At the same time Ruth impressed me with her spirit, determination, and her insistence on getting what she needed. In the past when I worked in a more classical mode, I would have been put off by and interpreted her assertiveness and her lack of compliance, as I suspect happened with her other analysts. Now I could hear in her complaints the desperate pleas of a small child who, although wanting connection, was not willing to subvert her sense of individuality to get it. My guiding belief now is that patients know what they need, and my job is to infer how they need to use me in their process of getting better.

One day Ruth reported a bitter dispute with a faculty member who was on her dissertation committee. She was enraged at feeling disrespected by him, she wanted to demand that he apologize, and I worried that she would sabotage her chances of getting her degree. She felt that her honor was at stake, and any advice I might give about being political or pragmatic would be interpreted as wanting her to submit to abuse. Yet she wanted me to tell her what to do.

I then remembered a personal experience, and now feeling more free to be myself, I decided to share it with her. I told her that in my culture it was natural for people to carry a grudge. Sometimes in my family people would not talk to each other for days at a time. She smiled and said that in her family people would not talk to each other for years.

I then said that my wife was raised in a different culture. She was raised Catholic, and the emphasis in her culture was forgiveness after someone hurts you. "It took me a long time to learn about forgiveness," I said, "but once I learned it, our relationship greatly improved."

She realized, through my example that she could act in her best interest without feeling she had
compromised herself, and she could maintain her self esteem; she did not have to feel abused. She had grown up in a culture where, she explained, if someone insulted you, you had to kill them. We now could understand why she got into frequent fights with people close to her. She then invited her adviser out to lunch, had a constructive talk with him, and they negotiated a resolution to their conflict. With her old ways of being in a relationship now in the background, she was able to practice a new way of being both with me and with her adviser.

By sharing my personal experience, which was comfortable for me, I became a role model, someone she could emulate. I didn't tell her what to do, the choice was hers, but I showed her a new way of relating. By watching her immediate emotional responses, I was able to be more open about my inner processes, avoid canned responses, and respond in a more genuine manner. These new ways of relating eventually become encoded in what Stern has called implicit relational knowing (Stern, D. N. et al., 1998).

Control Mastery Theory

The idea of watching a patient's immediate emotional responses is something I learned from Joseph Weiss (Weiss, J. 1993), a San Francisco psychoanalyst who developed a theory that patients come to therapy with an agenda or plan. He believed that patients suffer from pathogenic beliefs, beliefs based on early learning such as if one pursues a developmental goal it will cause damage to an important relationship. A person might feel, for example, that becoming independent and self sufficient will hurt his or her mother. Patients' plans in therapy are to subject their analysts to a series of tests in the hope of disconfirming their grim beliefs. Weiss believed, and the research confirmed (Weiss, J. et al. 1986), that tracking a patient's immediate affect whenever the analyst makes an intervention can determine if the analyst is on track.

This is a research project that analysts can conduct in their own consulting rooms. For example, if the analyst is on track, a patient's immediate emotional response will be bolder, stronger and more
insightful. Even if the patient's response is to complain or disagree, if it is done in a bold, strong manner, then the analyst need not worry.

If, however, the patient's immediate emotional response is anxious, diffuse or resistant, than the analyst is off track. Patients may agree with the analyst's interpretation, but the life goes out of them. They are complying and the analyst needs to be aware that something is amiss. When I remember, and am free enough to pay attention to my patients' immediate responses, I can relax and feel free to try out various interventions trusting that the patient's responses will keep me on track.

One day Ruth was upset when her daughter came home from school and cried that other little girls wouldn't play with her. Ruth felt guilty and believed that her daughter's social difficulty on this particular day was the result of her faulty mothering. She looked to me to help her be a better mother, and she wanted advice, not understanding.

I found myself feeling guilty, that her “faulty” mothering was a reflection of my faulting analyzing, and I pulled away from her by making a canned, mirroring response. I said, "You worry about your daughter." She became distant and said, despairingly, "You are very empathic. You use it like a technique. Well, that it is not what I need; it doesn't work for me."

I felt taken aback, and was speechless. Looking at her despair I realized I had distanced myself, and had been feeling pressured by her the way she felt pressured by her daughter. She had stirred up in me a feeling of responsibility to fix her the way she felt responsible to fix her daughter. I tried to picture her anxiety and I said, “You have a deep seated belief, a conviction, that there is something about you that is toxic. Anyone who is close to you will be hurt, and now your daughter's difficulty is proof of your toxicity. There is nothing that I can say, or anyone can say, that is going to change that belief.”

