Obsessional Disorders: A Developmental Systems Perspective

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The paper resumes the discussion of obsessional disorders in view of developments that have followed the 1965 Congress of the International Psychoanalytical Association when the last systematic analytic discussion of the Obsessional Neuroses took place. The paper reexamines principal contributions to that congress in an attempt to understand the failure of psychoanalysis to favorably influence the course of these disorders. It notes the subsequent findings of a burgeoning field of child observation that have called attention to the larger infant-caregiver constitutive system within which the intrapsychic phenomenology of the obsessional neuroses is produced and maintained. It draws attention to the crucial impact of the analyst and his causal theories, insufficiently recognized at the time, in the co-determination of the course and outcome of analytic treatment and proposes a contextual systems approach to the reconfigured understanding of normal and pathological development.

The paper discusses the special role of cumulative trauma in the infant-caregiver system on the formation of enduring obsessional and compulsive patterns. It suggests that in the traumatic developmental system, endangerment to the self and
unbearable pain are ever-present threats to the child, and protective strategies, including importantly the processes of pathological accommodation, occupy a primary motivational status. It describes the automatic shaping of subsequent experience by the internalization of such processes in template formation. Freud’s emphasis on aggression and unconscious guilt in the pathogenesis of the obsessional neuroses system is reexamined in the light of the contextual perspective proposed, and a clinical excerpt is offered to illustrate the thesis of aggression and guilt as contextual products of a traumatic developmental system. Special considerations that enter into the reconfigured analytic treatment of obsessional disorders are proposed, and some observations follow about problems commonly encountered in the new approach.

The paper argues for the systematic extension of the quintessential psychoanalytic tools of empathic-introspective investigation and illumination into the contextualization of inner experience in a fresh approach to the psychoanalytic treatment of these disorders.

Freud (1926), at the age of 70, concluded that the problem of obsessional neurosis, “unquestionably the most interesting and rewarding subject of analytic research,” had not been mastered. This opinion might well have been delivered today, for the illness remains tormenting not only to those who suffer from it but to those who try to understand and treat it psychoanalytically. Psychoanalysis was built on the study of hysteria and obsessional neurosis. However, “obsessional neurosis has actually become more perspicacious and familiar to us than hysteria, and we have learnt that it displays certain extreme characteristics of the nature of neurosis most glaringly” (1916, p. 258). “No other mental phenomenon displays with equal clarity the human quandary of relentless and unceasing battles between innate impulses and acquired moral demands,” Anna Freud noted (Nagera, 1976, p. 9).

Discouragement with the efforts of Freud and his followers to treat obsessional neurosis has had a profound effect upon the subsequent history of psychoanalysis. It brought to an end the “golden era” psychoanalysis had enjoyed at the close of the Second World War, and disillusionment with the therapeutic claims of psychoanalysis more generally has contributed to the diminished support for psychoanalysis in psychiatric training centers and the general population. It lent powerful encouragement to proponents of extra-psychological causation, as well as to a variety of non-psychoanalytic approaches to the treatment of psychological disorders. While only the potential of specific psychoanalytic concepts had been exhausted, not that of understanding itself, a body of work has been introduced that bases itself on theories of the “therapeutic” power of nonspecific relational factors. The shift frequently has taken place at the expense, rather than in the service, of intensive analytic inquiry into the “relational” dimension of experience itself. In new perspectives, distinctive contributions that psychoanalysis might make have been bypassed, as, for example, a therapeutic bond based on a passionate commitment to sustained investigatory focus on the unfolding relational context within which enduring patterns of compulsivity can be seen to emerge and maintain themselves; a therapeutic process which permits observations of second to second shifts in affect states so that distinctions can be made between primary and reactive factors in pathogenesis as they are revealed at the interface of interacting worlds of patient/analytics subjectivities; and a method in which reflective self-awareness and shared understandings encompass inner life as it unfolds in depth. In these developments the discrimination between transformational change and behavioral cure and seeming cure are in danger of becoming obscured.

The therapeutic impasse, at the same time, has stimulated efforts to reexamine and reconfigure the human quandary that continues to generate such tenacious and widespread psychological morbidity. A half century after Freud’s (1917) paper, Anna Freud deplored the scarcity of original findings, and characterized the main bulk of publications after Freud “as merely amplifying and corroborating.” She emphasized that the psychoanalytic descent into the obsessional neurosis would have to await the creation of new conceptual maps (Nagera, 1976, p. 9).

This paper will propose a developmental systems perspective for an understanding of the predisposition and focal psychopathology of obsessional disorders. It will reconsider the primitive strata of experience within which obsessional patterns have been laid down
and become resistant to change. It will bypass the diagnostic distinctions of DSM II and IV categories, pleading that they belong to the realm of clinical psychiatry, were not established on the basis of psychoanalytic investigation and involve a different frame of reference and discourse. In the discussion which follows, I will treat them as expressions of a common underlying psychopathological pathway, referring to "obsessional disorders" as comprising both obsessive and compulsive features, acute and chronic, in the manner in which Freud first distinguished the syndrome of the "obsessional neuroses."

**Historical Notes**

The last systematic discussion of Freud's Obsessional Neurosis appeared in the psychoanalytic literature following the 1965 Congress of the International Psychoanalytical Association (Eisman, 1988). Neurobiologists have attempted to fill the breach with more aggressive pursuit of OCD research. Their shift in emphasis raises questions, if it fails to provide definitive answers, as to the formative role of early experience in shaping symptom and character formation. It leaves unanswered the central question of the extent to which gene expression is determined by environmental transactions in any specific individual and at any given time. This nature/nurture interrelationship "has led one researcher (Kandel, 1983), working at the cellular level, to comment that enduring psychotherapeutic effects may have their final common pathway at this level" (Emde, 1988a, p. 25). Experience with patients treated psychopharmacologically for this disorder supports Freud's (1917) observations. The drug can down-regulate the intensity of the symptom and, perhaps, dilute its recognizable effect, "but not remove it" (p. 259). In a similar vein, psychopharmacology can displace psychoanalysis but not replace it, even while adding additional complex contextual factors, e.g. the impact of the analyst's confirmation of an incurable flaw in the patient, a core constituent in a developmentally determined pathogenic compulsive belief system (Orange, Stolorow, and Atwood, 1997, pp. 45–47).

In her comprehensive summary of the psychoanalytic knowledge then available, Anna Freud (1966) noted the wide range of its occurrence and severity of the obsessional neuroses, expressing her conviction that the structural theory offered the essential basis for understanding. She reiterated her father's views that the role of warded off impulses belonging to the anal-sadistic stage was central. Incorporating findings of ego psychology, she described the pathogenic conflict as between these impulses and a variety of specific defense mechanisms. Tying the onset of obsessional neurosis to a particular level of ego development and closely following her father's formulations (Freud, 1926, pp. 112–118), she asserted that the obsessional defense sets in if the ego matures more quickly than the drives and sets the preconditions "where the individual regresses libidinally from the phallic to the anal-sadistic level while ego and superego retain their moral and aesthetic standards."

The 1965 Congress took place in a historical setting in which persistent questions were first being raised concerning the relative roles of intrapsychic and environmental influences. In her response, Miss Freud mentioned the influence of severely obsessional parents and traumatic events during the anal phase as contributory environmental factors. She returned to her emphasis on intrapsychic causality, however, citing "intrasytemic contradictions" such as love-hate, feminine-masculine, present in everyone as normal ambivalence, but persisting in obsessions because of ego dysfunction. "It is the failure of fusion and synthesis above all which determines the occurrence of an obsessional neurosis" (1966, p. 117). Miss Freud's statement was a summary of the extent to which the contributors to the Congress had been able to penetrate the disorder, and it defined the limits of their understanding. "Why this happens," Miss Freud concluded, "is an open question still... Perhaps where excessive amounts of aggression are turned inward against the self, the individual becomes torn within himself and develops a preference for inner strife as opposed to striving for inner harmony... for the obsessional it is, then, as natural to be at cross-purposes with himself as he is invariably at cross-purposes with his objects. Aggressive argumentation and hostile attitudes to the environment run parallel with the torturing relationships which exist between his inner agencies" (p. 117).

