Panel: The Alchemy of Attachment
Trauma, fragmentation and transformation in the analytic relationship

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Abstract: This panel emerged from shared clinical concerns when working with adult patients whose presentation style was reminiscent of a disorganized (Type D) infant attachment pattern. Psychotherapeutic work with such patients poses complicated transference and countertransference dilemmas which are addressed by all four panellists via theory and clinical vignettes. In common is an interest in contemporary attachment, neuroscience and trauma theories and their relationship to analytical psychology. Intergenerational trauma seems to be a salient factor in the evolution of fragmented and fragmenting interactions that lead to failures in self-coherence and healthy interpersonal relationships. Such early relational trauma is compounded by further episodes of abuse and neglect leading to failure in a core sense of self. These clinicians share how they have integrated theory and practice in order to help dissociated and disorganized patients to transform their dark and extraordinary suffering through implicit and explicit experiences with the analyst into new, life giving patterns of relationship with self and others. The alchemy of transformation, both positive and negative, is evident in the case material presented.

Key words: alchemy, Boston Change Process Study Group, disorganized attachment, dissociation, internal working models, mismatch, self agency, shame, transcendent function, trauma

A Jungian contribution to a dynamic systems understanding of disorganized attachment

Linda Carter

Experienced clinicians know all too well—dynamically, explicitly and implicitly—the ambivalent back-and-forth movement of analysands who have suffered early relational trauma. Threads of connection can be woven together into a co-created fabric only to be unravelled and left in tatters by the next session. Disruptions can become sequences of explosions and repair not
experienced in early relationships or held in current memory—a novel and unexpected experience. The dyad is at the edge between order and chaos where the analysand is surprised by repair and the clinician is surprised that the repair can seem to dissolve between sessions almost without a trace.

Jungian psychology places high value on notions such as integration, teleology, wholeness, synthesis and the transcendent function. Of course, this has consistently been juxtaposed to Freud’s reductive method with its emphasis on causality and early history. Beginning with Bowlby, however, the world of psychoanalysis has been profoundly affected by the burgeoning work in studies of communication, attachment and trauma. The observational and clinical work of researchers and writers such as Beebe and Lachmann (2002), Stern (2004), Tronick (2007) and Sander (2008) have profoundly altered theory development and clinical practice. Undergirding these new ideas is dynamic systems theory which explores the emergence of ever more complex networks forming spontaneously through self-organization. This way of thinking moves beyond simply causal models and necessarily into the realm of multiplicity, so well described through Jung’s theories of complexes and archetypes. The work of Cambray (2004), Hogenson (2004) and Knox (2004) suggests that we need to move beyond ideas of incarnation of pre-existing forms into understanding that archetypal patterns are emergent properties. As the neuroscientists have taught us, there is an inclination to repeat interaction patterns that have become instantiated in the brain but these patterns themselves can be altered when something new is introduced into the relational system which leads to reorganization of brain in conjunction with interactive tendencies. At the emergent edge between order and chaos, the clinician is alert to indications of the presence of the transcendent function—not necessarily bringing together the tension of opposites in content—but in the process of being together. The focus on process is central to the clinical dilemma that I will present. Through attention to process can come cohesion in the moment, coherency of self over time and, potentially, an ‘earned secure attachment’ (Hesse 2008, pp. 586–88).

In a recent JAP article (2010), I have discussed the case of Alan and I will turn to a specific moment in that analysis for discussion here as I think it highlights the significance of process in the work with patients whose interaction patterns remind me of those described by infant researchers as disorganized attachment. I would like to make clear that it is impossible to diagnose adults with this particular pattern as there is no way to draw a direct causal line between early interaction and adult behaviour. Further, disorganized attachment is not a diagnosis of pathology, it is descriptive of a particular style and is used as a research classification that may correlate with adult dissociative symptoms. Therefore, it may predict with a probability greater than chance alone that an adult may show dissociative symptoms but it does not cause them. I see development not in linear steps but as emergent with multiple variables contributing to the emergence of the self. As we have learned from the Boston
Change Process Group (Stern et. al. 1998), interpretation tends to be related to the transference grounded in early history while a moment of meeting or, in Jungian parlance, the transcendent function tends to emerge from new, co-creative aspects of the current analytic dyad. Such relational encounters can lead to the emergence of new archetypal patterning that, with repetition, becomes instantiated in brain functioning. The clinical moment that I will present helps to consider both the success and also the failure to achieve the dyadic consciousness of the transcendent function. With the following case, I consider the pattern of disorganized attachment as a kind of amplification for my experiences with the patient. I believe that the manifest affects of anger and aggression were employed to protect against deeper feelings of shame with the consequence of preventing the attachment system from moving toward greater cohesion, coherence and complexity.

Alan was ambivalent. Ambivalent about everything—especially about analysis. After several years of four times a week treatment, he told me about his internal turmoil in the waiting room: He simultaneously wished to run toward me and to run away. In my mind, I imagined him saying, ‘To and fro, to and fro. Should I come or should I go’. This back and forth movement that characterized his silent contradictory struggle at the moment of greeting was kept secret for several years. Prior to that time, I had only known what I could observe or implicitly sense: each session began with Alan’s stony and silent hostility. He would glare at me as if I had made some grievous error even though the end of the previous session may have gone quite well. This repeated pattern never ceased to amaze me and I would find myself in a state of acute hyperarousal requiring deep breathing in order to self regulate. There was something aggressive and hateful about his presence, his body posture and what felt like disdain. Moving through my own distress, I would embark on a quest to find him, or more specifically the part of him that I remembered from the previous session as related and engaging. I guessed, I commented, I imagined until finally I would hit on something that would open the door. There was not a particular topic but this messy process of hide and seek seemed to work. This was not necessarily a playful process as the stakes were high. I continually felt that I might lose him and that he might lose himself.

Verbal acknowledgement of the ‘to and fro’ behaviour heralded a change in the analysis. Alan was reflecting on his behaviour which opened a discussion between us. This did not unfold easily and it was only with time that I began to appreciate that the intensity of his aggression was related to the depth of shame that he felt over his longing for a secure attachment and a home base. He had an almost phobic resistance to coming close to me as if I were his hostile, intrusive and abusive mother who herself had suffered early relational trauma. This style of interaction reminded me of a disorganized attachment pattern that is thought by some researchers to be intergenerational (Liotti 2004, p. 11). Hesse and Main (2000, p. 1177) quote Carlson (1998) who states that ‘[i]n late adolescence,
early disorganized attachment status has been linked to disruptive/aggressive disorders, and to increased vulnerability to dissociation’. Sroufe and colleagues (Ogawa, Sroufe et al. 1997) have concluded that early more so than later trauma has a greater impact on the development of dissociation (Schore 2003, p. 199). Studies by Ogawa & Sroufe (1997), Liotti (2004), Lyons-Ruth (2006) have found a positive correlation between disorganized attachment and dissociation.

