Attitudes of Embeddedness and Transcendence in Psychoanalysis

Subjectivity, Self-Experience, and Countertransference

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Everyone and anyone is much more simply human than otherwise—Harry Stack Sullivan

The continuing paradigm shift in psychoanalysis focuses our attention more than ever on our subjectivity and the powerful impact it has on our selves and others. It compels us to examine more closely our subjectivity and the ways in which it shapes our self-experience, our countertransference, and our patients. It is especially crucial that we examine, however, how our attitudes about our subjectivity fundamentally create and inform how we experience our selves, our beliefs about what we do and what our patients do, and our sense of certainty and conviction vis-à-vis our patients. The attitudes we hold toward our subjectivity represent a meta-organizing principle. They play a vital role in the way we organize other personal organizing principles and determine among other events how lightly, or tenaciously, we hold our own belief systems.

In the absence of reflection, these attitudes operate in the background, much in the way other organizing principles may operate prereflectively.

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** The use of the term “meta-organizing principle” was suggested by Dr. Philip A. Ringstrom and here does not connote a principle that is “overarching” or that stands in a privileged position vis-à-vis other organizing principles. “Meta” here connotes the notion of “being about” something (i.e., an organizing principle that is about other organizing principles).

A closer examination of our attitudes toward our subjectivity and their epistemological frameworks will help illuminate how self-experience and countertransference develop within us and ultimately how we will interact with our patients in the context of an intersubjective field. They also determine how we regard the experiences of certainty and conviction, how we respond to the feeling that we “know a thing” and that we are “committed to knowing that thing.” Further, our meta-organizing principles also shape and inform our perspectives regarding unconscious communication and other vital concepts such as affect attunement and information transfer.

Certain authors speak of our subjectivity as an inescapable liability, a chronically and permanently clouded lens that prevents us from ever really seeing, experiencing, and knowing our patients fully. We are relegated to working with our limited, idiosyncratic perspectives. Others envision our essentially subjective stance as perpetual and pervasive, but at the same time as a source of relational experiences that are informative and that evolve out of hermeneutical dialogues with the other (Orange, 1993). Still others consider it to be an inevitable, foreseeable, though mutable quality of humanness around which we need to work (Kohut, 1984), but from which we are, with concerted effort and discipline, ultimately capable of extricating ourselves. This extrication is thought to lead to a more “objective” and “truer” view of our patients. At the end of this spectrum resides the psychoanalytic empiricist, who feels that he or she approaches the patient with a mental apparatus, like a laboratory instrument, capable of fundamentally clear, objective vision, hindered only by the occasional countertransference anomaly (Freud, 1910a).

My thesis in this article is that our personal attitudes toward our subjectivity contribute heavily to our creating and informing our self-experience and our countertransference vis-à-vis our patients and the intersubjective field. This
meta-organizing principle determines which aspects of the patient's subjective world we choose to highlight and articulate, or choose to ignore. It also determines to what degree we generate and sustain experiences of certainty and conviction and in what manner we will consequently interact with our patients. Further, this article intends to draw more needed attention to the notion that our personal sense-experience of what is real and of what is true is context dependent and context driven. This idea is easily illustrated when we consider how what we record as experientially familiar, real, and true about ourselves in one setting can transform into something novel, surrealistic, uncertain, and perplexing in another.

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Background

Traditionally rooted in a one-person model science, psychoanalysis and its related fields have witnessed a continuing paradigm shift predominantly in the last half of this century. This revolution has been characterized by postmodern perspectives that have reorganized our notions of truth and reality. It has engendered concerns about subjective experience, meaning, and an openness to more dynamic, pluralistic, perspectival thinking (Mitchell, 1994; Aron, 1996). Orange (1995), for example, reviews the development of psychoanalytic epistemology: She discusses and integrates notions of subjectivism, relativism, objectivism, and realism—each a salient view in its own right. She posits a synthesis of these perspectives, her notion of perspectival realism, in which “the real is an emergent, self-correcting process only partly accessible via personal subjectivity but increasingly understandable in communitarian dialogue” (p. 62).

Aron (1996), as another example, uses the term “relational-perspectivism” in his effort “to link together the epistemological shift from positivism to constructivism and the shift within psychoanalytic metapsychology from the drive-discharge, energic, one-person model to the relational, or two-person, perspective” (p. 27). Stolorow (1997) goes as far as considering the distinctions between the one-person and two-person models “obsolete.” He feels that nonlinear dynamic systems theory (Thelen and Smith, 1994) contributes significantly to the revolution in paradigm (see Orange et al., 1997). Shane, Shane, and Gales (1997) also invoke nonlinear dynamic systems theory as an integral component of their developmental systems self psychology model. Their innovative perspective is a poignant example of the paradigm shift we continue to witness in our field today.

