BUT WHAT DO YOU WANT? THE PROBLEM OF AN ABSENCE OF DESIRE
Presenter: Joyce A. Slochower, Ph.D.
Discussant: Giselle Galdi, Ph.D.
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Dr. Slochower’s presentation centered around the question of how to treat patients who cannot access their feelings and desires and who are therefore unable to express them to others. She began with the case presentation of M, a man who reported that his girlfriend had nearly broken off their relationship because of his inability to express his desires, which resulted in her feeling suffocated by his tendency to go along with her. According to his girlfriend, he did not seem like a whole person because he had no access to his feelings. M was surprised by her reactions to him, but nevertheless, he was still unable to please her by identifying and expressing what he truly wanted. Dr. Slochower sought out ways of identifying, understanding, and facilitating the communication of M’s inner thoughts, feelings, and experiences.

Central to Dr. Slochower’s paper was the concept of interiority. This refers to the sense of the self as a subject and was described as “a basic ability to turn inward and contact affective states that can then be symbolized and articulated.” M clearly lacked this sense of interiority. Dr. Slochower proceeded to describe the development of the sense of interiority and the complex processes by which we locate our inner experience. Drawing on infant research by Beebe, Lachman, and Jaffe, she reminded the audience that internal experience always arises out of the subtle interplay between self and others and that, even when alone, we always define ourselves in the context of interactions with others. Dr. Slochower then related the concept of interiority to what Winnicott described as the capacity to be alone, the infant’s experience of aloneness in the presence of the mother. For individuals who have not developed a capacity to be alone, the step of looking inward and getting in touch with one’s inner experience is especially anxiety arousing because it implicitly requires a person to experience “aloneness” and detach from the other’s experience. This can be threatening if it is perceived as an abandonment of the other

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person. Dr. Slochower also suggested that the mother’s capacity to access her own inner experience is crucial for the child’s development in the sense that it creates a buffer between the self and the outside and allows the child to contact his own “aliveness.” Dr. Slochower stated that the parents’ containing and validating functions create the necessary holding environment in which the child can “feel out the contours of its own insides, of an affective, cognitive, and body self, that can engage in complex, intersubjective cognitive-emotional processes” and thereby develop a sense of interiority. Dr. Slochower concluded that the experience of interiority is a multidimensional phenomenon. She described it as including “1) the subjective experience of self as subject and object; 2) a fairly steady awareness of the other’s separate reality as both object and subject; 3) a capacity to explore and articulate inner experience; 4) a tolerance for such experience when its affective color is anxiety arousing or aversive; and 5) an ability to self-soothe.”

Using M's case as an example, Dr. Slochower went on to talk about the therapeutic dilemmas that can arise out of a disturbance in a patient’s sense of interiority. M’s behavior in therapy left the analyst with a feeling of frustration about his superficial compliance and his lack of “insideness.” A major difficulty with such patients is that they often become dependent on an external object to help them process and regulate their affective experiences. In these cases, patients might use the analyst as the “defining source of interiority and/or the single vehicle through which affect is processed.” However, interpreting patients’ dependency on the analyst might lead to a new cycle of acquiescence, in which patients will superficially agree with the analyst’s interpretations exactly because of their inability to access their own emotions. A solution for working with this dilemma is, according to Dr. Slochower, the analyst’s shift toward a rather silent approach. This prevents patients from being “pulled” in any direction by the analyst’s comments and provides a holding environment, which allows patients to turn inward and to develop their sense of interiority. In a later stage of therapy, the impact of these silent moments can be articulated and used to explore the patient’s dynamics.

In the discussion of Dr. Slochower’s presentation, Dr. Galdi conceptualized M as a Horneyan patient and described him from this viewpoint. Dr. Galdi understood M as being identified with his idealized self, which is experienced as always being cautious, rational, calm, reasonable, free from conflict, and free from other’s intrusions and demands. The analyst, on the other hand, was able to sense M’s hated, disowned, hidden self that seeped out as an anxious, angry, needy, wishful, wanting, desiring, selfish person. Because M’s hidden self was intolerable to him, he had to disown it by externalizing it onto others. M’s lack of experiencing all of his inner processes had become for him a whole way of life, what Horney referred to as “externalized living.” The outcome for M was the total loss of feeling himself as an organic whole, what Horney called “alienation.” Citing the writing of Marianne Homey Eckardt, Dr. Galdi concurred with Dr. Slochower’s opinion that in M’s case, interpretations would only perpetuate the cycle of acquiescence. Instead, Dr. Galdi recommended exploring all aspects of M’s life where he behaves as an active agent with the goal of having him own his externalizations in order to make them internal again.