The trends toward diversity that have subsequently become a prominent feature of the psychoanalytic literature (Lear, 1993; Gill, 1994) impart a special interest to the 1965 Congress. Winnicott (1966, p. 144) was critical of the understanding which surfaced around the
case presentation. He disagreed vigorously about the role of the child's sadism in relation to his mother, emphasizing, instead, an aspect of the mother's relation to the infant that was overlooked in the presentation. He suggested "a stage of absolute dependence, before the infant has separated out the mother from the details of the infant care provision" as the setting within which difficulties predispose to obsessional formations (p. 144). Greenon (1966) observed "Frankie suffered from a mothering-deficiency disease, as a consequence of which he could not differentiate and individuate himself from his mother" (p.150). These investigators were calling attention to a larger infant/caregiver constitutive system, stimulating interest in the direct observation of the developmental process and foreshadowing a fresh look at the analytic transference which had provided the basis for psychoanalytic reconstructions of developmental pathogenesis. Increasing recognition of the impact of caregiver on the development of the child was to proceed hand in hand with increased attention to the impact of the analyst and his theories, not as outside the psychological field, but as intrinsic to the data observed and psychoanalytic course (Kohut, 1977; Schwaber, 1983c, 1986). The complex domain of intersubjective relatedness was opened to sustained investigation and questions might be raised and understanding expanded in a closer look both as to what psychoanalysts were attempting to treat in the obsessional neuroses and their failures thus far to do so effectively. A moment in science had arrived "in which the emergence of new knowledge depends on new integrations of previously separated domains" (Sander, 1992, p. 583).

At the time of the 1965 Congress, Melanie Klein (1950) was a widely respected authority on obsessional disorders in children. Donald Meltzer (1966), discussing the case from the Kleinian perspective of the time, emphasized the role of anal masturbation, "far more widespread than the analytic literature would imply," and disagreed with the implication of severe pathology that had come to be attached to the practice. He linked obsessional symptoms to concepts of "false self," "pseudomaturity" and "as if" personality, observations not incompatible with those of Winnicott, but, following Freud and Abraham, maintaining that fixation at the anal sadistic stage was central in causation. He explained this fixation as rooted in a "preference for over-idealized (sic!) feces" as a concretized object over an available relationship with a live object as a defense against the intolerable affects which dependence entails. The strength of all such argument hung on the critical assessment of an "available relationship". Meltzer's (and Mrs. Klein's) assumption, borrowed from Freud, that for the infant, its object is a creation of its phantasy, is pivotal to the argument for endopsychic pathogenesis, and thus to his therapeutic approach. Meltzer used Klein's concept of unconscious phantasy as the expression of instinctual forces occurring at the most primitive strata of mental development, and, especially, the infant's need for objects to deal with the death instinct as its primary psychological task (Klein, 1957). In a footnote, Klein recognized that "the infant, incidentally, has some real grounds for fear its mother, since it becomes growingly (sic!) aware that she has the power to grant or withhold the gratification of its needs" (pp. 268–269).

The availability of a mother who is psychologically responsive to the basic developmental needs and affective communications of her child was widely assumed under the rubric of "average expectable environment" during that time, a presumption sharply contradicted by subsequent infant and child observation (Sander, 1976, 1987; Ainsworth, 1978; Emde, 1988a; Steele, 1994). The psychoanalytic approach to treatment was generally based on the belief that the infant's perception of its caregivers (and of itself) had been distorted by primitive defenses (splitting and projection) against an intolerable death instinct. The patient's perception, whether past or present, accordingly "was relegated to a secondary phenomenon, distorted by already present intrapsychic processes" (Schwaber, 1983, p. 21).

No systematic place was assigned to the impact of the observer and his theories on the elucidation and understanding of the transference from which the developmental theories were derived, nor on the "reconstructions" which were to form the basis of understanding of normal and pathological development. There was a failure to recognize that the analyst's perception of the subjectivity of his patient was a function of the analyst's own interacting subjectivity, hence a failure to investigate the constitutive role it might have played in determining the course and unsatisfactory outcome in analyses. In its attempt to "base its therapeutic efforts on the claim that its theoretical position possessed antecedent knowledge of the nature of psychic reality that was to be investigated" (Schwaber, 1983, p. 21), a circular and compulsive system had evolved as therapeutic context.
and had been transmitted transgenerationally in psychoanalysis and its training facilities: “Two realities, hierarchically arranged... the one the patient experiences, and the one the analyst 'knows'—the analyst as the detached scientist-observer comprehending a truer reality and prepared to clear the dark glass of neurotic distortion” (McLaughlin, 1981, p. 655). Psychoanalytic inquiry was entrapped and blind-sided, and psychoanalysis, to that degree, tended to become “an unquestioned and unacknowledged belief system, aiming at predetermined and thus extraneous goals... towards which the patient is led and which, on the basis of an unacknowledged dimension of his transference, the patient tries to reach (emphasis added)” (Kohut, 1981, p. 400). The “unacknowledged dimension of his transference... the patient tries to reach,” is that of “pathological accommodation” (Brandchaft, 1995), a process which I believe is basic to the understanding and treatment of obsessional disorders. Perceptive “dissidents” at the time of the 1965 Conference (Balint, Fairbairn, Bowlby) were already coming to realize that the epistemological stance and metapsychological theoretical structure of traditional psychoanalysis lent itself readily to an unrecognized and unacknowledged repetition of the developmental trauma its proponents were faced with treating. “The patient... can collaborate indefinitely with the analyst in the side of the defenses, being so to speak on the analyst’s side in the game” Winnicott (1965, p. 152) wrote, undoubtedly drawing not only on his observation of his patients but on his own experience as a patient as well. Riviere (1936), following her traumatizing analytic experiences with Jones and, subsequently, Freud, wrote of “a collusion between patient and analyst,” and expressed the opinion that “a great deal of therapeutic success in former years... actually rested, and still may do, on the illusion of cure rather than the fact” (p. 320).

Contemporary research on infant and child development suggests a revised understanding of the role of unconscious phantasy in development and obsessional disorders. The framework which has emerged takes as its focus the particular dyadic system formed by the reciprocal interplay between the worlds of experience of child and caregiver. Viewed from this perspective, unconscious phantasy appears as the outcome of intersubjectively determined lived experience, rather than as the expression of instinct and isolated intrapsychic mechanisms (Bowlby, 1988, p. 22; Steele, 1994), and depicts specific invariant processes that have come to organize the child’s attachment experience, from the most primitive, to its objects. It must be added here that in the subjective world of the mother, unconscious phantasy organized in her childhood, plays its own constitutive part in the quality of attachment that emerges as she nurtures her own child. In contrast to the “death instinct” of Freud and Mrs. Klein, and the instinctual aggression against the object and “primary sadism” which the theories of Ego Psychology hold as irreducible (Hartmann, Paul Gray, et al), the alternative viewpoint provides the basis for the contextual understanding of developmental trauma in contrast to the instinctual or intrapsychic. It holds that affective experience, and destructive feeling in particular, is context-rooted within a specific intersubjective developmental system. “The embeddedness of mind in context becomes an essential component of the concept of mind” (Crittenden, 1997).

