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On Digital Consciousness and Psychic Death

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This paper describes states of consciousness in some disturbed or traumatized patients in which time is not experienced as being linked to future or past. The patient’s experience in this state is “digital” rather than continuous, making it difficult for him to have an inner sense of continual “aliveness” and to link analytic sessions together. In extreme cases, his world may be experienced as a succession of moments interrupted by little blanks or psychic deaths. The experiential, developmental, and neurobiological aspects of these states are explored with an emphasis on implications for psychoanalytic treatment.

This paper is about a particular class of states of consciousness that can be found to varying degrees in patients who seem challenging to treat and who might be classified as extremely narcissistic, borderline, or sometimes even psychotic. On occasion, however, they can form a part of anyone’s repertoire of states of consciousness as, for example, in the traumatic moments after a car crash or some similar shocking event.

One of the distinctive parameters of this state is the experience of time, which in this state exists only in the moment so that the patient experiences neither his past nor his future but lives entirely in the present moment of the trauma. I refer to this as a digital state as opposed to the more usual ana-
log state in which experiences of the past as well as the potential for a future are felt to exist simultaneously, interpenetrating and affecting each other at every moment. As a consequence, people who are usually in the normal analog state experience a continuity in their life because at any given moment they know where they have come from and can imagine where they might be going, just as with an analog watch one can see the hour from which the hand has come and the hour to which it is going as well as its location at the present moment. Thus the analog state relies on reflective self-awareness so that consciousness is experienced as a “thick” time (Ludden, 2006) in which memories from the past and expectations for the future blend together with the experience of the current moment.

In the digital state, where time is “thin” rather than “thick,” without past or future, patients lack this sense of continuity and consequently feel vulnerable and uprooted, as if they were constantly balancing on one foot. While in this state their experience of life is a succession of instantaneous digital moments, without connection to or even memory of where they have come from and where they are going. Each moment is split off from the previous or following moment so that a discursive account that links even the immediate past to the present and future is often not possible. Many of these patients, as competent as they might appear in real life, often live with an internal experience of not knowing how to get from one place to another or how to get from here to there. One consequence for the analysis is that their memory does not link past sessions to the present session and therefore learning from experience becomes difficult if not impossible.

But a far worse consequence for the patient’s internal life is that the discontinuity between each digital moment and the next is sometimes experienced as a gap or a void or even a psychic “death of the self.” Sometimes the patient may find himself abstracted or “spacey” or staring off into the void with a glazed look; sometimes someone in the room might ask him, “Are you all right?” These moments differ significantly from hysterical abstraction, where the continuity of thought is interrupted by unconscious repressed material and can be restored when the repressed or denied material is again made conscious. But in these digital states the gaps in consciousness feel like a void, empty of any material that feels alive, that can be thought about or verbalized. On the contrary, one might characterize them as the extinguishment of life, a psychic catastrophe or the “death of the self.”

Thus, instead of the continual flow of life experienced in the analog state, there is an experience of a series of moments followed by little blanks or gaps or psychic deaths, keeping the patient in a continual state of anxi-
ety, uncertainty, and mistrust. The patient distrusts this succession of labile, unfocused, and disconnected moments and cannot make them cohere into a unified narrative that might feel like a usable self or an identity that he can trust. Reciprocally, he finds it difficult to build trust in either the analyst or the analysis, and without a certain degree of trust he can neither fully reveal himself nor truly engage the analytic process.¹

Of course I am here emphasizing the parameter of time in this digital state, but there are many other parameters of states of consciousness that are also affected because they are all part of an interdependent system. For example, thought processes are usually linear, are concrete, and tend to be either/or, with little shading or gradation. The ability to symbolize and make playful transformations and the sense of agency and reflective self-awareness may also be severely diminished or absent. What people are nowadays calling triangularity or the analytic third may equally be absent or unavailable and the transitional area may be defective or entirely lacking. Another way of summarizing this is to say that the person’s psychic space is severely constricted.