Attachment is, of course, central to survival and is dependent on proximity to the caregiver for comfort, safety and support. With Disorganized or Type D infants, the mother tends to be frightened or frightening. Main and Solomon (1990) reported that unclassifiable [or disorganized] infants exhibited a diverse array of inexplicable, odd, disorganized, disoriented, or overtly conflicted behaviours in the parent’s presence (Hesse & Main 2000, p. 1098). What characterized these infants was the theme of disorganization, or an observed contradiction in movement pattern. This contradiction could be sequential or simultaneous (Hesse & Main 2000).

Alan’s intense longings for closeness terrified and shamed him, triggering a wish to run. When I met him in the waiting room, he was in a state of rageful hyperarousal with the fight/flight mechanisms of the autonomic nervous system in gear. I eventually came to learn that, once seated in the consulting room, he would feel angry and then go blank, falling into dissociation. He later let me know that any closeness that he may have felt in the previous session was something that he both wanted to replicate and simultaneously wanted to destroy. The overwhelming nature of his shame set off hateful and destructive feelings that manifested in aggressive behaviour toward me and toward the analysis.

In this case, it took me some time to realize that shame was an emergent property of the constellated attachment system. Overseeing the co-creation of the analytic dyad was the presence of a many headed hydra threatening every positive interaction. Shame over longings for closeness, shame over his history of abuse, shame over tyrannical behaviour toward me and even shame over shame secretly stood between us. Due to his concealment, I couldn’t fully appreciate that, consumed by shame Alan was oppressed by anxieties over abandonment, expulsion or emotional starvation which may have endangered coherence and threatened his psyche with disintegration (Hultberg 1988, p. 116). Hultberg (ibid.) notes that shame threatens the individual with psychic death which he sees as equivalent to extinction—‘destruction of the personality without any possibility of resurrection’. Indeed, Alan came into analysis with a limited repertoire of relational skills. That disruptions and mismatches could be repaired and that our dyadic system could come back to a regulated state was surprising to him. There was most certainly an asymmetry to this process as I ‘pedalled hard’ to find words and sometimes images to match what I imagined his state to be. However, being accurate and finding him sometimes caused further shame as my ability to ‘see’ him exposed what made Alan feel vulnerable and small. A barrage of hate would often ensue. I, would then, in
turn, feel belittled and shamed by the intensity of my anger toward him. We both were frequently surrounded by an atmosphere of anger and shame. The pull to withdrawal was great. I could feel in me an intense yearning to split and blame the patient rather than see our dilemma as co-constructed. I wanted to quit. I wished that he would quit. I had lost my grounding and felt powerless. Shame as an aspect of the shadow had emerged between us. As Judith Herman (2007, p. 13) notes, shame is contagious emotion. What helped me to persist was honest and full expression of my dark emotions in the context of consultation. Open discussion of my anger and shame with an empathic other allowed me to take a more empathic position toward myself and therefore use shadow material as a lens for understanding the patient. I could use my own experiences of humiliation to appreciate Alan’s affective states. Further, remembering that our current dilemma reflected Alan’s early pattern that could be compared to disorganized attachment allowed me to regain my bearing. Exploration of this pattern in my imagination created breathing room. Eventually, internal repair and forgiveness led to the possibility of re-engagement with Alan. I hoped that we could develop a new pattern other than one where parents of disorganized infants induce fright without solution (Liotti 2004, p. 13). The consultant functioned as a mediating and transcendent third facilitating a move from the constriction of symbiosis to a more separate and differentiated position, thus allowing me to access reflective functions more flexibly.

In her 2007 John Bowlby Memorial Lecture, Judith Lewis Herman noted that we see disorganized attachment where the primary attachment figure is a source of fear. She argued that we also see disorganized attachment where the primary figure is a source of unremitting shame. In this case the child is torn between the need for emotional attunement and fear of rejection or ridicule. Herman says that the child forms an internal working model of relationship in which his/her basic needs are inherently shameful (p. 3). Further, Schore states that ‘[e]arly experiences of being with a psychobiologically dysregulating other who initiates but poorly repairs shame-associated misattunement are also incorporated in long-term memory as an interactive representation, a working model of the self-misattuned-with-a-dysregualting-other’ (Schore 2003, p. 31). The child comes to experience him/herself as unworthy of help and comfort (ibid.). This internal working model of shame is necessarily triggered in the close proximity of the therapeutic relationship but exerts its presence covertly as it is by nature hidden. Shame resides in the shadow as the underside of narcissism as has been pointed out by Andrew Morrison (1989). Further, an internal working model of shame with disorganized attachment emerges in the first years of life when non-verbal communication predominates in the non-conscious system of the implicit domain which is outside conscious awareness. Like the Titans, this emotion is primitive, imageless, formless and overpowering when set in motion. Its searing nature is hot and manifests in the redness of blushing which results from a rapid shift in the autonomic nervous system.
Shame as both an affect and a defence (Morrison 1989) is fundamentally isolating. It results from a failure of the attachment system to emerge and become more complex, cohesive or coherent; instead the mother and baby function in a state or mutual withdrawal and the system dissipates. For development to proceed in the therapeutic dyad or in the mother-infant relationship, dyadic expansion of consciousness is required whereby the interaction between two partners contains more information and is more complex than either partner’s state of consciousness alone (Tronick 2007). This model of emergence resonates with Jung’s notion of the transcendent function which is a lynchpin of a prospective model for the unfolding of the self in the individuation process. Shame constricts forward movement into the future which can be witnessed in the compulsion to get small and even disappear.

Rage and dissociation are evident as defensive manoeuvres to protect the integrity of the self. Morrison (1989, p. 103) notes that narcissistic rage reflects ‘an attempt to rid the self of the experience of searing shame’. Alan’s revelation was a movement away from rageful defence and a movement away from paralytic withdrawal. Indeed, he was self reflectively engaging in the process of mutual collaboration in a new kind of interactive exchange with the potential for expansion rather than dissipation of self and relationship. A new paradigm was emerging alongside the limiting pattern of disorganized, disoriented attachment. His ability to think through and observe the contradictory wish to run toward me and to run away, marked a turn toward cohesion, coherence and complexity of the self within relationship. The transcendent function was constellated within each of us and within the relationship. Micro-processing of significant analytic moments with an empathic consultant allowed me to metabolize my own anger and shame and to use my self understanding as a means to help move the system toward expansion rather than dissipation. Constellation of shame in the mutually constructed therapeutic relationship threatened to constrict or even sever the work but full expression of shame and rage within the mediating third of clinical consultation renewed energy and mobilized empathy thus allowing for a difficult but ongoing and ultimately creative process.

References


Dissociation and shame: shadow aspects of multiplicity

Jean Knox

In this paper I shall explore a shadow side to multiplicity, namely when multiple and distorted viewpoints cannot be integrated into any meaningful whole, but exist as dissociated fragments inside the psyche.