In the pathogenesis of obsessional disorders, trauma (taken here as a state of mind responsive to extreme self-endangering threat) plays a special role. Trauma relentlessly undermines support for the establishment of the secure setting, external and internal, that is indispensable if the child is to develop a nuclear sense of confidence and purposefulness in its own being and expression. Accordingly, development in the traumatizing system will advance along a fundamentally different axis. The child’s central purpose will be harnessed to its compelling need for safety and protection, not from a “death instinct.” The danger it faces is that from the threat of continuing trauma from its ties to caregivers, and, in addition, that posed by the weakening or loss of connectedness to the only source of life-preserving protection it has known. An attempt to conceptualize such a pathogenic system was advanced in an intersubjective perspective on development (Atwood, Stolorow, and Brandchaft, 1984). “When the psychological organization of the parent cannot sufficiently accommodate to the changing, phase-specific needs of the developing child, then the more malleable and vulnerable psychological structure of the child will accommodate to the archaic needs of the parent, in order to maintain the needed tie at whatever cost to authentic self experience” (Miller, 1979, p. 69). The intersubjective perspective subsequently moved toward a view that all selfhood, including enduring patterns of personality and pathology, develops, is maintained within and is a function of the interplay
between differently organized subjectivities (Stolorow, Atwood, and Brandchaft, 1994). When the threat of trauma becomes preoccupying, the attachment becomes compelling, and *pathological accommodation becomes organizing process*. At an infra-symbolic level, a *template* forms and, largely beyond the corrective influence of reflective self-awareness and/or relational experience, continues to shape the conditions which the child perceives as promoting safety or danger. It predetermines what the child expects and believes is required of it, positively and negatively, in ensuing relational encounters including that with the analyst. The *template*, a condensate of what co-workers and I have described as "*invariant organizing principles*" (Atwood and Stolorow, 1984; Stolorow, Atwood, and Brandchaft, 1994) enshrines the basic principles that sustain, maintain and restore the pathogenic child-caregiver contextual system. The attachment system from its internalized position also leaves a crucial and enduring imprint on the child's self-concept, for the *self-experience of having a distinct and enduring existence will be heavily dependent on the child's recognition of the specific and familiar thematic referents in its human surround to which it has been conditioned to respond* (Stolorow, Atwood, and Brandchaft, 1994).

"The need to keep maladjustment in repair" is Bion's (1992, p. 99) elegant description of the living out of this paradoxical Faustian compulsive bargain. The patient's anticipation *and perceptions* of the analyst's wishes, needs, and expectations, together with the impact of the analyst's reactions, will form a continuing and fundamental dimension of the patient's self-experience. In analysis the template continues automatically to provide a silent subtext into which experience is assimilated, keeping the fears of displeasing, exhausting, or damaging the analyst and the threat of retaliation or loss of the tie ever-present. The interaction will inevitably contribute to replications of developmental trauma and initiate recurring obsessional states and their compulsive co-ordinates. However, the shifts into these domains are also re-opened thereby to renewed observation, dialogic investigation, and the hope of change.

In the incompetent system (Sander, 1987) of pathological accommodation, the pathways laid open and pursued continue to show a preference for traits that, from an evolutionary point of view, appear to favor the preservation of the species at the expense of the individual. "Common sense," Bion writes, "is a function of the relationship of the individual to his group, and, in his relationship with the group the individual's welfare is secondary to the survival of the group." The patient continues selectively to cling to noxious external relational ties and experience self-endangerment when these come under threat. In the inner world, similarly exhausting obsessive ruminations cannot be relinquished because they carry the unrecognized proxies for the insecure attachments of childhood. Obsessional preoccupations become "state-entrapment systems" because the person is unable to recognize them as trauma-produced disregulative disorders of the thinking process itself, just as he was unable to recognize the patterns of traumatic impingement, neglect and abuse as rooted in disregulated thought disorders of his caregivers. He continues to feel them as oracular prognostications and they serve automatically to initiate coercive organizations of thought and ritualized behavior.

The "current stimulus" to these "state entrapments" which characterize acute symptomatic OCD phases of this syndrome may be found to reside in fresh replications of developmental trauma that occur in on-going relational encounters, as in the analytic transference. Alternatively they may reflect a continuing primacy of the archaic contextual patterning of inner-world experience, as, for example, when the person's attempt to form new ties with the analyst reactivates states of mind and unconscious memories in which such attempts were responded to as betrayals and damaging to caregivers. Only sustained empathic inquiry, and its timely pursuit into microscopic and fleeting bits of experiential sequences, can protect the analytic process from premature influence of whatever explanatory theory the analyst (and/or patient) might embrace in order to put to rest the perplexing ambiguity disregulating shifts in the patient's state have brought to the surface.

At the center of obsessional rumination, the question "to be or not to be" persists, hopelessly conflated within the *template* of "should be," "should not be," or "should not be," or "have been." Choices are perpetually weighted with fiercely unforgiving and deadening unconscious sets of ancestral meanings and the dreaded consequence of object loss. In the precarious world of cosmic issue that has been created, no room exists for casual or random events, no space for trial and error or for the unfettered questioning of established conventions and belief systems. Self-delineation can be felt fleetingly
as liberating, and instantaneously as callous betrayal of deeper roots; harmony with one’s objects as mindless surrender and as enobling. In the pathogenic accommodative system, the person is enjoined from bringing his own reflective processes to bear in the service of freely exploring, questioning, learning and growing from what uncertainty and ambiguity might otherwise have uniquely to teach. In this connection it is impressive to observe how obsessional thinking consistently reconfigures an experience of object failure, or object loss, into “what have I done wrong?” agonizing. When the individual so attached embarks upon a differentiating course, a switch is thrown and “the patient is compelled to brood and speculate against his will. Indecision sets in, and with it a crippling foreboding, and the person is compelled to abandon the course which began with a sense of liberation, and re-instate one of self-hatred. The liberating organization and direction are repudiated in a propitiating avowal of self-blame. The unconscious bond is restored, and with it, an internal stability that had come under accelerating threat (Brandchaft, 1993).

Freud and Obsessional Neurosis

In his clinical description of obsessional neurosis, Freud noted three main characteristics, involving thinking, affects and actions, and he observed that symptoms in one or another of these areas typically dominate. The phenomenology of obsessive thinking is generally overlooked, he noted, and during analysis “the patient, who has hitherto turned his eyes away from his own pathological productions begins to attend to them and obtains a clearer and more detailed view of them” (1909b, p. 124). He emphasized the affect of “repressed self-reproach” which he related to early childhood sexual trauma and which could be transformed into any other type of unpleasurable affect as shame, brooding and hypochondriacal anxiety. Obsessional acts, the third form of the disorder, are always secondary, a defense against obsessional ideas and affects, and “against the derivatives of the initially repressed memory” (1896b, p. 172).

Preoccupation with unbidden thoughts, strange impulses and the joyless compulsion to perform ritualistic acts, all attest to the involuntary nature of the disorder. At this stage, the obsessions initiate a cycle of exhausting mental activity and the patient is compelled to brood and speculate against his will. Doubt relentlessly “begins to gnaw even at what is usually most certain (and) ends up in an ever-increasing deluge of indecision, loss of energy and restriction of freedom.” At the same time, Freud (1917) noted, “the obsessional neurotic starts off with a very energetic disposition, is often extra-ordinarily self-willed and as a rule has intellectual gifts high above the average.” (p. 258).

A consistent feature was the “psychological affinity between melancholia and obsessional neuroses” (1917, p. 8). A recent article notes that OCD “is continuously underdiagnosed or misdiagnosed in large part because of its co-morbidity with depression” (McAuliffe, 1994, p. 5). Depression invariably accompanies and may conceal chronic and debilitating obsessional ruminative thinking. The co-morbidity of obsessional disorders has been recently noted to extend also to a variety of symptom complexes, including anorexia-bulimia, substance abuse, Tourette’s syndrome, phobias and behavior disorders (Pray, 1995 pp. 38–41). The widening scope of OCD is generally attributed to an enhanced appreciation of the role of brain chemistry. However, these observations suggest that a wide range of disorders may have their common origin in specific nodal areas of traumatic developmental transactions, a possibility that calls to mind Freud’s observation that obsessional neurosis “expresses characteristics of the nature of neurosis most glaringly.”

