Discussion of Dr. Judy Pickles's Paper: The Perspective of Nonlinear Open Systems Theory

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Nonlinear dynamic systems theory originally began as an attempt to understand interactions in both living and nonliving systems such as ecosystems and cloud formations. Because it is a field and systems theory, dynamic systems concepts offer a rich source of patented applications to the psychoanalytic situation. This article first briefly reviews some basic dynamic systems principles. The clinical material presented by Dr. Pickles is then discussed with an effort to apply dynamic systems concepts. In particular, the notions of introducing novelty and the need for measured perturbation as part of the process of analytic change are emphasized.

Nonlinear dynamics was initially developed as an application to the understanding of physics and chemistry. The principles of this theory have increasingly been applied to the study of biological systems (Stolorow, 1997). While it is conducive to think of human development as unique, dynamic systems theory looks at the processes in diverse systems, such as cloud formations and ecosystems, alongside human psychological development to find commonalities among all open systems. Dynamic systems theory attempts to understand how patterns arise by cooperation of many parts to create an emergent sense of order. The theory emphasizes the importance of the individual and unique contexts that drive development.

The issue of the definition of context itself is an important one. To say that an organism adapts to a context or set of contexts, however, is problematic as it implies that an organism "faces" a context or somehow exists outside of a context and then modifies itself to fit this change in a given environment. According to dynamic systems theory, adaptation to context merely describes the relation of an organism to a set of contexts in which a state of organization emerges through multiple and interlocking variables. Adaptation represents a mode of interacting with, reacting to, and providing input into a constantly changing world. Furthermore, the organism cannot be thought of as separate from context, but is itself part and parcel of contexts in which patterns arise. This form of thinking so stretches the conceptual boundaries of "context" as to make the notion seem vague and abstract. Yet one must still think of context as separate from organism, as an organism's history, its physiology, its genetic code, and mental states all enter into the idea of context. Indeed, factors such as brain physiology, mental states and inclinations, and history and social status represent important elements contributing to a person's organizing patterns. If one uses the word "context" at all, it is to refer to a totality of contexts and levels of organization. The notion of "context" in fact represents many different contexts.

Two dynamic systems theorists, Esther Thelen and Linda Smith (1994), describe their concept of development in the introduction to their work:

Although behavior and development appear structured, there are no structures. Although behavior and development appear rule driven, there are no rules. There is complexity. There is a multiple, parallel, and continuously dynamic interplay of perception and action and a system that, by its thermodynamic nature, seeks certain stable solutions. These solutions emerge from relations, not from design. When the elements of such complex systems cooperate, they give rise to behavior with a unitary character, and thus to the illusion of structure. But the order is always executory, rather than rule driven, allowing for the enormous sensitivity and flexibility of behavior to organize and regroup around task and context [p. xix].

From clinical observation and experience, the psychoanalytic situation is concerned with changing patterns of experience where patients seem to
be repetitively pulled toward familiar behaviors and modes of organization. These states appear to be intractable and often deeply engrained. In the case of the patient presented at this conference, the central conviction that she is bad and must have deserved the way she was treated represents a clear pull. It is a repetitive attraction to making sense of her world and her experience. Dynamic systems theory describes this process in natural systems as an “attractor state.” When systems self-organize under the influence of their unique contexts, they settle into preferred modes. The concept of attractor state is similar to the concept of an organizing principle within intersubjectivity theory.

Dynamic systems, however, are open systems. They have relative stability and the capacity to “soft assemble” new solutions. The psychoanalytic situation itself constitutes an unpredictable environment in which the object of inquiry represents precisely those contexts that have pulled our patients toward certain ways of thought, experience, and behavior. One of the most relevant aspects of dynamic systems theory as it relates to psychoanalytic practice is the centrality of novelty and the possibility of change. As a person develops, she or he may exhibit pathological patterns of thinking, feeling, and behaving. The repetition of these patterns often draws a person to process experience or act in accordance with her or his prior patterning activity. I believe that the goal of psychoanalysis is to disrupt the pull toward the unhealthy or pathological patterns and to instigate the development of new, “healthy” patterns of thinking and acting.