A baby’s sense of identity comes from the meaning attributed by the mother to his or her actions, which, when positive, provide the foundation for the healthy development of self-agency in early infancy. But the infant’s dependence on key attachment figures to give meaning to his/her actions makes him or her uniquely vulnerable to negative attributions from parents who interpret their infant’s healthy appetite as greed, or see normal aggression as evil. This kind of parental rejection, which often takes the form of a mere facial expression of disapproval or even disgust, is often fleeting and usually entirely unconscious.

These negative attributions are internalized to become a core part of the sense of self, with devastating consequences—a kind of antithesis of ‘moments of meeting’. The child becomes literally ‘ashamed of himself’, of his or her self-agency and libido in the sense Jung used. Echoing Jung’s insights (1920), Alicia Lieberman says that the child may become ‘the carrier of the parents’ unconscious fears, impulses and other repressed or disowned parts of themselves’ and that ‘these negative attributions become an integral part of the child’s sense of self’ (Lieberman 1999, p. 737). I have suggested (Knox 2007) that this is the basis for the ‘fear of love’—a kind of autistic defence against relationship in those who have experienced such colonization by the disowned parts of the parental psyche.

Very recent research provides striking evidence of the powerful and enduring effects of such negative parental attributions to their babies. Broussard and Cassidy (2010, p. 165) found that even something as apparently innocuous as a mother’s mild sense of disappointment that her baby is not a ‘better than the average’ baby correlates with a higher risk of psychosocial problems in later childhood and that this negative effect continues right into adult life, making them 18 times more likely to have insecure attachment patterns than adults whose mothers had perceived them positively.

A key question is how the baby detects such negative attributions. A one-month old baby cannot mentalize about his mother’s state of mind, cannot think ‘oh, she doesn’t think I’m good enough’. What the baby does see is the caregiver’s reactions to his or her agency in the turn-taking that forms the core of human communication. A caregiver’s negative attitudes show themselves in avoidant, aversive or conflictual responses to the baby’s agency so that, in the words of the Boston Change Process Study Group (BCPSG), the baby learns ‘what forms of affective relatedness can be expressed openly in the relationship
and what forms need to be expressed only in “defensive” ways, that is, in distorted or displaced forms’ (BCPSG 2007, p. 851).

A number of research studies highlight how crucial are the caregiver’s reactions to the baby’s agency:

1) Ed Tronick (2007) emphasizes that mother and infant collaborate to communicate and coordinate the timing of their respective contributions, with rules governing their interactions that allow each to predict the response of the other. Tronick suggests that in general, when the caregiver does not follow the rules of reciprocity, a helplessness is learned by the infant—he or she gives up trying to elicit a normal response. When a depressed parent responds to the child’s positive displays with negative reactions of withdrawal, anger or despair, the child comes to experience his or her own agency as the cause of these negative reactions and may well conclude that any expression of agency is destructive (ibid., p. 217). Tronick concludes that ‘in such withdrawal a denial of the child’s self is produced’ (ibid., p. 261).

2) Beatrice Beebe and colleagues have found that many 4-month old infants who later show disorganized attachment have mothers who are pre-occupied with their own unresolved abuse or trauma and cannot bear to engage with their infants’ distress. Essentially, the mother is unable to regulate her own distress when faced with her infant’s distress and so cannot regulate that of her baby. These mothers are unable to allow themselves to be emotionally affected by their infants’ distress; they ‘shut down’ emotionally, closing their faces, looking away from the infant’s face and failing to coordinate with the infant’s emotional state, a self-protective dissociation, as though they are afraid of the facial and visual intimacy that would come from more ‘joining’ the infant’s distressed moments. These mothers are showing disrupted and contradictory forms of affective communication, especially around the infant’s need for comfort when distressed (Beebe et al. 2010, p. 99). It is as though these mothers might feel:

‘I can’t bear to know about your distress. Don’t be like that. Come on, no fussing. I just need you to love me. You should be very happy’. ‘Your distress frightens me. I feel that I am a bad mother when you cry’ . . . ‘Your distress threatens me. I resent it. I just have to shut down’.

(Beebe et al. 2010, p. 100)

These 4-month infants, who are later classified as having disorganized attachment at one year learn to expect that their mothers are happy, surprised, or ‘closed’ when they are distressed (ibid., p. 100).

For the infant, this kind of discordance between his or her own emotional distress and the non-contingent, aversive response from the parent that follows
is a profound assault on his or her experience of agency in the relationship. Under these conditions, splitting and dissociation become the mechanisms for creating multiple selves, each reflecting different aspects of self-agency of which the individual has come to feel ashamed as a consequence of the rejecting response of the parent (Slade 1999, p. 802; Bretherton 1995; Fonagy et al 2002, p. 239). In its extreme form, in dissociative identity disorder, self-agency may be distributed to one or more alternative dissociated personalities. This is the shadow aspect of multiplicity, the failure of integrative processes, such as the transcendent function and the deintegration-reintegration cycle.

3) Now the briefest of words about possible neuroscientific mechanisms that contribute to the findings such as those of the BCPSG, Tronick and Beebe. fMRI scans show that observing disgust on another’s face activates the same parts of the insula as the participants’ direct experience of disgusting smells, suggesting that mirror-neuron activity occurs in the insula. But the insula may also be a critical relay from the mirror-neuron system to the cortical and sub-cortical midline systems that underpin the core-SELF experience described by Panksepp (1998).

These pathways may provide the route by which the negative expressions on a mother’s face in response to her infant can therefore directly impact on her baby’s core-SELF experience. The infant’s joyful agentive communications are met by an expression of disgust or fear on the mother’s face. The infant’s mirror-neuron system activates the corresponding networks in the baby’s brain so that he or she also experiences disgust or fear at his or her core-SELF positive or negative emotional states.

**Analytic approaches and the effect on the patient’s sense of self**

Just as a parent’s responses of her infant’s intentions can profoundly damage the child’s developing sense of self-agency, the same can also be true in a psychotherapy relationship if the therapist’s approach also denies the patient an opportunity to express his or her agency in the relationship between them.

But this denial of the patient’s need to experience agency in the therapeutic relationship can be the unintended consequence of psychotherapy theories and practice which focus primarily on innate or objective aspects of the unconscious. The most obvious example of this is the psychoanalytic view of unconscious phantasy as an expression of the death instinct. A therapist’s constant focus on unconscious ‘destructiveness’ may be experienced by the patient as a denial or pathologizing of the patient’s relational needs. For example, one therapist described a case vignette about a patient who one day took a present of a loaf of bread she had made to give to the therapist. The therapist did not take the bread but simply let it drop on the floor between them, treating the gift as a manipulative seduction. Such a therapist focuses on interpreting the negative
transference and sees no need to co-construct a dialogue and a relationship with the patient that will create a safe framework within which painful material can be explored. It is a toxic combination of a failure of turn-taking with a negative perception of the person’s intentionality. Such an approach is deeply alienating, especially for those who have suffered from the early relational trauma and negative parental attribution in childhood that has already made them feel like a ‘bad’ person. It takes no account of the need for the therapist to facilitate a process of disruption and repair (Beebe & Lachman 2002) in which the patient has an opportunity to correct the therapist’s misattunements (Benjamin 2009).