She visibly relaxed, and with warm smile said, "Sometimes the understanding helps." I was back on track, and we were reconnected. I hadn't formulated that thought, it just came to me and I said
it. Looking back I realize that I know how it is to feel toxic in a relationship.

Ruth's early abuse caused her to feel that she was unlovable, and that she must have done something to deserve the abuse. When she experienced that with me and I felt it, I put it into words. She felt her daughter's complaints were a reflection on her. Instead of trusting her daughter to work out her problems with her friends, she felt compelled to fix them. Now she wanted me to fix her. My comment indicated that I understood her, and I did not need to fix her. I trusted her, and she came to trust her daughter. As I weathered her storms and continued to care about her, she came to trust that she could also be lovable, and by seeing that I was not damaged, came to believe that she was not toxic. I needed to draw on the introspective-empathic mode from self psychology, the impact we had on each other from intersubjective and relational theory, and the close tracking of her emotional responses from Control Mastery theory.

The Unconscious and the Nonconscious

Freud believed that everything that is unconscious was at one time conscious and was repressed. But consciousness requires symbolization, language, to connect feelings and experiences with words, something that does not occur until the second year of life. Yet if you pick up a four week old baby, you can tell immediately if it is breast fed or bottle fed. How? A breast fed baby will turn its head toward your chest when you pick it up, while a bottle fed baby will look up. Where and how that memory is stored was an enigma to early analysts.

The neuroscience concept of implicit memory has changed the way we think about unconscious material (Pally, 1997). Implicit memory refers to aspects of experience that are stored in memory and may never have been subject to conscious awareness. This can include skills, like riding a bicycle, and early nonverbal emotional responses, like fear generated by experiences with parents. Stern (1985, 2004) has described how interactions between infants and caregivers become generalized into expectations, and he has described how a 12 month-old-infant, when reunited with the mother after a
short separation, will “know” whether to approach the mother with open arms, pretend not to see the mother, exaggerate the need for the mother, or ignore the mother. This learned way of being in a relationship is not conscious, nor is it dynamically unconscious (repressed) because it was never conscious, but it resides in the domain of implicit knowledge -- and it impacts all subsequent relationships in later life, including the treatment relationship.

With the development of speech, nonconscious emotional events may become conscious, if the child's environment provides words for the feelings and makes it safe for the child to talk about the feelings. Experiences of trauma may never become conscious if they occur before the time of speech, or if the child never feels safe enough to talk about them. The traumatic experiences will remain encoded in implicit memory where they are not available for naming or discussing. While early trauma may not be consciously remembered, it can be re-experienced through relationships, including the one with the analyst. The experience can not be told, as Jessica Benjamin says, it can only be shown (Benjamin 2006), and the therapists' use of their own bodily states of awareness can, as Jody Messner Davies says, serve as a map through the “minefield of potentially explosive and disorienting transference-countertransference reenactments.” (Davies 1994, p.167). In other words, the way I am with my patient, and my awareness of my reactions, may be more important than what I say.

Brandchaft and Pathological Accommodation

Mahler, et. al. (1975) have described how, in the second year of life, infants begin a process of self individuation from their mothers. The child who was compliant, now in the service of individuating, becomes difficult or even provocative. For example, the baby being fed in the high chair no longer passively opens her mouth to accept the waiting spoon of applesauce. Instead, she now reaches for the spoon because she wants to do it herself. Unfortunately her coordination at that age is such that the applesauce more likely ends up in her ear or hair or on the floor.

The stage is now set for a conflict between the baby's agenda, to do it herself, and the mother's
agenda, to see that the baby gets adequate nutrition. Most mothers manage a creative strategy where both agendas can be met. For example, the mother may give her baby the spoon and quickly pick up a second spoon. When the baby opens her mouth, and is struggling with her spoon, the mother deftly using the second spoon, slips in the food.

But if the mother becomes anxious and insists that the baby eat compliantly as before, the baby has two choices. One is to comply, to not reach for the spoon and passively let the mother feed her, a type of accommodation. The other is to resist and refuse to eat unless the mother relents.

When a child feels compelled or required to go along with the dictates of the caregiver, and passively acquiesces to the caregiver's needs at the child's expense, a pattern of pathological accommodation is set in motion (Brandchaft, 2010). Normal accommodation is when the two people in a relationship negotiate a compromise that meets each others' needs respectfully. It becomes pathological when one party is required to give up his or her needs as the price for maintaining the relationship. Such individuals can only feel secure in a relationship by denying or disavowing any needs of their own. These individuals can feel true to themselves only by maintaining a state of isolation, and of perpetual aloneness.