In setting out to accomplish this goal, I view dynamic systems theory as providing a potential methodology of perturbation through the introduction of novelty into a system of pathological patterns. It is novelty and perturbation that disrupt the attraction to pathological patterns. As Thelen and Smith (1994) state, there exist “attractors of such strength and stability that only the most severe perturbations can disrupt them” (p. 61). Thelen and Smith emphasize that “developing systems must be in [an] unstable or quasi-stable mode to explore new cooperative patterns (or strategies) and select those that provide a functional match” (p. 65). A system must be unstable to pave the way for the development of new patterns. The co-creation of the experience of instability and perturbation is the analyst’s most important function.

Perturbing the system is not, however, tantamount to producing a shock effect; creating the proper form of perturbation depends on the unique, interactive, and dynamic contexts between patient and analyst. For example, an empathic understanding can be one of the factors that alter a patient’s subjective world and disrupt the emergence of pathological patterns. For some patients, being understood may represent a form of novelty, and an empathic listening stance may procure precisely the perturbation of the system needed to facilitate the alteration of a pathological state. For many others, however, it is often necessary to introduce analytic observations and communications that create considerable anxiety and disruption.

Changing a patient’s pathological pattern is therefore a matter of co-creating a context in which novelty can occur. The primary contextual domain of psychoanalytic activity is the intersubjective field in which a patient and analyst interact. However, the development of a person is not limited to intersubjective interaction; rather, dynamic systems theory forces the analyst to think of a broader, more inclusive contextualism. The patterns in the relationship between patient and analyst may be influenced by factors as subtle as movement, action, the spatial configuration of the office, or other phenomena that go beyond the concept of intersubjectivity. Although a contextualist approach includes intersubjectivity as the main therapeutic form in which the patient and analyst will come to know and influence one another, it goes beyond intersubjectivity in thinking about the way a patient has developed patterns of thinking, feeling, and behaving.

The introduction of this new framework raises a problem in psychoanalytic practice by bringing into question the usefulness of the clinical environment as it represents a very specific context. Even if the analyst is able to help the patient discover and alter patterns of behavior and thinking within the clinical space, there is no guarantee that these states will move across the board to infiltrate into other areas of the patient’s life. In the language of dynamic systems theory, the clinical exchange may be seen as its own state space, with its own construction of degrees of freedom. The hope is that the patient will begin to alter patterns outside the clinical exchange and that this change will allow the patient to enter into dynamically stable states that are more conducive to her or his own sense of well-being, self-esteem, and personal agency.

There are other clinical implications of using a contextualist, dynamic systems approach in psychoanalysis. Another methodological insight occasioned by dynamic systems theory is the importance of action in pattern formation. Thelen and Smith (1994) claim that “Patterns of repeated activity over time become stable attractors” (p. 180, emphasis added). One can thus alter patterns of activity to change a dynamically stable psychological state. In traditional psychoanalytic theory, the patient comes to reflective self-knowledge through introspection and must consciously change his or
her pathological ways of viewing or behaving in the world. Dynamic systems theory acknowledges the potential benefits of such a methodology in certain cases but opens up alternative avenues of exploration. A patient, rather than gaining reflective knowledge of the patterns according to which they experience life, can be helped to alter behavior and then come to an introspective insight or a change in pathological pattern formation. Introspection and self-reflection can provide insight that leads to changes in behavior, but in addition, changing patterns of behavior and activity can provide opportunities for insight. Because psychoanalysis emphasizes understanding, the analytic process can become potentially stalled when understanding is used to avoid the anxiety of change. There may be multiple pathways to altering psychological states and inclinations, and changing patterns of behavior can be enlisted as one strategy that a contextualist approach makes available.

I will now turn to some specifics of this case. First, I would like to state that Dr. Pickles clearly has done work of great quality and Ann has been able to make significant gains. She has begun to integrate a sense of self-expression and sexuality that had been missing in her severely traumatic childhood. My viewpoint will be presented to illuminate particular moments where I have some individual differences and potential ways of altering the interaction between analyst and patient. I hope to do this with an appreciation of the courage and commitment of both Dr. Pickles and her patient Ann. Also, I am very aware of the limitations inherent in my comments, as Dr. Pickles may have actually addressed some of the issues I raise in sessions and not had the time to present this to us. This conference and this panel, however, are part of a dynamic open system. I present my remarks with the hope that the interface between my comments and the comments of Dr. Pickles and the other panelists will provide novelty and stimulation.

