Chapter 12

Systems of pathological accommodation in psychoanalysis

COMMENTARY

By the early 1990s, Dr. Brandchaft’s distinctive clinical sensibility and his reconsiderations of extant theory had come together in a series of papers describing a tenacious defensive structure he had observed and its clinical treatment, and the stage was set for a fuller explication and elaboration of the syndrome he had identified as “structures of accommodation.” To delineate further the theoretical and clinical implications of his observations, in 1993 and 1994 Brandchaft produced a number of drafts of “Structures of Pathological Accommodation and Change in Analysis,” which were sent to a small number of close colleagues for comments. Although a published version didn’t appear until 2007, and the original manuscript was available only with Dr. Brandchaft’s consent, for over a decade the phrase “structures of pathological accommodation” or “pathological structures of accommodation” became increasingly widely known in the worlds of self psychology and intersubjectivity through Brandchaft’s own teaching and through the teaching and supervisory activities of his colleagues, students, and supervisees.

As depicted in the 1994 manuscript, structures of pathological accommodation arise developmentally in the course of repeated traumatizing interactions with caregivers whose personality rigidities prevent them from recognizing and sensitively responding to crucial aspects of the child’s experience. In such intersubjective systems, children maintain their attachment bonds by accommodating themselves more rigidly to the parent’s psychological world. The specific principles that characterize the child’s intersubjective interactions then come to constitute the child’s “psychological software,” for it is the interaction that becomes part of the child’s subjective repertoire and the basis for automatic processing. Even—and especially—when the early tie disaffirms or usurps the child’s own subjective experience, the need to sustain the attachment bond carries with it an enduring adherence to the principles through which it was formed, as these have acquired an inflexible rigidity due to the fear of loss of emotional
connection introduced by the traumatic impact of the parenting. In the adult, patterns so acquired are highly resistant to change as the psychological conditions inherent in the maintenance of the archaic bond limit or foreclose full access to and utilization of self experience.

Brandchaft originally made several points about this developmental deralement and its legacy. First, here and elsewhere, Brandchaft spoke of the self that is constructed as dependent on “borrowed cohesion.” This is a phrase Kohut originally employed (1984, p. 167) to describe graduates of psychoanalytic institutes whose capacity for initiative, originality, and creativity is delimited by their preemptory allegiance to their teachers’ views.

Second, in the analytic process, when moments of spontaneity and clarity are regularly supplanted by self-doubt, self-criticism, or confused, unproductive preoccupation, the patient may well be reproducing the sequence of an interaction regularly experienced developmentally. The patient’s own views, affects, or intentions are erased by him, just as once they were disarticulated in interaction with another. Such a disarticulating response to his own productions reflects the residue of the patient’s earlier intersubjective environment. The automatic, unquestioned patternning that eventuates is a major impediment to the capacity to reflect on and to learn from one’s own experience.

Third, the function of such emotional sequencing is the maintenance of the tie to the archaic object and the maintenance of self-cohesion. Episodic movement toward self-articulation provokes a terror of the loss of self.

Fourth, the patterned sequencing of thoughts or feelings are inscribed in organizing principles that operate continuously out of awareness. Though properly called “defensive structures,” these structures are different from defenses utilized to protect the self from new editions of psychological injury. Rather, they protect against archaic threats of disintegration due to self-loss and/or object loss and tend to emerge in those moments when an individual’s distinctiveness might otherwise become most apparent. Any experience of success or steps toward strong, proud adult fulfillment may trigger a retreat to self-debasing self-criticism or to debilitating worries about the object’s response in someone who has formed pathological structures of accommodation.

Fifth, the person so affected is enduringly compromised. “The individual feels there is always or imminently something wrong but cannot set it right” (Brandchaft, 1994, p. 23).

As exemplified by his use of the term “borrowed cohesion,” Brandchaft understood early that structures of pathologic accommodation operate in many social systems beyond the child–caregiver developmental context. In his 1994 contribution on pathologial accommodation, and again in the present one, he reviews developments in psychoanalytic theory and contends that previous theorists had come upon aspects of accommodative structures but failed to fully recognize them as such, due to their own allegiance to what he refers to as “the dictates of antiquity”1—modes of thinking infused with past authority that preempt the influence of fresh observations.

In the 1994 version, Brandchaft followed up his assertions with a detailed explication of the case of Mr. N (see Chapters 5 and 8), in which he demonstrated the layering of defense and resistance. He noted that resistances related to the defenses described by Kohut and named by Anna Ornstein (1974, 1991) “the dread to repeat” did have to be interpreted and worked through in order to establish a bond of security that made it possible to reach more frozen, more tormenting fears. However, Brandchaft emphasized that Mr. N’s more gradually revealed fears of physical and psychological death were he to lead his own life sustained by his own values were largely not based on fears in the transference. Nor could they be influenced, even by extravagant reassurance. Mr. N was trapped in a catastrophic, ancient developmental conflict from which he only slowly emerged. The capacity to recognize, question, and challenge constructs Mr. N had accepted as objective truth was a painful process marked by terrors of self-loss, sometimes concretized in somatic symptoms. The transformation that took place in Mr. N’s inner world involved breaking the ties between the only self he had known and the only security he had had in his childhood in order to free himself from a compulsive self-abasement.