Freud’s (1927) attempt to understand obsessional neurosis led him inexorably to the sense of guilt: “in obsessional neurosis the sense of guilt makes itself noisily heard in consciousness; it dominates the clinical picture and the patient’s life as well, and it hardly allows anything else to appear alongside of it” (p. 135). This concept formed the basis of Freud’s final understanding of the obsessional neurosis as an intractable resistance to analytic change, and, beyond, his explanation for the joylessness of human existence. From this perspective came Freud’s disheartening conclusion that psycho-analysis should content itself with the prospect of being able to change neurotic misery into ordinary human unhappiness. “In all that follows, I adopt the standpoint that the inclination to aggression is an original, self-sustaining instinctual disposition in man, and I return to my view that it constitutes the greatest impediment to civilization” (Freud, 1930, p. 122).

In obsessional disorders, a relentless underlying self-hatred exists, even when it is disguised beneath compulsive cravings for constant
reassurances of love and affirmation, as in “erotic transference” manifestations (Brandchaft, 1988, 1995). However, beneath such self-hatred are to be found profound feelings of worthlessness and despair at one’s utter failure to have brought joy into the lives of caregivers, when nothing else has been found to give meaning to existence, theirs and one’s own. Primal failure and incurable defect have been transgenerationally transmitted from within an incompetent developmental system, to become installed at the very core of the child’s “being.” They cannot be let go of, for somehow they have become both the defining link and protective talisman. When the child attempts to throw off shackles of abuse or accommodation, enveloping and spiraling obsessive ruminative states appear. The loss of object foreshadows terrifying states of estrangement and encroaching non-existence. Even rebellion or protective withdrawal are accompanied by a sense of worthlessness so that traumatizer and traumatized remain as one. A “borrowed cohesion” (Kohut, 1979) now serves the enduring purpose of restoring the tie. The meaning/beliefs encoded in such systems come fully endowed with the primitive aura of Absolute Truth and constitute a most serious resistance in analysis. When “fundamental change” is reconceptualized as involving liberation from confinement inside a closed system of archaic bondage, what “sets itself against recovery, and is dreaded as though it were a danger” (Freud 1923 p. 49) is the experience of approaching self dissolution signaled by the threat of disappearance of archaic bonds. “It is a matter of general observation,” Freud (1916) noted, “that people never willingly abandon a libidinal position, not even, indeed, when a substitute is already beckoning to them” (p. 244).

Such observations suggest a fresh understanding of the dilemma of human discontent. The “conservative character of instincts” as the route by which “civilized man” exchanges “a portion of his possibilities of happiness for a portion of security” (Freud, 1930, p. 115), needs to be reconfigured to take into account the transgenerational transmission of traumatic developmental systems ( Fonagy, 1993; Main, 1993). A system of pathological accommodation is the well-traveled route by which so many individuals feel compelled to isolate themselves from any defining essence of their own. Without continuing and sustaining support for fragile tendrils of self-delineation, happiness remains a fiction (Brandchaft, 1994). The system renders the individual insensitive to broad areas of his own experiential universe, and subsequently to that of his children, as such sensitivity was too little a part of the tradition established with his own caregivers. “Of the many types of psychological disturbance that are traceable to one or another pattern of maternal deprivation, the effects on parental behavior and thereby on the next generation are potentially the most serious” (Bowlby, 1988, p. 37).

Clinical Illustration

A, a young male business executive, in analysis for 3 to 4 months, had a past history of drug addiction which culminated some years before in hospitalization. He was a latchkey child raised in a midwestern urban slum area by a working mother who was away all day and a father who worked at a menial department store position. The parents’ quarrels frequently culminated in volcanic eruptions of temper and physical violence. An intense rivalry with an older brother with whom A was left during the day frequently led to savage reenactments of the sadomasochistic relationship of their parents. There was little place for comfort in A’s world, for his mother’s brittleness and vulnerability apparently left her with too little for herself. His brother shared her room while A slept in a room with his father and became “his father’s son.” The boy’s athletic talents, compulsively driven by what it meant to “lose,” became his father’s only source of pride, albeit “borrowed,” the two finding shelter in each other in this bleak domain. Such solace as A took from his father’s pride entailed heavy costs, however, for he came to feel compelled to keep feeding it by continually surpassing himself in order keep his father’s spirits afloat. In a recurrent dream, A was in a gymnasium, in a large pool which completely occupied the room. There were no ledges to the pool, the water enclosed within glistening tile walls stretching to the high ceiling. A was swimming furiously, and he realized that he had to keep swimming in order to stay alive.

The pattern for later symptomatology was set in this lonely childhood by A’s ritualized preoccupation, hitting a ball endlessly against a wall or pitching coins against a line until he was exhausted. Driven by his need to render himself unaware of an unbearable loneliness and a pressure constantly to be more than himself, the counting, checking and decontaminating rituals began, and he would be assailed by a merciless doubt and self-abuse whenever he fell
short. His childhood movements were circumscribed by an assortment of geographical prohibitions and sanctions were compulsively inflicted whenever he violated any of these rules, always in response to the expectation of abuse and loss such behavior entailed for him. Ritualized behavior continued to invade his later life, as obsessive rumination about what he had done, or should have, triggered interminable checking and endless brooding about money, weight, or dates he had or had not had. A suffocating template of who A felt compelled to be was encircling his existence. A early sought diversion in masturbation from the terrors of his battles with his brother, anticipation of his mother’s tirades, or just the unbearable meaningfulness of existence. Having discovered a source of some pleasurable relief, he was unable to disentangle himself from a fearful conviction of his mother’s omniscient presence and the anticipation of her crushing criticism. This internal circuitry became established as a permanent feature of his guilt-ridden experience of himself, its impact intensified whenever she assured him caustically, in whatever context, that she knew what he had been up to or thought he was getting away with. Later it would only require a raised eyebrow or a delay in her response time to reactivate the same circuitry. The pattern was set in this way for tormenting doubt and self-condemnation to assail whole segments of A’s inner experience. As this cycle early imprisoned his sexuality, it led to pleasureless exhaustion and set the pattern for later substance addiction.

As the analysis proceeded, A cautiously described a pattern of compulsive behavior. Late at night, he would seek a partner with whom to enact spanking and beating fantasies. These cravings had proved as irresistible to him as had his continuing masturbatory urges. As A sought to understand this behavior, a significant pattern emerged. These enactments always followed when he had avoided his mother for some time or had broken contact with her abruptly. Whatever transient comfort he found in avoiding her was inevitably eroded by the brooding pre-occupation which followed. The relief he had felt when he could pay attention to her noxious influence and distance himself from her presence disappeared because then he could not get her out of his mind. What he was doing to her now began to commandeer his attention and his mother’s reproaches and wounded expressions would fall upon him as encoded lashings. Any attempt to dis-entangle himself were followed by relentlessly inflicting the trauma upon himself. Trapped in this downward spiraling state of mind, his obsessionality would shift to erotic yearnings and, so driven, he would search out a suitable partner, confess to having been “bad”, and begin the purging process which would culminate in rituals of scolding or spanking.

As A’s relationship with his mother came to occupy the focus, his dreams reflected his enduring experience of her as a woman whose complaints and curses felt like whips. In one dream, A was huddled in a corner trembling with fear as she, sitting in boots and uniform, commanded her minions to beat him up. In childhood, A’s brother had discovered that he could ingratiate himself with their mother by goading A into voicing irreverent complaints about her and then beat him. In the evening, the brother would report these events. If A attempted to explain himself or seek to be comforted, she would respond caustically, “Don’t complain to me, you brought it on yourself!” His dream followed a letter of reproach about his neglect of her to which he had failed to respond.

