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The Early Deposit Ion of Adults (TEDA)

Focsaneanu IS*

Psychoanalyst, Romanian Society of Psychoanalysis (SRP), Romania

***Corresponding author:** Ina Simona Focsaneanu, Psychoanalyst, Romanian Society of Psychoanalysis (SRP), 12 buzesti street, Bucharest, Romania, Tel: (+4)0743-150090; Email: ina.focsaneanu@gmail.com

Clinical Note

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Once I met a person a year and a half ago, I began thinking that, if I were to be invested with the power to choose the general profile of people, I would definitely choose the profile of that person. I began asking myself, as an analyst, why was this idea coming to mind so frequently, bringing about such joy. The answer arose: our life gathers another meaning once we appreciate and see a person as a real competent adult.

Our desire to live seems to be related with our capacity of valuing (not idealizing) the external world (we first like people, and then objects, ideas, places, etc).

This capacity of valuing is learnt and exercised in the relationships with parents/adults/siblings. When we are LUCKY enough, we get the opportunities to develop the capacity of valuing inside the family, developing into a valid function at adolescence.

I do not know how many instrument s does someone need in order to interact with the external world, but I am certain that the following two aspects are essential: the emancipation and independence instinct and the valuing function.

I have frequently observed with my patients how powerful their testing is. I am referring to transference testing and testing by turning passive into active [1], but especially in regard to testing as a competent adult/analyst.

I started focusing my attention on my patients' unconscious repeated attempt s to depose me from the competent adult/analyst position. I am referring to the new patients, not to the grown enough patients, where the deposition of the adult/adult values is nor mal, because they need to take their independence and "kill the adults by love" [2]. I began thinking that they already possess the knowledge (unconscious and conscious) of deposing someone; they had become ... experts in deposing.

Thus, with Loewald and Odgen (Killing the values of our adults by love), Joseph Weiss (successive Testing of the analyst) and Peter Fonagy, Anthony Bateman - Metallization- based treatment for borderline personality disorder [3], in my mind, I got the following idea:

The illness seems to appear in someone by the early deposition of his adults (during the childhood, before adolescence).

The consequences of the early deposition of the adults (TEDA®) are catastrophic:

LSL - The lack of the sense of life (LSL) caused by the lack of the sense of value; HOW could it be possible to get relaxed and curious in the interaction with the external world, if you lack one of the quintessential instrument s, the function of valuing (some characteristics of another person, object or idea)?! I POW®- I imaginary power (I POW®) is the someone's conviction in all his pathological beliefs (conscious and unconscious, positive or negative), developed by him in order to face trauma. It is "imaginary" because it is artificially created in someone's mind, and it is "power" because its power will become strong enough to make its deconstruction difficult during analysis. The development of IPOW® is mandatory and unavoidable, given the conditions of TEDA®. I POW® appears because the child cannot continue trusting in his adults' values, and because he cannot remain depleted of any sense of value (and any sense of life); he develops an artificial and imaginary structure (I POW®), from his pathological beliefs, and starts t rusting and exercising his valuing function with his own I POW®; this structure resembles a psychotic core with function of auxiliary self

(as in Kohut's analysis). Lack of progress - The child fails to make any progress, because the concept of competent adults gets displaced, along with the difference between generations, which makes it impossible to accept learning with and from any adults. I am certain that you have knowledge of that type of patients, who seem to have no progress for a long period of time in analysis, in spite of interpretations, good interactions and "moment s of meetings" [4]. From a clinical point of view, we can identify two situations of I POW®:

When I POW® remains completely outside of any relationship, it continues to grow and becomes an imaginary world (and, subsequently, a delusional world); the competent adult is completely replaced [5] by the delusional world.

For example, my patient A, who was brought up by his grandparents for his first seven years of life, recalls that he used to develop imaginary elaborated games by himself , and nobody played them with him, or at least ask him about the games. After that he moved in with his mot her (his father having left the family before his birth), she started telling him a lot of strange and recurring things, as his vital importance to humanity, being given the mission to interpose conflicts between nations. His mother was certain of his importance because she had a dream before his birth in which Jesus gave her a carpet and this carpet was he, her son.

After that, at about 10- 14 years of age, he had a "magic phase" when he used to pray for several hours every day. Finally, at 19 years old, the imaginary world became a psychotic one – he had a major psychotic episode in which he believed that he was Jesus and next day he became Mircea I of Wallachia. We could easily see that I POW® was not detected by the adults and was never brought and played in a relationship. Later (after moving in with his mot her) the imaginary world become a refuge for the patient from the interactions with his mot her and continued to develop in a psychotic [6] level.