I want to make clear that I am using digital and analog as signposts for either end of what is in actuality a continuum of states of consciousness ranging from one extreme to the other. For example, a multiple personality disorder might be thought of as one extreme of digital consciousness because of the almost total lack of connectedness, integration and continuity between the various psychic nuclei.

It seems that in the development of the mother–infant dyad, the growing self and mutual regulation and the interpenetration of affects and states of consciousness make for a continuity that the infant experiences as an ongoing sense of being. The child feels an elated sense of agency after experiencing his ability to make something happen, to have an effect on someone, or to make his mother enjoy him. But this continuity of being, this sense of agency and of the ongoing-ness of things, this feeling that we are living a connected analog experience rather than a series of disconnected digital moments, can be easily disrupted by trauma of any sort.

I will for the moment define trauma as a situation in which some new internal or external experience of the baby cannot be adequately held or contained by the environment and in which this disruption is not repaired.

¹I should note here that I am writing about digital time, time without past or future, purely in its pathological aspects. There is another mythical or mystical time, the time of Eliade’s in illo tempore, a magical reality that takes time out of history, but unfortunately I cannot go into that here.
When trauma occurs, then the experience of continuity becomes radically disrupted and the child or even the adult is suddenly thrown back upon his own resources to sustain life. That is to say that life, which up to that moment had been a collaborative effort between the child and his environment, now suddenly becomes a traumatic solitary endeavor. The child or adult, abruptly forced to manage things all on his own, can either sink or swim. Either he may survive and grow from this effort or else he may revert to the most primitive defenses such as denial, projective identification, or dissociation that will ultimately affect his reality testing. In either case, the child has been prematurely ejected from Eden, from a state of subjectivity in which he is being safely carried by an environment of which he may not even have been aware, into an objective state where in order to save his life he must become prematurely aware and self-conscious, often with feelings of shame, guilt, and humiliation. These feelings arise because the traumatized child or adult so frequently blames himself for his predicament, and he usually does so in order to spare the person who has failed him and thus maintain his object tie.

While the continuous analog state I have been describing can be experienced as coexisting with the normal oscillations between subjectivity and objectivity that we all experience, the digital state entails either a frighteningly depersonalized objectivity that cuts the patient off almost entirely from his own feelings or else a total immersion in subjectivity that feels to the patient as if he is drowning in unbearable traumatic pain.

One man, who was so terrified of the return of his mental pain that he would put his fist through the window whenever this threatened, began slowly to find a space in which time was not so fragmented. He spoke in a highly intellectualized way in order to keep his emotions and pain at a distance. He said,

I’ve had no appreciation for process. I’ve had a fundamentally skewed vision. Rather than freaking out because I don’t have coffee and I have to go and get some or because I have to change some word for the third time—I don’t realize that it’s not about having written the book, it’s about writing the book. I’m not willing to give myself five more minutes.

It begins with memory. It’s not about “what do I see?” It’s about what I do see. Memory has always been a problem. I have an expectation of my ability to remember, a presumption that doesn’t bend. I can’t stand it when my daughter says: “I remember when we did that.” I often say to you—I don’t understand … I don’t remember … I think all the details have to be right there, immediately.
Yesterday you said something to me about continuity. I’m afraid to look in my notebooks, afraid that they’ll be inaccessible. But then I thought—they’re a part of me, my present. Like my school notes. I can go back to them. It has that time element. It can come alive to me again. I was leaving here thinking, feeling a sense of space. You could go back if you wanted to, if you gave it what it required, patience and time. I always wanted it to be done immediately.

This man, as he slowly found continuity in the analytic transference, began to connect process, time, and memory, and as his sense of time began to include a past and a future, he became more able to be patient with himself and with others.

A similar process occurred in a man whose clinical material I published many years ago (Bach, 1985) but whom I believe I now understand somewhat better than I did at that time. This young professional man had a severe narcissistic disorder that interfered with both his marriage and his work. After several years of analysis he had made considerable gains and was now terminating because of external circumstances, but not without ambivalence. As one expression of this conflict he had lost his old analog watch and replaced it with a digital watch. Reflecting on his new watch he said,

Digital time is unyielding, it’s absolute, but the hands on an analog watch never stop at any particular time, it’s an unfolding …

Digital time is the here and now; it allows for change from moment to moment but each reading is only itself. How can you be sure that the next reading will really be one second or one minute after that one? It requires a certain trust, a trust that something will remain the same even in the process of change, that there will be continuity behind or beneath the change. You remember how I used to feel that when I turned on the water tap, blood might come out? I used to marvel at how certain you seemed when you came into the waiting room that you would find me there and not someone else—a plant or a monster. … Now I rarely think about those things. … I guess I’ve developed some sense of trust that things will remain the same.

This sense of trust that things will remain the same even in the process of change, this feeling of self-continuity and of environmental continuity had been one of the major achievements of the analysis. At that time we had understood his losing his analog watch and replacing it with the newest dig-
ital variety as an attempt, in part, to make time stand still, to put off the termination and return to his earlier digital state of timelessness, particularly by eliminating the future without me. While this was undoubtedly true, I now feel that we slighted the importance of coming to terms not only with the separation but also with Death itself as a major unspoken component of separation, of process and even of the sense of time.

At that time when both the patient and I were younger, I was not so sensitive to the importance of Death as a component of life, although the patient had told me often enough of his discontinuous experiences and of his terror that he might not remain the same person or even remain the same species from one moment to the next. Where had I imagined that he existed in between these drastic transformations?

What I am trying to say is that the death of the self that occurs in between digital moments of consciousness, or the death of the self that a young child experiences after trauma or after the loss of a primary object, is an experience so frightening that for us it is almost unthinkable. Adults may describe it as imploding, or entering a black hole, or falling endlessly forever. In working with the most challenging patients, I have frequently observed an omnipresent fear of death or of dying, expressed either directly or indirectly through a complete avoidance of change, agency, initiative, or futurity. Eventually, following Winnicott’s insight that a fear of breakdown might indicate that the breakdown had already occurred, I began to see that many cases of fear of death were indeed a fear of the psychic death that the patient had already experienced at earlier times in his life. This realization made it somewhat easier to understand and work with extreme disturbances.

I remember another patient, a talented and extremely suicidal young woman, who once wrote to me,

When I was 10, I first tried to kill myself. This is a fact, although at that time I had no conscious idea that suicide was my aim. What I was trying to do was to reaffirm, or for once affirm, my own existence. I knew that whoever I was, was gone . . . . I needed an explanation for the turmoil of sudden understanding that whoever I was had escaped and left me with no center. . . . It isn’t that I’m drifting or a chameleon, because then I could not have this dreadful detachment from my own feelings. . . . When I was 10 and in the park and saw the broken green glass, all that went through my mind was that I wanted to see if it could cut me, I wanted to see if I could feel pain. I wanted, in other words, to find out if at least the physical organism existed, if it still remained. I did not think of death.
This woman made a suicide attempt after her very first consultation with me, but fortunately she survived and the resulting analysis led to a rather successful outcome. At the time I wrote about her I spoke of the fantasy of “death of the self” (Bach, 1985), but I still had not understood clearly enough that for many patients this is a terrifying lived experience that can be repeated many times a day, and defended against with manic, schizoid or projective defenses. This patient, for example, would rent a room in a boarding house and late at night would start screaming uncontrollably. One of the reasons she screamed was that it made her feel for a moment that she really existed. After a few weeks she would be evicted and then repeat the incident in yet another rented room. She was struggling against the overwhelming trauma of re-experiencing her earlier psychic death.