Ann has a horrendous history of abuse. The background of her childhood reflects a paucity of alternative viewpoints to challenge her prevailing ways of organizing experience. While it is tempting to ascribe responsibility to Ann's father, the paternal grandmother's role in turning her over to him is also significant for the patient who says: "Why, no matter what I did was it ever enough for her? What was it she really wanted from me?" Thus, the patient was faced with multiple interlocking contexts, grandmother and father, that reinforced the central perspective that she did not belong to herself. Also, the patient was increasingly sequestered away from friends and a social life, particularly as she entered adolescence. This additionally de-

proved her of the potential interaction with peers that might have provided her with some recognition of her plight and the possibility of viewing herself differently.

At the beginning of treatment, Dr. Pickles skillfully noted Ann's increasingly withdrawn reactions to comments about the source of her problems. Ann experienced Dr. Pickles's formulations about the origins of her sense of badness as invasive and as an attempt to infiltrate her experience with the therapist's vantage point. As Dr. Pickles states, when she began to listen more carefully without attempting to illuminate the cause of her patient's problems, there was a notable shift in ambiance. Part of the early bond was facilitated by Dr. Pickles's acknowledgment that in fact she couldn't know exactly what it felt like to be Ann but could only imagine how terrible it had been.

The struggle to disengage from the enmeshing requirement to see herself as bad and as a "piece of garbage" had thus been joined initially by Dr. Pickles by promoting her viewpoint that the patient was not bad or disgusting but felt that way because she was treated as though she were disgusting. The dilemma in this formulation, which continues during the treatment, is that Ann feels caught between two alternative viewpoints, her father's and the therapist's. I think it would be valuable to explore in depth the details of Ann's past and ongoing experience. How did she think she was bad during her childhood or in the present time? What had she done that felt disgusting or deserving of retaliation? What were the specific moments that were interwoven into these self-punitive themes? These particular fantasies and details that underlie the rigidity of feeling like "a piece of garbage" are specifically meaningful in giving opportunities for creating alternative narratives.

During her childhood, Ann developed stoicism in response to her terrible abuse. Her defiance and refusal to cry were motivated by a wish to not give her father the satisfaction of seeing her reactions. Clearly, Ann's subsequent dissociation was an adaptation to a toxic, sadistic, and inhuman context. This adaptation protected her from registering certain affective experiences and also preserved a sense of efficacy by noncompliance with his wish to make her cry. Dr. Pickles states: "Her strength served her well; proving her father wrong was a powerful organizing theme that allowed her to use her resources to go forward with her life." In actuality, Ann has suffered from an inability to experience him as wrong. Her sense of competence could only be felt as defiance around limited affect, that of not crying. The problems subsequently addressed by Dr. Pickles in this treatment are
that this adaptation has left Ann with impaired capacity to identify and integrate experience. Disassociation and disavowal, reactions to an overwhelming sense of trauma, remain part of a continuing process to manage affect. The legacy of her early years was a capacity for stubborn defiance, as she had no opportunity to develop thoughtful opposition or a sense of healthy accommodation. I am drawing attention here to the distinction between pathological accommodation and healthy accommodation. Flexibility and accommodation to others in the fulfillment of personal ideals is an aspect of all relationships. This patient, faced on every level with requirements to surrender herself, would necessarily have difficulty in developing an experiential distinction between the two dimensions.

I will now look at several moments in the psychotherapy. The first episode concerns the events leading up to Ann’s elective surgery to remove scars caused by her abuse. Ann was clearly in a state of conflict as her husband was urging her to do the reconstructive surgery. As Dr. Pickles states, “To cover up the scars through surgery felt to her like a denial, once again, of her abuse, leaving her to act as if everything was OK. With me, Ann spoke strongly against the surgery. When I explored the possibility of her expressing her reluctance to her husband, she first contemplated doing so, but after leaving the session, she went through with it without voicing her concerns... after the surgery, she withdrew from her husband because she felt that he and the surgeon had railroaded her into the operation.”