A brief vignette from a transcript of an analytic session demonstrates the destructiveness of this kind of impasse. This session powerfully illustrates the patient’s frustration that there was no room for him to assert his self-agency in the relationship with the analyst. I have the patient’s permission to use the transcript.

**Analyst**: ‘I wish to interpret not how you think you are or claim that you are, but how you actually are behaving, by the way that you’re communicating to me’.

**Patient**: ‘You can talk about how I actually am behaving and communicating to you today but I would like you to answer the question: how can we be remotely confident that tells us anything very much about how I was five hours ago or how I’ve been in the last twenty-four hours since I last saw you?’

**Analyst**: ‘That’s not a question that interests me’.

**Patient**: ‘But it is the question I’m addressing’.

After continuing in this vein for the rest of the session, towards the end the patient neatly summarizes the problem:

**Patient**: ‘Your basic premise is that I’m here to help you find out what’s in my unconscious’.

**Analyst**: ‘Yes’.

**Patient**: ‘And I say that is not how I perceive your role and I do not want to employ a psychoanalyst to do that. I want to employ a psychoanalyst to help me to find out what is in my unconscious.’

The analyst’s refusal to consider that the patient’s conscious perception of himself has any relevance for the analytic work is experienced by the patient as so destructive of his subjectivity and agency that the work quickly reaches a stalemate. This patient had an enduring belief that he was, in essence, a ‘bad’ person, an experience partly rooted in his early childhood experience of a depressed, disorganized mother who could scarcely hold herself together at times, retreating to bed where she would curl up in a foetal position with one arm under the pillow and the other over her head, as though she was afraid of being
hit. At such times the patient was told that ‘Mummy must not be disturbed’ and he somehow knew that she was feeling suicidal. He came to feel that any emotional demand was too much for her and caused her distress and that he was a bad person for wanting his emotional needs to be met. This belief, that any expression of his self-agency in terms of a need for emotional engagement and relationship was bad, meant that the analytic experience described above was simply disastrous for him, re-inforcing his belief that his need for relationship and dialogue produced catastrophic defensiveness and withdrawal from his analyst.

In contrast to the previous illustration, Frieda Fordham described 50 years ago how she modified her clinical approach in the light of her intuitive understanding of the patient’s need to have a real emotional impact on her. This patient clearly suffered from an extremely traumatizing childhood and in fact one of her comments had been, ‘My mother had to die so that I could live’. As a baby, she said, her mother had got to hate the sight, or perhaps the sound, of her. There had been feeding difficulties which meant that she had cried perpetually.

Fordham then goes on to make the point that

Up to this point an ordinary technique had been used in as much as I had remained passive and interpreted the material when I could, but now I found that for a long time I had to adapt myself to my patient as though she were in fact a hungry wailing baby, and I had to evolve a method of dealing with it. Her needs became absolute and I had to adapt myself to them... Though she consciously tried to be otherwise, she was in fact quite ruthless in her demands on my time. The session had to be at a certain hour, which could not be changed. I did not accept this at first but found the distress caused by a change and the hindrance to analytic work so great as not to be worthwhile. Nor could she be kept waiting without sinking into despair and feeling utterly rejected. Any change in the room caused agitation, as did real or fancied changes in my appearance. There was nearly always a threat as to whether she would leave or not at the end of the hour, and though this was never actually carried into effect on some occasions it was a near thing.

(Fordham 1958)

Fordham recognized that her patient needed to experience and express her own self-agency in the therapy. She needed to discover that to have such a powerful effect on the analyst did not drive her away, the effect it seems to have had on her mother. The hardest part of our work as analysts and therapists is to hold this balance between allowing the patient to ‘get inside’ us without having our own sense of identity annihilated and so becoming ourselves victims of the very colonization process for which they seek our help, an issue that Marcus West explores in his paper (see further on).

Conclusions

Research evidence is rapidly accumulating that

• the unconscious is inextricably rooted in intersubjective turn-taking;
what makes effective clinical practice is the co-construction of meaning between therapist and patient, rather than the meaning being determined by the therapist’s interpretations.

Georgia Lepper (2009) uses the method of conversation analysis (CA), to identify more precisely the fine details of the therapist-patient turn-taking, in a way that parallels the second-by-second study of videos of mothers with their infants. Both methods highlight the turn-by-turn interactions of each partner in the dyad, which in adult therapy take the form of the conversational responses of patient and therapist to each other, as they try to achieve a shared understanding.

In the study of conversations, it is the response of the hearer to the previous turn, and the production of the next turn in the conversation, rather than the interpretations of the investigator, which provide the evidence for what meaningfulness is. (Lepper 2009, p. 1078)

This is a cooperative meaning-making effort on the part of therapist and patient that is far removed from the patient as a passive recipient of the analyst’s interpretation of his or her unconscious, a model in which the patient’s own views are seen as irrelevant. In contrast, an intersubjective, relational approach in which the patient’s experience of self-agency plays a vital role is in keeping with the studies that demonstrate the central role of the relational processes that contribute to healthy psychological and emotional development in childhood and also in psychotherapy.

References


The role of disorganized attachment and insecure environment in the development of pathological dissociation and multiple identities

Joseph McFadden

Dissociation is a splitting or separating of different aspects of experience and its representation, whether that experience arises from an internal or external source, environment or the psyche-soma. Normal dissociation is a useful process that occurs and is used by all humans. Pathological types of dissociation result from the experience of trauma greater than that which can be processed by the psyche. It is the premise of this presentation that dysfunctional or pathological dissociation has its roots in very early developmental, relational dysfunction between the infant and mother or primary caregiver, resulting in the failure of a good-enough secure or protecting environment and leading to acute or chronic trauma. Pathological dissociation ensues in both the sense of identity (vertical splitting), and in the representation of experience (horizontal splitting of experience and its compartmentalization or layering). Both are the results of trauma and become defensive processes against trauma. Furthermore, trauma produces a sensory and emotional overload in the infant that cannot be transformed into symbolic form to be known or thought because it exceeds the mother-infant unit’s capacity to metabolize and integrate it (Bion 1967; Stern 2003). It is this last aspect, described by Bion as an impairment or deficit in alpha function that leads to an accretion of un-metabolized sensory experience, experienced in dreams as ideograms, or somewhat similarly described by Winnicott as the ‘cataloguing’ of mental functioning which ‘acts like a foreign body if it is associated with environmental adaptive failure that is beyond understanding or prediction’ (Winnicott 1954, p. 248).