Subsequently, A became painfully aware of how rigorously he had replicated the pattern of early neglect in his care of himself. His apartment remained as empty and barren as his childhood home. His decision to furnish the apartment led to such a flurry of doubting that he was compelled to put the matter into the hands of a decorator. As they were discussing plans panic overtook him and compelled him to end the consultation. Alone, a period of black despair and the “most utter aloneness” he had ever experienced descended over him so that it was all he could do to resist a renewed craving for cocaine. Spells of heaving began and he noticed that they brought a bit of relief from the feelings of deadness that had begun to develop, but for the next 24 hours he could not manage to hold any food or liquid down, and this added to his fright. The next day, a Monday, he appeared in great distress and reported that he had had great difficulty in getting to his analytic appointment. He spoke of “waves of unbearable aloneness” and having to fight against overpowering desires simply “to curl up and lie in bed in a vegetative state”. He felt in mortal danger and was considering checking himself into a mental institution.

Subsequently it emerged that A, in the throes of his panic state, had concluded that the analyst would get rid of him as too disturbed for analysis, and turn him over to institutional care and psychopharmacology. This anticipation had contributed a “last straw” to his panic and despair. As these fears were discussed in the next few
sessions, A came to recognize that the analyst might not think A’s distress was reason to get rid of him, but rather one for deeper analytic understanding. As his agitation subsided, he was able to discern more clearly that his violent reaction had been triggered by a growing sense of excitement at the prospect of freeing himself from his entrenched self-deprivation. Becoming aware that following such a seemingly innocuous intention had precipitated overwhelming chaos, A remembered a “remarkable” and frightening dream after he had finally fallen asleep following the conversation with the decorator. “I was in a field near a gymnasium. I looked up and to my horror there was a plane rapidly losing altitude and I had a sickening feeling (he was reminded of the waves of nausea that came over him the day before) as I saw the plane out of control and about to plunge to the ground. There was a loud roar as it hit and then everything burst into flames. I felt terrible and wanted to hide.”

A’s associations first went to his uncertainty over whether it was himself or his father in the plane, before settling on his now deceased father. He recalled his mother’s contempt for his father’s lack of success, and her interminable complaints of “not being taken care of.” He remembered that his father’s lavish praise of him was frequently interspersed with melancholic ruminations of “should have” and “should not have” that his father believed had accounted for his abject failure. He recalled that his father’s sense of self seemed to crumble whenever he contemplated a successful future for A that contrasted so depressingly with his father’s failure, and that ultimately A would abandon him. He remembered trying to combat his father’s obsessive self-flagellation by avowals that he would never be able to live without his father. Memories returned of dreams they had spun together turning their lives from disaster to sweet triumph. As he spoke, A became aware of his belief that his father’s expansive love had been his only under the condition that he allow himself no relationship whose influence on him might surpass that of his father, nor develop confidence in his ability to find his own way without his father’s management.

A’s move to furnish a house of his own threatened to lift him out of the squalor to which his pledge to his father had condemned him. He was now breaking the “contract” on which he believed his father had survived. The new tie to the analyst and the understanding it afforded was empowering A to reassess his earlier ties and raising his hopes to free himself of enslaving influences. At the same time, paradoxically, his new attachment to the analyst was threatening to dispossess the old. An unconscious archaic conviction emerged and began to torment him. He was removing his father’s only reason for living, and his own! The violent upheaval in the depths of A’s internal world signaled the impending rupture of the bond on which his own psychological survival had depended. The symptoms of estrangement and the approach of “a vegetative state” were fearsome reactions to this deadly threat.

Setting foot into a strange and estranging world of his own making was for A an experience very much like embarking on a bungee leap while leaving the tether behind. The dream also signaled, it emerged subsequently, intense fears of his growing dependence on the analyst and the accompanying terrors of betrayal and loss.

The View from Below

In this segment I wish to view A’s obsessional operations through a micro magnifying focus. I will take the position that theories of an “original, self-subsisting disposition” to instinctual destructiveness, or self and object entanglements of love and hate could not adequately explain the formations of central significance. I will try to show that these hypotheses bypass more fundamental configurations in which traumatizing developmental systems continue as central organizers of experience. In these systems, the infant’s experience, and subsequently basic aspects of its beliefs about itself, are surrendered to information derived from interacting pathological personality formations of its caregivers. The amalgam which persists is experienced as “true” or “authentic,” indeed frequently the only “real” self. “In many of the people we deal with, an authentic self-life or self-expression is beyond their reach—it remains for these like color to the color-blind” (Bowlby, 1988, p. 276).

The Stance of Empathic-Introspective Inquiry

The question of transformation in depth necessarily turns, not on the appearance of the product arrived at, but on the processes traversed or left unexplored. Commitment to the stance of empathic-introspective inquiry is based upon the understanding that self-experience is at the center of the psychological universe (Kohut, 1977 p. xiii), and that “meaning” is an essential property of subjectivity,
a self-relational system in general. This goal requires especially that the analyst recognize the universal tendency to substitute one's own "understandings" for data missing from the patient (Freud, 1917; Bion, 1962; Schwaber, 1988, pp. 92–93). Such difficulty in suspending the tendency to substitute leaps of inference for observational data reflects an intolerance of uncertainty and constitutes a claim to the equivalent of Revealed Knowledge and a limitation in the ability to learn and especially self-correct from experience. "The essence of psychoanalysis lies in a passionate commitment to investigate what the particular characteristic has come to mean for the particular patient, and how, developmentally, it has come to have this meaning. In this enterprise it is essential that the analyst put aside his notions, however cherished, of what these experiences mean to his patient, even if, perhaps especially if, his notions contain what has become conventional wisdom. The analyst's preconceptions of what the patient's experiences mean are certain to be more illuminating of the analyst's mental processes, much less so of the patient's" (Bion, 1980 p. 25).

With these preliminary remarks, let us turn to A's experience. As A was encouraged to articulate what he had previously only been able to describe as being "alone," it became clear that masochistic preoccupation and enactment followed a regular and predictable pattern. An interaction with his mother, in person or by letter or phone, would occur in which he felt trapped and forced to listen to her complaints. In the preoccupying states of self-vilification and relentless " needling" of himself that always followed such events A seemed to lack the will or ability to find any defense for himself. These states resembled those of post-hypnotic suggestion and reminded one of the "programmed" behavior of the accused in the Moscow trials described by Koestler (1940). Early in his development, A had found that the only way he could bring her loss of control and accelerating violence to an end was by merciless criticism of himself. Warnings, when she was displeased, that she would send him away "for good," or leave and never return, were emphasized by icy withdrawals, so that soon no words were needed for him to feel compelled to convince her that he realized how awful he had been and how "really" sorry he was.

These states of obsessive preoccupation with her loss seemed to stem, not primarily from A's hatred of his mother turned round on himself, but from his attempts to break free. At first, he would feel

determined by the context within which it emerges and is maintained (Schwaber, 1983b). The stance of empathic-intrusive empathy is essential to the investigation of contextalized experience as it provides moment-to-moment focus on verbal and non-verbal cues that register the impact, intended or unintended, of the analyst's silent or stated interventions on the patient's experience of object and self. It affords access to defensive withdrawals and dissociated painful affect states and ultimately facilitates the articulation and understanding of the exquisitely personal meanings that are embedded in human experience and particularly the repetitions of developmental trauma in the patient. This view of mind as essentially context processing is hierarchical and multi-layered. It must take into account the on-going relational transactions, the background of meaning into which these events will be assimilated by each of the participants (especially the history of specific contextualized developmental trauma, protective strategies that each have developed, their co-contributions in the emergent process; and, finally, the complex ongoing dynamic and reciprocal relationship between these various factors. The complexity suggests the relevance to psychoanalytic inquiry of Sander's (1993) observations of the "vast complexity of determinants" and the "dangers of reductionism" in attempts to understand the developmental process itself (p. 281). The stance makes common cause with the patient's desire, latent or active, to first understand what he wishes to change. Such understanding belongs inextricably to an intrinsic motivation to order one's universe and is therefore an essential building block in a therapeutic alliance (Brandchaft and Stolorow, 1990).