A few authors (e.g., Rabin, 1995) address some of the practical implications of these alternative perspectives for practicing therapists: How we might behave differently with our patients, how we might feel differently in the context of treatment, how our assumptions about what is going on interpersonally might change our experience of our selves and our patients, and how we and our patients might be affected.

Intersubjectivity and relational theories contribute heavily to the rethinking of etiology and epistemology. The development of these and related approaches, many of which keep in mind the mutual and reciprocal influences of both analyst and patient, has various precursors. One such precursor is the borrowing from physics the notion of complementarity (Bohr, 1963) and the principle of indeterminacy (Heisenberg, 1958) —what was suggested in Sullivan's (1962) notion of participant-observation. Sucharov (1994) explores the impact of these perspectives, derived primarily from quantum physics. Infant research has also contributed heavily to the reconceptualization of psychoanalytic etiology and epistemology (Beebe and Lachmann, 1994; Stern, 1985; Trevarthen, 1979; Tronick, 1989). These ideas not only highlight the uniqueness, limitations, and advantages of the subjective observer, but they underscore an intersubjective field (Stolorow, et al., 1987) or analytic third (Ogden, 1994) in which “the interaction between observer and observed forms an intrinsic feature of the [relationship] phenomenon” (Sucharov, 1994, p. 188) and in which the line of demarcation between the observer and the observed can be arbitrarily though meaningfully chosen. The work of Winnicott helped set the stage for the recognition and use of this dimension of “transitional space” shared by analyst and analysand.

Subjectivity

Central to many of our contemporary paradigms is the notion of subjectivity—that of the patient and more recently that of the analyst. The patient's view of himself or herself and the world, presumably emanating
principally from what has been called nervous diseases or emotional disorders, had always been conceptualized as subjective if not distorted, delusional, transference-based, or in some fashion inconsistent with an objective truth. This perspective is consistent with traditional science and objectivist notions of reality.

More recently, the analyst's subjectivity and its impact on the patient have been more seriously considered and reconceptualized. From a contemporary viewpoint, it is not solely that the analyst's perspective about what is real and true is informed by his unique, preconfigured organizing principles (Stolorow, et al., 1987), but that the analyst's resulting percepts and experiences have in turn a compelling impact on the perceptual configurations of the patient (Mitchell, 1993)—and vice versa. Infant research tends to substantiate this natural, human tendency toward reciprocal and mutual influence shared by two or more individuals. Here I am drawing on the work of Bowlby (1969, 1973, 1980), Ainsworth and Bell (1974), Main et al. (1985), Stern (1985), Tronick (1989), Beebe and Lachmann (1994), and others.

Some authors feel that the analyst's subjectivity essentially determines the ultimate shape and character of the patient's analysis. The Balints anticipated this in their 1939 article in which they consider “whether transference is brought about by the patient alone, or whether the behavior of the analyst may have a part in it too” (Balint and Balint, 1939, p. 223). Even contemporary fiction writers acknowledge the analyst's essential contribution to the clinical exchange: “The true story of a therapeutic exchange begins not with the patient's present problem but with the healer's past” (Yglesias, 1996, p. 9). Kohut (1984) states that the analyst “acknowledges [ideally] his own impact on the field he observes and, through such acknowledgment, broadens his perception of the patient” (p. 111). Cooper (1996) underscores this: “The choice of where to begin to formulate and what to interpret, as well as the goals of analysis, are the most visible expression of the analyst's subjectivity” (p. 265).

From the standpoint of subject-centered and other-centered listening perspectives (Fosshage, 1995), Fosshage makes explicit the powerful impact of the analyst's subjectivity. He underscores that “[a]lthough this listening stance [from within the analysand's vantage point] is designed 'to hear' as well as possible from within the vantage point of the analysand, this is clearly a relative matter, for what is heard is always variably shaped by the analyst” (1992, p. 22). The analyst's experience of the patient, even while listening through the “empathic mode of perception” (Kohut, 1971; Lichtenberg et al., 1996), contains in it artifacts of the analyst's subjectivity.