Winnicott first presented his ideas of the relationship of the mind to the psyche-soma in 1949. He describes the psyche-indwelling-in-the-soma as the successful outcome of the process of ‘personalization’ that occurs as a result of the mother’s ‘handling’ of her infant during the holding phase. This is the time of absolute dependence, when the (healthy) mother is in a state of primary maternal preoccupation. He recognized the critical infantile need of a secure and protected experience for the development of what he termed the ‘true’ self. In health the singular infant-mother unit, the initial perfect environment, is provided through maternal preoccupation and attachment. Rapidly this becomes

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1 Winnicott’s use of the word ‘psyche’ is described by Abram as the ‘imaginative elaboration of somatic parts, feelings, and functions’ (Abram 1996, p.263).
the ‘good enough’ environment through graduated, manageable and expectable maternal failures or impingements on the psyche-soma. Mind and thought develops as compensation for these gradual failures and traumas and the gap in containment or security. Whether through acute, repetitive or chronic trauma or failure of protection from excessive or conflicting stimulation—what Winnicott describes as the ‘tantalizing’ and inconsistent mother—there occur not only the splitting of identity nuclei, but also the establishment of mind as an entity isolated and separate from the psyche-soma. Goldberg (1995) has further elaborated on this process as a defensive relationship between mind and the sensorium—the various types of cognitive-sensory input that become a sensory cocoon, separating mind from true connection to psyche-soma. Left in its wake is a sense of numbness, deadness, disconnection, amnesia, fugue states etc—a lack of any linkage to needed sources of aliveness or vitality. Dissociation occurs between behaviour, affect/feeling, sensation, and cognition, preventing their integration into a unified personality.

In 1969 John Bowlby, in presenting his theories about the attachment system, emphasized the innate property of the infant to seek protective proximity to an attachment figure whenever exposed to any fearful or traumatic event. Bowlby also introduced his concept of internal working models as a basic mental representation of encounters with objects, experience and their effects. Knox (1999) has described the similarities and differences between Jung’s complex theory, internal objects, and internal working models. Bowlby recognized that the original internal working models of the early attachment relationships influence all subsequent searches for the protection a secure attachment provides and, under some circumstances, even inhibit it. He attributed the development of these models to implicit memories of the patterns of attachment in caregiving interactions that would normally become gradually integrated with the parallel-developing semantic knowledge system. It has been postulated that secure attachment constitutes a protective factor against the development of acute or chronic PTSD following trauma (Liotti 1999). In disorganized attachment, however, the most impairing of the insecure types of attachment where there has been gross impingement and inconsistency, unusual vulnerabilities to trauma result. Due to their expectation of additional fright and pain, children with these types of attachment relationships experience inescapable and paradoxical feelings of ever-increasing fear accompanying their need for closeness. This becomes a major risk factor for reacting to trauma with dissociation.

Liotti (1999) cites evidence that disorganized infants and children are unable to synthesize their overall experience with their caregivers into a cohesive memory structure. Memories in such children appear to be composed of multiple separate meaning structures that cannot be reciprocally integrated. They are developed by the synthesis of repetitive, implicit, contradictory memories of the infant-caregiver interactions, complicated by excessive and disorganizing sensory stimulation. With time, these differing implicit memories
of attachment relations become generalized and developed into multiple semantic memories that can be expressed verbally.

Internal working models of secure attachment and their associated semantic memory meanings carry an expectation of receiving appropriate care and comfort. With this goes a positive appraisal of one’s feelings and emotions. In children with disorganized attachment, based on frightened and/or frightening parental reactions, the internal working models contain the experience of fear in the child and the memory of negative parental reactions. There result mental structures that are split between these implicit memories of fear and aggression and those involving comfort. It is not surprising to find that, as well as the ambiguous and multiple perceived behaviours of the attachment figures, the sense of self is also correspondingly split. Each structure also carries its own divergent or oppositional expectations. From this, Liotti posits that where there have been adequate, secure and consistent infantile attachments to the caregiver, later stresses and traumas will not produce multiple identities.

In the clinical case that I will now discuss, dual aspects of pathological dissociation were seen with splitting both of identity as well as aspects of sensory and cognitive experience.

Anna and her alters

Anna (a pseudonym), a 55-year-old mother of two adult children, in her second marriage of over 20 years when we met, has given me permission to discuss her case. She had been a lifelong healthcare worker. Following a job-related back injury she had undergone several failed surgeries and extensive rehabilitation efforts. She continued to have severe disabling pain, marked limitation in strength and activities of daily living, and significant depression.

Anna was found to suffer from Dissociative Identity Disorder and to have an array of alter personalities, each with its own different experiences, and emotional and physical sequelae. There emerged a history beginning at the age of three or four of physical, sexual and mental abuse and overt torture at the hands of a maternal uncle and grandmother—her caretakers in the absence of a father and a mother working in another city. Anna had no memory of her mother being aware of or trying to stop the abuse that had continued well into adolescence. Neither was there any memory or feelings of closeness between Anna and her mother. Anna had completed college and had a lifetime history of successful work and a relatively functional family life in her second marriage, although not in her first. Her physical condition clearly had worsened considerably from her initial denial of her injury, with increasing pain symptoms and physical limitations. During the third year of her twice weekly therapy, just before a holiday, an alter personality informed me that hospitalization was needed so that Anna could tolerate the memory that was about to emerge. In an inpatient setting, a child-alter told of the holiday visit of an aunt and young cousin, Ella, to be with Anna and her family—both girls were six or seven at the time.
Living in a distant city, Ella had not been subject to the extensive torture and conditioning to block crying or reacting to sexual abuse that Anna had suffered. During the holiday, both Anna and her cousin were molested by the uncle. The young cousin became hysterical and continued screaming in spite of threats from him. Anna watched as he murdered Ella. She was then forced to help him dig a grave and bury the body. Her uncle manufactured a fictional story to explain Ella’s disappearance, saying she had wandered off and that no one knew her whereabouts. Following the emergence of this dissociated trauma-history these many years later, Anna informed her family. Ella’s remains were recovered and given a proper burial. This was only one example of the extreme abuse and torture experienced by this woman.

By the sixth year of Anna’s therapy, her mother had developed severe Alzheimer’s and was living in a dementia facility. She knew and recognized no one, including Anna. As we worked, a child-alter manifested, that might be designated as carrying the ‘personal spirit’ (Kalsched 1996) or true-self representation (Winnicott 1960). This alter was persistently troubled by her inability to adjust to ‘present time’, and her lingering questions over what had happened to her mother, whom she had loved.

Anna was, by this time, able volitionally to switch to the child-alter state. With considerable advance planning, she induced such a change while visiting and alone with her demented mother. At first, the child-alter could not accept that this woman could possibly be her mother. After a period of time, and a number of such encounters, a startling event occurred. In the presence of the child-alter, her mother had a period of considerable lucidity. She recognized her daughter in the child-alter state. In repeated episodes over the next several months, Anna’s mother sang songs which she had sung to her as little girl, and expressed her love and care for her. When asked by the child-alter why she had not protected her when the abuse began, her mother told of her own childhood abuse by Anna’s uncle with the consent of her own mother. She had been told by her brother that if she interfered or reported anything, he would kill her and her daughter. Now having this knowledge and experience, the child-alter was able to move in to present time and circumstances. Within the next several months Anna’s mother died. Over the years of our work, there had been a diminution of Anna’s dissociative self-numbing and distracting defences with a greater connection to her psyche-soma and true self. Concomitantly there was a diminution of her residual physical pain, amelioration of her depression, and a marked increase on her part to be able to recognize and experience impingement, trauma or boundary violation. With this there was significant integration of her sense of self and cessation of any overt identity switching.

