Because Connection Takes Two:
The Analyst’s Psychology
in Treating the
"Connection-Resistant" Patient

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That “we are the tools of our trade” (Pearlman and Saakvitne, 1995) and thus, need to address the impact of who we are on what we do suggests an omission in Steven Stern’s article—namely, attention to the role in the analysis of the analyst’s psychology. Drawing on attachment research, I theorize that we clinicians are often shaped by the unresolved trauma of parents that leaves us with (at least traces of) disorganized attachment to which we adapt with the “controlling-caregiving” strategy identified by Mary Main. This history (which is mine and perhaps Steve’s as well) welds trauma to shame, may thus have us trying too hard to be “good,” and may be part of what apparently encouraged Steve to valorize acceptance and marginalize his own subjectivity. His evolving stance was clearly healing, but the work might have been deepened had Steve explored—at times in dialogue with his patient—the impact on their relationship of his own attachment history and patterning.

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As I begin again—the third draft of this article—I find myself (half facetiously) tempted to title it: “Arguing With Success: A Churlish Critique.” For it’s hard not to feel ungracious when questioning an approach to a patient’s suffering that was as profoundly healing as Steve’s was. I’ll get back to Steve’s article, but first I want to recall for you my rather tortured experience of getting to the second draft. Arising much earlier than usual, I meditated, and then wrote these words: “I settled into the peace, calm, stillness, and spaciousness of meditation after waking in a vise of


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mental and emotional tumult as I contemplated with fear the challenge of completing this damn paper in two days max." Why so much angst? It wasn’t the deadline. It was, rather, that Steve’s clinical approach, as described in his account of his extraordinarily helpful work with Linda, somehow “triggered” me—and for reasons I’ve only gradually come to understand. Now the logic of beginning in this rather odd fashion is as follows: I’m guessing I was invited to discuss Steve’s article partly because of the teaching and writing I’ve recently done that’s focused on the ways in which our own psychology shapes our work—often constraining, but potentially enhancing our efforts to be of help to our patients. “We are the tools of our trade” (as Pearlman and Saakvitne [1995] have written) and therefore, we need to pay considerable attention to the impact of who we are on what we do. What I’m trying to convey here is that whether we’re responding to a patient or responding to an article, our freedom—to think, feel, communicate, and act—will largely be determined by the extent to which we can recognize in the present the hand of our past so as to begin to be able to loosen its grip.

I’ve struggled in responding to Steve’s article for reasons having to do with my own psychological history as it is engaged and activated by the stimulus that is Steve’s work with Linda. I’m guessing that my struggle in some way mirrors Steve’s as he attempts to serve two masters with apparently contradictory claims: One master asks for a response to the patient that is accepting, empathic, and understanding while the other asks for more from the patient: More openness, vulnerability, connection, and feeling. It’s my hunch that for Steve the injunctions of the first master are easier to heed than those of the second. Certainly that’s been true for me in my own clinical work (though less so as time has gone by) but now it seems to be true again as I respond to Steve’s article. I have wanted to convey my respect for, and my understanding of, Steve’s healing work with Linda but also—and in a way that’s much more conflicted—I’ve wanted to convey my reservations about that work and my sense of how it could have been deepened were Steve to have explored, inwardly but also at times in dialogue with Linda, the influence of his own history and psychology on his ways of being with her. So Steve struggled as Linda’s analyst and I have struggled as the discussant of Steve’s analytic work. Ultimately, I think, this is a struggle to move beyond the world of “either/or” to that of “both/and”—where a relationship can be experienced as a setting in which there’s room for two: Two subjectivities, two voices, two wills. This was the “journey” of Steve and Linda—to find a way for both to be present rather than to feel, as Linda did, that to yield to the relationship with her analyst was to lose herself or to feel, as I think Steve did, that to be more fully, transparently himself was to risk depriving his patient of the chance to find herself. I know the roots of my own struggle to be more fully myself lie in my history with a problematic attachment figure (my mother—an intrusive, controlling, and volatile presence very much like, but also unlike, Linda’s mother) and I suspect the roots of Steve’s struggle are similarly psychological, though he doesn’t discuss them as such.