Many contemporary analysts not only increasingly attempt to account for the inevitable impact on the patient of the analyst's subjectivity, but feel that it may be exactly the conveyance of this subjectivity that is facilitative and constitutive for the patient. Aron (1996) states, for example, that “all interventions, including interpretations, are expressions of the analyst's subjectivity and that it is precisely this that gives them whatever effectiveness they may have” (p. 94). I have discussed elsewhere (Coburn, 1998) that it is essentially our human subjectivity that facilitates the shared experiences, between patient and analyst, of what Stolorow and Atwood (1992) refer to as the “sense of the real” and that it is these experiences that are responsible for much of what is therapeutic in the psychoanalytic relationship.

I wish to underscore that our subjectivity is shaped and informed by the very meta-organizing principle that is derived from it. Each at once affects and is affected by the other. The derivatives of our meta-organizing principle or attitudes toward our subjectivity can be conceptualized as a specific type of countertransference. In some instances, self-experience and countertransference overlap in that countertransference reactions are sensed through what we typically designate as self-experience. When a supervisor asks a supervisee, “what is your countertransference with this patient?” he or she necessarily inquires about the supervisee's self-experience vis-à-vis another individual and requests elaboration regarding the intersection of two, if not three subjective worlds (Coburn, 1997; Fosshage, 1995). What is not experientially sensed can be conceptualized as unconscious and perhaps without immediate form. For example, one's organizing principles may remain partly unconscious, whereas their effects may be experienced directly (Stolorow et al., 1987).
The notion that our underlying theoretical assumptions directly impact how we organize our perceptions, and ultimately how we will be with our patients, is not new. Wolf (1983) examines how theory informs the character and direction of our countertransference. Also, in his discussion of the liberating effects of the paradigm shift on analysts, Rabin (1995) highlights the impact theory always has on the practitioner: “[E]ach theory brings with it a greater probability of certain kinds of clinical errors, although it is excruciatingly difficult for many of us to appreciate the errors that are more intrinsic to the approach to which we are deeply committed” (p. 476).

Furthermore, Cooper (1996) expands on the powerful impact of our subjectivity and our theory, noting how subjectivity, theory, and practitioner are inextricably bound. Friedman (1988) has gone as far as suggesting that “[p]sychotherapy is a relationship interfered with by theory” (p. 1). Whether viewed as interfering or as facilitative, the therapeutic milieu is inextricably tied to our subjective stances: Mayer (1996) emphasizes that “the observer’s point of view is necessarily part of what we are examining whenever we examine clinical facts” (pp. 715-716).

Inversely, Atwood and Stolorow (1993) discuss at length the impact one's history and subjective experience have on one's theoretical stance and consequently how one will work with patients. They clarify how the most powerful source of various theorists' psychological doctrines “can be found in the subjective experiential words of the personality theorists themselves…. The subjective world of the theorist is inevitably translated into his metapsychological conceptions and hypotheses regarding human nature, limiting the generality of his theoretical constructions and lending them a coloration expressive of his personal existence as an individual” (p. 5). Cooper (1996) echoes this sentiment when he states, “‘theory’ expresses our implicit or explicit technical stance, our views of therapeutic action, in sum, our subjectivity” (p. 256).

Just as one's personal history and previous subjective experience create and inform one's theoretical constructions and one's countertransference (Atwood and Stolorow, 1993), one's evolving attitudes toward one's subjectivity, at once stemming from and contributing to it, help determine the perceptual and relational configurations that coalesce in the patient-analyst relationship. Our attitudes toward our subjectivity, our meta-organizing principles, help structure how we experience ourselves (e.g., what it feels like to hold and use our belief system), how we interpret our countertransference, and how we affect the patient.

Our Attitudes Toward our Subjectivity

The predilection toward assuming the stability if not tenacity of one's subjectivity is now found in many contemporary schools of thought. In that light, we can explore a few of the numerous variations of this meta-organizing principle. The notion of the analyst's relative embeddedness in or freedom from his or her subjectivity occupies a vital position in the examination of potential attitudes toward one's own subjectivity. We can examine this dimension of our subjectivity as we view its impact on our self-experience, our countertransference, and ultimately our patients.

I have delineated two essential types of attitudes toward one's subjectivity, herein referred to as embeddedness and as transcendence. I have chosen these for the purpose of illustration and not to suggest that they denote overarching categories.* Although there is a wide range of diverse attitudes toward one's subjectivity from which I could choose, I have found the dichotomy between the notions of embeddedness in and freedom from one's subjectivity especially compelling. Indeed, for me, they represent the poles of a continuum on which our attitudinal metaoorganizing principles can potentially be plotted. They are examined here as a point of entry for future discussions regarding other dichotomies and other continua.