At the initial juncture during which Ann opposed the surgery, I would have reinforced for her the significance of finding her own feelings about such an important event. The importance of actually identifying and integrating her affective experience is a developmental achievement. I would have inquired why, if she felt strongly against the surgery, would she contemplate having it and surrendering herself? This conflict within her can be seen as constituted by a pull toward a familiar pattern of experience, the requirement to do what was expected of her, and a hope, reinforced in her analysis, to capture a new essence.

I would have vigorously supported her not having the surgery, only because that is the way she felt. I am not saying that the outcome of my interaction with her would have led to her not going ahead with the surgery. Perhaps, on a deeper level, her husband’s interest in her having the surgery provoked in her an intense reactive pull to automatically oppose him and a revival of her old defiance to preserve space for herself. In this case, with further examination, Ann may have eventually come to the conclusion that the surgery was actually in her own best interest and that her initial opposi-

tion was defensive. Alternatively, she might have become more consolidated around a view that removing the scars was an external manifestation of an attempt to cover over the painful emotional residue of her abuse, a search for an antidote to feelings of self-loathing. In this case, resisting the enactment and contemplating her deeper feelings would be a preferred course.

The sequence that follows the surgery, however, requires Dr. Pickles to explicate Ann’s husband Rick’s motivations. As she says, “I wonder if there might be a misunderstanding between you and Rick. Everything you told me implies that he actually was trying to do what he thought you wanted. Since you hadn’t told him otherwise....” The context, which is not addressed here, resides in the relationship with Dr. Pickles. Ann needed the therapist to forcefully interpret her fear of sustaining her own subjectivity, especially regarding an act of physical intrusion—the surgery. It is possible that if Dr. Pickles had explored more deeply the patient’s doubts about having the surgery, there might have been an opportunity to challenge/question her familiar pattern of disarticulating experience in order to maintain a tie. Accommodating her husband or her old perception that she is flawed is actually what is most comfortable.

Additionally, these events after her surgery provide an opportunity to examine the patient’s tendency to blame others when she is uncertain about her own perspective. Ann blamed her husband for her decision regarding the surgery. Also, she began intensely blaming Dr. Pickles for pressuring her to acquiesce to being presented at the conference. It seems clear that the patient’s capacity for self-differentiation and individualized thought was unrelentingly undermined in her childhood. I think that Ann could benefit from an awareness that she tends to blame others after she makes decisions, while feeling an internal pressure to accommodate. I realize that both the timing and presentation of this pattern of surrender and subsequent blame is a delicate issue.

The next situation that I wish to talk about concerns Ann’s response to Dr. Pickles’s proposal to present the patient at the conference. Ann reacted with a series of questions about how it could affect their relationship. She was clearly able to reflect on some of her own misgivings. She stated, “What if I read what you write and I never come back?” In addition, she articulated her fear about saying no to Dr. Pickles. She said, “Now I have to worry, especially since it’s easy to see that you want to do this. I wouldn’t want to say no.” The patient expressed her fear of being a disappointment, “that I’m not being what I should be, whatever that is.”
After this session, Ann called Dr. Pickles. She was worried about “her initial assertive, bold, and insightful reactions to my proposal. She left me a message, apologizing, saying that she hoped I wasn’t angry or upset.” Dr. Pickles called her back and reassured her that she wasn’t angry. She said to the patient: “Not only was I not upset; I welcomed your forthright responses. I sensed that something changed for us in our last conversation.”

The patient’s initial response to the request to be presented emerged as a questioning and assertive attitude, including a fear that she would be unable to say no. She called later and apologized, feeling fearful that Dr. Pickles was angry with her. The choice of the therapist at this moment was to provide reassurance that she was not angry. A dynamic view of this situation emphasizes the possibility of a relationship between her original state of confidence and the subsequent apology. I would see the issue that emerges as representative of Ann’s difficulty sustaining a sense of her own spontaneity and expansiveness. Dynamic systems theory might conceptualize this sequence as a new potential attractor of confident assertiveness, which is opposed by the powerful attraction of creating safety by apologizing and preparing to disown her experience.

