I describe an unobtrusive relational approach to the psychoanalytic treatment of nonalive and nonspeakable states and ways of being. I build upon a contemporary relational sensibility that values the intersubjective engagement of analyst and patient and the enactment of dissociated and unformulated states, together with the concepts of regression and the unobtrusive analyst central to the work of the British independent analysts, with a special focus on Michael and Enid Balint. I stress that in being unobtrusive, the analyst is not neutral or abstinent, but deeply engaged and becomes the analyst the patient needs. A case is offered as an account of analytic work that was enhanced and made possible by my engaged but unobtrusive presence, and the privileging of the patient’s own idiom, object relating and early developmental needs. I offer a contemporary rendition of regression that encompasses mutuality, regulation and accompaniment. I suggest a concept of “benign regressive mutual regulation” and outline and differentiate some of the influences from the contemporary psychoanalytic field.

“To put it quite pointedly, life itself, and especially individual life and separateness, are not taken for granted.” — Hans Loewald (1980), “The Waning of the Oedipus Conflict” (p. 399)

INTRODUCTION

I think it’s fair to say that from a relational perspective, clinical narrative takes its shape from the intertwining of the subjectivities, and conscious and unconscious processes of both patient and analyst. While some emphasize the role of dissociation and enactment and others have foregrounded the intersubjective matrix of the therapy dyad and the role of implicit relational knowing, I believe there is a common emphasis on careful communication of the analyst’s experience or countertransference in the moment as part of the co-creation of the clinical narrative—a version of what Edgar Levenson (1983) described as a constant orientation to wonder and ask “what’s going on around here?”—together with an invitation to the patient to think about and to engage with the analyst’s process, conscious or unconscious (Aron, 1996; Bass, 2009). In this more egalitarian and coparticipant approach, mutual interaction and influence is privileged.
I think that for many contemporary analysts, from many theoretical perspectives, and I dare say, for many patients too, the idea of psychoanalysis as a mutual enterprise has been freeing, inviting and basically more comfortable and respectful, and in keeping with our current feel for authority relations.

I would like to propose here that addressing the patient–analyst interaction in the here-and-now is not the only way that a relational analyst works, nor is it the way that a treatment with a relational analyst need unfold. My suggestion here is that there are other aspects of contemporary relational treatment that reach and allow for the emergence of different registers of the patient’s experiences. These, I believe, are less frequently foregrounded in the description of relational psychoanalytic treatment. I will describe a treatment approach that emphasizes an unobtrusive and companioning analytic engagement and illustrate this with a description of a case. I will offer a conceptualization of therapeutic action that embellishes and recasts the psychoanalytic concepts of regression, intersubjectivity and clinical intimacy.

In the effort to describe the clinical phenomena I will be focusing on, I will borrow from various threads of the contemporary psychoanalytic tapestry, including relational, object relations, contemporary Freudian, British independent, self psychology, intersubjective, infant research and more. I recognize that weaving these together can create some inconsistencies in language and theory, but I have found that it has been organic to me to proceed in this way in my effort to develop a functional language to convey these clinical experiences.

**WITHOUT ALIVENESS, REFLECTION, AND RECOGNITION**

When asked to engage in an exploration of mutual influence and “what’s-going-on-around-here?” the patient is asked to do collaborative mental work, to “relate.” This requires a level of psychological development, an ability to symbolize and mentalize, to think about things, a “reflective self-awareness” (Bach, 1994, 2006). Above all, it requires that the patient be alive and that the patient experiences him or her self as a whole person in the presence of another whole and separate person, as a subject with subjective experience in the presence of another subject. The idea that experience is mutually constructed may be theoretically true, but it can sometimes be far from the truth of the patient’s actual subjective experience of the analyst and of their own needs.

For patients who do not experience themselves as existing in time and space in a continuous and coherent way, and who do not regard other human beings as whole, coherent and separate beings, as subjects; it is too much to expect mutuality. Such patients’ reality often involves confusion as to whether they are alive or dead, and whether the world, other people, and the self actually exist and can be expected to continue to exist. These damaged self states may coexist simultaneously with verbally adept, intellectual and related self states. I would suggest that treating patients who suffer this way as if they are alive and whole, separate beings may retraumatize them, and an as-if analysis may be co-constructed. The related and expressive analyst, who can hold up his or her own experience for examination as it relates to the interaction in the treatment, can unwittingly shame and silence such patients, and this can compound the dissociation of the most damaged parts of the patient’s inner world.

Bromberg (1996, 2006) and D. B. Stern (2004) have suggested that in treatments of patients dominated by a dissociative structure, the engagement with intrapsychic conflict is the sign that the treatment is reaching a successful end, rather than the resolution of conflict being a necessary
THE UNOBTRUSIVE RELATIONAL ANALYST

part of the cure. Similarly, Slochower (1996) noted that “the intersubjective analytic relationship is a hard-won therapeutic achievement, that often does not emerge until well into the treatment process” (p. 33). One might further say that with patients such as those I am talking about, the ability to engage with and recognize another in the room is the sign that the treatment has worked, rather than the necessary part of the treatment.

The analyst who can analyze his or her own experience and invite the patient to do so may also induce an idealization. In the egalitarian spirit of Ferenczi, relational technique has emphasized the use of ordinary vernacular speech in psychoanalytic treatment. However, it is worth considering that analysts’ ability to express and analyze their own experience results in a kind of interaction far from ordinary vernacular conversation, and that kind of interaction, which may be beyond the capacity of the patient, can inadvertently foster deep idealizations. Such an analyst’s very humanity can be traumatizing to the parts of the self that are dominated by envy, omnipotence, and shame. I am reminded of Michael Balint’s observation that the patients with whom his friend Sandor Ferenczi applied his active and mutual technique showed more, not less, dependency on him (Balint, 1968, p. 174). Ferenczi was working toward an egalitarian relationship; his patients were spellbound by his ability to do this. I think this is sobering and perhaps cautionary.