Discussion
Liotti has suggested that disturbance in the earliest attachment relationship to the primary caregiver is a basic feature of the development of multiple
identities. Where this relationship has been reasonably secure, he posits that pathological dissociation does not occur. Without speaking directly to the issue of multiple personality, Winnicott laid a groundwork for understanding of this phenomenon with his concepts of the development of the true and false selves. Smith (1989) has expanded Winnicott’s original thinking about the true and false selves in relation to multiple personality. He suggests that rather than there being multiple selves, there is one true self—often the most hidden and regressed child-alter, even if only a potential self. Following Winnicott’s thinking, he believes there is also one principal compliant or adaptive false self, with any number of layered false-self derivatives. Each of these has catalogued some further unacceptable, un-metabolized impingement or trauma, and has its own way of adaptation or compliance which further distances the trauma from the true self. Kalsched (1996) has described a similar process in which the archetypal defences of the self-care system develop to protect what he designates as the ‘personal spirit’, akin to Winnicott’s true self. In addressing the development of multiple personality, Smith (1989, p. 143) writes,

it is not sufficient merely to withdraw cathexis from the body and experience the self as localized in the mind. A more drastic, but significantly more effective solution is to develop another false self to experience the physical sensations as they occur and to catalogue them (in Winnicott’s terms). Thus, the bodily sensations are neither experienced nor lost. They remain potentially available for future integration.

It is not often that we have a glimpse into the mental state of a caregiver in such situations. Nonetheless, it was a dramatic interaction between a victim of child abuse and her mother, herself a similar victim. There were clear indications that for Anna there had been some appreciable degree of maternal reverie, containment and development of a true self, separated and isolated as it had been. This history may well explain the degree to which Anna was better able to function on a higher level than many other similarly abused patients. There was a massive traumatic impact from the loss of this early relationship. This, with the later overwhelming intrusive hyper-stimulation and abuse led to additional conflicting internal working models or complexes. Thus Anna, with the occurrence of additional adult trauma and sensory hyper-stimulation, responded with dissociation of both identity and of sensory experience and processing and interpretation.

An early positive attachment with environmental security, even with some deficits, when predominantly positive and coupled with an ability to develop coping defences—dissociative and otherwise—did facilitate better adaptation for Anna. Excessive stresses and trauma broke through her adaptation, with repeated emergence of maladaptive responses. The dissociative process recognized and described by Jung (1934) thus continues to have major implications for understanding, experiencing and working analytically with individuals lacking in early appropriate attachment relationships in whom re-traumatization frequently occurs.
References


Attachment, sensitivity and agency:  
the alchemy of analytic work

Marcus West

Our attachment needs are the most fundamental and powerful elements in our makeup. They can bear little frustration and, if and when they are frustrated, they become split off and dissociated, yet remain embedded in insecure and disorganized patterns of relating which can have a defining influence on our lives.

Our attachment comes essentially from our need to relate, connect with others, and to form a secure base, and I will be exploring how this overlaps with the need to develop, unfold and express one’s self, which I see as the essence of Jung’s understanding of the process of individuation. Expressing ourselves is fraught and difficult because it is essentially an expression of our sensitive core self which opens that self up to rejection and narcissistic wounding; it is for good reason that Fordham called such self expression a ‘deintegration of the self’. I will be looking at the work of Ed Tronick and the Boston Change Process Study Group which I think throws vital light on these relational processes.

In this paper I will describe my work with ‘Eleanor’ and explore her disorganized attachment pattern and, in particular, the way that her unmet attachment needs led her to extremely chaotic and at times dangerous behaviour such as getting into physical struggles with the police, taking overdoses and other suicidal behaviour.

Eleanor

I am grateful to ‘Eleanor’ for her permission to discuss our work; the account that follows is necessarily abbreviated with only certain themes drawn out due to constraints of time and space.

Eleanor was the eldest child of very proper middle-class English parents. They were kind, but emotionally unexpressive and distant. Her mother described Eleanor as ‘clingy’, a description with which Eleanor herself readily agreed. Eleanor was 4 years old when her brother was born; he had severe physical, emotional and intellectual needs and required an enormous amount of care from her parents and healthcare professionals. Eleanor was expected to ‘be a big girl now’ and just get on with things as the household came to centre around her brother’s care needs.

Eleanor in fact grew very close to her brother, taking a significant role in his care at times, and it was very difficult for her when he was sent away to be cared for when she was 11 years old. Eleanor was very upset by this, but her mother told her ‘not to make a fuss’; I do not get the sense of her mother being
deliberately cruel, and one can imagine, perhaps, a mother who was herself upset at having to put her son into a home and who, as often before perhaps, had few resources to deal with her daughter's distress. However Eleanor vowed never again to tell her mother, or anyone else, what she was feeling. This vow can be traced back to earlier experiences of rejection, as I will describe, but it was one which had enormous significance on the course of her life.

Eleanor struggled at school; unable to share what was going on for her, she felt isolated and unable to cope. She married young and had two children. She trained in the helping professions, but found work hard as she was terrified she would be found not good enough by her managers. She was able to hold things together, after a fashion, whilst she brought up the children, but in her early 40s she broke down completely. She regularly took overdoses and would frequently run down to the local pier, two or three times a week, where she would hang dangerously off the end until the police would come to rescue her. At this point she would usually resist arrest and struggle with the police until they overpowered her and she achieved the experience she was looking for, as she described it to me, of being taken over and of feeling that she was inside someone else.

After a year in a specialist psychiatric unit, followed by a period of three times per week analytic psychotherapy, which she felt had broken down because her therapist felt flooded by her desperate telephone calls at 11 pm at night, she began twice weekly therapy with me.

In the therapy she was very 'well behaved' at first as she feared a repeat of the breakdown of the previous therapy. This meant that, as in her childhood, she was not expressing what was really going on for her, and she would occasionally take overdoses and regularly run down to the local pier.

I was not too drawn into 'managing' her behaviour—fortunately she had a good psychiatric support system—I concentrated with her on what she was feeling and what it all meant. She told me that she did not want to exist in the world, she wanted to come to exist inside someone else; at first, anyone else would do, as long as they took over, took responsibility, made decisions, were physically present and in control. As we explored this her running down to the pier and taking overdoses became less frequent and, within six months, had stopped completely; although she feared that people, and especially me, might think she was 'alright now' and discharge her.

Eleanor was adamant that she did not want to have to make any decisions or take responsibility in her life—she had no sense of agency and did not want one. Paradoxically this meant that everything, even taking the dog for a walk on a beautiful sunny day, became a chore, as it was something she felt she 'had to do' as she made no choices herself. Consequently she got no enjoyment or pleasure from life. Jean Knox describes someone with a similar aversion to self-agency, although with a different aetiology, in her excellent paper, 'The fear of love: the denial of self in relationship' (Knox 2007).