It’s this missing piece—Steve’s lack of explicit attention to the impact of his own attachment history and patterning—that strikes me as a puzzling and problematic facet of his work with Linda. Drifting toward self-referential hyperbole here, I find myself wondering how Steve could possibly have accomplished so much while failing to avail himself
of a resource I find indispensable. Like, how could he have played Bach so brilliantly with one hand tied behind his back? But I have to admit that while this is not my style, I found myself in the midst of the same meditation I referred to earlier thinking that Steve’s very healing work with Linda might mirror in some ways the very healing work my current analyst has done with me. In both cases, the therapeutic action may have depended on the analyst’s ability to compassionately witness the patient’s experience without intruding on it and thus, to function as a kind of antidote to the mother who regularly usurped the space that could have been her child’s. (And here, an “aha” moment: Of course, I’ve struggled with this discussion because I’m questioning not only Steve, but also my very helpful analyst. This is progress!) Steve sees himself as achieving some version of genuine acceptance only in the last two years of the analysis, but it’s my sense that for much of his relationship with Linda, Steve did a good job (perhaps too good a job) of staying out of the way, of being a relatively calm, benign, and un-intrusive presence who made room for Linda’s experience to be recognized, understood, and accepted (including her experience of not being accepted). Alongside whatever else I will have to say about the nine-year analysis I believe it was largely Steve’s quality of non-intrusive presence that allowed Linda to open up both to herself—her ambitions, her inspiration, her love—and to him, so that she could, by degrees, take him in as a kind of loving presence, offsetting the darker internal presence of her pained and painfully intrusive mother.

That being said, there is the “missing piece” to which I alluded above—the attention to Steve’s attachment history and its impact on his work with Linda that is simply omitted. This omission seemed, to me, forecast in the article’s title that refers to the “connection-resistant patient.” Granting that some of us are hungrier for connection and some more wary of it, connection is nonetheless a relational matter and relationships take two (at a minimum). Yet Steve writes very little and says very little to Linda about his own psychology as it relates to connection.

Needless to say, Steve is not alone in this way of focusing (or rather, not focusing). Despite the reality that, as I mentioned earlier, we are the tools of our trade, the impact of our own psychology upon our clinical conduct and effectiveness tends, in proportion to its real importance, to receive far too little attention in both our literature and practice. From the attachment perspective within which I work, this neglect appears very problematic. For I assume (as I suspect Steve does) that, in childhood and psychotherapy alike, the relationship is where the developmental action is: Just as the child’s original attachment relationships make development possible, it is ultimately the new relationship of attachment with the therapist that allows the patient to change. But development (like connection) takes two. For this reason, the finding of attachment research that the parent’s security, insecurity, or trauma is regularly transmitted to the child should catch our attention. For it suggests that not only as parents but also perhaps as therapists, our ability to generate a secure attachment relationship will be profoundly affected by the legacy of our own attachment relationships—a legacy that is, for many of us who choose this work, marked by trauma. As clinicians, our experience of an unhappy or traumatic childhood usually has a double impact: On the one hand, it produces vulnerabilities that can contribute to treatment impasses; on the other hand, it can be a source of both insight and inspiration. As Adrienne Harris (2009) puts it, “We need to see the inevitable presence
in the analyst of wounds that must serve as tools, aspects of the analyst's capacities that are simultaneously brakes on and potentials for change."

With what I've just said as a backdrop—and knowing nothing about Steve's attachment history, about the wounds that must serve as his tools—I'm going to try to sketch a useful understanding of Steve's profoundly healing work both as it was and how it might have been had he focused more—both inwardly and in dialogue with Linda—on the impact in their relationship of his own psychology. Casting aside my disinclination to lean too much on theory, I'm going to enlist in this effort a hypothesis I have concerning the developmental trajectory of many of us who choose to work as therapists or analysts.