Today we know somewhat more about the infant’s reaction to catastrophic trauma both from infant observation and from neurobiological research. In a review article on the subject, Alan Schore (2002) noted that the infant’s psychobiological response to trauma is comprised of two separate response patterns, hyperarousal and dissociation. In the initial stage of threat, a startle or an alarm reaction is initiated, in which the sympathetic component of the autonomic nervous system is suddenly and significantly activated, resulting in increased heart rate, blood pressure, and respiration. Distress is expressed in crying and then screaming … .

But a second later forming reaction to infant trauma is seen in dissociation, in which the child disengages from stimuli in the external world and attends to an ‘internal’ world. The child’s dissociation in the midst of terror involves numbing, avoidance, compliance and restricted affect (the same pattern as adult post-traumatic stress disorder). Traumatized infants are observed to be ‘staring off into space with a glazed look’. This behavioural strategy is described by Tronick and Weinberg:

[W]hen infants’ attempts fail to repair the interaction, infants often lose postural control, withdraw, and self-comfort. The disengagement is profound even with this short disruption of the mutual regulatory process and break in intersubjectivity. The infant’s reaction is reminiscent of the withdrawal of Harlow’s isolated monkey or of the infants in institutions observed by Bowlby and Spitz. [137, p. 66]

This parasympathetic dominant state of conservation-withdrawal occurs in helpless and hopeless stressful situations in which the individual becomes inhibited and strives to avoid attention in order to be-
come ‘unseen’ [14,44]. This metabolic shutdown state is a primary regulatory process, used throughout the life span, in which the stressed individual passively disengages in order to conserve energies … to foster survival by the risky posture of feigning death, to allow healing of wounds and restitution of depleted resources by immobility’ [150, p. 213]. … This elevated para-sympathetic arousal, a survival strategy [157], allows the infant to maintain homeostasis in the face of the internal state of sympathetic hyperarousal. (pp. 15–16)

Schore’s description of the neurobiological and behavioral consequences of trauma, which he has synthesized from many sources, seems to be linked to the phenomenological experience I have been calling “death of the self.” While my own clinical material is largely derived from psychoanalytic work and reconstructions in patients with severe childhood trauma, the phenomenological descriptions are fairly consistent across a large number of patients. Usually a current trauma, and most particularly a traumatic repetition in the current transference, triggers a remembered or repressed incident or an accumulation of incidents from childhood. The patient experiences a dramatic shock and a generalized hyperarousal, followed by a disorganization that is often described as a kind of “splintering,” “disintegrating,” or “falling apart,” often accompanied by intense feelings of shame. The content is variously described as a kind of “void,” an “emptiness,” a “disappearance,” a “death,” or a “black hole,” and it seems as if the humiliated person’s wish to become “unseen” or to disappear off the face of the earth had actually been realized.

What ensues in reaction to this trauma is often a series of digital states of the kind I have been describing. In certain cases where some degree of trust remains, a healthy reaction of rage can emerge and then the sense of time and of agency may begin to expand again. But with the most severely traumatized patients the rage never develops, the experience remains purely in the moment, the sense of agency is diminished and the regression to what Schore has called “dissociation” and what feels like a “death of the self” may continue unabated unless the patient encounters some kind of healing environment.

I mentioned earlier that one way to conceptualize trauma is as a situation in which some new internal or external experience of the child cannot be adequately contained by the environment and cannot be repaired. It implies a breakdown of the system and a failure of the continuity of symbolization. Conversely, healing or repair may be thought of as beginning with the re-provision of just those elements of the environmental system that had
been so dramatically lost or disconnected by the trauma. This would then permit the reworking of inner psychic conflict within the context of a more benevolent environment. I believe this is some part of what we mean when we speak of holding, containing, or helping to regulate the traumatized patient.

In an extraordinary series of experiments, Myron Hofer (2003) has begun to explore precisely what this might entail by analyzing catastrophic separation into its component parts. He has noted that every separation or transition means the “loss of a number of individual regulatory processes that were hidden within the interactions of the previous relationship, with individual components of the interaction regulating specific physiological and behavioral systems” (pp. 194–195).