As we explored making some small decisions—which route to walk the dog, what to do at the weekend —she experienced a remarkable change in her life: she
felt stable, that she had a direction and a sense of meaning, and her depression lifted and she began to enjoy things. A tentative sense of agency had developed.

This came crashing down after about a month when, in passing, she said in one session that ‘everything felt all right’. Afterwards she had an enormous backlash and was plunged into chaos, confusion and panic again, being unable to think and desperately wishing to be inside someone else. Essentially she feared she would have to do everything completely alone again, without support. Whenever any powerful feelings were triggered Eleanor became profoundly confused and unable to think—something that is well documented in the attachment and neuroscience literature as a state of hyperarousal due to a traumatic flooding of affect that cannot be regulated (see for example, Margaret Wilkinson’s book *Coming into Mind*, 2006).

Even though we discussed this whole scenario, and Eleanor could understand it clearly, she was equally clear that she did not want to take any control or responsibility for her life. I began to doubt that we could make much further headway and, after sharing this with a group of colleagues one day, I was struck by a powerful sense of shame, which I subsequently understood to parallel Eleanor’s own sense of powerlessness and shame at not being able to affect the world or, one could also say, to be in control of it in the way she would have liked.

Perhaps unconsciously picking up on my feelings of hopelessness, Eleanor began more actively exploring her state of mind with me and told me that she realized that what she had been wanting all this time was to go back to a state before she had any form at all—a point just after conception. Her exercising this thinking had an immediate effect, and her longing to be inside someone lessened due, I believe, to the fact that it was being contained by her own thinking ego-functioning.

I would like to pause briefly here to look at the work of Ed Tronick, as it was through focusing on the moment-by-moment interactions in the therapy that we were able to move further.

**Tronick**

In the 1980s Tronick and his colleagues made some simple but groundbreaking observations of the interactions between mothers and infants which I think throw a profound light on the significance of the way we interact and how that relates to the way we feel about ourselves.

Tronick described how, if the mother does not respond to the infant, or alternatively tries to engage the infant when they are doing something else (such as sucking their fingers), the infant experiences this as a ‘mismatch’ in relation to their expectations and desires. He says that such mismatches are entirely ‘normal, typical and inherent to an interaction’ (Tronick & Gianino 1986, p. 159), although they generate negative emotions.
However, Tronick describes the infant’s ‘coping behaviours’ which can repair the mismatch and turn it into a match, at the same time changing the negative emotions into positive emotions (ibid. p. 156). These coping behaviours are such things as signalling, cooing, making ‘pick me up’ gestures or making a fuss. If they are successful, it increases the infant’s sense of efficacy and mastery, their coping capacities are strengthened and elaborated, and the infant internalizes a pattern of interaction that they bring to interactions with others. In other words the infant gains a sense of agency and feels confident that others will respond to them. Tronick writes (p. 156),

Indeed, to the extent that the infant successfully copes, to that extent will the infant experience positive emotions and establish a positive affective core.

In other words, the way the mother responds (or not) to the infant’s ‘coping behaviours’ to repair mismatches affects profoundly the way infants feel about themselves. He continues, however, regarding the negative outcome:

The infant who employs his coping strategies *unsuccessfully* and repeatedly fails to repair mismatches begins to feel helpless. The infant eventually gives up attempting to repair the mismatches and increasingly focuses his coping behaviour on self-regulation in order to control the negative emotion generated. He internalizes a pattern of coping that limits engagement with the social environment and establishes a negative affective core.

(ibid., p. 156)

This, I believe, is what had happened with Eleanor. In the therapy we kept returning to an incident that pre-figured the time when her mother told her ‘not to make such a fuss’ when her brother was sent away. On this earlier occasion her mother was sitting dozing in her chair in the living room and Eleanor went up to her wanting a cuddle; her mother had said, ‘Not now dear I am trying to have a rest’, to which Eleanor had responded ‘I just wanted to tell you I love you’, to which her mother had said, ‘Yes dear, but I am having a rest just now’.

This might seem like a small interaction, one that might be repeated in any home, yet for Eleanor it was traumatic and she walked away feeling truly terrible: bad, humiliated, rejected and alone. I believe this was to some extent a screen memory, embodying many similar experiences from her early life.

Eleanor began to dare to let me know about a similar conflict she was having in the therapy with me. She told me that she was afraid of running up to me and hugging me, and that she knew this was ‘inappropriate’ as her previous therapist had told her so, and that she therefore had no option but to repress all these feelings.

Now my telling her it was all right for her to run up to me and hug me would have been no use as it would have avoided the opportunity to explore what, I suggest, was the core difficulty, namely the intense shame and rejection that she experienced when her expression of her vulnerable, loving self was not...
met in the way she hoped. This is exactly the kind of mismatch which Tronick
describes that generates ‘negative emotions’ in the infant, which makes them
turn away from relationship, as Eleanor had done.

When she ran down to the pier to grapple with the police she experienced
herself as having been taken over by split off feelings that she could no longer
resist. She did not ‘own’ these feelings, they ‘owned her’, as it were. They were
not integrated with her core self, so that she did not experience the same threat of
shame and humiliation, even though she was being driven, in utter desperation,
to take such extreme action in order to get the hugs and the sense that someone
else was taking control, in other words, to get some of her attachment needs met.

By paying attention to the moment-by-moment interactions in the analytic
sessions, it was possible to see and explore with Eleanor the moments when
she was struggling to express her sensitive, vulnerable, core self, and equally to
explore those moments when she either feared, or actually experienced, intense
shame and rejection if she felt what she was expressing was not going to be
heard or met; for example, in telling me about her fear of, and wish to, hug me.
My attunement to her emotional state, especially, here, her feeling of shame
and fear of rejection, served as a matching response which addressed her core
feelings of distress. Had I acceded to her wish to hug me I would simply have
reinforced her form of self-regulation, which she used to avoid her emotional
distress (see below for a discussion of how what may appear as interpersonal
regulation may actually be a form of self-regulation).

As we explored these things Eleanor began to be able to own and express
more of these core feelings and thus begin to integrate them into herself, so that
her life became a lot richer and fuller. As her repertoire of feelings increased
so her sense of herself became more substantial; everyday issues such as going
shopping or parking the car were no longer troublesome.

I believe that in this way she began to organically develop a sense of
agency. Until this occurred her attachment had been ‘adhesive’, requiring that
others take over her ego-functioning and regulate her experience of self (Stern
1985/1998). She was now much more able to negotiate the world and relate to
me as a separate other, relatively secure in the sense that I would accept what
she said and that we would find a way of helpfully engaging with it; as Beebe
and Lachmann (2002) would put it, she had developed more adaptive forms
of self-regulation as well as becoming more secure in our interactive regulatory
processes. I think previously she had just flipped between rigid self-regulation
and an intense desire that I would regulate her. Colman has pointed out however
(personal communication February 2011) that this form of regulation by the
other, for example, running down to the pier to get ‘rescued’ by the police,
is a form of self-regulation in disguise as Eleanor would remain ultimately in
control, having set up the scenario; these kinds of interactions do not allow for
relationship with a real other and are thus not ultimately satisfying.