I am talking here about the analyst’s receptivity to patients’ experiences of deadness, nonexistence, being in bits, or difficulties in simply going on being. The experience of states such as these can be interrupted by an analyst’s focus on the verbal realm as expressed, for example, by curiosity and the analyzing of what the patient is doing and/or eliciting in others and in the analyst. Bion talked of the “obtrusive object analyst” as curious but unable to withstand being the receptacle of parts of the patient’s personality that neither patient nor analyst can yet know, much less describe and talk about (Bion, 1962).

It seems to me that silence, quietness, patience, and not speaking the countertransference have been conflated with “neutrality.” Of course the concepts of “neutrality” and “abstinence” have been deconstructed as reflecting a one-person psychology (Hoffman, 2006). But perhaps an unintentional result of this analysis is that something of Winnicott’s paradoxical approach to transitional phenomena has been obscured (Winnicott, 1960). We can accept the relational credo that we continually co-construct experience in analysis and recognize that not all patients experience this or are even aware that this might be so, or even that bringing this to the patient’s consciousness is always of value. I take from Winnicott (1958/1965) that we are continually situated in the intersubjective matrix and that treatment can be allowed to unfold such that areas of psychological being that we are barely able to sense, let alone describe in words, can emerge and take shape.

I shall shortly be describing my work with an unusual young man, who overtly rejected any attempts of mine to examine the process between us and any interpretation of his psychological functioning. He was unusual in that he could clearly ask and even demand a very particular kind of object relationship with me. He was quite clear that he was not alive in the usually accepted use of the term, he did not feel he truly existed, nor did he take as a given that I was a whole person who lived in a coherent chronological and spatial reality. More of him later. My point is that parts of the experience of many patients are damaged in this way. These areas of their minds, or self states, are rarely described as such by the patients themselves, and can be chased underground by an analyst who may subtly convey that what is needed is a verbal, sentient, related partner/patient to join in relatedness with the analyst, or at least strive to do so. Ogden (1989)
talked about the “act of theft” (p. 176) whereby an analyst eager to connect with a patient can rob him or her of the opportunity to inscribe the analysis in the unique way that they consciously and unconsciously choose.

MICHAEL AND ENID BALINT AND THE UNOBTRUSIVE ANALYST

Writing in the sixties and basing his thinking on object relations and the Winnicottian-independent-tradition, Michael Balint (1968) described patients who could not use the standard psychoanalytic technique of the time. Interpretations were of no use to them; he observed that they craved not so much the “gratification of an instinct or drive” (p. 159) as a certain kind of object relationship, one that was “more primitive than that obtaining between two adults” (p. 161). The provision and welcoming of the emergence of that object relationship in the treatment was what could be healing to these patients. I have found his technical recommendations to be very useful and real. First and foremost he emphasizes the need “to recognize and be with the patient” (p. 172), and for the analyst to be “unobtrusive and ordinary” (p. 173). In Balint’s language, this facilitates a “benign regression” by which Balint means a treatment situation that will promote the emergence of the most “primitive” parts of the patient’s functioning, those that are most strongly implicated in the patient’s damaged way of being in the world. He distinguished benign regression from malignant forms of regression that can evolve from the omniscient and omnipotent aspects of the analyst’s technique. In Balint’s world the omniscient and omnipotent analyst is the one who adheres to and insists on the truth of his or her interpretations. In our contemporary psychoanalytic climate, “omniscience” and “omnipotence” can come in many other forms, including an unexamined tendency to proceed as if discussing the ongoing interaction in the moment is always a good idea—that is, proceeding without considering how working in this way may affect the patient whose facility in this area is not as well developed as the analyst’s.

Balint (1968) and his wife Enid Balint (1993), in a sequence of papers on psychoanalytic technique, talked about being “unobtrusive.” I read this as distinct from the idea of a neutral or abstinent analyst. Rather, I find much that is useful in the idea of not getting in the way of the relationship that the patient seems to be, and they would say, needs to be creating in the treatment. They highlighted that the only value from the treatment gained by patients like this—patients with much envy, hatred, and extreme vulnerability—has to be experienced as coming from them, from their minds, their words, and their efforts. This approach need not diverge from the sensibility that experience in the treatment is co-constructed. It does, however, allow the space for these patients to use the co-constructed “field” of treatment in the way that they need to, in the moment.

So, how to be with a patient such as this, or with self states such as this? Balint recognized the dilemmas involved and spoke of the almost entirely nonverbal medium in phases of a treatment such as this.

... for some years now I have experimented with a technique that allows the patient to experience a two-person relationship which cannot, need not, and perhaps, must not, be expressed in words, but, merely by, “acting out” in the analytic situation. (p. 174)

He continued that later, when the patient has emerged from this phase, the process and the “acting out” can be worked through. Nowadays we might say that when the dissociative structure is recognized, then we can experience and talk about conflict with the patient (Bromberg, 2006,
D. B. Stern, 2004). Balint’s approach suggests a living through of enactments and waiting for the patient to find the resolution in their own idiom. There is concordance here with some contemporary analysts, even as they themselves have differing conceptions of “intersubjectivity.” I am thinking of Bruce Reis’s (2009) recent work on enactive witnessing. Reis privileged the silent accompanying and “being-with the patient” as painful traumatic enactments take place in the treatment. A similar angle on the analyst’s position is found in much of Christopher Bollas’s (2009) work, and particularly in a recent paper on free association. Slochower (1996, 2004) has emphasized that the analyst can utilize a “holding” position when “intersubjective exploration can be disruptive rather than facilitative” (Slochower, 1996, p. 34). With these writers, I do not hear “silence” as the literal silence of “no words,” but rather as a tactful and connected “silence,” a “with-ness” (Reis, 2011) that does not intrude on the patient’s ownership of their own sensations and their own particular experience of the analyst, by knowing more than the patient or even offering the patient more than they create themselves in the moment. We can accompany patients with a “quiet that is not silence” (Reis, 2011) while they “are afloat in the reveries of their own subjectivity” (Bach, 2009, p. 41).