In the 1994 version, the case of Mr. N amply illustrated the role of structures of pathologic accommodation in the psychoanalytic process and further demonstrated their intimate relation to the process of change in psychoanalysis. In his discussion of the case, Brandchaft included his own contribution to the intersubjective circumstance within which Mr. N initially accommodated to his interpretations and noted, too, Mr. N’s unspoken anticipation that Brandchaft would eventually adopt the same lack of faith in him that his parents showed. In the present version, which does not utilize the case, Dr. Brandchaft more forcefully states his belief that analysts, too, bring structures of pathological accommodation to the therapeutic dyad. The system created between patient and analyst may evoke countertransference responses bearing traces of the analyst’s own reactions to having been thwarted developmentally; such responses may incline the analyst to take refuge in the “dictates of antiquity,” becoming more rigidly wedded to theory and less open to hearing the patient. This, then, fully structures the treatment situation intersubjectively, thereby creating a context for the instantiation of the patient’s pathological structures of accommodation.

In explicating this principle, Brandchaft here utilizes an excerpt from a case published in the Journal of the American Psychoanalytic Association to demonstrate that pathologically accommodative interactions may go

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1 The phrase comes from Sir Thomas Browne’s “Enquiries Into Vulgar and Common Errors: Of Adherence Unto Antiquity,” quoted on the title page to Bion’s (1977) Seven Servants: Four Works by Wilfred R. Bion.
unnoticed even with sophisticated analysts as commentators who are intellectually aware that interactive dimensions inherent in the relation between analyst and patient are mutual and reciprocal influences on the analytic process. Brandchaft’s own suggestion of how one might respond to the patient in the clinical excerpt taken from JAPA demonstrates his clinical stance. He attends to minute shifts in affect, attempts to align himself with the patient’s state of mind including how the patient might be experiencing him, expresses his thoughts provisionally, and, most important, welcomes the patient’s comments, emendations, and self-reflections. Brandchaft is aware both that experience in traumatic attachment systems compromises a patient’s access to inner experience and that the reestablishment of comfortable access to distinctive thoughts and feelings cannot be taken for granted. Rather, for many, such access to personal experience is a hard-won emergent feature of a psychoanalysis utilizing a disciplined empathic-introspective approach in which a new attachment bond, in a new intersubjective situation, liberates the patient to know his own heart and mind.

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But the mortal enemy unto Knowledge, and that which hath been done the greatest execution upon truth, hath been a preeminent adhesion unto Authority, and more especially, the establishing of our belief upon the dictates of Antiquity.

—Sir Thomas Browne, “Enquiries Into Vulgar and Common Errors: Of Adherence Unto Antiquity” (quoted in Bion, 1977)

The history of psychoanalysis is in large part a record of the continuing reexamination and reassessment of the factors that promote or obstruct change in psychoanalysis and in life. This book falls within that tradition. In it I attempt to investigate structures of subjectivity laid down in development by “preemptory adhesion” to the “dictates of Antiquity.” It describes a profound and fateful obstruction in the development of the personality, especially in regard to self-differentiation and authenticity, and thus in the quality of life. Man’s adaptation to the world is dependent both on the learning acquired in the transmission of culture from one generation to the next, and on his ability to challenge the limits of accepted wisdom. In this vein, Thomas Kuhn once wrote that to be successful a scientist must simultaneously display the characteristics both of the traditionalist and of the iconoclast (Bion, 1977).

When the child is required preemptively to adhere to inflexible personality organizations which caregivers bring to the child’s needs for psychological distinctness, these earliest attachments exclude or marginalize spontaneous experience and second-thought metacognitive processes of self-reflection alike. The child’s ability to process new information and, accordingly, to self-correct and grow are impaired as its emerging sense of self is usurped. By virtue of repetitive processes, the child’s first reality becomes patterned into a set of immutable belief systems. These belief systems subsequently find their place in retrograde social systems in which authoritative first truths remain absolute. Transgenerational transmission results here in the natural selection and preservation of entrenched characteristics impervious to changing needs and evolving circumstances. The ensuing pathological accommodation continues to operate as an entrenched system beyond awareness that seeks to preserve life by imprisoning it in archaic bonds.

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

In my view, psychoanalytic investigation into the domain of pathological accommodation has as well profound implications for understanding psychoanalytic group relationships and for reexamining the transgenerational transmission of psychoanalytic knowledge in training facilities (Kirstner, 2000) from whence it enters into analyst–patient relationships. For the subterranean world structured in these professional interactions to be revealed, a determined effort is needed to understand the processes in which understanding itself, our own and that of our patients, is contextually constituted and communicated.