As explained above, I think it was important that I did not try heroically
to rescue her, bending myself out of the analytic frame to protect her from
narcissistic wounding. In our work together I frequently thought of Edward Edinger’s (1972) excellent description of the cycle of narcissistic wounding and the recovery from that wounding that we must all go through in order to live realistic and fulfilled lives in this regularly frustrating and wounding world. The ‘wounding’ that the analytic frame inflicted on her in terms of offering limits to her sense of agency was both reassuring (that she was not, in fact, all powerful), as well as giving us the opportunity to work through her experience of mismatch, facing the reality of her core complex.

As the Boston Change Process Study Group (2007) describe so well, the answer lay ‘on the surface’, in the intricacies of relating and in the experiences of acceptance and rejection that naturally occur in every interaction and in every relationship. It was not a matter of a deep defence that needed uncovering. The myriad experiences of rejection of her sensitive core self had left Eleanor feeling intensely bad about herself, unable and unwilling to develop her self-agency and instead trying to obliterate herself; as a result her attachment needs had had no option but to emerge in a boundless and unboundaried way. Working with the shame induced by the rejection was key to helping her relate from her core self, and learning to trust that she could affect me and that I would engage positively with her.

The patient comes to us feeling like shit about themselves and shamefully fearing interaction with others; the real alchemy of analytic work is transforming these shitty and shameful feelings into the gold of self-expression and fulfilling relationship.

References


TRANSLATIONS OF ABSTRACT

Ce panel a émergé à partir de préoccupations cliniques partagées autour du travail avec des patients adultes dont les caractéristiques rappellent un pattern d’attachement infantile désorganisé (type D). Le travail psychothérapeutique avec de tels patients pose
des dilemmes transférentiels et contre-transférentiels compliqués. Ceux-ci sont envisagés par les quatre participants au panel via la théorie et des vignettes cliniques. Tous partagent un intérêt commun pour les théories contemporaines de l’attachement, les neurosciences et les théories du trauma, dans leurs rapports à la psychologie analytique. Le trauma intergénérationnel semble constituer un facteur saillant dans l’évolution d’interactions fragmentées et fragmentaires générant des fractures dans la cohérence interne et dans les relations interpersonnelles. Un trauma relationnel si précoce est composé d’une accumulation d’épisodes d’abus et de négligence, produisant une faille dans le noyau constitutif du sentiment d’être-soi. Les cliniciens partagent leur intégration respective de la théorie et de la pratique de ces patients dissociés et désorganisés. Elle vise à les accompagner vers une transformation de leur sombre et extraordinaire souffrance et ce, au travers d’expériences implicites et explicites du lien avec l’analyste, donnant naissance à de nouveaux patterns relationnels, internes et externes, porteurs de vie. L’alchimie de la transformation, intérieure et extérieure, est évidente dans les situations cliniques présentées.


Questo panel nasce da aspetti clinici condivisi nel lavoro con pazienti adulti, il cui modo di presentarsi risentiva di uno schema di attaccamento infantile disorganizzato (Tipo D). Il lavoro psicoterapeutico con tali pazienti pone complessi dilemmi di transfert e controtransfert che vengono indicati dai 4 autori dei panels mediante vignette teoriche e cliniche. In comune vi è un interesse riguardo le teorie contemporanee sull’attaccamento, sulle neuroscienze e sul trauma e sulle relazioni con la psicologia analitica. Il trauma intergenerazionale sembra essere un fattore saliente nell’evolversi di interazioni frammentate e frammentanti che conducono al fallimento della coerenza di sé e della costruzione di relazioni interpersonali sane. Questo trauma relazionale è composto di vari episodi di abuso e di trascuratezza che hanno condotto a un fallimento nel senso nucleare del sé. Questi clinici condividono il come hanno integrato teoria e
pratica in modo da aiutare pazienti dissociati e disorganizzati a trasformare, mediante esperienze implicite ed esplicite avute con gli analisti, la loro oscura e enorme sofferenza in nuove e vitali modalità relazionali con sé e con gli altri. Nel materiale casistico presentato è evidente l’alchimia della trasformazione, sia positiva che negativa.

Обсуждение на этой панели сосредоточилось вокруг общих для многих присутствующих клинических вопросов о работе с взрослыми пациентами, чей стиль самопредъявления напоминает паттерн дезорганизованной младенческой привязанности (тип Д). Психотерапевтическая работа с такими пациентами ставит нас перед сложными переносными и контрпереносными дилеммами, к которым каждый из четырех панелистов обращается с помощью теории и иллюстраций клинических случаев. Общими для них являются интерес к современной теории привязанности, к нейронауке и к теории травмы, а также отношение к аналитической психологии. Межпоколенческая травма, похоже, является ярким фактором в эволюции осколочных, фрагментированных взаимодействий, приводящих к неудачам в связности самовосприятия и к срывам в построении здоровых межличностных отношений. Подобные ранние отношенческие травмы сочетаются с последующими эпизодами насилия и запущенности, ведущими к срыву глубинного самооощущения. Клиницисты делают тем, как они интегрируют теорию и практику, чтобы помогать диссоциированным и дезорганизованным пациентам трансформировать темные невыносимые страдания в новые, жизнеутверждающие паттерны отношений с собственным «Я» и с другими – посредством имплицитных и эксплицитных переживаний общения с аналитиком. Алхимия трансформации, как позитивной, так и негативной, ясно видна в представленном клиническом материале.

Este panel surgió de preocupaciones clínicas compartidas al trabajar con pacientes adultos cuya forma de presentación recuerda a un (Tipo D) patrón infantil de relación desorganizado. El trabajo psicoterapéutico con tales pacientes se complica por conflictos detransferencia y contratransferencia, estos son discutidos por cuatro panelistas a través de la teoría y de viñetas clínicas. Existe un interés común en la teoría contemporánea de las relaciones, la neurociencia y el trauma, y su relación con la psicología analítica. El trauma intergeneracional parece ser un factor predominante en la evolución de las interacciones fragmentadas y por fragmentar las cuales llevan a fallas en la auto-coherencia y las relaciones interpersonales sanas. Tal trauma relacional temprano es compuesto por episodios adicionales de abuso y descuido que conducen al fracaso en la adquisición de un claro sentido identidad. Estos clínicos comparten la forma en la cual han integrado teoría y práctica para ayudar a pacientes disociados y desorganizados y transformar su oscuridad y sufrimiento extraordinarios, mediante experiencias implícitas y explícitas con el analista, en nuevas patrones de vida para una mejor relación consigo mismo y con otros. La alquimia de la transformación, en ambos sentidos, positivo y negativo, se hacen evidentes en el material presentado.