Balint (1968) talked about accepting that for the patient in these times, words are not truly functioning as the means of communication. “They are lifeless, repetitive and stereotyped, they do not mean what they say” (p. 177). The analyst has to accept this and “abandon any attempt at organizing the material produced by the patient” (p. 177). Accordingly, Balint recommended that “the analyst must create an environment, a climate, in which he and his patient can tolerate the regression in a mutual experience” (p. 177).

In this image, psychoanalytic technique involves a sensitivity to the needs of the patient, such that these regressed parts, or self states, can find their expression. One needs to be mindful to not be too distant, which can be experienced as abandoning, or too close, which can be experienced as encumbering and intrusive. This is a “mutuality,” which is governed by sensitivities to the patient’s most intimate and complex needs. The developmental metaphor is inescapable here: Like a parent with a small child, the interaction is mutual, but is governed by sensitivity to the needs, limitations and tolerances of the child. Mutual but not symmetrical (Aron, 1996).

Within this unobtrusive and mutual relationship the patient will find himself and get on with himself, knowing all the time that there is a scar in himself . . . which cannot be analyzed out of existence; moreover he must be allowed to discover his way to the world of objects—and not shown the “right” way by some profound or correct interpretation. (Balint, 1968, p. 180)

This embodies a central contribution of the independent tradition of psychoanalytic practice, as described by Parsons (2009). Elaborating on Ferenczi’s (1926/1950) ideas of clinical process, Parsons (2009) emphasized that what comes from the patient, and what the patient experiences as his or her own discovery in the analytic encounter, matters far more than anything that comes from the analyst. What comes from the analyst is crucial, of course, but only for the way it facilitates patients’ own experience of themselves. (p. 223)

Thomas Ogden (2005) talked about the earliest holding that the mother offers the infant, that fosters the infant’s sense of being alive, of “going-on-being,” the sense that the continuity of being is sustained over time. This state is “subjectless” and asks of the mother an “abrogation of herself in
her unconscious effort to get out of the infant’s way” (p. 95). The mother’s “unobtrusive presence
provides a setting for the infant’s constitution to begin to make itself evident, for development to
unfold, for the infant to experience spontaneous movement and become the owner of their own
sensations” (p. 95). Ogden suggested that if the mother intrudes herself as a subject apart from
the reverie with the infant it will “tear the delicate fabric of the infant’s going on being” (p. 94).
“Unobtrusive” is not neutral or abstinent. Far from it: it implies the very deepest engagement that
is humanly possible.

The analyst offers him- or herself as “the human place in which the patient is becoming whole” (Ogden, 2005, p. 96). This type of holding is “most importantly an unobtrusive state of coming
together in one place” (p. 97).

Often this involves interactions that do not feel anything like “psychoanalytic work.” Winnicott
talked about the patients who come in and tell about the details of their day or week as if that
is all that is required, leaving the psychoanalyst feeling that no analytic work has been done; and
Ogden describes conversations about art, sport, and other aspects of the patient’s life with
no interpretation of the content or commentary about the unfolding relationship. Far from being
nonanalytic work, these comprise the most profound human interaction, in their very ordinariness.
In these “ordinary” conversations, we find the growth of the ability to derive thoughts from lived
experience and the ability to dream, to process the raw data of experience into thoughts. The
analyst’s work, then, is to engage with the patient in these ways and to tolerate the feeling that no
analytic work is being done. As Parsons (2009) added, this involves much patient waiting on the
part of the analyst.

THE CASE OF KYLE

Kyle has taught me how to be his analyst. Entering my office for the first time seven years ago,
a tall, slightly chunky, and stylishly dressed blond man in his twenties with thick glasses and an
intense gaze, he stood in front of the couch facing me and then seemed to let his body fall into a
sitting position on the couch. I understood that he inhabited his body and being in a very particular
way, and figured that his body was already telling me a story of falling, of being dropped, and
that much of our work and communication was going to be in the realm of physical sensation and
action; his and mine.

His speech, very articulate and full of psychological insight, came at me like a pulse, an unstop-
pable tsunami of word-things. His words continued to come at and into me, sometimes slamming,
sometimes penetrating and sometimes caressing. Always totally physical. He told me that he was
struggling with deep depression for which he had been in therapy since he was a teenager. He had
just moved to be with his boyfriend and had ended a therapy of a few years, which had helped
him with procrastination while he had been in graduate school. In New York he had consulted
with a few therapists and had yet to find someone with whom he felt comfortable. He told me that
he was struggling with powerful feelings of hopelessness and familiar impulses to shut himself
away in his apartment and withdraw from the world, something he had done repeatedly in recent
years. He and his boyfriend of seven years were fighting with increased frequency and their sex
life had dwindled to almost no contact at all. His boyfriend had become very overweight, and
neither seemed to be attracted to the other anymore. He was not working and was unsure what
his next move would be. The boyfriend was independently wealthy and had a prosperous career,
and Kyle experienced no urgency to find his own income. Kyle knew something was very wrong with him and his life.

Amidst the flow of words I gathered that when he would withdraw into himself, he would disappear into a timeless zone, a numb haze where he would become immersed in reading or the Internet and would exist completely out of time, forgetting to wash, eat, or sleep. Hence the “procrastination” of his graduate studies.

At the center of his world was his mother. “She is a good person, but . . . .” He described her total involvement and impingement on his life. Most recently, via almost constant phone contact, she and her current husband had chosen all his graduate school courses and guided his day-to-day schedule and activities, although he attended school in another state. The relationship was laced with aggression and hatred and utter dependence. “She’s a severe borderline personality disorder. It’s all mood swings and tantrums,” he said. He described screaming fights. “When she flips, I flip.” “The thing is, I love my mother, but I need time to myself. I need to make decisions, to motivate myself.” When he had told her that he was in a relationship with a man, she had shown up the next day to intervene and to take him home. He resisted, but some months later he was duped into visiting home for a “family crisis.” “They trapped me, which was OK, I guess: my life was going nowhere.” He did subsequently reunite with his boyfriend.