When I POW® can be put in and played in a constant relationship (for example with brother/sister/siblings), it seems to be useful for the development of some positive characteristics of the child, but these characteristics are considered (by the next patient) to be strictly related to I POW®. Later on, the child as an adult cannot distinguish his real positive characteristics from I POW®. If his positives results emerge, he attributes these results to the I POW®, and his attachment to I POW® grows.

The typical moment when symptoms appear, seems to be when the child, as an adult, obtains some positive results, which increase his I POW®. He starts wanting to manage everything; but, at the same time, he has to face some events, that are completely out of his control. Panic attacks are the main symptoms for this kind of patient in an apparent nor mal and successful time.

A typical patient is a young adult with great professional achievement s without showing any symptoms. He starts to develop panic attacks in front of the situations which are out of his control. I t is a signal that the level of I POW® is too large and it takes control of the subject, much like the psychotic core in psychosis.

This imaginary power (I POW®) seems to be a helping structure, but it cannot be deposed like an adult (in a logical situation one has matured enough, during adolescence, so that he can "kill" the value and authority of his parents). A real attachment to I POW® exist s, and if the analyst manages to change this attachment, we can say that the subject has reached the half point of his therapy. The patient will again be able to attach to another human structure.

From the clinical observations we can describe two types of TEDA®, total and partial; this classification seems to be necessary because the evolution of the pathology and the therapy is different:

TEDAT®– the early deposition of the adults (the "parricide") [7] is total and usually conscious; it habitually appears when the mot ifs of TEDA® are clear: the adult's psychic disease, alcohol abuse, clear child abandon. The second adult (when he exists) is also deposed.

When siblings exist, they are invested with the artificial/pathological value of adults. This kind of patient easily recalls the moment when they started distrusting one or both parents, and started to reorient to their siblings or to their imaginary world. The pathological valuing (of the second adult or brother/sister) deter mines the pathological attachment (identity issues) without the possibility of natural deposition of the valued person at adolescence.

TEDAP®– this kind of TEDA® is not really unconscious, but it is impossible to be put in words, because it appears before the language development: it is the case of child abandon with the present parents. This is caused by lack of representation (in the mind of adults) of the child as a new person or by the lack of authenticity in

the interaction with the child. This seems to be the case of local level perturbations of human interactions, which need the "local- level" process as therapeutic action [8].

I n the TEDAP® cases, the second adult is artificially valued, and remains valued, without the possibility of being naturally deposed during adolescence. This kind of child/adult seems to be impossible to achieve real independence; he either gets stuck with his parents, permanently attempting to offer his adult new opportunities for the revaluing (it is that unconscious goal that causes him to keep near his family in order to perpetually create these new opportunities), either the child "develops" the same characteristics as his parents, as shame, lack of authority, alcohol abuse, perverse characteristics, etc, turning these characteristics from negatives to positives. The most difficult cases, from a therapeutically point of view, are the cases of TEDAP® patients, which artificially sustain the values of their adults by offering them new opportunities to develop their values. I t is difficult to convince a TEDAP® patient to work for himself, to develop their new personal values, and to use these values for themselves, not for their adults.

As a consequence to uncovering the early deposition, the patient now has to face the unconscious guilt of TEDA® that can be placed close to 'The three sisters of guilt'–omnipotent responsibility guilt, separation guilt and survival guilt [9].

The fact that I am trying to prove is that, during the psychoanalysis with a TEDA® patient, the analyst has to t ry to:

Detect the patient's unconscious beliefs, if possible, from the very beginning of the analysis, as Joseph Weiss suggested in his papers; Detect and explain to the patient when he introduced the use of I POW®(and underline the attachment of the patient to his I POW® Change/limit the attachment to the I POW® by developing the valuing function-necessary for the reintegration of the relationship with the external world; Limit and interpret any kind of guilt-including TEDA® guilt-by authentically speaking about the moment s of TEDA® Conclusions:

The paper presents the development of I POW® which is the attachment of the adults to his pathological (conscious or unconscious, positive or negative) believes. The development of I POW® is mandatory in the case of the early deposition of the adults (TEDA®); the level of this attachment seems to be different from patients to patients depending of the degree in which IPOW® was played or not in a relationship (usually with siblings).

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