Primary Process Communication

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An unorthodox view of the function of primary process is presented with a view to enlarge, rather than diminish Freudian assumptions. One of the basic tenets of Freudian hypothesis was the supposed lack of influence of outside experience upon primary process functions. Yet we see demonstrated on a daily basis that primary process cognition is at work in any human interaction or experience. The mental structures of the self in interaction with the nonself is constantly monitored, added to, or subtracted from during contact with others. It is a prereflective mode that does not immediately rise into awareness. We give meaning to all interactions without necessarily reflecting upon them or even clarifying them to ourselves. Without allowing for such meaning to be integrated, we would lose or misinterpret large portions of our daily interactions. Flaws in communication occur every day and are demonstrable particularly in therapy when therapists are not attuned to their patients’ emotional needs. It is demonstrated that nonverbal avoidance behavior of disturbed infants is the precursor for disturbed object relations of adults. Therefore, it makes no sense to interpret unconscious meanings—there are none. The difficulty lies in the inter-subjective realm and serves defensive modes. However, if...
patients present an inauthentic self, it is often difficult to decide if one is indeed in the presence of such a maimed self. The therapist’s countertransference aids in detecting inauthenticity. Ever-present, unconscious meaning analysis must be brought into consciousness by the therapist in order to further the therapeutic process.

The major thesis of this article is that the primary process system is immediately and directly involved with perception and with an individual’s affective communications with others. Until recently, many analysts followed Freud in viewing the primary process as the archaic residue of the infantile narcissistic period, unmodified by learning, and in which cognition is without relation to reality. Freud viewed the primary process as taking place in the id, which, in contrast to the ego system, is cut off from perception and relations with the external world (Freud, 1940). Freud was mistaken in linking the primary process and the id with what is internal, instinctual, and cut off from relations with the external world. These obsolete views are challenged and overthrown by the studies of Fast (1985), Holt (1967, 1976), Langs (1986), Noy (1969, 1979), and others.

The primary and secondary process may be conceptualized as two parallel and relatively independent systems for the reception, analysis, processing, storing, and communication of information (Rogers, 1980). In normal awake adults, these two modes are integrated and all psychic functions (such as communication, cognition, perception, memory, and so forth) have both primary and secondary process elements, although one or the other may predominate. The derivatives of the primary process system include affects, imagery, metaphors, and nonverbal communication.

Event Theory Primary Process System

The primary process system analyzes, regulates, and communicates an individual’s relations with the environment. Events are the fundamental units of primary process cognition, and Fast’s (1985) event theory proposes a basic unit of experience and mental structure, which represents the self in interaction with the nonself. The basic
content of primary process cognition and communication is a representation of a specific relationship between self and object.

The contribution made by mature primary process cognition to a person’s understanding of his or her object relations should not be dismissed as primitive or unrealistic. Intuitions, images, and emotions derived chiefly from the primary process system provide an immediate and prereflective awareness of our vital relations with both ourselves and others. Primary process cognition and communication does not deceive, and it is at bottom the only means by which we can free ourselves from the vicious circle of abstract thought and make contact with the reality of the self and its relations to both internal and external objects.

Primary Process Meaning Analysis

Individuals reflect upon and make conscious judgments about the nature of their interactions with others. My claim is that a similar process of meaning analysis goes on unconsciously during one’s waking hours and that the products of this process are what psychoanalysts call primary process derivatives (i.e., affects, imagery, narratives, metaphors, nonverbal communication).

A major function of the primary process system is to make unconscious, automatic, and rapid evaluations of current events involving self and others. The meanings attributed to these interactions play a central role in the following psychic functions: in making judgments and inferences about the self and the other, as well as about the probable causes and likely outcomes of the current interaction; in the activation and deactivation of certain schema; in the arousal and regulation of specific affects; in the initiation of defensive and adaptive activities designed to cope with the event being processed; and in nonverbal communication. The subject may or may not be aware of the content and conclusions of this unconscious process of meaning analysis. The subject’s unawareness of the meaning of some primary process derivative is not always caused by defense. Oftentimes a person may, by reflecting on the derivatives of his primary process functioning, become aware of their previously preconscious meaning. The notion of unconscious meaning analysis discussed in this paper has been borrowed from cognitive...
psychology where it has a similar, though not identical, meaning to the one proposed here.