I tried to get a grip on the narrative of his and his family’s life, but, as was to become so familiar to me with Kyle, I’d become so flooded and confused that coherence was impossible. I did gather that his biological father had left his mother before he was born, that there had been some unsuccessful attempts at reunion, that he had been brought up primarily by his mother and her second husband, whom he also referred to as his “father,” that there were two other major relationships in his mother’s life. All these men were referred to interchangeably as “my father.” His mother was one of ten Irish American children in a large, extended, and alcoholism-dominated family. I could not sort out who were the mother’s cousins and who the siblings; all were referred to as “my cousin,” “my uncle,” and so on, by Kyle. And to round things off nicely, some had the same names. Listening to all of this, I was imbibing the profound confusion that was the hallmark of his being. The closest and most meaningful relationship in his life seemed to be with his “grandparents.” It took me some time to figure out that they were the parents of his biological father. Kyle made great efforts over time to visit and maintain a meaningful relationship with them.

I found myself continually confused. At first I panicked and would ask questions in a futile attempt to gain clarity, interrupting his flow of words. Explanations did not help. I learned that I had to settle into this felt world of confusion and near-psychosis, and somehow to find some way to get comfortable, or at least survive and keep my own mind intact. About a year into the treatment his “father” died of a sudden heart attack, and I felt like I was falling into a deep pit, desperately trying to grab onto something to help me. Who, in fact, had died? For months he became embroiled in a lawsuit; he was the only beneficiary and there was a common-law wife who legally fought him and stole all the belongings from the deceased “father’s” house. It did, eventually, become clear that the man who had died was his mother’s first spouse after his biological father had disappeared from the scene. “We had a great relationship for a while,” Kyle said. “We’d get high on pot together.” My mind would scurry for a lifeline, a timeline. Hadn’t this man been in his life when he was a young boy? They must have been getting high together when he was what? 11? 12? 13? “But,” Kyle went on, “once the violence started things were never the same, and it never stopped.” This father had systematically terrorized him and his mother for a
number of years before finally leaving. The only relief had been getting high together. He was
now inheriting some considerable amount from this man.

With nothing stable to hold on to in reality other than overarousing intrusion, it was no sur-
prise that he was sexually precocious and promiscuous from a very early age. He masturbated
compulsively from age 7 or 8. From age 14 or so he regularly had sex in public bathrooms with
men. He describes being popular in those environments, where older men would perform oral
sex on him or mutually masturbate. More panic on my part, as this world of abuse unfolded, but
I did register that as he described sex, I felt that we actually had a subject, almost even a focus,
and my mind could almost settle into a groove. Aha: an abuse narrative. This was, of course, the
power of sex. He, as I, in these moments, could fleetingly feel oriented in a reality, in the space
of the physical/sexual. As an adult his sexuality had been a zone of compulsion, psychological
grounding, and mad manic omnipotence. He told me with a sense of jaded pride: “When it comes
to sex and drugs, I’ve done everything. Outside of heroine, I’ve done every drug. Outside of dead
bodies and children, I’ve done everything sexually.” Indeed, he would go to great lengths to find
an experience of ever-increasing arousal: defecating in a man’s mouth, watching a woman have
sex with a dog, beating men on their testicles until they threw up in pain are just some of the
experiences he described. “I feel like god; I can treat a man like a toilet.” “I am above the laws of
reality. I can come while he throws up in pain. I am a god.”

Degradation and control. No surprise, I felt coiled into this dynamic in the treatment. I drew
attention to this. Was he not controlling and manipulating me, tying me up, in some kind of
sado-masochistic relationship? I can’t recall the exact words I used. But here’s the point. He’d
agree. Of course I am. This is me. What else would I do? I’d say “Can we examine this?” And
of course he understood that this was what he did with people all the time, that it is what his
mother and the “fathers” had done to him and that it was a repetition of unbearable trauma.
To him, humdrum psychological insight. “Of course. I knew that.” And he’d be off on some
other narrative. More words coming at me. More experience, shit, flowing into me. Over time he
did, however, recognize that this is why he has such difficulty with friendships. “I do see how I
browbeat people. I just don’t listen.” He did dearly want to be more of a human among humans.

He became addicted to online sex. He’d create a persona for himself and disappear into
an illusory world with various partners. “I can create myself in the persona of their ultimate
fantasies.”

I held on. Of course his disregulation of time and space infused our work with increasing
intensity. He’d miss appointments and offer no explanation. He’d call in for sessions sometimes
on time, sometimes late. On numerous occasions I thought he had dropped out, only to answer
the phone when it rang at the time of his session and hearing him start talking; no “Hello, this
is Kyle,” just picking up the session from where we’d left off some time ago. I was living in a
world where one is continually forgotten and where one fears that everything can be gone with
no reason or warning and where there are tears in the fabric of time.

He always paid for all scheduled sessions. The phone sessions became more bizarre and dif-
ficult to manage. A half hour into a session, he’d mention that he was driving in the car with his
mother, or had a friend sitting next to him. He’d disappear for weeks and call, and only after a
while mention that he was in Thailand or Indonesia with his boyfriend. No mention of whether
he might have informed me. The prize goes to the session where I heard a persistent noise while
we talked, and in response to my inquiry, he mentioned, “Oh, I’m in the shower.” What country
he was in? I didn’t feel it really mattered at that point.
I tried to set some limits. More than with anything else, I was struggling with the unannounced absences. I addressed the issue and said that treatment required a more coherent structure, that he be present and at least give notice of his upcoming movements: seemingly ordinary boundary requirements. He was furious. The treatment almost ended. He was persistent and absolutely solid in his conviction. “That is your problem, not mine. This is me. I can’t do this any other way,” and so on. I was very affected by his rage with me. I felt deeply that I was in error to have tried to impose this structure on him, that it was my need to take back some power, some purchase on the out-of-control feeling that permeated the treatment. I could find no other thought in my head: he was right. This was about me, what I could or would not let myself tolerate.