The subject of pathological accommodation has been repeatedly approached phenomenologically within the analytic literature during the past half century under such rubrics as as-if personalities, identification with the aggressor, bad and persecutory internal objects, and especially through

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2 An earlier version of this chapter, discussed in the commentary and written in 1994, was widely circulated in the intersubjective and self-psychological communities but has been omitted from this volume for lack of space. A revised version, upon which this chapter is based, appeared as “Structures of Pathological Accommodation and Change in Analysis,” Psychoanalytic Psychology, 24, 667–687.
Winnicott's contributions on false and true self structures. Nevertheless, I believe the operation of these structures has been insufficiently recognized and understood within the field. Analytic access to this realm, this subjective field of force going unexamined by conscious awareness, has been restricted because such investigation itself remained under the influence of basic belief systems that had already entered into the realm of "dictates of Antiquity." The metapsychological theories upon which the theoretical and institutional hegemony of psychoanalysis had been established internationally continued to be staunchly defended, while the intrinsic impact of the observer and his own psychological reality on the processes being observed in treatment remained largely unrecognized (Bowlby, 1940, 1958; Kohut, 1977; McLaughlin, 1987; Winnicott, 1965).

Gill (1994a) once termed Freud's discovery that he had been mistaken in believing his patients' tales of childhood sexual seduction "the single most fateful event in the history of psychoanalysis" (p. 140). Gill's contention deserves discussion. At that crucial juncture, a massive shift in theoretical and clinical emphasis occurred—at the expense of the lived interactive experience of the patient. What had begun as the investigation of complex contextual factors and their psychological elaboration turned to the study of the comparatively isolated impact of the biological and innate on psychological life. This new course of investigation, premised on an exclusive focus on the intrapsychic life of the patient, occupied the center of psychoanalytic discourse and thereafter determined the transgenerational transmission of knowledge in training facilities for much of the succeeding century. Its influence continues to the present day, infiltrating many of the new theoretical constructs and clinical practices that have evolved (see Stolorow, Atwood, & Orange, 2002). The field does not readily move past this originating shift in Freud's approach: "The continuing influence of Freud's writing is remarkably constant. ... It is a voice in which no other analyst has written because no other analyst has had the right to do so. The voice Freud creates is that of a founding father of a new discipline" (Ogden, 2002, p. 769).

However seemingly diverse the new developmental and clinical theories of recent vintage have been, and however seemingly removed from the founding doctrines (Fonagy, 2001), none is free of the potential for recruitment into the silent service of pathological accommodation. For the new developments have been assimilated each in their turn into new theoretical and institutional hegemonies, each with its own set of constricting fundamental assumptions. The extent to which any particular analyst, at any particular moment, is free from the imprisoning attachments of his own personal and professional development to think for himself remains the decisive, and by no means settled, issue.

Such observations as the foregoing reflect the extent to which I believe that enduring mental structures, including allegiances to abstract depersonalized organizing principles, can mirror the continuing influence of attachments to early objects, a statement that I believe applies to both patient and analyst. The transfer of attachment from object tie to unconscious and depersonalized organizing principles ("internalization") does not alter the fact that the tie retains the quality of those archaic attachments. The structures of pathological accommodation that persist in this fashion, like the original bonds, can be seen to regulate the first and only reliable cohesion that the individual has known. In this manner, the depersonalized principles tacitly protect against the unbearable terror of early object loss and the dissolution of selfhood whenever fundamental differentiating change might occur. In the process, repetition is inexorably substituted for change; ways of being remain determined by an other.

This chapter will maintain that pathological accommodation emerges ubiquitously in the clinical situation and is best illuminated when approached from an intersubjective perspective wherein an awareness of the continuing reciprocal impact of analyst and analysand is never far from the center of attention. This perspective permits understandings radically different from intrapsychic determinism to emerge, and these have the potential to clarify the distinction between the contextual and the intrapsychic and to illuminate their complex interconnection. Clearer recognition of false and true self-structuring, which oscillates almost instantaneously in treatment, together with the elucidation of the triggering contexts in which these shifts take place, provides a richer latticework for the recognition of, and for an effective approach to the treatment of, structures of pathological accommodation.

The recognition of development as a function of the infant–caregiver system (Bowlby, 1988; Emde, 1988a, 1988b; Sander, 1988; Stern, 1985; Winnicott, 1963) and the subsequent emphasis on the intersubjective developmental context of nuclear conflict (Atwood & Stolorow, 1984; Stolorow, Brandschaft, & Atwood, 1987) within which pathological accommodative structures come to be constituted have cast a new light on the problems of adaptation to reality, conceived earlier in terms of the intrapsychic movement from the pleasure principle to the reality principle. In the disorders I am describing, the reality that dominates is that of the caregiver in his or her impingement on the child resulting in the exclusion of whole domains of the subjective reality of the child. The expanding discipline of child observation in the past half century has yielded findings that have contradicted once prevailing notions about the quality of the "average expectable environment." These studies have resulted in an awareness of the widespread extent to which trauma embedded in the attachment relation, especially in very early development, is a primary etiological factor in what earlier had been ascribed to instinctual trauma or constitutional defect. In these disorders, the factors leading to breakdown are embedded in the total infant-caring system. They are inexorably reactivated within succeeding attachment systems, including the analytic transference, whenever an
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individual has remained psychologically dependent upon his or her ties to an attachment figure in order to sustain a belief in the continuity of his or her own existence.