Such patients in analysis may very quickly accept all of the analyst's interpretations and may organize themselves in ways that meets the analyst's needs and expectations, such as confirming their analyst's theories. Much of what looks like resistance or acting out, like coming late to appointments, may be attempts by these patients to belatedly assert their individuality, something they could not do normally at age two.

These patterns of pathological accommodation, learned in early development, are automatic – like a reflex. They take place outside of conscious awareness, but because these patterns are often learned before the time of speech, they are not part of the dynamic unconscious. They are, instead, encoded in implicit memory, or as Stern et. al. (1998) have described, in implicit relational knowing.
Brandchaft calls these patterns deeply unconscious structures or systems of pathological accommodation that are not subject to interpretation or insight, and they require a specific type of introspective-empathic investigation.

Brandchaft (1993) says that a pitfall of self psychology has been a tendency to rely solely on empathy. When Kohut described the introspective-empathic mode of investigation, he meant it as a mode of investigation and not as a technique of therapy. Yet many of us discovered that using this mode of investigation itself was often therapeutic, and we idealized it often insisting that it be the only technique. This set the stage for a type of addiction to analysis where patients who feel badly about themselves, feel relief when the analyst empathizes with their self hate. But this relief is not maintained when contact with the analyst is interrupted, and such patients continue their analyses because it is the only way they know to feel better.

Brandchaft's solution is to deeply immerse in the patient's experience by closely monitoring subtle shifts in the patient's emotional tone or affect. For example, a patient may come in and report progress in an important relationship. The patient's affect is one of pleasure. He may appear brighter and talk with more feeling. A minute later, for some unknown reason, the patient may be expressing frustration or disappointment about the same relationship. And now the patient is doubting himself or even putting himself down. He no longer appears bright and pleased but instead is discouraged with himself and looks sad.

Such a subtle shift in affect from pleasure to self doubt is a signal that a deeply unconscious structure of pathological accommodation has been triggered. The empathic mode of investigation here is not to sympathize with the sadness and discouragement, but to note the shift in feelings and invite the patient's curiosity: “I notice that when you came in you were pleased with progress in your relationship with your husband. But now it seems that you are feeling discouraged and putting yourself down. Does it seem that way to you?” Patients make these shifts automatically and without awareness.
The patient might say that she sees that but that she shouldn't have been so grandiose as to think that things were better. She might add that she was in a state of denial. Or she might say “who am I to think I can make such progress – this is how I always end up shooting myself in the foot.”

The analyst now wants to know if he has contributed to this feeling, and he might wonder aloud if this shift in feeling might have been triggered by some observation of the analyst. For example, the analyst might say: “Do you really believe you are grandiose and in denial, or is it perhaps something you were anticipating I might be thinking?”

The patient might say, “my last analyst was always pointing out my denial and how I was always shooting myself in the foot, so of course you would think that too.” Now the analyst wants to carefully explore from an introspective-empathic vantage point this assumption. He does not want too quickly to let himself off the hook by attributing the patient's feelings to her previous analyst. He might say, for example, “I'm not aware of thinking that you are grandiose, or in denial, or shooting yourself in the foot, but is there anything I have said or done that might give you that impression?”

The patient might say no, you didn't do anything, but it opens the door to the patient being able to consider that you are willing take responsibility for your contributions, and will not immediately blame the patient – the beginning of a new relational experience where the analyst demonstrates a readiness to receive the budding shoots of the the patient's developing assertiveness. But sometimes a patient will say something like “Well, you didn't say anything, but I heard your chair creak and I thought – Oh no, he must think I'm in denial and being grandiose.”

The analyst can now draw the patient’s attention to another pattern by noting that, instead of asking the analyst – was that what he was thinking – she just assumed that was the case and, like a reflex, automatically and unconsciously discounted her feelings and organized her thinking and her self image in accordance with what she thought the analyst was thinking.

This approach helps patients become more sensitive to their shifts in affect, and to become
aware of the underlying behavioral patterns that activated these shifts. In time they will become sensitive to behaviors that previously had just been taken for granted. They will not be able to change these ways of reacting in relationships, but as they become conscious of them, especially when they happen in the relationship with the analyst, they can begin to practice new ways of being that can overlay the old ways.