It’s so simple. Listen to the patient and be the analyst that the patient needs you to be. Not the analyst you think you are, or ought to be. I actually found this completely liberating. Was this masochism on my part, or “surrender” (Ghent, 1990)? Probably a bit of both, but once I allowed the experience in, and ceased trying to get him to talk about our relationship, to understand what was going on; once I allowed myself to flow with him, and “abandon any attempt at organizing the material,” the treatment changed. In retrospect, I believe that his rage and insistence paradoxically provided a container for the treatment at that time, and enabled me to relax my own anxieties about his absences and disregulation. Steven Cooper (2000) has offered insights about “mutual containment” in analysis, and I believe that here we see Kyle protecting his own treatment and containing his analyst’s fears, such that we and the treatment could thrive in his own idiom.

He had grown up, it emerged, with the persistent thought that he did not exist. Throughout his life he felt that he was a figure in someone else’s dream, and that when they would wake up, he and all the world around him would no longer exist. He had grown up playing on the edge of existence: the sexual acting out, and hyperstimulation; an obsession with poisons—as a youngster he had elaborate plans to poison everyone he knew and had actually carefully made poisonous concoctions; and repeated experiences that he was not there. He said that he could differentiate what he called his dissociation and his not being there. Dissociation, for example, when faced with his “father’s” violence, was out of fear and being overwhelmed. It was, according to him, soothing and sweet to dissociate, to feel nothing when beset by pain and terror. At least one is alive in order to dissociate. Most of the time he wasn’t. He began to open his adolescent journals and we’d look at them in sessions. The sadness and constant longing to be dead. The daily onslaught of screaming fights and frequent violence. An obsessive interest in the Aztecs. They feared the sun wouldn’t rise the next day, so they would make human sacrifices to the gods to be sure that the sun would indeed rise. Finally, this was him.

He never responded with much recognition to my comments that I now understood who he was and how he lived in this not-alive twilight zone—but then, almost nothing I said ever was, even though he would harangue me for my responses to him. However, more and more there would be sessions where he would make comments such as: “as I’m talking this is coming together, I can feel something.” Of course, he was not going to take in from me. He had “to find his way to the world of objects” (Balint, 1968, p. 180).

There is much we can say about Kyle’s developmental history to describe and explain his way of being in the world. Suffice it to say that I believe that the failures in holding and containing, along with the annihilating intrusiveness of his mother and the environment, kept from him the experiences that would have fostered an existence. He had no object or environmental constancy, and consequently could not trust that either he or the world would exist from one moment to the next. The treatment hinged on my being able to live with him in this ongoing nonexistence and
know it and tolerate it, and expect no more. In the words of Balint: “to create an environment, a climate in which” the patient and analyst “can tolerate the regression in a mutual experience (p. 177).”

Sessions were often filled with news items from the press and political discussions. He wanted to know my points of view on a variety of political and historical questions. The theme of much of the discussions was power, cruelty, and domination. He wanted to know about my family background, my family history. He became very involved with the Holocaust and read voluminously. I would speak openly and honestly to him. I left the question of the analyst’s self-revelation many miles behind. I understood that he needed someone to partner with, to think with, to know, and be known by, in a nonimpinging manner, someone with whom he could “dream himself into existence” in the words of Ogden (2009, p. 15). As Winnicott suggested, often these sessions did not appear to be anything like analysis or therapy. The crises of the Middle East, the troubles of Northern Ireland, the role of the Ukrainians in World War II, the Chavez regime in Venezuela, and so on. On occasion he’d e-mail me long essays that he’d written, or articles that he had found on the web, and he’d want to engage me in discussion about them. I would be with him in these discussions and only engage with the personal relevance to him on the rare occasions when he would offer it. For instance, he commented when talking about imperialism, that he understood now that his mind had been “colonized” by his mother’s madness.

Generally, I was unobtrusive while being totally and intimately engaged. I’d silently make connections to myself tracking my reverie and my thought about his psychic process, while engaging in these discussions with sincerity and real interest. My strong feeling in these times is the opposite of what one hears most frequently, across psychoanalytic approaches: it is OK for these kinds of extra-therapy interactions or enactments to occur, as long as they are talked about or analyzed after. My feeling was that it was of the utmost importance that I enter these interactions as me, unadorned; and it was equally important, that they were not talked about after, unless he brought in the kind of connection such as the one I mentioned about his being colonized.

He was “dreaming himself into existence” with me. To play with Ogden’s words, I believe my unobtrusive presence provided the setting for Kyle’s constitution to become evident, for his development to unfold and for his spontaneity to develop such that he became the owner of his own sensations. I believe I would have obstructed and diverted the whole endeavor by impinging my subjectivity unbidden by him: the part of me that needed to “analyze,” “have good analytic sessions,” to be a “subject” in an “intersubjective relationship,” and to “resolve enactments.” He had never had the experience of a mother who allowed herself the reverie of primary maternal preoccupation, wherein both the mother and the infant live in a co-constructed reality that is governed by the care and responsiveness to the infant’s primary needs, and wherein the mother surrenders a part of her own orientation to the real world outside of their cocoon. Winnicott tells us the mother is in a kind of psychosis. I know what he means.

As with other patients like him, he would show rather than tell. He had liposuction surgery. He came to my office while still healing, peeled off his shirt to show me his torso, which had four small holes in, out of which oozed the last drops of the fat that had largely been removed. I stayed in the idiom of the moment. We talked about the liposuction treatment, the physical feeling of discomfort and his wishes for a leaner body, his appreciation of the doctor, who helped him feel better without questioning his motives—he had not been that overweight. I held my thoughts about his showing me the embodiment of the damaged container of his mind, the ruptures in his
psychic skin and in his reality, and his appreciation for me, that I was now meeting him where he needed to be met. In the language of Bion, we witnessed the introduction into the treatment of beta elements, “something more basic, more concrete and physical than what we generally mean by feelings” (Lombardi, 2007, p. 388). As Lombardi (2007) suggested, this process can only emerge within and through the actual physical bodies of the patient and the analyst. These elements, emerging via Kyle’s body in the consulting room, were transformed, within my reverie and in the process of talking with him in his idiom, into the beginnings of alpha elements of more coherent experience.