Fortunately, this research also suggests that the catastrophic depressive reactions resulting from the simultaneous loss of multiple “hidden” regulators may sometimes be partially reversed by re-providing some of the individual regulatory components such as the mother’s warmth and stimulation that were offered by the lost relationship.

Hofer went on to say that

The discovery of regulatory interactions and the effects of their withdrawal allow us to understand not only the responses to separation in young organisms of limited cognitive-emotional capacity, but also the familiar experienced emotions and memories that can be verbally described to us by older children and adults. It is not that rat pups respond to loss of regulatory processes, while human infants respond with emotions of love, sadness, anger and grief. Human infants, as they mature, can respond at the symbolic level as well as at the level of the behavioral and physiological processes of the regulatory interactions. The two levels appear to be organized as parallel and complementary response systems. Even adult humans continue to respond in important ways at the sensorimotor-physiologic level in their social interactions, separations and losses, continuing a process begun in infancy. A good example of this is the mutual regulation of menstrual synchrony among close female friends, an effect that takes place out of conscious awareness and has recently been found to be mediated at least in part by a pheromonal cue (Stern and McClintock 1998). Other examples may well include the role of social interactions in entraining circadian physiological rhythms, the disorganizing effects of sensory deprivation and the remarkable therapeutic effects of social support on the course of medical illness (reviewed in Hofer 1984).
this way, adult love, grief and bereavement may well contain elements of the simpler regulatory processes that we can clearly see in the attachment responses of infant animals to separation from their social companions. (pp. 204–205)

Personally, I have found this point of view remarkably useful in the clinical situation. For example, I have come to understand that certain patients who arrive for analysis bringing along a retinue of physical therapists, personal trainers, yoga teachers, Pilates instructors, and massage therapists may very well be attempting to do for themselves the same thing that Myron Hofer did for his deprived rat pups. Here we are again dealing on a more sophisticated level with issues similar to those that Groddeck was discussing with Freud in the early years of psychoanalysis.

I have tried in this paper to delineate a class of states of consciousness that seem to arise as a reaction to trauma and may continue thereafter either sporadically or on a regular basis. I have called this class digital states of consciousness because one prominent feature is the experienced sense that time exists only in the here-and-now of the trauma, as opposed to analog states of consciousness in which present, past, and future are experienced as connected and interpenetrating. This lack of a feeling for the past and the future profoundly affects the person’s sense of continuity and the ongoingness of his being, as well as affecting his object attachments including the treatment relationship. The fragmented and digitalized nature of this experience interferes with symbolization and with the formation of a continuous self-identity and the consolidation of a sense of agency. The profound feelings of loneliness, guilt, and shame that often accompany this state were viewed as part of a narcissistic reaction to trauma in which the victim feels responsible for his mishap and believes that the trauma has revealed some unspeakable defect in his very being.

I have also tried to suggest that a healing response is possible if the regulatory environmental interactions that were so shockingly disrupted by the trauma can somehow be reinstated. With challenging patients, the trauma has usually been reenacted in the transference, and if this rupture can be somehow repaired then the possibility is reopened for working through psychic conflicts and disturbed relationships. One way of repairing these disturbed interactions in analysis is through the creation or recreation of a shared, mutual, or dyadic state of consciousness, that is, a regulatory state of consciousness created and shared by analyst and analysand, which bears some relationship to Winnicott’s (1953/1958) transitional area, and which is often referred to nowadays as an analytic third (Aron, 2006). There may
also be other ways of doing this, as suggested by Hofer’s remarks about menstrual synchrony, social interactions, and social support. This is a huge area about which we know very little and which is now potentially ripe for psychoanalytic research. But I hope I have raised some questions worth thinking about the next time that we see a patient in what seems to be a traumatized or unusual state of consciousness.

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