An example of pathological accommodation to me is a patient who started therapy to work on his tendency toward self-defeating behaviors. He was making excellent progress, but one day he reported a setback where he went along with his wife in something that was against his best interests. But this time he was aware of his behavior and was pleased with his ability to recognize it. This was a new awareness, and I was impressed. As he talked I found myself thinking about a similar experience he had reported earlier in the therapy where he also went along with his wife at his expense, and I shared that memory.

Suddenly I was aware of a subtle shift in affect. "You are right," he said in response to my comment, "I really am a loser," and he began to put himself down and called himself pathetic. I felt a pull to empathize with his self-hate— to be understanding of how badly he was feeling. That would have been a mistake.

This shift in affect was the signal that a deeply unconscious process of pathological accommodation to me was emerging. Brandchaft says that "deep empathic immersion" means not to empathize with his self-hate, but to focus instead on meanings implied by the shift in his feelings.

I said to my patient: "I notice a shift just now. A few minutes ago you were feeling insightful and confident, and now you are putting yourself down." He went on to say that I was right, he was a loser. I said that looking back on my comment, I had misunderstood what he was saying, and I made a mistake. I had not appreciated his pleasure in his new insight, and how his reaction to his wife was because, at a deeper level, he felt frightened and vulnerable at that moment. Because he felt vulnerable
at that moment, he was desperate to maintain a connection at any cost. He feared at that moment that if he stood up for himself, she would reject him and he would lose his tie to her. At that moment he was in the throes of his old fear that his tie to his wife was vital to his very existence. Going along with her was his attempt at survival. He was not a loser, he was a survivor.

"I never thought of it that way," he said brightly. We were back on track, and I now pointed out how the two of us together had been involved in a reliving of his early childhood experiences where he felt required to go along with me, as he did with his wife in order to survive – a pattern he learned at an early age in his relationship with his mother. My reminding him of a previous experience was like an interpretation that he was being self defeating, and he felt automatically required to go along with this interpretation in order to maintain his tie with me.

In another case, a woman I worked with for seven years was trying to understand what blocked her from completing her dissertation. One day when I wondered if something from her past might be affecting her, she said, impatiently, “I don't want to talk about the past.” With tears in her eyes she said, “I just want to finish my dissertation.”

I was taken aback, and for several days I could not get her out of my mind. There must be some new way to understand this block, I thought. Then I remembered an incident from when I was eleven or twelve years old and had been taking piano lessons for about four years. I had made reasonable progress, and from time to time played in recitals that my teacher organized. One day my teacher said I was ready to play a two piano concerto with another of her students. I liked the music, and I liked the other boy, but I found myself blocked whenever I tried practicing this particular piece.

Day after day, week after week, month after month, I put in my time at the piano and went through the motions, but I could not practice this piece. My teacher was frustrated, and eventually she played my part at the recital. I felt an enormous sense of shame and failure.

Looking back now I realized that my mother's intrusive pressure had gotten in my way. My
playing the piano was more her agenda than mine, but I was not conscious of it, nor did I feel safe
enough to rebel in a more assertive way. When I next saw my patient I told her this story and said I
thought we were dealing with a struggle to maintain a sense of personal integrity. She listened intently
but made no comment. The next day she left a message thanking me for sharing my story, and saying
that she realized she had in fact already completed her dissertation. It had been completed for some
time, but she had been locked into a pathological relationship with her adviser, a woman who was also
her friend for 26 years.

The adviser had been pressuring her to do the dissertation her way, which didn't fit with the
patient's ideas, and the patient had not felt free to confront the advisor and assert her own ideas. Now
she could confront the adviser, and when she felt freer to assert her own ideas, she was able to see her
accomplishment, and to complete and successfully defend her dissertation.

While there are many things that take place between patient and analyst, in this case it was her
shift in affect from collaboration with me to tearful despair and distance: “I just want to finish my
dissertation,” that signaled to me we had become enmeshed in our own system of pathological
accommodation where I made the interpretations and she tried to go along with them whether or not
they fit. I didn't know at this point what I could do to be helpful, but I did know that I had to do
something different from what I was doing.

Of all the things that occur in a psychoanalytic process that leads to change, I have come to
believe that a central, if not crucial factor is paying close attention to subtle shifts in affect,
investigating those shifts, and understanding what is taking place between patient and analyst that is
triggering them. For me, this is Bernie Brandchaft's legacy.

References:


