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What follows are references and extracts from Sue Austin's paper 'Complexes and the Early Relational Origins of Inner Landscapes'.

This paper was given on 22nd July 2023 as part of the Centre for Applied Jungian Studies' "Jungian and Post-Jungian Clinical Concepts Course".

Following up on discussion of Paternal function in anorexia nervosa:

I suggest;

Wooldridge, T. (2021) The Paternal Function in Anorexia Nervosa. Journal of the American Psychoanalytic Association 69:7-32.

1st of 4 extracts from Sue's paper, plus references

In order to provide a link between the papers you were invited to read and today's discussion I'm going to outline 4 main points of reference and key images which I've accumulated over decades of working such analysands.

At the end of the presentation I'll also offer a few stand-alone images to illustrate the clinical inner landscape which underpins how I work with my own inner otherness and that of my patients.

The first of my points of reference is: David Orlinsky's 1994 Summary of Psychotherapy Outcome Studies

Back in the mid-1990s I attended a seminar in Sydney given by Professor David Orlinsky which changed how I sit with and make use of my countertransferntial feelings of uselessness, despair and frustration when working with people with severe and enduring eating disorders and / complex trauma. Orlinsky's chart is the bedrock of my practice.

Orlinsky (now retired) was a psychologist and professor of psychiatry and comparative human development at the University of Chicago and the seminar was on his groundbreaking research and chapter in Bergin and Garfield's 1994 fourth edition of the Handbook of Psychotherapy and Behavior Change.

In this research Orlinsky summarises the findings of 2354 outcome studies which correlate therapeutic treatment time-frames with therapeutic outcomes to produce a one-page chart (p.276).

Orlinsky's research findings and chart gave me a huge sense of relief. It was the first time I had seen anyone describe what I was already beginning to suspect about therapeutic timeframes which was, that they were much longer than most people were prepared to own up to in clinical conversations, let alone in publications. And this was especially so

when the patient was looking for a personality change or modification of an axis-II personality disorder.

*Note: highlight the difference between Level 7 (personality change, e.g., modification of defences, removal of **neurotic** blocks to growth) = Long term treatment episodes, e.g., 2 – 7+ years AND Level 8 (character change, e.g., modification of **axis-II personality disorde**r) = sequential treatment episodes over **Small multiples of decades***

Implication 1 = even really skilled clinicians in treatment trials can't turn a patient with an axis II personality disorder around in 6 to 12 months, so the fact that I can't either doesn't ***necessarily*** mean I'm a useless therapist.

Implication 2 = reading between the lines, if working with these patients in a way that generates change is measured in, as Orlinsky puts it, 'small multiples of decades', any change is probably going to happen very, very slowly indeed, and a lot of the time it's likely to feel like nothing much is happening. So doing therapy with a desperate patient whose sense of self/interiority is abject is probably going to feel hellishly stuck and tormenting for them a good deal of the time, and probably for me also.

Again-feeling like this doesn't mean I'm ***necessarily*** a useless therapist (I might be, but this isn't proof of it).

What it does suggest is, however, that therapy has something of an organic nature, with its own time frames which do not correlate to conscious, will-based effort (be that effort from the therapist, the patient, or us as a pair).

While I may be able to use therapeutic tools (including, as I will outline, the frame and the therapeutic relationship) to explore possibilities of change with my patient as they arise in the here and now, we are both powerless over how this trickles down into the deeper layers of the psyche-soma and gives rise to deeper change, and the time period over which this might (or might not) occur.

Lacan argues that all resistance in therapy comes from the analyst. And Jungian Analyst, Harriet Machtiger describes how when an analysis is stuck, the analyst should work on their own countertransference.

Consequently, I have found that working with my own countertransferential shame, frustration and despair arising from my resistance to the powerlessness that is at the very heart of working with the kind of people I see is more likely to be of use to them as it means that I am less likely to get in their way as they try to explore the possibility of making use of the therapy space.

Relevant sources for 1st point of reference:

Orlinsky, D. E., Grawe, K., & Parks, B. K. (1994). Process and outcome in psychotherapy—Noch einmal. In A. Bergin, & J. S. Garfield (Eds.), Handbook of psychotherapy and behaviour change (4th edition, pp. 270-378). New York: Wiley.

2nd of 4 extracts from Sue's paper, plus references

The second of my points of reference is: how to work within this powerlessness on a moment-to-moment basis. Key to this is how I set up my analytic frame as it signals to my patient's unconscious whether or not I am prepared to go to these kinds of extreme unravelled and unravelling places and whether I am prepared to build and maintain a container which is strong enough for both of us to take that risk.

Within the relatively psychoanalytic tradition I was trained in, this means that:

My own practice is not to disclose personal information, or answer personal questions. The purpose of this is not to maintain analytic detachment - it is to protect my patient's therapy space. So, for example, if a patient asks me a personal question, I would usually reply something along the lines of 'I could answer your question, but I'm concerned that the more of "who I am" there is here, the less space there will be for "who you are and who you might become".

The point here is that if I fill up all the gaps in the therapy relationship, I deny my patient the opportunity to fill those gaps in the way she does in her day-to-day life, and use therapy space to become aware of her patterns. By leaving these spaces I am making room for her to become aware of the **kinds** of unconscious assumptions and fantasies with which she habitually fills these gaps in her day-to-day relationships, thus shaping those relationships and her life.

Analysands will always consciously or unconsciously try to figure out who we are and who they are for us from our accent, manner, consulting room, etc. but I find it helpful not to put who I am too much 'on display' in my consulting room. That's why I don't have any of my books in my consulting room – the books you can see here are in my study at home.

Please note, I'm not telling you how ***you*** should structure ***your*** clinical frame – only you can decide that based on your own therapy, supervision and training(s). However, I am encouraging you to think about your frame in terms of how much space it offers to these marginal states in the people you see.

I also try, as much as is possible, not to ask my analysand questions. This is because in order to answer a question my patient has to engage their cognitive function, which, while valuable, is likely to disrupt the more free-associative space I am trying to hold.

To the best of my ability I start & finish sessions on time, and I take regular, predicable breaks – the NSW School holidays and, as part of exploring the possibility of working with someone I give them a copy of my consent form which covers confidentiality, fees and so on. It also includes a paragraph on what happens when they miss a session – we can arrange a catch-up session within a week or so, or, if they can give me notice of the missed session, I will spend the session reading over my notes & think about the work we are doing.

At first most analysands doubt I'll keep my side of the bargain & are surprised when I keep it consistently.

Also in my consent form I invite my potential analysand to commit to 3 ending sessions when they want to finish. The aim of this is to set up a space in which there's a chance of getting what might otherwise be a destructive ending of the therapy into the room. I can say 'My sense is that you may not have experienced a thoughtful ending of a relationship or piece of work in the past & I want to make sure we have an important opportunity to do something different here'.

The aim of these ending sessions is to make space to reflect on the work we've done & (if possible) what we've not been able to do. Specifically, I'm trying to facilitate an awareness that the work we've been doing is, with its accomplishments and failures, coming to an end and will shortly finish.

The point here is that, while we are working together, the therapy space stays alive whether my analysand is there or not: I am continuing to think about them and hold a space for their process. But just as important is the fact that by looking after the frame I am doing something which I can do, and I need that in order to survive the work.

Basically; primitive material needs regularity and structure if it's to emerge.

Relevant sources for 2nd point of reference:

There's an immense literature on the frame. One paper I like especially is by London trained Jungian analyst, Warren Colman.

See:

Colman, W. (2011) Symbolic Objects and the Analytic Frame. Journal of Analytical Psychology 56:184-202

3rd of 4 extracts from Sue's paper, plus references

The third of my points of reference: is the work of psychoanalyst Andre Green, whose seminal thinking on what he describes as 'The Dead Mother' explores what happens when a mother is experienced as so emotionally and/or mentally absent or unusable that the baby becomes more attached to her absence that her presence.

A lot of the people I see have unconscious attachments to absences (as well as unconscious attachments to destructive presences). I need a firm frame if I am to stand a chance of getting these absences into session. In order to explain what I mean by this I will introduce an image from a paper by Howard Levine, a colleague of Andre Green's.

Levine writes:

> If we think of the psyche as metaphorically possessing an inner theatre, akin to Joyce McDougall's (1985) metaphor of the 'theatre of the mind', a stage upon which various actors (i.e., internal objects) appear, speak their lines and live out their parts, the neurosis and the repressed unconscious might be thought of as a play in which some actors exert influence while remaining out of sight.
>
> For example, we know H.G.Wells' "invisible man" is on stage, even though we can't see him, because objects inexplicably seem to levitate or move about, other characters' paths are suddenly blocked by something present but unseen, et cetera.
>
> In contrast, what Green might have us think of is that the stage theatre itself has been wrecked or dismantled or there are black holes and other powerful, invisible voids in the very air of the stage-setting that suck things into them unexpectedly. Without seeming reason things explode or implode, fragment, or disappear.
>
> Still another possibility is that this absence or void becomes a kind of character that is clung to and cherished (Green, 1980) … [one] might think here of Lewis Carroll's Cheshire cat, whose smile remains after he is long gone.

Working with this kind of inner othernesses means actively making space for that which is inner and other and experienced as a presence (albeit often an enigmatic. troubling, painful presence). But, as Green and Levine point out, it also means that I need to set up my analytic frame so that there is space for inner othernesses whose core is absence.

The other thing I can do is to actively slow things down in sessions. The aim of doing this is that sometimes, when things are slower, my analysand and I can notice tiny gaps or incongruities which were previously overwhelmed by the 'white noise' of agitation and resistance.

Relevant sources for 3rd point of reference:

Levine, H. B. (2014) Beyond Neurosis: Unrepresented States and the Construction of Mind. Rivista di Psicoanalisi 60:277-294. P.281

4th of 4 extracts from Sue's paper, plus references

This leads to the fourth of my main points of reference which is contemporary research on the neuroscience of perception

Emerging neuroscience research offers images and metaphors which I find useful for trying to imagine my way into these vital clinical processes. This research identifies a neurological state between the brain registering incoming 'perceptual data', and having organized that data into 'conscious perceptions'. Using Laplanche's imagery, I imagine this 'in-between' zone as offering a gap or crack in the ordinary, solidified, 'filled in process of things'. This crack or gap exists before we have domesticated incoming perceptual data by organizing it into familiar 'knowledge'.

In their (2013) research Sid Kouider and his team found that, as adults, we have to look at an image for 300 milliseconds before we are conscious of what we have perceived. Prior to 300 milliseconds we are 'unconscious' of what we are looking at – we have yet to bring incoming perceptual data together into something we can describe. Clinical experience suggests to me that the roots of a sense of oneself as abject, and the self-hatred through which it expresses itself, are to be found in these very early stages of experience of self and the world. It is as if the act of drawing perceptual data together into 'a something' (and this includes the experience of oneself as 'a something') is shot through with a deeply distressing sense of badness or wrongness which is simultaneously diffuse and cellular. Consequently, consciousness itself is experienced as excruciatingly painful, demanding behaviours such as self-harm and eating disorder to manage it.

Kouider's team's research also shows that in infants between 12 and 15 months, this delay between stimulus and the patterns of neural activity which indicate conscious perception is about 750 milliseconds, (2014, p. 376). When I encourage an analysand to 'slow down', I am trying to help them to intermittently 'drop down' into an affect-based, almost light trance-like state in order to regress to younger states of consciousness where the fluid zone between stimulus and perception was longer, thus increasing the likelihood of catching a glimpse of the othernesses around which my patient is organized through cracks or gaps in her ordinary 'filled' in, domesticated (and domesticating) patterns of perception. As such, I am trying to offer my analysand a space in which the habitual processes which knit a sense of themselves as abject into the very process of perceiving might become a little slower, perhaps more child/infant-like, and a little less concrete and impenetrable.

Basically, I am focusing on facilitating a more loose weave, 'pre-pre-symbolic' state of consciousness. This also resonates with the emerging neuroscience understanding that consciousness is a spectrum with 'access consciousness' (Block et al., 1998) (i.e. being aware enough of something to reflect on it and talk about it) residing at one end.

Alongside this Randy Buckner team's 2008 findings indicate that there is an anatomically defined brain system (the default mode network or DMN) that activates when we engage in internal tasks such as daydreaming, envisioning the future, retrieving memories, and gauging others' perspectives. DMN activity is also negatively correlated with brain systems that focus on external stimuli. Furthermore, Noah Philip (2013) has found that (in the absence of psychiatric illness and psychotropic medication) people who had been exposed to early life stress demonstrated decreased DMN connectivity, and Judith Daniels (2011) argues that DMN activity is defective in people with post-traumatic stress disorder related to early-life trauma.

In the terms of this discussion, I would say that I am trying to find ways to help my analysand 'trust' their DMN and through that, let themselves become more open to glimpses of the inner othernesses around which they are organized and the possibility of making new translations of those othernesses.

One of my colleagues describes this state as having developed enough internal space to pause and decide whether the dark shape on the path ahead of you is a deadly brown snake, or just a stick.

Relevant sources for 4th point of reference:

Austin, S. 'Working with chronic and relentless self-hatred, self-harm and existential shame: a clinical study and reflections' Journal of Analytical Psychology, 2016 61, 1, 24–43.

Block, N. (1998). 'On a confusion about a function of consciousness'. In Block N., Flanagan, O., Guzeldere, G. The Nature of Consciousness: Philosophical Debates. Cambridge, MA: MIT Press.

Buckner, R., Andrews-Hanna, J., Schacter, D., (2008). 'The brain's default network – anatomy, function and relevance to disease'. Annals of New York Academy of Sciences. New York.

Daniels, J., Frewen, P., McKinnon, M., Lanius, R. (2011). 'Default mode alterations in post-traumatic stress disorder related to early-life trauma: a developmental perspective'. Journal Psychiatry Neuroscience, 36, 1, 56–9.

Kouider, S., Stahlhut, C., Gelskov, S., Barbosa, L., Dutat, M., de Gardelle, V., Christophe, A., Dehaene, S., Dehaene-Lambertz, G., (2013). 'A neural marker of perceptual consciousness in infants'. Science, 340, 376–80.

Philip, N., Sweet, L., Tyrka, A., Price, L., Bloom, R., Carpenter, L. (2013). 'Decreased default network connectivity is associated with early life stress in medication-free healthy adults'. European Neuropsychopharmacology, 23, 1, 24–32.