Pathological accommodation in the history of psychoanalysis

From its start, problems around pathological accommodation formed a continuing part of the developmental fabric of psychoanalysis itself. Recognizing the role of unconscious structures in shaping mental life, Freud turned initially to the techniques of hypnosis. He observed, initially with equanimity, that hypnosis was marked by subjection and credulity;

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

Soon realizing that the process of inquiry under hypnosis was dominated by the suggestive influence of the analyst in conjunction with the accommodative inclination of the patient, Freud attempted to get around these obstacles by turning his quest for purer truth to the process of free association. Nevertheless, conceptualizations of the nature of cure in psychoanalysis continued to show, even celebrate, the hypnotic-like influence of the analyst, as in the following remarks by Freud to the Vienna Psychoanalytic Society in 1907:

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

There is a basic conflation here in that no distinction is drawn between compulsive attitudes of accommodative submission and voluntary wishes to please; both are being indiscriminately regarded as characteristic of "love." Accommodation out of love, with a respect for the legitimate needs of one's partner, is the successful outcome of healthy development and remains the sine qua non of any wholesome relationship. Pathological accommodation, by contrast, shows the continuing influence of traumatic developmental attachment experience and is marked by its essentially compulsive quality. The conflation of the two kinds of accommodation, ultimately rooted perhaps in Freud's ideological preference for love—hate as a primary motivational basis, serves to obscure the primary and underlying role of an unbearable terror of early object loss that drives attachments characterized by "credulous obedience." Freud's remarks here illustrate in their own way the crucial impact of the observer and of his theories and should make us ponder anew the extent to which masochistic self-surrender can be underestimated, confused with normal human experience, and idealized as exalted, most especially when these characteristics are given sanction by an authoritative attachment figure. Elsewhere, addressing himself pointedly to the intractable qualities of such attachments, and thereby tacitly attesting to the continuing life-and-death nature of the experiences they mediate, even when they reappear in depersonalized forms, Freud (1937) wrote,

Even in normal development, transformation is never complete and residues of earlier libidinal fixations may be retained in the final configurations. The same thing is seen in quite other fields. Of all the erroneous and superstitious beliefs of mankind that have supposedly been surmounted there is not one whose residues do not live on among us today in the lower strata of civilized peoples or even in the highest strata of cultural society. What has once come to life clings tenaciously to its existence. One feels inclined to doubt sometimes whether the dragons of primeval days are really extinct. (p. 229)

The problem of suggestion has not been laid to rest in psychoanalysis. Pathological accommodation, in which the patient automatically surrenders his capacities for self-determination and self-reflection, is an ever-present pathway that accompanies the formation of new attachment bonds. The unrecognized impact of the analyst and his investigative stance of presumed neutrality and privilege continue to provide a context of coercive assumptions that shape free associative processes and are incompatible with the essential conditions for free and voluntary discourse. To be sure, concern over the indoctrination of patients has persisted within the field and, indeed, has come to be shared by supporters and critics of psychoanalysis alike. Schwaber (1983), addressing the traditional view of transference, has noted pointedly its insistence on the dichotomy between the patient's experience of the analyst as distortion and the analyst's experience of himself as real. Together with Stolorow, I have discussed the serious and insufficiently acknowledged consequences of the clinical application of this position (Brandchaft & Stolorow, 1990). We have stressed our agreement with Schwaber that the only reality relevant to psychoanalytic inquiry is subjective: the subjective reality of the patient, that
of the analyst, and the psychological field created by the interplay between the two. More recently, Schwaber (1998) has ventured the intriguing further thought that “the central question is how do we discover in our clinical work what we had not before even considered” (p. 645). She describes a different mode of listening and observational stance which attempts to keep clear the delimitation of whose perspective we are referring to, patient's or analyst's, and she discusses the important, conceptual, methodological, and epistemological ramifications at issue.

The problem of resistance in analysis has never been free of the vexing question of what is being resisted and from whose perspective. Classical analytic theory, as it developed following the decisive shift described by Gill (1994a), regarded the resistances variously as those deriving from narcissistic inaccessibility, hostility toward the analyst, or “the most powerful of all obstacles to recovery,” an unconscious sense of guilt (Freud, 1923, p. 49). No less than narcissistic inaccessibility and hostility to the analyst, this guilt, which operates to undercut success in the treatment, derived from the realm of enduring unconscious intrapsychic instinctual forces in the patient: “It is possible to discover the repressed impulses which are really at the bottom of the repressed sense of guilt. Thus in this case the superego knew more than the ego about the unconscious id” (p. 51). In the previous chapter, I used the specific example of the obsessional neuroses to show how psychoanalysis, in its unquestioning adherence to Freud's underlying instinctual precepts, had brought psychoanalytic investigation of this condition to a halt. Freud's acknowledgment of his failure in regard to obsessional neuroses—“it has not yet been mastered” (1926, p. 113)—and the failure of succeeding psychoanalysts to do better (Esman, 1988; A. Freud, 1966) vis-à-vis this most pervasive and disabling of psychological disorders contributed importantly to the protracted and ongoing crisis in psychoanalysis over the years and more recently has helped fuel a decisive shift in the direction of relying on pharmacological attempts to treat this and other psychological disorders. The careful examination of clinical examples, as I contended in the previous chapter, argues strongly for the view that the conflicts and compromises embedded in the structures of pathological accommodation comprise the quintessential element in the quality of superego pathology seen in obsessional disorders and that these conflicts and compromises have their origin in the caregiver-infant contextual domain within which self-differentiation and the ontology of the sense of self originally emerge (Brandchaft, 1988a). The child's development has been fatefully compromised by the compulsively selective inclusion and exclusion (and dissociation) of information that experience might otherwise have provided, with such incremental self-mutilation being regarded as mandatory in order to preserve and protect a tie upon which life itself depends. Obsessive-compulsive disorders display most convincingly the operation and imprisoning character of systems of pathological accommodation.

The belief that failures in life, reenacted on the stage of psychoanalysis, were the result of a primary sense of guilt originating from a punitive superego long remained at the center of therapeutic attempts following Freud's elaboration of his tripartite structural theory of the mind. That belief all but completely bypassed a deeper investigation for a considerable period. Freud himself, however, as noted in the previous chapter, was too astute an observer to ignore completely at least one clinical phenomenon pertaining to the superego, even though apprehending it called for a radical departure from his most advanced revision of the tripartite theory (in which his biological orientation led him to attribute the deadening characteristics of a punitive superego to a “death instinct”). Returning to a contextualist perspective he had so long ago abandoned, Freud (1923) wrote of the superego in a footnote in *The Ego and the Id*:

One has a special opportunity to influence it when this unconscious sense of guilt is a “borrowed one”—when it is the product of an identification with some other person who has been the object of an erotic cathexis. A sense of guilt that has been adopted in this way is often the sole remaining trace of the abandoned love-relation and not at all easy to recognize as such. If one can unmask this former object-cathexis behind the unconscious sense of guilt, the therapeutic success is sometimes brilliant, but otherwise the outcome of one's efforts is by no means certain. (p. 50; see also Orange, Atwood, & Stolorow, 1997, p. 93)

In 1930, however, he decamped again to the biological realm: “In all that follows, I adopt the standpoint that the inclination to aggression is an original, self-subsisting instinctual disposition in man, and I return to my view that it constitutes the greatest impediment to civilization” (1930, p. 122). Profound questions are raised by this unqualified support for the position of intrapsychic instinctual determination which, after a lifetime, Freud had come to recognize as inadequate clinically, and by his neglect of the contextual factor, which earlier he had found to offer sometimes brilliant results. Juxtaposition of these disparate comments by Freud points to a route through which idiosyncratic “dictates of Antiquity” have unwittingly contributed substantively to accommodative influence in analysis. Serious consideration needs to be given to the implication of an understanding that, in the treatment of obsessional neuroses, not only does, as Freud suggested, the patient cling to what has lost its value for him but so, similarly, does the analyst.

Just as it has been necessary to reconceptualize the psychological forces at work in obsessional disorders, so also with the whole range of psychopathological syndromes. The proposition that all self-experience, growth-enhancing and growth-obstructing, is embedded in a constitutive and sustaining intersubjective matrix facilitates the emergence of new understandings in areas
from which it has been previously excluded. Intersubjectivity theory constitutes a radical departure from the tendency to locate the origins or continuance of psychopathology solely within the patient (Orange, Atwood, & Stolorow, 1997). It enables psychoanalytic understanding to be extended to the full range of psychopathological disorders, including psychotic and borderline states (Brandchaft & Stolorow, 1990, p. 105; Stolorow et al., 1987, pp. 132–179), grasped as by-products of a pathogenic developmental system.

**Trauma and pathological accommodation**

A vast literature has begun to stress the role of trauma, incurred from the dawning of consciousness itself (Bowby, 1969, 1973, 1980; Cicchetti & Greenberg, 1991; Crittenden, 1994, 1995; Main, 1995; Meares, 1998; Stolorow, 1999), in shaping development. It is relational trauma, I submit, that initiates the co-creation of complex systems of pathological accommodation. These systems crystallize within the attachment system and thereafter occupy central experiential pathways in personality formation. The course and goals of a psychoanalytic treatment of developmentally based disorders must bring these traumatic attachment systems to light and address them therapeutically. An understanding, in depth, of the effect of unresolved trauma requires a recognition of the ways it is contextually constituted and repeated in psychoanalysis.

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

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

**Words dry and riderless**
**the indefatigable hoof-taps**

**While**

**From the bottom of the pool, fixed stars**
**Govern a life.**

Sylvia Plath, “Ariel” (1965)

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

Relational trauma, such as accompanies a serious mismatch of the caregiver’s experience and response with that of the infant—or a retraumatizing disjunction in the analytic bond—can be observed to result in a shocklike state. In an instantaneous, tsunami-like reaction, the time-space dimension of experience undergoes collapse while the fragile structures supporting a continuing sense of self are crushed. This state, as it can be observed in the therapeutic interaction, brings together a cognitive-affective montage in which are indissolubly fused unconscious memories of threatening early experience and the expectation of future threats of extinction. In this process, damage keeps being inflicted on the quality of one’s personal
experience and upon the entire spectrum of one’s relationships. The hole created will be filled in by a combination of compensatory enactments and distancing structures together with those of renewed pathological accommodation, which “heal” the breach.