On the basis of his observational research, Fonagy (1995) concluded, "It is clear that while certain individuals repeat adverse or abusive experiences with their children, others find a more adaptive resolution. (What) particularly distinguishes resilient individuals from those who remain damaged and damaging is a capacity to reflect on mental experience" (p. 245). The impaired capacity for self-reflection continues as a limitation in the psychoanalytic treatment of obsessive disorders where it can result, on the one hand, in its conflation with rumination, and on the other with reductionistic and unshakeable defensive convictions about the interpretation and meaning of events. The regeneration of the capacity for self-reflection and the recognition of human fallibility and mortality, are of primary and irreducible importance in a depth analytic process and indeed in
an oppressive burden lifting, but any feeling that his purpose had been to find protective distance from her abuse, was entirely canceled out from some domain entirely beyond his control. What he had formerly recognized as distinctly him, now belonged in another world. In its place he felt compelled to make sense of her feelings and justify her complaints as his initial feelings were being systematically redefined and repudiated. The “mental laundering” taking place were reminiscent of “hand-washing” rituals which had been designed earlier to rid himself of the contaminants that were “driving her crazy.” Spasms of self-hatred began to seize him as he kept reminding himself of his “utter lack of appreciation,” “selfish neglect,” and pain he “continually enjoyed inflicting” on her, and these came more and more to define him for who he really was. As his mind turned to the relentless consequences she had assured him he was “asking for,” and for which he would have “only himself to blame,” he felt spasms in his gut. In this state of obsessive foreboding, his inner world came more and more to resemble the world of his childhood. He remembered being alone and feeling transfixed to his bed, trapped and forced to listen to the tragedy he had made of her life. The feeling returned that he was the embodiment of some evil penance that had overtaken her life, and he felt compelled to join her by enacting it upon himself. Beneath the downward spiraling he was living a form of archetypal traumatic memory, but it appeared to him to be a clairvoyant glimpse into a predetermined future. An apocalyptic peril had been brought about because he had succeeded finally in driving her mad. With her destruction complete, every trace of his existence was now being erased from the face of the earth. However punitive and terrifying living with her had been, a life without her remained beyond his conception since no part of it had ever taken place.

Dissociation from awareness of whole segments of innermost experience, as brought to light in A’s stream of consciousness, forms an integral form of being in the continuing ebb and flow of the processes of selective disconfirmation and privileged attraction where the compulsive template of “shoulds” and “should nots” unconsciously regulates experience. The accommodative process creates a continuing need to sever connection with experience the caregiver(s) could not bear to hear and the child “should not” entertain, and a need equally to restore whatever connection would breathe a semblance of “life” back into the caregiver. Within the template formation, the archaic attachment remains frozen to become the breeding ground for the compulsive strategies designed to combat the extreme danger to the self associated with the loss of indispensable caregiver ties.

In a letter to Jones, Freud (1922) wrote, “But one important point soon emerged. She cannot tolerate praise, triumph or success, not any better than failure, blame and repudiation. She remains unhappy in both cases, in the second directly, in the first by reaction. Whenever she has got a recognition, a favor or a present, she is sure to become unpleasant and aggressive and lose respect for the analyst” (Freud, letter to Jones #364, 4 June 1922, quoted in Kris, 1994, pp. 655–656). The problem was to preoccupy Freud to the end of his life. “What do men want and show by their behavior to be the purpose and intention of their lives? What do they demand of life and wish to achieve in it? The answer to this can scarcely be in doubt. They strive after happiness; they want to become happy and remain so” (1930, p. 76). “Why then” he asked, “is it so hard for men to be happy?” (p. 86).

Sixty-five years later a contemporary novelist writes, “Early in my treatment, Alexandra told me to take a sheet of paper and write down a list of all the good things about my life in one column and all the bad things in another. Under the ‘Good’ column I wrote, ‘Professionally trained, well-off, good health, stable marriage, kids successfully launched in adult life, nice house, great car, as many holidays as I want.’ Under the ‘Bad’ column I wrote just one thing ‘Feel unhappy most of the time’” (Lodge, 1995, p. 23).

In 1923, Freud had described such experiences as characteristic of the obsessional neuroses and explained their occurrence in analysis as the ultimate resistance, the “negative therapeutic reaction”. “There are certain people who behave in a quite peculiar fashion during the work of analysis. When one speaks hopefully to them or expresses satisfaction with the progress of the treatment, they show signs of discontent and their condition invariably becomes worse. One becomes convinced not only that such people cannot endure any praise or appreciation, but that they react inversely to the progress of the treatment” (1923, pp. 49–50). Freud went on to explain this resistance as rooted in an unconscious sense of guilt, “the most powerful of all obstacles to recovery. In the end we come to see that we are dealing with what may be called a ‘moral factor,’ a sense of guilt, which is
finding its satisfaction in the illness and refuses to give up the punishment of suffering. We shall be right in regarding this disheartening explanation as final. But so far as the patient is concerned this sense of guilt is dumb... he does not feel guilty, he feels ill. This sense of guilt expresses itself only in a resistance to recovery which is extremely difficult to overcome. It is also extremely difficult to convince the patient that this motive lies behind his continuing to be ill: he holds fast to the more obvious explanation that treatment by analysis is not the right treatment for him” (1927, pp. 49–50).

In an earlier paper (Brandchaft, 1983) I described clinical experiences which had led me to question and then abandon my attempts to understand negative therapeutic reactions from the perspective of intrapsychic determinism, as proposed by Freud, and subsequently by Kleinian investigators (Segal, 1964; Rosenfeld, 1987). When my investigational stance shifted subsequently to a focus on the embeddedness of experience in intersubjective transaction, a compulsive sequencing became evident (1993, 1994):

What happened in my consulting room... was a faithful replication of what occurred when Patrick was by himself. Observing how his mental operations always came to ground zero in this repetitive self-negating process, I got a vivid sense of how like a cell Patrick's mind was. Each time the cell door opened and an innovative thought or exuberant feeling entered, it clanged shut again. Only by immersing himself in work to the point of exhaustion had Patrick been able to find some measure of relief. Whatever transient feeling of well-being, enthusiasm or hope, arose from some still-active spring inside himself would regularly disappear, relentlessly vitiated by some self-disparaging thought. Then the feeling of aliveness would be replaced by the more familiar empty malaise and joylessness that had pervaded his childhood (1993, p. 215).

Such patterned nullification, as Freud described in the passage quoted above, is insidious and ubiquitous. A surgeon appears at my office, glowing with pride at the result he obtained in a just completed complicated three-hour procedure. “Yes, but,” he remembers as his enthusiasm collapses, “I still can’t tie my surgical knots nearly as fast as the fellows who trained with me!” “My mother,” another patient reports wistfully, “always seemed to have a thousand and one tasks for me. But above all, she just wanted me to pay attention to her.” When he discovered the excitement in reading, his mother would open the door to his room and berate him for wanting to get away from her. Activities that opened life to a purpose for him continued simultaneously to render hers purposeless, and unbearable states of loneliness, sadness, and self-loathing set in whenever pleasure might have begun to find its way into the closed circle of his being. In the unfolding of these processes one can trace and re-travel the route by which the traumatizing developmental system has been replaced by one in which both the traumatizer and traumatized are now eternally linked in the inner world. One feels inclined, with Freud, “to doubt sometimes whether the dragons of primeval days are really extinct” (1937, p. 229).