The hypothesis I'm proposing (one I recently learned is shared by the Italian attachment researcher-clinician, Giovanni Liotti [personal communication, 2013]) is that the path to our "impossible profession" often begins with a history of early trauma to which we adapt with what attachment researchers call a "controlling-caregiving strategy." Longitudinal studies show that many infants assessed at 12 months as "disorganized"—presumably as a result of growing up with attachment figures whose own unresolved trauma made them frightening to their babies—have by school age developed an organized, distinctly solicitous, role-inverting attachment strategy (Main and Cassidy, 1988; Wartner et al., 1994). Like these previously disorganized children, many therapists-to-be have learned to take control of scary parents by taking care of them. Put differently, many of us are "wounded healers" who in the role of "parentified" children first acquired many of the skills we now bring to our work as therapists. This early clinical training confers advantages, to be sure, but also vulnerabilities—one of which is the vulnerability to shame, that is, the sense not that one has done something bad but that one is bad. In their recent book, Listening With Purpose: Entry Points into Shame and Narcissistic Vulnerability, Danielian and Gianotti (2012) write:

Shame cannot be understood, let alone treated, unless the therapist has processed the deeper levels of his or her shame. As therapists, when we see shame, we should look for trauma; when we see trauma, we should look for shame. (p. 193)

As protection from our trauma-based vulnerability to shame—shame that wears different colorings of badness, from destructiveness to selfishness to humiliating insufficiency and powerlessness—we may feel not just committed to healing, but compelled to heal, compelled to be good and effective.

Clearly trauma and shame figure in the psychology of Steve's patient Linda. She is articulate about her shame, and her habit of dissociation points in the direction of her trauma and disorganization. I'm suggesting, of course, that trauma and shame very likely figure as well in the psychology of many clinicians (including myself). Without knowing Steve, yet looking at his work with Linda, it is easy for me to imagine that his profound intuitive understanding of her as well as what I would call his inhibition both stem from his partial identification with her, presumably based on some overlap in their histories. Obviously I'm speculating about Steve's psychology here—so it should be kept in mind that as I discuss the possible meanings of what Steve did and didn't do in
the analysis, I'll be considering what the nature of his participation in the analysis may suggest in its own right, but also in the light of my theory about how clinicians come to be clinicians.

Steve frames the analysis as a story of two distinct subjectivities engaging, navigating, and negotiating their differing, shifting, and internally somewhat inconsistent and conflicted views of what Linda needs from Steve in order to heal. He "knows" that what she needs is a relationship of dependency within which to feel her problematic feelings. But he also knows—and fears—that to insist on such a relationship would be to disregard her deepest fears. For her part, Linda "knows" that she can't allow such a relationship and can't bear to feel her terrifying feelings, while at the same time she wants someone to "hold her feet to the fire" and someone to somehow be the mother she never had. These tensions between them, but within each of them as well, create two closely linked dilemmas that Steve wrestles with in the analysis, almost from start to finish. Part of what makes Steve's account so compelling is that, as clinicians, most of us so regularly confront the same dilemmas. The first dilemma concerns the extent to which we should accept the patient as she is or expect more from her than she presently believes herself capable of. The second question concerns the extent to which we should make room for the patient's perspective and experience or offer her our own perspective and experience.

It's easy and true to say that these dilemmas aren't matters of either/or, that the most therapeutic stance is both/and—both accepting the patient and expecting more, both making room for the patient and making room for the therapist. Yet like most of us at times, Steve seems to have had to work very hard to somehow balance the competing desiderata. And like many clinicians with the modal history I've sketched—and the schooling in a "controlling-caregiving" approach to regulating the emotions of suffering, but also threatening, others—Steve may lean toward acceptance and toward marginalizing his own subjectivity in ways that are determined not only by his sense of what's in his patient's best interest, but also by his psychology.

As therapists, our conduct is usually shaped by several intersecting influences. A partial list: Our theory of therapy, our conscious sense of what the particular patient might need from us, the pressures the patient unconsciously exerts upon us, and our own history and psychology. Regarding the drift I've ascribed to Steve's conduct, I'll offer these speculations. To the extent that Steve's theory is influenced by self psychology, he may be inclined to privilege the subjectivity of the patient while "bracketing" his own. His sense of what Linda, in particular, might need from him seems to nudge his approach in a similar direction. Having grown up with a needy, controlling, judgmental, and "mind-blind" mother to whom she was required to cater, Linda was left with an all-too-fragile, shame-saturated sense of self. Regarding her as one of those patients who are "exquisitely sensitive to any pressure or message that the therapist needs them to be a certain way" (Stern, this issue, p. 181), Steve was extremely cautious about imposing on Linda his own expectations or judgments. He notes, for example, "I worried to myself that I was enacting something through a subtle expectation that she be able to feel her feelings" (p. 186). Reinforcing this tendency to sideline his subjectivity was the influence Linda exerted by regularly ascribing to him the qualities of self-interest that she had known, first
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and most painfully, in her mother. Thus, Steve was seen initially to have ulterior and presumably selfish motives: He might use, exploit or hurt her; these “paranoid” attributions soon abated, but Linda continued quite relentlessly to regard Steve as judgmental, controlling, and (implicitly) needy. To counteract Linda’s impressions, I’m guessing Steve felt pressed to shrink the “footprint” of his own subjectivity. Finally, of course, there’s Steve’s psychology—or is it mine, or that of the therapist of my theory? In any case, with such a shame-prone psychology amplifying the aforementioned influences—of theory, of Linda’s “bad” mother and her fragile self, and of Linda’s attributing to her analyst some of the qualities of her “bad” mother—I can imagine that Steve (or any of us) might be unconsciously caught in the undertow of the need to be the “good” mother, which in this instance, might mean the mother (or therapist) who inhibits conspicuous expressions of the self.

In this connection, I think of the point Jody Davies (2004) makes in her article, “Whose Bad Object Are We Anyway?”—namely, that what can have us bending over backwards to be “good” is not just the threat of being seen as the patient’s bad object but of seeing ourselves as bad because this is how we were so painfully misperceived by our own parent(s). Davies is highlighting, as I do, the constraints imposed by the therapist’s shame, itself often welded to trauma. The threat of being nudged in the direction of my own shame and/or trauma has certainly inhibited me at times with my patients. Perhaps the same was true at times for Steve in his relationship with Linda.

Notwithstanding this “inhibition”—doubtless in part as a result of it—Linda got better. At various points and in various ways, she had expressed the longing for someone to somehow be the mother she never had. By the end of the analysis, Linda seems to have allowed Steve to be that mother (and for that matter also the father she never had, the father who never abandoned her). In order for this fundamental transformation to have occurred, Linda had to have changed. But I think Steve and I would agree that this change in Linda was enabled in large part by the ways that Steve also changed. From his perspective, the change began with “an inner sense of giving up” (Stern, this issue, p. 187) that gradually “evolved from resignation to acceptance to what I think of as true surrender” (p. 189) which allowed him to “relax into a dialogue of difference” (p. 189). I would propose a complementary perspective, suggesting that what was equally significant to the process of change in Steve and in Linda was Steve’s growing ability to take the risk of letting Linda in on his views, his emotional reality, his life (think, the Bat Mitzvah)—that, in turn, made it easier for him to surrender to her reality. Perhaps for Linda to let Steve in to her heart, as she did, Steve had to let Linda in. And I think Linda was actually “coaching” Steve to do exactly that when she invited him, implicitly or explicitly, to open up with her more, to direct the action more, to inhibit his anger less, and to be stronger so that he might be her “protector.”

Scrutinizing his own psychology to learn how his constraint might have been over-determined could have loosened its grip. Moreover, Steve’s apparent failure to focus on the impact of his psychological conflicts robbed him of a resource he might have used to better understand himself and his patient. The same sort of focus, particularly if it had been shared with Linda, might have helped to render less compelling some of the enactments in which the two of them were ensnared—enactments that “interpersonalized”
what might otherwise have come to be recognized as internal conflicts for Steve as well as internal conflicts for Linda. If, for example, Steve had been able to talk about his own discomfort at being seen by Linda as a stand-in for her judgmental mother (perhaps because such an experience pushed him in the direction of his own vulnerability to shame), then it might have been easier for her to relinquish her idea that she was simply struggling with Steve’s judgments about, say, her anger or her fear about being close.

In other words, had Steve been more openly thoughtful about his internal conflicts, it might have enabled Linda to be more curious about her own.

Needless to say, there’s much more that could be said. Obviously I’m advocating for increased attention to the impact on our work of our own psychology and a greater openness to sharing that focus with the patient. Part of the logic of this approach is that we are no less vulnerable than the patient to the problematic influence of our history and the ways it continues to shape us. If (following the lead of a younger Steve Stern [1994]) we are to provide for our patients the needed rather than only the repeated relationship, then we need to be as aware as possible of the ways in which our own patterning can stand in the way of our efforts to help patients deconstruct their old attachment patterns and construct new ones in the present. Another part of the logic here is that our willingness to be more transparent and reflective about our own shameful vulnerabilities can help both to model mentalizing and to de-toxify the patients’ shame. In this connection, I’ll close by quoting Irwin Hoffman (2013) who recently wrote: “Let’s not forget this simple truth: ‘We’ are also the patients. This is a large self-help group.”