From infancy, a preternatural sensitivity has been retained. A rigid template is formed through which all experience comes to be filtered. A patient so traumatized will frequently display a knowledge of the analyst’s unconscious intentions before the analyst knows about them (however reductionistic or distorted this knowledge will be from the analyst’s point of view). Embedded at the sound-bite level of experience is the patterned belief that such knowledge must be disavowed and disposed of because it is unwelcome or damaging to the analyst. What remains may be only the briefest pause and an all but imperceptible shift in affect state, microscopic elements easily ignored in the search for familiar macroscopic themes. Also in place in such experience is the patient’s unquestioned belief that the analyst’s appraisal of her, and of himself, will be based at every stage on how well or poorly the patient is able to please and affirm the analyst by showing progress in the program on which the analyst rests his claims for fostering the patient’s well-being. The making of a hypnotic-like imposition of love is in progress. Transgenerational transmission of accommodative pathology is making its contribution to keeping “maladjustment in good repair” (Bion, 1977, p. 99).

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

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

Within traumatic attachment systems, the child develops a lasting hatred of reality and may spend a lifetime attempting to evade it or, “born again,” to superimpose a more acceptable substitute upon it. The hated reality is one that has been imposed and has come to crush spontaneity and individual joyfulness. At its center, the traumatized child has come to feel itself as bad. Its experience has been interlaced with threats and episodes of abandonment, physical and psychological, and so soon as a first belief in causality is established, the child learns that it has done something egregiously, malignantly, and selfishly “wrong.” The child is forced to adopt or embrace this alien impinging referent as not-to-be-questioned Truth because threats of abandonment leave it helpless. Intense anxiety is aroused, and anger is generated as the only means the child possesses to attempt to prevent the caregiver from carrying out or continuing the threat. Subsequently, as the child’s anger is ignored or thrown back at him or her and he or she is blamed for the difficulty, a dysfunctional hermetic feedback circuitry becomes firmly established. Chronic rage and desires for revenge follow, laying the foundation for sadomasochistic character formations. This child carries the stigma of badness driven into his selfhood and will never be able to put the torment to rest: “Like damn little men at my brain with picks and axes and chisels” (Stevenson, 1989, p. 36).

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

The analyst's ongoing and scrupulous introspection will be a critical ingredient in enabling him to recognize the continuing intrusion of his own contribution. By contrast, an analyst's fixed beliefs as to what the patient should and should not believe, as well as what would be "best for the patient," tend to concretize and move the patient's pathological system toward intractability. The goals and processes of psychoanalysis must be based, in my view, on the recognition that this complex developmental interweaving of subjective and intersubjective patterning constitutes the nucleus of the psychopathology as it is inevitably interacted and maintained reciprocally in analysis. The analyst's self-reflective disentanglement from that patterning is a mandatory, if by no means simple, requirement for such patterning to become the focus of investigation.

On analytic process

The clinical application of the principles of intersubjectivity have been described in detail in a number of previously published case illustrations (Atwood & Stolorow, 1984; Stolorow et al., 1987). Clinical material discussing more specifically the treatment of patients whose primary developmental disorder resides in systems of pathological accommodation may be found in Brandchaft (1983) and, of course, in previous chapters.

For my present purpose, I will use as text a brief case report of "Mrs. C" contained in a recent paper, "On Analytic Process," by Ablon and Jones (2005). The paper describes an important research project and was published with extended comments by Blatt and Fonagy, as well as a reply by Ablon. The case material itself, meanwhile, had been previously published by Weiss and Sampson (1986) as part of a different research project.

The research report attempts to operationalize contemporary conceptualizations of the "interactive dimensions inherent in the relation between analyst and patient" as "the context for therapeutic interaction" (Ablon & Jones, 2003, p. 557). (The intersubjective perspective, though not specifically referenced in this report, is exactly such a conceptualization.) The unnamed treating analyst in the case vignette, in the course of the original treatment, had come to label one such recurring interaction sequence "Playing Stupid": "In this recurrent interaction, the patient's thoughts become muddled and confused when she talks of sexual feelings and her wish to arouse men; the analyst finds himself talking more than usual in an effort to explain matters." (p. 556). An excerpt from the fifth year of the analysis provides the clinical illustration of this kind of interpersonal interaction sequence in the report.

Below is the excerpt from the case report exactly as it appears in the article. A comment within the excerpt that specifically concerned the ongoing research project has been omitted and is indicated by brackets. Numerals following a passage refer to portions of the text on which my comments will follow. First the brief summary of Mrs. C as she presented for treatment:

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

The analysis was conducted over a 6-year period or for approximately 1,100 hours; its outcome was considered to be very good by both analysts and patient. (Ablon & Jones, 2005, p. 555)

Now the excerpt from the transcript of a session during the fifth year of the analysis:

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

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

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

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

Now you see, I think what really started this was when you made love Sunday afternoon with (husband) during your daughter's nap. (4) I think it's been since then that increasingly you've felt it necessary to be in this frame of mind, where you're sort of pseudo-stupid. Playing stupid, confusing yourself, muddling things.