Freud observed the data himself that supports such a contextual theory of developmental psychopathology as a systems incompetence, but he marginalized it, perhaps because it would contradict the theory that obsessional neurosis was firmly rooted in the “original, self-subsisting instinctual disposition of aggression.” His attachment to the theory preserved whatever concretized meanings the ultimate finality of a “death instinct” had come to have for him from within the context of his own primeval attachment experience (Gay, 1988, p.396). In a footnote, he (Freud, 1923) wrote,

One has a special opportunity for influencing it when this Ucs sense of guilt is a “borrowed” one—when it is the product of an identification with some other person who was once 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 Ucs. sense of guilt, the therapeutic success is sometimes brilliant, but otherwise the outcome of one’s efforts is by no means certain” [p. 50].

The footnoted observation would suggest a revision of Freud’s conclusion that the patient clings “to what has lost its value to him,” perhaps to “the patient frustratingly clings to what should have, but has not, lost its singular value for him.” Freud seemed to have clung similarly to his causal theories on aggression long after they had
exhausted their explanatory value. Wherever primeval attachments organize experience they retain their singular value in the protection they continue to afford against the ultimate danger from which there is no recovery, the loss of an object vital to existence. The revision brings into question the finality of Freud’s concepts of pathogenesis, placing these conclusions instead in the historical perspective of a science of psychoanalytic understanding whose horizons invite continuing psychoanalytic exploration. “Borrowed guilt” opens the path to fresh investigation of developmental trauma and context within which the processes of pathological accommodation “borrow,” support and maintain the unconscious sense of guilt. It leads directly to the functional domain of pathological attachments and the role they play in the pathogenesis of obsessive and compulsive states of mind.

**Attachment and Systems of Pathological Accommodation**

Attachment theory addresses directly the issue of response to developmental self-endangerment. The function of theory is not to represent ultimate truth, a leading investigator (Crittendon, 1997, p. 2) points out, as “truth is not always true or enduring.” Rather, attachment theory is to be approached on the basis of whether “it can improve the process of accumulating organizible information” in respect to the problems of developmental trauma and responses to self-endangerment in early experience, and what it can contribute to an understanding of the “sorts of meaning that might be found in the behavior of endangered people” (Freud, 1923, p. 50). Specifically, what can it contribute to a reconfigured understanding and a psychoanalytic approach to obsessional disorders?

In the years since Freud constructed his structural theories, the nature of the child’s tie to mother has become a field of systematic research. Considerable new data has emerged to alter and expand our understanding of the developmental context in which the predisposition to normal and psychopathological development are laid down. Steele (1994) remarked on the vast expansion of our knowledge of psychic development in the past 50 years far beyond the early concepts of libidinal phases outlined by Freud (1905) and Abraham (1916, p. 1011). Emde (1988) noted wide acceptance among researchers of a systems perspective of interaction in the developmental process. Bowlby and his followers have made significant contributions to a reconfigured understanding of the nature of normal and pathological ties in development. His work on the role of early trauma, that of Ainsworth (1978) on early parent-child interaction patterns and Main (1985) on “tentative analogies between insecure patternings of attachment and ego functioning” constitute core contributions of Attachment Theory. Bowlby defined attachment as the biologically determined predisposition of an infant to seek and maintain proximity to and contact with a caregiver to promote the safety and protection of the attached person, a disposition which persists and “changes only slowly over time” (pp. 28–29). By the end of the first year, behavior becomes organized and operates automatically. The making and maintaining of this bond is “postulated to be controlled by a cybernetic system situated within the central nervous system utilizing working models of self and attachment figure in relationship with each other” (1988, p. 120). The contextual genesis of the focal symptomatology noted by Freud and discussed in the previous section, the inability to sustain states of happiness, appears in the following: “The intensity and kind of emotion that is aroused depends on the relationship between the individual attached and the attachment object. If it goes well, there is security and a feeling of well-being or joy; if it is threatened there is jealousy, anger, and anxiety” (Bowlby, 1988, p. 4).

In patients with the background of insecure attachment, the child’s ability to maintain or restore urgently needed contact with caregivers’ whose self-regulating and self-reflective abilities are rigidly circumscribed, comes to depend on his ability to comply with the requirement that he hold himself responsible for his own unhappiness and for caregiver’s states of dysphoria. Consequently the child remains unable to sustain any happiness because the onset of such affect states tend to isolate the child from his surround. Such tendrils are nullified by the impact of traumatizing “borrowed guilt” that the child has failed in its preordained purpose to bring happiness to the lives of its unhappy caregivers.

Prospective studies have shown that each pattern of attachment, once developed, tends to persist. Crittenden observes that the onset of compulsions, “when danger is expected frequently,” may occur as early as the end of the second year (1977, p. 6):
As a child grows older, the pattern becomes increasingly a property of the child himself, which means he tends to impose it, or some derivative of it, upon new relationships, such as with a teacher, a foster-mother, or a therapist. The pattern of attachment assessed at 12 months is found to be highly predictive of patterns of interaction five years later [Bowlby, 1988, p. 127]. Cross-sectional studies have made it appear more than likely that these patterns persist in young adults, and all our clinical experience strongly supports that view [p. 129].

Bowlby's observations lend support to the importance of an internal “supra-system,” modeled according to the archaic developmental system, upon which psychological existence is believed to depend. (The concept of “internal supra-system” corresponds closely to that of “template” referred to previously in this paper—BB). Where pathological attachments characterized the traumatizing developmental systems, the initiation of a differentiating and self-delineating break-out from the rules of engagement, codified in the infra-system, signals the loss of contact with caregivers and the breakdown of supports for the sense of on-going “being.” Chaos begins to replace established order and the child's entire world, in which his connections with caregivers occupied the center, begins to crumble. The patient will repeatedly seek to limit or abandon any activity, including most importantly the psychological activity and understanding which constitute the tie in analysis. Even, perhaps especially, when he might have come to recognize that the analytic bond was opening the prospect of freeing himself, paradoxically it also awakens fears of “losing” himself, and he will continue to restore familiar enslaving attachments in his relationships and his internal world. The subsequent course and outcome in analysis, however, will be co-determined by the level of the analyst's informed understanding as that is experienced by the patient, and the analyst's responses will subsequently constitute his co-contribution to the intersubjectively organized attachment system that is present.

Attachment theory is an important theory about contextual determinants of observed behavior patterns. However, only an analytic process informed by a sustained empathic-introspective focus of inquiry can enter the world of reciprocal interplay between the subjective worlds of patient and analyst and the developmental systems which are at their roots. From this observational focus analytic inquiry and dialogue can clarify the illusive causal relations between the exquisite personal meanings embedded in attachment experience and the obsessive/compulsive patterns that are produced as endangerment is perceived to enter the interaction.

Understanding the phenomenology of obsessional disorders in the context of developmental trauma carries profound implications for the analytic treatment. Of fundamental importance are the exacting requirements for bringing into existence a secure context where one has never existed before and the recognition of impingements that degrade it from time to time. The concept of the bi-phasic nature of developmental trauma (Socarides and Stolorow, 1984/1985) and its role in shaping the experience of unbearable pain and extreme endangerment, helps us to understand the matrix in which it takes place. It also helps illuminate the pitfalls we are likely to encounter and the understanding needed if these are to be surmounted. The first phase is marked by repeated injury from neglect, abuse or impingement and painful feelings of disappointment, rejection and unworthiness. The wounded child, his resources already impaired, turns to caregivers in an urgent need to have them understand his distress and respond in a way that will restore a reparative connection of calming and healing. When, instead, caregivers react with wearied distancing (“he's just trying to get attention”), contempt (“he's always making a big thing out of nothing”), or additional abuse and blame (“it's his own fault, he never listens!”), a crushing second component is added. A psychological disaster is in the making as feelings of estrangement, devastation, utter “aloneness” and despair accelerate and threaten to inundate the mind of the child. An imprinting of the traumatic experience is taking place which may be reproduced subsequently in dreams of gigantic waves, crumbling cliffs, capsizing vessels, or an airplane crashing, as some replicating event threatens.