References


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TRANSLATIONS OF ABSTRACT

Que «nous sommes les outils même de notre métier» (Pearlman et Sackvitne, 1995) et que nous devons porter attention à l’incidence de ce que nous sommes sur ce que nous faisons semble être le point oublié dans l’article de Steven Stern, soit l’attention portée au rôle de la psychologie de l’analyste dans l’analyse. Partant de la recherche sur l’attachement, j’émets l’hypothèse que nous, cliniciens, sommes souvent modelés par les traumatismes non-résolus de nos parents, ce qui nous laisse avec (au moins des traces d’) un attachement désorganisé auquel nous nous adaptions par la stratégie, identifiée par Mary Main, du «soignant-controlo».

Cette trajectoire (qui est la mienné et peut-être aussi celle de Steve) soude le traumatisme à la honte et peut par là nous amener à vouloir un peu trop ardemment être «bons». Cela peut-il faire partie de ce qui a incité Steve à valoriser l’acceptation et à marginaliser sa propre subjectivité? Si sa position évolutive a incontestablement ouvert un chemin de guérison, le travail aurait pu être approfondi par l’exploration, à certains moments du dialogue avec sa patiente, de l’impact sur la relation de sa propre histoire d’attachement.

Dal principio che "siamo gli strumenti del nostro mestiere" (Pearlman and Sackvitne, 1995) e dobbiamo analizzare l’impatto di ciò che siamo su ciò che facciamo, risulta nel lavoro di Steven Stern una omissione—precisamente l’attenzione al ruolo che in analisi ha la psicologia dell’analista. Rifacendomi alla ricerca sull’attaccamento, formulo la teoria che noi clinici siamo spesso modellati sui traumi irrisolti dei nostri genitori che ci lasciano quanto meno delle tracce di attaccamento disorganizzato al quale ci adattiamo con la strategia di “controllo/accudimento” identificata da Mary Main. Questa storia (che è la mia e forse anche quella di Steve) salda il trauma alla vergogna e così ci spinge a sforzarci fin troppo per essere “buoni” e può aver avuto un peso in ciò che portò Steve ad accettare e a rendere marginale la sua soggettività. Il cambiamento del suo assetto ebbe di certo un effetto terapeutico, ma il lavoro avrebbe potuto essere approfondito se Steve avesse esplorato—in un dialogo condotto a volte con la stessa paziente—l’impatto sulla relazione della sua personale storia di attaccamento e di come essa lo avesse modellato.

Da wir gemäß Pearlman und Sackvitne (1995) „Werkzeuge unseres Handwerks sind“, und daher den Einfluss dessen, wer wir sind auf das was wir tun, berücksichtigen müssen, stellen wir etwas heraus, was uns in Sterne Artikel nicht ausreichend berücksichtigt zu sein scheint: die Aufmerksamkeit auf die Rolle der Psyche des Analysten in der Analyse. Mit Bezug auf die Bindungsforschung stelle ich theoretische Erwürkungen dahingehend an, dass wir oft durch unbewältigte Traumatisierungen durch unsere eigenen Eltern geformt wurden, die uns in (mindestens Spuren von) desorganisierten Bindungsmustern gefangen halten, die zu Strategien führen, die Mary Main als „kontrollierende Fürsorge“ bezeichnet hat Diese Vorgeschichte schmiedet (in meiner und vielleicht Stevens Biographie) Trauma im Schum und kann uns dazu verleiten, mit allen Mitteln „gut“ sein zu wollen und kann Teil dessen werden, was Steve offenkundig dazu gebracht hat, Akzeptanz zu bevorzugen und seine eigene Subjektivität zu vernachlässigen. Die Haltung, die er dabei herausgearbeitet hat, hat eindeutig heilend gewirkt aber die Arbeit hätte vertieft werden können, wenn Steven—zeitweise im Dialog mit seiner Patientin—untersucht hätte, welchen Einfluss seine eigenen Bindungserfahrungen auf ihre Beziehung hatte.