*Primary Process Communication and Secondary Process Communication*

Investigators of human communication view language as a system consisting of two levels of communication, and these two levels can be described as primary process communication and secondary process communication (Wittgenstein, 1921; Russell, 1940). Both primary process communication and secondary process communication are present in ordinary conversation where objective, factual (secondary process) information is transmitted by the meaning of the uttered words and where affective and object-relational information is transmitted predominantly by primary process communication. Nonverbal communication includes body movements (kinesics), posture, gesture, facial expression, voice inflection, and the sequence, rhythm, and pitch of the spoken words. Primary process communication and secondary process communication exist not only side by side, but they complement and are contingent upon each other, often in highly complex ways.

Secondary process communication has a highly complex and powerful logical syntax but lacks adequate semantics in the field of relationships, while primary process communication possesses the semantics but has no adequate syntax for the unambiguous definition of the nature of relationships.

*The A, B, C, and D Modes of Communication*

Some of the most comprehensive studies on the clinical significance of primary process derivatives in verbal communication comes from the writings of Langs (1978, 1982) on communication modes and unconscious communication. He describes three communicative modes (Types A, B, and C), and I add a fourth, the Type D mode (Dorpat, 1999).

The Type A mode, characterized by a predominance of symbolic imagery and metaphors, communicates the most meaning and is geared toward insight. Individuals communicating in the Type A mode
employ a predominance of mature, over archaic, forms of primary process communication. In contrast, the Types B and C modes tend to include more archaic than mature primary process cognition.

In the Type B mode, the individual uses projective identification as a mode of communication and as a method of defense. The Type C mode of communication is one in which emotions and other primary process derivatives such as imagery, metaphors, and narratives are reduced or absent. The Type D mode is inauthentic communication (Dorpat, 1999).

The Type C Mode of Communication

Here my aim is to provide a description of the Type C mode, together with a theory of the Type C mode which says that the Type C mode is brought about by an unconsciously motivated defensive suspension of the primary process system.

The same or similar clinical phenomenon has been called by different names by different writers, and these terms include the defense of nonrelatedness (Modell, 1984), attacks on linking (Bion, 1959), the computer mode (Elgin, 1980), alexithymia (Krystal, 1988), and the Type C mode of communication (Langs, 1978, 1982; Dorpat, 1993).

Ogden (1982) describes projective identification as simultaneously a mode of communication, a type of pathological symbiotic relatedness, and a type of defense. In my opinion, his description also applies to the Type C and D modes. The B, C, and D, but not the A mode, are at the same time a type of interational defense, as well as a mode of relating and communicating; the Type A mode is not defensive.

The Type C mode of communication is one in which emotions and other primary process derivatives such as imagery, metaphors, narratives, and nonverbal communications are reduced or absent. As a type of relating, the Type C mode is one in which the subject distances himself from personal and intimate interactions with others. The Type C mode tends to be formal rather than informal, impersonal rather than personal, distant rather than close.

The defensive aspect of the Type C mode is its inhibition of emotional expression. Emotional communication between mother and infant is one of the earliest relational bonds and precedes the
attainment of symbolic (e.g., language) functions (Modell, 1984). In adults as well as children, emotions are the central medium through which vital information, especially information about interpersonal relations, is transmitted and received. Therefore, the suppression of emotional expression and receptivity in the Type C mode is a way of blocking an important way humans communicate and interact.

In the Type C mode, the need for defense brings about a massive inhibition or shutdown of the primary process system. This inhibition may include the expressive functions or the receptive functions or both; this shutdown accounts for the absence of affect and other primary process derivatives in the Type C mode.

An Intersubjective Perspective in the Type C Mode

For most individuals, the Type C mode is not a fixed and unchanging mode of communicating. Like the other modes (A, B, and D) of communicating, the Type C mode is dependent on the context. The interpersonal environment plays an important role in initiating, shaping, maintaining, and terminating Type C communicating as well as the other modes.

Frequently, schizophrenic patients show a kind of Type C communication marked by a flat affect and withdrawal from interpersonal and social relatedness. The following vignette shows that their diminished affectivity and their withdrawal are not necessarily fixed, unchangeable characteristics of their communication.

A 31-year-old patient with chronic schizophrenia was referred to me for a forensic evaluation. He had a 10-year history of chronic alcoholism, drug abuse, and unemployment. He came reluctantly to my office, and he appeared withdrawn and disheveled. He avoided eye contact with me, and he spoke without any emotional expression in answer to my questions. I tried unsuccessfully to engage him in conversation. All of my overtures were met by avoidance responses, and he behaved as if I were not in the room with him.