The analyst goes on, in a lengthy interpretation, to connect this state of mind with a memory the patient had reported. There was a time, when she was a little girl, she was supposed to be taking a nap, but wasn't, and she saw something that troubled her. What she saw is never clarified. She was supposed to be sleeping but wasn't, so she had to “play dumb,” to hide what she knows. The patient has trouble understanding what the analyst is saying, demonstrating in the interaction what the analyst has been interpreting. [...] In fact the analyst is induced to repeat the interpretation later in the hour. (5)

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

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

**PATIENT**: (silence) Mrn, it's not that I'm getting anywhere, and maybe I am. But I was just thinking of the fact that in not letting myself know—because I feel as if that's what I am doing right now too—and not understanding in the way I should, what you've just said. Or not just this last time, but before. Because I did understand what you said and it just reminds me of this tension that I had all weekend. (7, 8) (Ablon & Jones, 2005, pp. 555–556)

Ablon and Jones conclude their commentary on the vignette thus:

This illustration captures what we have termed an interaction structure. It is clearly an interpersonal interaction that both the analyst and patient identify as repetitive and recurring. The reciprocal, mutually influencing quality of these repetitive interaction structures can be seen in how the patient's stance evokes in the analyst his own countertransference reaction. His interpretations are lengthy, carefully explanatory, and contain some exasperation. Interaction structures are mutually created or engaged in by patient and analyst. Therapeutic action is located in the recognition and understanding of these recurrent interactions by both analyst and patient. The experience, interpretation, and comprehension of the meaning of such repetitive interactions constitute a major component of therapeutic action. (p. 557)

**Comments**

I stress at the outset that everything in the earlier theoretical portion of this chapter supports the conclusion reached in the final sentence quoted above: “The experience, interpretation, and comprehension of the meaning of such repetitive interactions constitute a major component of therapeutic action.” Beyond this, the excerpt does indeed describe an “interpersonal interaction pattern that both analyst and patient identify as repetitive and recurring.” However, the writers appear to believe that the data supplied supports the conclusion that the analyst’s interpretive stance and his responses were ultimately beneficial, as evidenced not only by mutual acceptance of the treatment as successful but also by the diminution of the particular pattern over time. They compare this case favorably with another case, where mutual understanding was lacking and the pattern persisted, and they hold that “the verbatim excerpt from the case of Mrs. C, on the contrary, illustrates the simultaneous process of experiencing, recognizing, and understanding the interaction” (p. 563).

However, I believe the report demonstrates the unidirectional application of this principle and ignores an essential component of the principle that “interaction structures are mutually created or engaged in by patient and analyst” and that therapeutic action resides “in their recognition and understanding by both the analyst and patient” (p. 563 [italics added]). To my mind, the part played by the analyst’s interpretive stance and responses here remains unrecognized and unacknowledged both in the outcome rating previously assigned the case as “very good” and in the tacit use of the interactional sequence as a comparatively benign model for psychoanalytic conduct. Taking the analyst’s contribution into account leads, I believe, to the conclusion that the agreement reached by patient and analyst
as to outcome, and also perhaps the gradual diminution of the particular interaction sequence over time, was the outcome of a system of pathological accommodation, co-constituted and co-maintained reciprocally by the impact of the analyst’s interpretive stance and responses and Mrs. C’s compulsive compliance within that system.

I have chosen this brief case excerpt because of the significant epistemological problems it raises and because it provides the opportunity to distinguish between a change at the psychological surface based upon a pathological accommodation that, requiring and maintaining at its core a debased and enslaved sense of self, is a perversion of an analytic process, and a genuinely liberating change at the psychological depths. The latter would take into account that central in Mrs. C’s pathology is her inability to sustain the validity of her own perceptions and “hold her own opinions,” and that encoded in her subjective universe as an organizing principle is a firm belief that a secure relationship with a man can only be maintained by her submissive compliance with his needs and opinions. These residues of her unique developmental attachments had undoubtedly already shaped her frightening experiences as a little girl trying to nap to which reference is made. There is also ample warning that this early established belief is likely to have played an essential part in the sexual difficulties Mrs. C had encountered subsequently in her marriage.

Genuine transformation requires that the reciprocal, mutually influencing structures of pathological accommodation will have been recognized by both analyst and patient. In such a process, Mrs. C’s own experience, heretofore a developmental casualty, will have to emerge and be maintained as central in her perception and in the generation of her subsequent behavior in the dyadic relationship. Where pathological accommodation, however enthusiastic, is shaping the agreement of patient with analyst, the agreement itself is a continuing activity of the interactive relational context in which the underlying pathological structures are being maintained. This kind of agreement is characteristic of a false self-cure as described by Winnicott and Bowlby. Thus, I will examine the sample more carefully, not for the purpose of criticism of the conduct of the case or the technique employed but rather to call attention to important principles elaborated in the preceding body of the chapter.