The patient with such a background begins analytic treatment with a hyper-sensitivity to perceptual cues, conscious and unconscious, verbal and non-verbal, that alerts him to danger, and he will react automatically according to a preformed anticipation of its impact and meaning to evidence that led to trauma in the past. The information-providing signal function of affects and the discriminatory capability that enables an individual to weigh probablistic factors in anticipating the future and determining
appropriate action or delay have been casualties in him of the traumatic developmental process. A child who has never been free of the expectation of danger is left with neither time, nor space nor the security of a support system for contemplation, and the development of these neglected functions awaits the opening of new pathways of therapeutic rehabilitation.

A developmental systems perspective introduces the far greater complexities of intersubjective transactional experience into the treatment of a disorder already considered sufficiently enigmatic as to have created widespread discouragement. However, the introduction of the new perspective also opens a central experiential domain hitherto inaccessible to the analytic tools of sustained inquiry and thereby the prospect of a wider data base with unanticipated possibilities for psychoanalytic understanding and therapeutic action. The analyst’s understanding of the connection between affect shift and the approach of a replication of developmental trauma can bring about his more sensitive attention to context over content. The creation of a therapeutic milieu secure enough to provide encouragement increasingly to the patient to confront his fears of endangerment, rather than disavow them, and articulate the preconceptions and experiences that are at work, becomes a primary therapeutic objective. It constitutes a special challenge when the patient may have had experiences with the analyst that have lent confirmation to these fears. Bringing these states out of sequestration and into the very center of the investigatory focus and dialogue makes it possible to disentangle the contribution of the analyst from that of the patient’s developmentally preformed expectations into which the activity has been assimilated. The analyst’s commitment to his stance will help bring him closer to the patient’s experience, serve to soften the patient’s helplessness and despair and limit the expected spiraling that has contributed to the patient’s fearful anticipation. The analyst’s analogous commitment to the introspective component of his investigatory stance, in concert with an appreciation of his fallibility, will provide a crucial element of safety relatively unknown in the patient’s developmental experience. The momentum of the analytic process may be sustained through the analyst’s informed self-corrective efforts at crucial junctures where insufficiently informed interpretation might otherwise have brought the process to a halt.

Critically important is the analysis of the patient’s persistent belief that he has to maintain the therapeutic connection by continuing to please the analyst or take responsibility for the analyst’s well-being. The discussion of these critical themes opens domains to inquiry which clarify the connection between the patient’s perception of endangerment and the onset of obsessive fears and compulsive behavior. The analyst’s expanding awareness of the reciprocal interaction between templates developmentally established of should’s and shouldn’t’s, for himself and his patient, can lead to an increased appreciation of the constitutive role they may play in producing accommodative or resistant responses in ongoing interactions.

Especially familiar and important are feelings elicited in the analyst by the repeated and seemingly interminable states of retreat and apparent cancellation of progress so characteristic of this disorder. Especially when they include strenuous disavowals of progress previously acknowledged by the patient are they likely to be discouraging to the analyst and wounding to his pride. I have described previously how a child’s central purpose becomes harnessed to a compelling need to do ever more to fulfill unsatisfied developmental yearnings and archaic needs of caregivers. From a background in which such elements have played a familiar role, an analyst will react with amplified feelings of responsibility when his patient’s unhappiness seems intractable. As the patient continues unrelentingly to communicate feelings of utter failure, the analyst will feel an unwelcome sense of his own “failure” and an unsettling foreboding about its consequences. To that quagmire will be added the drag of a “conventional wisdom” that remains deeply enshrined in the history of the unsuccessful analytic treatment of obsessive/compulsive disorders. The patient, in turn, will unerringly pick up cues of the overburdening impact his feelings are having on the analyst. Riven with doubt, either the analyst or patient, or both, may come to conclude that “analysis is not the right treatment for me.” The reciprocal interaction has activated in each the fear of the replication of a nodal developmental trauma, the tragic loss of an irreplaceable object. A set of beliefs in “incurable defect and hopeless future,” established in the antiquity of that trauma, may be undergoing reification and being brought up to date.
However, if the analyst can consider that he may be reacting, not merely and appropriately to the event and its presumably inexorable outcome, but from within an obsessional process, born of his frustration, in which the childhood trauma is being replicated congruently, he will be in a position to bring a revitalized inquiry and shared understanding into the interaction at the precise point where progress had become obstructed. Continuing inquiry may then be resumed into the problems presented to the patient by the threatening and depressive meanings of the analyst’s emotional state, and to an understanding of the developmental context in which such states came to acquire those meanings.

I have emphasized the tenacy of the “resistance to change” that accompanies a liberating fundamental shift. The resistance appears in the form of an intolerable anxiety, finding expression in a variety of channels, whenever the patient enters the domain of specific transformational change. Growing feelings of estrangement and loss embedded in the departure from the matrix of developmental attachments signaled by the opening of new pathways of experience may combine with increased fears of abandonment by, or loss of, the analyst to create an anticipation of unbearable pain and inconsolable grief. Fundamental change involves departures from life-long habituation to familiar sequences and modes of feeling, thinking and being. Consequently the drama will necessarily continue to resemble that which Freud and the psychoanalytic pioneers encountered and described so well. However, persisting in my attempts to understand this discouraging experience, I have come to recognize that the assessments that are made, always, and only, reflect the context within which they emerge. Advances in the patient’s understanding regularly appear to vanish when he once more comes under the grip of an obsessive danger. But whether such gains survive in some unseen domain will also depend on whether these tendrils of emotional growth are nourished or nullified by the analyst’s responses as their transience and relative insignificance may affect him and his own prefigured expectations of himself and his patient. When one is able to become reasonably comfortable in continuing to wonder and pursue the investigation of what is happening, in the place of discomfort in comparisons with what “should be” and is not taking place, change will frequently emerge. Evidence of such change is for the most part silent, slow, precarious and incremental, and it is more likely to occur when it “just happens” and is not being looked for. It may also sometimes turn out to be not the basis for retreat but for more enduring and far-reaching growth.

Conclusion

I return now to my starting point, the history of psychoanalysis and the task of reconfiguration of its focus that was set when the founders were able to frankly acknowledge their disappointment in the results of their therapeutic efforts. Far-reaching conclusions were drawn from the failure and a “crisis in psychoanalysis” followed which has not run its course. The “crisis” seems to reflect a kind of traumatic reaction, commonly shared, sometimes disavowed, that resonates with and runs parallel to personal disappointments so commonly encountered developmentally. However, we are left, as they were then, with an awareness of the appalling waste and unhappiness that continues to be exacted by psychological ritual and dysfunction, and the priceless heritage of psychoanalytic inquiry to bring to the task. The paper describes my attempt to overcome the trauma and resume the psychoanalytic discourse by an attempt to apply increased understanding to the conceptual tools which were then available. The obsessional disorders are no less “perspicacious and familiar to us” in our day than they were to Freud in his, and my attempt at reconceptualization and reconfiguration bases itself on the indispensable work they did with such added advantage as has been provided by information not available to them. My interest is sustained by the deeply personal wish to preserve the continuity and enhance the influence of what I regard as irreplaceable in the psychoanalytic enterprise—its reliance on the unique and continuing power of human understanding to face and overcome adversity in promoting emotional growth and improving the quality and heritage of being human.

REFERENCES


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