The patient’s chair and my chair were at opposite ends of a large floor-to-ceiling window looking out over a fenced garden. Suddenly, I noticed a marked change in the young man’s facial expression, when he turned his head to look outside the window toward a cat walking slowly through the garden. The patient laughed and exclaimed with
intense feelings of pleasure and enthusiasm, “Hello, Pussy Cat!” Then he turned toward me, and he said with obvious delight, “Isn’t that a cute little pussy cat?” I agreed, and he went on talking in an animated way about his love of animals. After a few minutes, our mutual friend, the intruding “cute little pussy cat” walked off. Following the departure of the lovable cat, my patient resumed his Type C communication. Saddened by the departure of the cat and feeling frustrated and helpless in my efforts to make contact with the patient, I resumed my task of carrying out a forensic psychiatric examination. He responded to my questions with monosyllabic answers devoid of feeling or any sign of the liveliness brought out by the pussy cat’s visit to my garden.

**Clinical Studies**

Various kinds of interventions by therapists that are threatening or hurtful to patients can bring about rapid transitions from the Type A and B modes to a Type C mode (Langs, 1978, 1982; Dorpat, 1984, 1985, 1991; Dorpat and Miller, 1992). Some of the more common and significant precipitants include therapist’s communications that are disturbing or shaming or that disrupt a selfobject transference. In several writings, I point out how directive questioning usually leads to a switch toward the Type C mode (Dorpat, 1984, 1996).

The following case vignette illustrates how the therapist’s interventions brought about a disruption of a mirror transference and a rapid shift from a Type A mode to a Type C mode.

**Case Vignette**

A 25-year-old single graduate student with a history of chronic depression formed a mirror transference with his therapist. A year of efficacious psychotherapy helped him to overcome inhibitions against his competitive strivings sufficiently to allow him to aggressively compete in and win a tennis tournament. With unaccustomed emotions of pride, he told the therapist about his triumph over his rival, and he described how his “pounding serve” had overwhelmed his tennis competitors. The patient paused and waited for the therapist to say something that would recognize the patient’s achievements.
The therapist ignored the patient’s comments about his tennis victory and asked a question (“How did you do on your examination?”) about a topic the patient had mentioned earlier in the session. The patient responded in a matter-of-fact, subdued tone of voice, drained of all excitement or other emotion. There was a rapid shift from a Type A to a Type C mode of communication. After providing an affectless and factual description of the examination, he became silent and began to feel depressed.

The therapist’s question disrupted the mirror transference because it was not attuned to the patient’s emotional state. The disruption led to the emergence of the patient’s Type C communication and then to his becoming depressed. The therapist’s question frustrated the patient’s desire for recognition of his victories, but it also abruptly derailed the dialogue because it changed the topic of what was being talked about.

Fortunately, the therapist was able to understand how her unempathic question had fragmented the patient’s experience and temporarily had broken her mirror selfobject bond with the patient. Together, they discussed how her question had disturbed the patient and derailed the therapeutic dialogue. Through her reparative interventions, the mirror transference was restored and strengthened.

Like Modell (1984) and Krystal (1988), I trace the development of the Type C mode to traumatically experienced object relations, and this mode constitutes an effort to avoid repetitions of such disturbing relationships. The defensive process itself is not solely an internal (intrapsychic) event, but one occurring between two persons in the intersubjective field. Because all human communication is intrinsically interactional, both parties of the therapeutic dyad contribute to the initiation of the Type C mode, as well as to its particular content and form. Neither the Types B, C, nor D modes of communication can be accurately described or defined in intrapsychic terms because they are defensive actions occurring within the context of a two-person psychology.

Inhibitions Against the Reception of Primary Process Communication—Affective “Deafness”

The primary process system includes both the transmission and the reception of ordinary process communication, and individuals for
unconscious defensive purposes may block the transmission of primary process communication or the reception of the primary process communications from others, or they may block both. In previous publications, I described patients who, for unconscious defensive reasons, do not “hear” or understand the affective communications of others (Dorpat, 1985; Dorpat and Miller, 1992). This self-protective blocking out of others’ affective communication is a frequently overlooked clinical phenomenon, and though it occurs commonly in patients with disorders of the self, it may also be used by others.

The emotional “deafness” of these patients is not a global one, nor is it necessarily an unalterable unresponsiveness to others. They understand and respond appropriately to some affective communications, but not to others. Such patients “turn off” more with some individuals than with others, and the proximal and critical determinant of their affective “deafness” is the interpersonal context. Their block against receptivity to the affective communications of others is like a variable threshold or gate regulated by their self-protective need not to hear or respond to some of the affective messages of others. They preconsciously scan incoming communications, and those that at this first global appraisal seem disturbing, they do not attend to or respond to.

Studies on the Development of Avoidance Behaviors in Infants

The nonverbal avoidance behaviors of the emotionally disturbed infants described by Ainsworth et al. (1978), Bowlby (1973), Fraiberg (1982), and Mahler, Pine, and Bergman (1975) are essentially the same as the nonverbal behaviors observed in adult patients communicating in the Type C mode. There is abundant evidence that pathological avoidance responses in infants to emotionally traumatic relations with their caretakers provide important development beginnings of the Type C mode (Dorpat, 1993).

Clinical Implications

The vignettes in this paper and some other publications of the author provide many examples of clinical situations in which patients switch
from Types A and B modes to a Type C mode in response to some intervention of the therapist (Dorpat, 1984, 1985, 1991).

A clinical rule of thumb I use while treating patients or in supervision is that, when a patient switches to a Type C mode, one should look for some communication from the therapist occurring immediately prior to the shift that the patient experiences as threatening, disruptive, controlling, or abusive. The most salient aspect of the Type C mode is that it arises out of a defensive need to withdraw from personal and affective relatedness.

It does not make sense to interpret the unconscious meanings of the verbal content of Type C communication, because it does not have any. The Type C mode, by definition, does not contain primary process derivatives. There are, however, two other approaches to the interpretation of Type C communication. One is the approach of Bion (1959) and others who interpret the unconscious motives such as the wish to attack links or to destroy personal relatedness. The other approach is the interactional approach discussed in a previous publication (Dorpat and Miller, 1992). Most often, this takes the task of acknowledging and then investigating the kinds of interventions by the therapist that have triggered the patient’s Type C communication and the conscious and unconscious meanings these events have for the patient.

Inauthentic Communication—The Type D Mode

A specific type of inauthentic communication, which I shall later describe, is, in my opinion, a defining property of what Winnicott (1960) calls the false self. My clinical experience with patients who communicate inauthentically indicates many of them suffer from a relatively undeveloped true (spontaneous) self, which is for the most part concealed and defended against by a false (compliant) self.

Because inauthentic communication differs fundamentally from the other three modes (A, B, and C) of communication categorized by Langs (1978), I have labelled inauthentic communication as the Type D mode of communication (Dorpat, 1999).

Both the secondary process communications and the primary process communications of patients with a false self organization are inauthentic. I do not mean to imply that patients who suffer from
false self-pathology never communicate in a genuine manner. Though they often or even predominantly communicate in the Type D mode, they are also capable (as nearly all nonpsychotic and awake adults are) of communicating also in the A, B, or C modes.

Although individuals with a false self-organization and who communicate inauthentically are attempting to relate affectively with others, they tend to do so in a compliant and ingratiating way. For therapists to be role responsive to the unconscious communications of Type D communicators is often to be authoritarian, directional, and controlling.

Oftentimes, it is difficult for clinicians, as well as others, to make the distinction between authentic and inauthentic communication, and part of the difficulty stems from the fact that many persons with a false self-organization have developed highly sophisticated and socially adaptive skills for communicating. Frequently, they have learned to speak in a way that appears (but is not actually) normal and authentic. Type D communicators with false self-pathology communicate what they sense others want them to communicate; thus they often do not speak for themselves, but rather for others.

Ordinarily in listening to patients psychoanalytically, we listen for the patient’s emotions as well as for other primary process derivatives for clues about what is going on unconsciously in the patient. Though the maxim of “follow the affect” is often a valuable heuristic strategy, it does not provide a reliable guide to unconscious contents when the patient is not expressing his or her authentic and spontaneous emotions or ideas. The usual way analysts infer unconscious meanings and contents from primary process derivatives only works when the patient is communicating authentically.

Using Countertransference to Detect Inauthentic Communication

In order to diagnose inauthentic communication, the therapist must often examine and reflect upon the derivatives of his own primary process system. Clinicians need to use, in an imaginative way, their own emotional responses, spontaneous imagery, and intuitions as clues for diagnosing inauthentic communication.
To illustrate and explain this point, I shall present a vignette about my countertransference-based images and emotions, to show how they were examined to discover the occurrence of inauthentic communication in an analytic patient, Ms. S.

Several months into the analysis of an intelligent, middle-aged married woman, Ms. S, I found myself feeling uncomfortably irritated and inattentive to her communication. This puzzled me because the patient appeared to be freely expressing her feelings and I had previously and incorrectly assumed she was communicating in an authentic Type A mode.

Gradually, an examination of my countertransference responses to the patient’s communications revealed the causes of my feelings of inattentiveness and irritation. While trying to listen to her, a scene from a television show came to my mind—the television show showed moving pictures taken of a depressed Judy Garland about 2 weeks before she destroyed herself with an overdose of sleeping pills. In these moving pictures, she still had her outstanding singing voice, but something was missing from her affective expression. On closer examination, I noted that her smiles appeared to be forced. After what seemed more like a grimace than a smile, her facial expression sometimes appeared, if only for a moment, sad and depressed. My conclusion was that Ms Garland was attempting to act being happy, when actually she was suicidally depressed and profoundly unhappy.

Another image came to my mind while attempting to listen to Ms. S. I remembered sitting in the front row of a theater, close enough to the stage to touch the actors. I recalled feeling disappointed by the performance of one actor whom I knew to be a highly respected performer. Ordinarily, audiences suspend their knowledge about the performances they are watching as being merely acting, and one indication of an actor’s competency is his or her ability to evoke in their audience the illusion of reality. My physical closeness to the nearby actor destroyed the illusion for me.

My associations about the depressed Judy Garland who pretended to be happy and about the actor who stood near me in the theater provided the clues I needed for understanding what was going on in my interactions with my patient and what had led me to be inattentive to her. The patient was not expressing her spontaneous and genuine
feelings. Rather, she was in a sense “acting,” and her emotional expressions were frequently not genuine. Her inauthentic affective expressions came from her *false self*, and her spontaneous emotional responses were often repressed or disavowed. Though her animated, but inauthentic, affective expressions were designed to ingratiate herself with others and to compel their attention, they were sometimes judged by discerning listeners to be hollow and insincere. From early childhood on, her life was spent in acting the role she preconsciously believed others had designed for her. During childhood, traumatic disruptions in her relationships with her parents had left her with intense fears of abandonment, and these anxieties provided a motivation to maintain her false (compliant) self.

*Primary Process Meaning Analysis*

The theory of primary process meaning analysis explains my countertransference responses of inattentiveness and irritation to Ms. S’s Type D communication (Dorpat and Miller, 1992). The patient’s inauthentic communication unconsciously triggered in me a process of unconscious meaning analysis. In this process, the patient’s inauthentic communication unconsciously activated in me a preexisting schema concerning false, insincere, and inauthentic communications. My primary process system then made an unconscious judgment that the patient’s communications were not authentic, and this unconscious judgment led to my inattention and irritation.

Other primary process derivatives of this process of unconscious meaning analysis included the memory of the depressed Judy Garland’s unsuccessful efforts to look happy, as well as a memory of another actor whose behaviors, while standing close to me, destroyed for me the illusion regarding the part he was playing.

In the final and conscious phase of my investigation of my countertransference, I deliberately reflected upon my primary process derivatives in order to *consciously* comprehend my interactions with Ms. S. My images of Judy Garland and the actor who stood too close symbolized and exemplified my unconscious judgment that the patient was merely “acting” a part. Then, after comparing this new understanding about the patient with my previous insights and
observations about her, I was able to make a *conscious* judgment about the patient’s inauthentic communication. I want to emphasize both the clinical and theoretical significance of the fact that my primary process system had first *unconsciously* made such a judgment and also had unconsciously initiated responses such as inattention at least 10 minutes before I *consciously* made a similar judgment of the patient’s inauthentic communication.

In sum, derivatives of an unconscious process of primary process meaning analysis (such as inattention, irritation, memory images of an actress and an actor) were silently investigated by myself to arrive at a conscious judgment about Ms. S’s inauthentic communication.

**Concluding Comments—Clinical Implications**

The analyst’s use of his own primary process cognitions and communications is a vital investigative tool especially useful for the understanding and interpretation of what is going on unconsciously both within the patient and in the interaction between the patient and analyst.

Because the primary process cognition system represents relationships rather than abstract ideas, imagery may be a particularly useful way for the therapist to attune to the event-centered nature of the patient’s primary process communications. The Chinese proverb “A picture is worth a thousand words” describes the values of imagery and of imagination for capturing salient intrapersonal and interpersonal relations.

What in the past has been called “regression in the service of the ego” may be identical with, or at least include, a therapist’s ability to suspend attention to secondary process cognition while attending to the patient’s and the therapist’s own primary process derivatives. Self-reflective thought and secondary process revision may often be needed to complete and to articulate one’s understandings of one’s own as well as the patient’s primary process derivatives.

**REFERENCES**


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