I think that the patient could benefit from understanding the sequential nature of this event and an awareness that it was a manifestation of her difficulty in regulating states of well-being. In the transference, Dr. Pickles has inevitably become assimilated as requiring the patient to surrender herself. Ann was fearful that her prior comments would jeopardize the tie with Dr. Pickles. Underneath this familiar sequence is the threat of change and the specific danger of states of expansiveness. At this particular moment, therapeutic reassurance may act to foreclose an awareness of this sequence and the patient’s difficulty in regulating confidence and assertiveness. An interpretation of this sequence as opposed to a reassurance might reestablish the tension within the patient about the fear of change and the unfamiliarity and discomfort with new states of personal agency and self-differentiation.

Many authors in our field have described the fear of change and specific danger mobilized by states of expansiveness. Burke (2001, unpublished manuscript) has discussed several patients who had difficulty sustaining states of expansiveness and notes the “disassociation and lack of awareness of the sequential relationship between expansiveness and the subsequent emergence of familiar dysfunctional patterns.” She also emphasizes “the inherent anxiety in confronting entrenched patterns” and notes that “the therapist’s stance should facilitate the tension between old and new pat-

terms of self-organization so that patients do not foreclose too early on novel and painful choices.”

Brandchaft (1994) also describes the importance of this process. He states: “The anxiety that accompanies the shift that occurs each time the person strives once more to break from the constraints of established principles of organization and the habitual processes built up over a lifetime may be so subtle as to escape notice” (pp. 72–73). He goes on to state: “The attempt to organize experience in a new way frequently results in a pervasive and disarticulating doubt about the truth of subjective experience. However, if the context in which this experience regularly recurs can become familiar to the patient, that is, if it regularly follows an attempt to free himself from a constricting relationship, ... he will recognize it as a sign of forward movement, even if it is subjectively frightening” (p. 74). Reassurance and attempts to normalize states of anxiety and dread can potentially undermine and cover over the awareness of the anxiety and disruption that accompanies change.

I do not want to be misunderstood as advocating a lack of warmth or environment devoid of mirroring responsiveness. I am describing the importance of a particular nuanced sensibility about system change and a deepened awareness of the potential benefit, along with the cost of dampening affect.

The last issue that I would like to address concerns the communication between Dr. Pickles and Ann about the conference presentation. I will leave aside the details of a more personal response except to say that I am not sure that the patient had the sense of agency to actually say no to this request. Here I will defer to Dr. Pickles; she was there and was able to make the judgment. The issue that I do raise is the free time spent outside of session to discuss the presentation. This was suggested initially by Dr. Pickles and then withdrawn. Then, when the patient became enraged and “objected to using her time and her money to talk. ...” Dr. Pickles responded by going back to having Ann decide if she needed free time to discuss her feelings about the presentation.

Operating from a dynamic systems framework, it is not possible to isolate feelings about the presentation from the therapeutic relationship. The dilemma that faced the patient was the process of choice and conflict surrounding self-delineation and compliance. The notion that one can effectively separate and identify affective experience specifically is not dynamically coherent. It has the potential to reinforce the patient’s presenting problems with disavowal by indicating that certain experiences are reduc-
Editors’ Commentary

on the Five Discussants’ Views

JUDITH PICKLES, PH.D.
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OPENING PROCESS

In the first section of her paper, Dr. Judith Pickles describes the opening process of her work with Ann. In response to Ann’s self-presentation as sad and disgusting, Judy offered the distinction that Ann feels bad and disgusting because she was treated as if she were bad and disgusting by her abusive father and her critical paternal grandmother. While Ann at first responded positively to this alternative view, soon she began to protest, and Judy came to understand that her challenging Ann’s view represented for Ann a repetition of the original trauma of having her reality denied.

Several of the discussants responded to this extended interchange. Jeffrey Trop conceptualizes the problem for Ann as being caught between two subjective worlds, that of her father’s and that of her therapist’s. Dr. Trop then makes a connection between the enmeshed perspective that Ann struggled with and continues to struggle with and her inevitable surrender of herself to the other in a pathological accommodation to that other’s point of view. Along the way, Trop makes a distinction between such pathological accommodation and a healthy accommodation generated in the service of one’s own values and ideals. Trop notes that Ann, in the historical context of having had to surrender herself so extensively, would justifiably confuse these two discrete ways of joining with another.

Harold Sampson delineates two sets of responses that Ann makes to Judy’s initial interpretive stance. Initially, Ann understood that Judy would