He has begun to get better. The sexual compulsivity is a thing of the past. He looks back on this and can now talk about his desperate attempts to find contact and a sense of being alive. He has enrolled in a doctoral program in his field and, although attention is still an issue, is managing to get from one semester to the next. He ended the long-term relationship, realizing himself that he felt abused and victimized by his partner’s neglect and emotional abuse. He has actively impressed upon his mother and his stepfather that they must be in therapy, and although this is hard going, and there are not great resources where they live, they are both being treated and the whole family scene has calmed down. He sets reasonable limits with them, and seems to appreciate how difficult it is for his mother, also, to be a human.

Most powerfully, he says that he is now alive and talks about never having felt like a living human among others before. He did not exist. This was most salient during the breakup with the boyfriend, which unfolded over a few years. On returning to the apartment they had shared to recover some belongings, some months after the breakup, he found the now ex-boyfriend to have morphed into another being. He was now a thin man, his face altered by cosmetic surgery and the apartment transformed into a black-painted sado-masochistic dungeon. As Searles (1960) would say: “a non-human environment.” He felt that the ex-boyfriend’s metamorphosis not only revealed the boyfriend’s true madness but also served to illustrate the degree to which he, Kyle, had not existed but had been a thing, using stimulation and perversion to construct a pretend dress-up version of being a human being. He thanked me. He was alive. We continue our work.

I offer my work with Kyle to illustrate that there are patients who can benefit from a wider range of relational practice. A technique that encompasses the ability to be unobtrusive while being related to the patient in the register and idiom that they require; a technique in which unobtrusiveness is not neutrality and in which enactments are to be lived with and through (Joseph, 1985), and not brought into the sphere of understanding or resolution, in which enactments foster the coming to life of the patient.

REGRESSION, MUTUAL REGRESSION, AND REgressive MUTUAL REGULATION

Together with Kyle, I was able to “create an environment, a climate” in which we could both tolerate the “regression in a mutual experience” (Balint, 1968, p. 177). Kyle could regress and bring in his deadness and not-yet-aliveness, and I found a way to tolerate the disturbances in the field of the analytic setting and in my own mind, so that this could to be a productive experience.

Regression is here not viewed as an artifact of psychoanalytic treatment, including the couch and the analytic setting, but rather as the emergence of the patient’s inner world and his or her way of being in the world. Etchegoyen (1991) put it this way: “The patient comes with his regression,
his illness is the regression” (p. 553). I would elaborate on this and say that the patient is his regression. Kyle was his regression, and by my being unobtrusive yet connected to him, he was able to be this Kyle in the treatment. Bronberg (1979) echoed this and suggested that when the analyst can be unobtrusive, the patient’s regression

is something that will in and of itself occur under certain conditions, a primary one being that one allows it to happen. With many patients, in fact, I began to observe that the only way regression did not occur during the course of therapy was if I consciously or unconsciously prevented it by becoming increasingly interactional. (p. 651)

Aron and Bushra (1998) overviewed the concept of regression and reconsidered it in the light of the contemporary relational emphasis on mutuality, and elaborated on Balint’s idea of regression as a “mutual experience.” They cast regression as the accessing of different states and underlined that the most important aspect of the analytic situation is the facilitation of this access to altered states. Furthermore they emphasized that this accessing of altered states is not and cannot be the property of the patient alone. There has to be a mutual regression, a mutual accessing of altered states. The analyst has to be available to enter and dwell in altered, uncomfortable, and sometimes traumatizing states, which may themselves elude description and elucidation. Acknowledging that my language is insufficient to describe the kinds of bizarre experiences I underwent with Kyle, I can say that feelings of catastrophic fragmentation, aloneness, uselessness, omnipotence, bizarre fantasies, and body dysmorphia were almost commonplace for me over a prolonged period of time. I would suggest that an insistence on intruding my own presence would have obviated the emergence of these phenomena in the analytic relationship and might have amounted to a version of Bion’s “obtrusive object analyst” who would introduce interpretations to obviate being the receptacle for the psychotic parts of the patient’s personality. I would add that introducing my own experience and pulling for a more mentalized and reflective interaction would have been an attempt to save me, not just from encountering the near-psychosis of Kyle’s experience, but would also have protected me from the near-psychotic and fragmented states generated in my own mind. For instance, I could have insisted on a more detailed description of his family relationships in order to clarify who was who. You will recall the chaos I experienced as Kyle described the various family members and “fathers.” Perhaps one might have tried to build a genogram, formally or informally. This might have allayed my anxiety and confusion and might have brought coherence to the proceedings, and my notes. However, the “information” being conveyed was not simply the names and relations that comprised his family. Most important for our work, it was the sense of boundlessness, fragmentation, and absence of individual identity that was given to me, that I received, and then struggled to live within. When his “father” died, I lived through almost psychotic anxiety: (“Who in fact, had died?” see above). This is a “mutual regression” (Aron & Bushra, 1998) that allowed me to deeply “enter his world” (Ellman, 1991) and “company” him (Kahn, 1975).

The mutual regression required my availability to a mutual regulation (Stern et al., 1998). I adjusted to the unusual rhythms and outlines of Kyle’s way of being. I had to tolerate his nonappearance in sessions, his bouts of incessant and pressured speech, and above all his unique signature and idiom that infused my mind and the total “field” of our work (Baranger & Baranger, 2009; Ferro, 1992). The mutual regulation that Stern et al. (1998) described is always goal directed and in the service of growth. There were certainly long periods of time when I made myself available to be regulated in the direction of Kyle’s internal world, his particular rhythms
and emotional cadences. This was a *benign regressive mutual regulation* where the “moving along” (Stern et al., 1998, p. 907) paradoxically involved a palpable loss of coherence and sense of direction on my part. But as Lachmann and Beebe (1996) suggested, it was this ongoing mutual regulation that was the therapeutic action itself, ultimately promoting the growth of Kyle’s own sense of aliveness and self. Lachmann and Beebe also emphasized that these ongoing regulations between analyst and patient are internalized and ultimately affect the patient’s own internal world and regulations “*regardless of whether they are ever verbalized.*” This, they suggested, is the “therapeutic action of ongoing regulations” (Lachmann & Beebe, 1996, p. 5).

I found the uncertainty around Kyle’s disappearances to be most unbearable for me, and when I tried to force him to adjust his behavior to fit with my psychological needs those feelings almost lead to a rupture in the treatment. Ghent’s (1990) description of the experience of surrender, and his contrast of surrender with masochism, which he portrayed as the perversion of surrender, was most useful to me in this work. To allow ingress to the patient’s deadness and bizarre psychological life, to allow oneself to be a part of this regressive mutual regulation, one must surrender, and welcome these experiences that can take us far from our ideas of ourselves as analysts, and far from the ideal of the relational analyst–patient relationship.

**CONTEMPORARY OBJECT RELATIONS AND THE UNOBTRUSIVE ANALYST**

The contemporary Bionians such as Ferro (1992, 2002, 2009) and Lombardi (2002, 2005, 2007) have helped us understand and engage with deadened, autistic-like states and breakdown in our patients. There is an appreciation of the analyst’s participation in the construction of the field of analytic engagement, the use of the analyst’s reverie as the pathway into the emerging narrative of the field and the construction of narratives that “alphabetize” and make coherence (alpha function) out of the pieces of proto-experience (beta elements) that are often located in bodily sensations and symptoms (Lombardi, 2007).

For example, Ferro (2009) recommended staying as close as possible to the patient’s own “narremes,” “the various minor functional units” (F. Corrao, as cited in Ferro, 2009, p. 46) that have the potential, via the containment process, to be united in a narrative with meaning. Thus the patient’s own story can be “opened up” (p. 6) and with the analyst’s use of his own subjectivity and creativity, “original thinking” can begin. Very much in keeping with the image of the unobtrusive analyst that I am describing in this paper, Ferro recommended that the analyst not interfere with the patient’s own story and use the “ingredients” and “worlds” (p. 6) that the patient offers. The analyst must not use “words that alter the patient’s proto-narremes and do violence to them” (Ferro, 2009, p. 14):  

> the analyst’s contributions must be minimal so as to avoid administering doses of sensory or other stimulation that exceeds these patients’ capacity to “alphabetize” them. There must be no active interpretative activity centered on the patient’s internal world or on the relationship, as the quanta of proto emotions aroused would give rise to their own immediate evacuation, given that the mind lacks the capacity to transform them into images emotions, experiences or thought. (p. 14)

Sentiments that capture vividly those of this paper. However Ferro then recommended that the analyst “has no choice but to act like a Greek chorus in a Greek play, confining himself to
commenting on the action that unfolds on the stage.” This is where the conception of the unobtrusive analyst diverges. Certainly Kyle could not ingest anything offered to him, and I learned about his propensity to “immediate evacuation” of any elements that he was not ready to receive, and did not come from him. The image of the analyst acting like a Greek chorus commenting on the action on the stage conjures an analyst who is outside the interaction and can see it clearly. In this conception of treatment, the patient needs to be available for, interested in, and able to metabolize the ideas and observations of the analyst. The analyst’s tool is interpretation above all else, even if it takes into account, with utmost sensitivity, the patient’s readiness to ingest and stays as close as possible to the patient’s own narremes and proto-mental activity. Certainly, Ferro’s work is full of beautiful and evocative examples of the analyst’s ability to play with the patient, to “stay as long as is necessary, with the manifest text” (p. 19) until the patient “has developed a gut, or mental function, capable of retaining, digesting and assimilating interpretations” (p. 19). I myself have metabolized much of this work and taken much clinical nutrition from it. I would add, though, that, again, the emphasis is on the analyst’s interpretation as the ultimate tool of analytic healing. The analyst is described as lending his mind to the patient until the patient is able to metabolize interpretations. My approach places less emphasis on interpretations that come from the analyst, and places central importance on the healing power of the sharing and accompanying of the patient as the regressed states are entered. This foregrounds the accompanying and sharing of states of being and focuses less on the talking (interpretation) about what is happening or what has happened. Kyle, I contend, was helped to become alive, because he found someone who could accompany him in his deadness and terror, who could live through it with him and survive with him; someone who did not insist on imposing his own person/analyst and allowed Kyle to forge his own particular path to sentience and coherence: “to discover his own way to the world of objects” (Balint, 1968, p. 180).

Utilizing the work of Bion and the contemporary Kleinians, Riccardo Lombardi outlined the dense struggles within the analyst and the treatment relationship when working with people who are overwhelmed with shame, depersonalization and psychosis (Lombardi, 2002, 2005, 2007). There is a focus on patients who do not experience themselves as located in their bodies or their own minds, and Lombardi offered feelingful descriptions of the analyst’s physical response (Lombardi, 2005, p. 1092; Lombardi, 2007, p. 387) to the undigestible pieces of the patient’s regressed experience and “modes of being” (Matte-Blanco, 1988). Lombardi did emphasize the importance of the shared experience of these modes of being. However, the interventions that he described involve the analyst explaining the ongoing experience in terms of the patient’s internal world such that the patient can begin to occupy his or her own experience and discriminate self from other. These interventions may be contrasted with my work with Kyle, where rather than conveying understanding through spelling out what I believed was going on inside him and in the analytic field, I would engage with him in the very space that he was occupying, say, talking about the breakup of the Soviet Union. Yes, this kind of material suggests many interpretations of his internal world (the fragmentation that he may fear should he try to free himself from the tyranny of the colonizing internalized mother, etc.), or of our relationship (his wish and fear to take back his own autonomy and the terror that he would be left with new and pernicious persecutory objects that could infuse our relationship), but I would suggest that the “leading edge” (Miller, 1985) of these moments, to use Kohut’s term, was the mutual engagement that Kyle was looking for as he worked with these issues in a symbolic register. My unobtrusive partnering with him allowed him to find his own way through these issues with the stability and
holding of my company and emotional engagement. I would hold in mind the kinds of analyses
explicated by Ferro, Lombardi, and others.

It seems to me that there are different ways to usefully understand the therapeutic impact of
these discussions with Kyle. Certainly they could be said to involve the transformations of beta
elements and that our relationship was providing the alpha function necessary for this. My obser-
vation was that Kyle was able to come together in aliveness in my engaged company, and was
simply and explicitly not available for the ingestion of meta-analyses of what was transpiring
between us. One might also emphasize the function of implicit relational knowing and a process
of fittedness between us that the Boston Change Process Study Group has described, and I’d
like now to consider how the unobtrusive analyst might relate to these conceptions of therapeutic
action.

SELFOBJECT FUNCTION, EMPATHY, AND THE UNOBTRUSIVE ANALYST

Certainly there is much confluence between the conception of the unobtrusive analyst and
the Kohutian idea that the analyst must be available for whatever “necessary but absent”
(Lichtenberg, Lachmann, & Fosshage, 1992) selfobject function the patient needs in the trans-
ference (Kohut, 1971, 1977), and must strive not to derail the development of that transference.
Likewise, the self psychology emphasis on the careful use of empathy as a means of listening
to and knowing the patient (Lichtenberg, Bornstein, & Silver, 1984; Orange, 1995), the analytic
couple’s regulation of affect and arousal, the disruptions and repairs that comprise the treat-
ment relationship (Lachmann, 2008; Lyons-Ruth, 1999), are all relevant to the formulation of the
unobtrusive yet intimately engaged analyst that I am outlining.

Kohut, however, was skeptical about the ability of psychoanalysis to address patients who
could not form stable narcissistic transferences and who exhibited “borderline” or “manic depres-
sive” tendencies (1971, p. 18). He felt that patients who could not integrate their archaic
exhibitionism and grandiosity “within the total structure of the grandiose self” (p. 18) would
be unable to form the narcissistic transferences that constitute the curative factor in treatment.
Accordingly, Kyle would not have been regarded as available for the kind of treatment that he
and I built, particularly when we consider the degree of instability in his sense of self and other,
together with his creation of the unusual treatment frame in terms of time and space.

In terms of the unobtrusive analyst, we find much in common with the work of the Boston
Change Process Study Group (Boston Change Process Study Group et al., 2002; Stern et al.,
1998), who suggested that at times the change that occurs in analysis is not, and need not be,
accompanied by explicit verbalization of the process. Lyons-Ruth (1999) suggested that implicit
or procedural forms of knowing exist in “an implicit or enactive domain” and only emerge “in
the doing” (p. 578). I would suggest that for Kyle, treatment could proceed only in a certain
register: my thoughts about our process could not be made explicit, and instead we had to be
engaged together in a certain form of “doing.” For instance, when he showed me his punctured
torso I stayed within the register and content that he occupied and talked about liposuction and his
doctor, without any insertion of an understanding from outside of his immediate felt experience.
I silently contained my intellectual and gut reactions to this moment.

Furthermore, perhaps the manner in which I allowed Kyle’s disturbed inner world to manifest
and fill up the treatment space between us and within me can be fairly described as a form of
empathic connection. This empathic connection involved little in terms of expressions of my understanding but involved a growing implicit bond between Kyle and me that coheres with the caretaker–child “empathic connection” that Lichtenberg et al. (1984) outlined.

If there is a divergence between this work and that of the intersubjective “friends of empathy” (Lachmann, 2008), I believe it would be in the area of technique and mutual regression: the allowing and holding of deeper and more disorganized states of being in the treatment. One might say that “moments of meeting” and “implicit relational knowing” are way stations on the road to improved internal organization, integration, regulation, and relatedness. In the case of Kyle my “empathic connection” allowed him to bring his less regulated, less organized, less related states into the treatment and into my internal world. I believe I had to live through these with him and not do anything to him, in order for him to own the treatment space and shape it according to his own image.

CONCLUSION

I have described my work with Kyle to outline a contemporary reading and clinical utilization of the conception of the unobtrusive analyst outlined by Michael Balint (1968) and Enid Balint (1993). The related emphasis on the value of silence, waiting, and regression in a mutual experience are all seen as complementary to contemporary concepts of co-creation and the deep emotional engagement of the analyst with the patient in the analytic field. There is an emphasis on the analyst allowing for the patient’s inner world to emerge within the analytic relationship in the idiom of the patient so that the patient can come to own their own sensations, body and mind. Particularly, but not only, with patients like Kyle who are not psychologically alive in a felt and recognizable way, the emergence of these regressed states often comes in the “enactive” register. I emphasize the value of the analyst allowing this process to unfold, to accompany the patient, and to not close it off with interpretations or investigations of the relationship that do not come from within the patient.

I have touched on some, but not all, of the influences from the contemporary psychoanalytic environment that are woven into my understanding of this feature of analytic process, and have tried to outline some similarities and some differences between this conception of the unobtrusive analyst and other ideas of clinical process.

Kyle was able to tell me that he felt alive for the first time in his life. He has continued to experience his own consciousness for the first time. He has described feeling peace in his mind, having clear thoughts and listening and noticing others as having similar processes. He is excited and daunted by these seemingly simple everyday phenomena. He is still very much, and always will be, Kyle. As I write, he has begun to talk to relatives and intends to figure out a time line of his childhood and his life. He would seem to have begun to discover his own subjectivity: his own “new beginning” (Balint, 1968, p. 131).

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