The research article portrays the stance of Mrs. C, “Playing Stupid,” as a determinant in the analyst’s countertransference reaction. Yet the co-determining impact of the analyst’s stance, verbal and attitudinal, is almost visibly an intrinsic, omnipresent, reciprocal influence on Mrs. C’s experience and responses, including her “Playing Stupid.” His position is that of an observer from above and outside the intersubjective dimension of the interactive field. In the report, the significant events are described as if taking place within the essentially isolated domain of the patient’s intrapsychic world, and her behavior is held to be exerting a unidirectional effect upon the analyst’s psychological structure. This isolating focus is a creation of the analyst’s own subjectivity. It reflects a crucial dimension of psychological remotes of his own personality from its actual participation in the events he is witnessing. The unstated assumptions of objectivity and the repeated assertions of privileged superiority in his knowledge of Mrs. C’s reality, to which she must finally agree, set the conditions for a repetition of the developmental trauma that has been the subject of my thesis.

The template that permeates the intersubjective context (what the patient should or should not feel or think, how she should or should not behave, as well as who she basically is) is a developmentally embedded pathological interaction structure. It can readily be recognized as taking its own particular form in her personality structure. A parallel and reciprocal template may be organizing the analyst’s experience as it repetitively asserts itself. Such a template can take the form of a compulsive attachment to unquestioned assumptions about the events unfolding before the analyst, long after these assumptions should have required questioning and reassessment. Each of these templates represents the transfer of early attachment ties to depersonalized structures as discussed earlier: in the patient, an invariant belief about the conditions in which a tie, and life itself, can be sustained; in the analyst, an addictive attachment to idealized theoretical convictions that protect against fragmenting uncertainty. Their tenacity as templates can be attributed to the crucial defensive function they have been required to fulfill in preventing the reexperience of the developmental trauma of early object loss and the threat of psychological chaos. Careful investigation into Mrs. C’s successive responses might well disclose these primary motivational factors at work, as I will describe subsequently. The analyst’s template, meanwhile, can be made available by his self-reflection into his “countertransference” reactions when a patient’s unyielding disaffirming responses, such as are reported here, represent a profoundly unsettling challenge to the analyst’s sense of self and the certainty that defensively supports it. Here the forceful reassertion of the analyst’s perspective brings to a halt a threatening descent into a chaotic unknown.

Such templates are intersecting transgenerational transmission vehicles for the bond and bondage of pathological accommodation, the “mortallest enemy unto knowledge.” It is likely that they have profoundly influenced and affected the thematic content and course of the treatment to this point. Such templates represent essential qualities of the analytic attachment bond and are clearly functioning outside the reflective understandings reached by the analyst in the report. Never made available for attenuation in the treatment, they will nevertheless continue to live on and exert their shaping influence on life’s meaning.

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

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

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

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

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

(4) The analyst returns to his preoccupying interpretive theme, further endowing it with the authority of objective and preemptive Truth: “I think what really started this...” The crucial question is “What’s true and whose idea was it?” (Ogden, 2003).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Having recognized and aligned myself with the patient's state of mind and his need to recover from the acute overstimulation, I and he were subsequently able to return to the investigative function of the analysis. Locked within this state of mind were profound archaic existential anxieties and fears of madness that had tormented the patient in every relationship from very early on. The patient became aware of another characteristic that marked every relationship, the need to make himself absolutely indispensable to his partner, including the analyst. He became able to recognize the triggering experiences, the "warning signs," which always portended the loss or prospective loss of an important object, and became better able to deal with the hitherto rapidly spiraling, "out-of-control" incremental mental processes.
Chapter 13

Reflections on the unconscious

Patient I begins a session by reading from a diary she has been keeping during the analysis. In the previous session new information emerged concerning her early relationship with her father. He had returned home a war hero when she was 3 years old. In the previous session, however, significant details emerged about the traumatic nature of that relationship, details that had hitherto remained hidden. “We are all little Hansels and Gretels,” her diary reads, “abducted and lost, waiting for someone to follow the crumbs we have left and help us find our way back.”

I hope that readers of this book have been as impressed as I have been, over the years of my career, with how readily inner workings of systems of pathological accommodation, whose symptomatic expressions were always evident, become almost invisible in any treatment that insists upon an intra-psychic focus on the patient to the exclusion of contextual factors. Indeed, it was only with the advent of the empathic-introspective approach of Kohut that the patient’s experience began to be examined with sufficient attention paid to the context of the treatment, and to the analyst’s immanent role in it, that the details of such systems could begin to make their presence consistently felt. And it was only with the further elaboration of the intersubjective viewpoint that such systems, which when present constitute the nuclear pathology of the patient and the outstanding obstacle to true analytic transformation, could begin to come fully into view. This progression of understanding quite obviously has implications for our understanding of the unconscious and how it may best be approached in treatment. In this postscript, I propose to reflect more deeply on the means by which an expanded view has lately emerged of how unconscious memory may be accessed in treatment to the patient’s advantage.

As a form of treatment, psychoanalysis is distinguished by its historical claim to be a method for illuminating the unconscious determinants of human experience and behavior. It does so by investigating the patient’s experience of the analytic relationship and uncovering the ways in which