Embeddedness

The attitude of embeddedness assumes the inevitability and inextricability of one's subjective state. We are necessarily subjective, despite our penchant for measurement, replication, and common scientific languages. Even the subject matter of scientific inquiry, in many circles, is
* I wish to thank Dr. Joanne Moran for pointing out the necessity of avoiding either/or thinking here and of not “recreating a kind of historical fatal flaw by thinking our personal attitude toward our subjectivity is either this or that.” I agree with her conceptualization that we should see “our attitudes as continually shifting, not just with each patient but in the second by second exchanges with any patient at any time” (1997, personal communication).

Admittedly subjective. Mayer (1996) points out “that our work [while scientific] is quintessentially subjective and intersubjective” (p. 712). According to Renik (cited in Mayer), what actually characterizes science is “rigorous method. We can be scientific... if we acknowledge our subjectivity as clinician observers (pp. 1245, 9, my italics)” (p. 712).

This particular attitude may be placed in conversational terms in the following manner: I feel I know something about this person, but I can't really be sure; and even if I feel certain, I need to tread carefully in exploring and discussing the issue with the patient—it might not mean to the patient what it means to me; and furthermore, should we reach consensual knowledge about something, that something is dynamic and may have changed by tomorrow.

The nature of this embeddedness is not limited by the invariance of one's organizing principles: One's subjectivity can potentially be broadened and expanded (Atwood and Stolorow, 1987) through the development of new organizing principles derived from “positive new experiences” (M. Shane, et al., 1997). However, we remain necessarily subjective and bound by our humanness. Sullivan (1962) emphasizes that “[t]his fundamental entity, this mind, can never effect its own apotheosis, be its verbal fog ever so dense, be its ‘logic’ ever so shiftily propagandistic. No mind can exteriorize itself for complaisant meditation about less transcendent minds...” (Sullivan, 1930, p. 259).

Questions of subjectivity, or objectivity for that matter, vis-à-vis notions of truth and reality, naturally stimulate concerns about one's experience of certainty and conviction about our selves and about our patients. The experience of certainty and conviction about something inclines us to claim knowledge of that thing. After all, from one perspective, we sit with our patients to generate insight, to increase our knowledge of the patient's subjective world, to stimulate constitutive and mutative experiences, to offer “positive new experiences,” and in general, to learn and develop. Sometimes this includes increasing our sense of certainty and perhaps conviction about phenomena pertaining to the self, the other, and the relational configurations between the two. Our purpose generally is not to encourage in our patients a sense of ongoing perplexity, confusion, and befuddlement, though helping ourselves and certain patients to develop the capacity to tolerate these states is vital to their continued progress.* We want to learn, we want to know, and we want to feel we know.

* However we may conceive of the clinical process, we must differentiate between the phenomenon of the analyst's experience of certainty and conviction about the patient from the conveyance of that experience from the analyst to the patient.

Despite this penchant for wanting to know, and to keep hold of what we know, conveying a sense of certainty and conviction to the patient about the patient in some contexts subverts needed, continuing reorganization of the patient's developing sense of what feels right or clear about his or her own self and self-experience. In a given intersubjective context, depending on the foreground experience of the patient, it may be exactly a sense of uncertainty about himself or herself, for example, that the patient needs to experience with the analyst, developmentally speaking. The patient may need to sense a capacity and willingness in the analyst to tolerate not knowing and to delay the formulation of conviction in favor of play and ambiguity. This may be what is constitutive and transformative for the patient at this point—that is, to allow continued transitional space and play (Winnicott, 1971) via suspension of knowledge, certainty, and conviction vis-à-vis the patient. An attitude of embeddedness about one's subjectivity might help facilitate this experience between patient and analyst, as play, ambiguity, and uncertainty are perhaps more concordant with the analyst's self-experience, and this may be more developmentally helpful with certain patients in certain contexts.
I am not suggesting that an analyst with an “embeddedness” perspective would not experience a sense of truth, reality, and conviction about the patient via his or her self-experience and countertransference. As Aron (1996) states, “an analyst may interpret with a sense of conviction even while eschewing certainty and abandoning positivist epistemological presuppositions” (p. 94). This is a way of conceptualizing what Cooper (1996) refers to as the “impermanence of a clinical fact” (p. 258). The analyst's subjectivity in some contexts may facilitate knowledge and conviction about the patient and help provide what is constitutive for the patient, as alluded to previously.

That analyst would be more inclined toward, in Aron's words, “deconstructing whatever storylines our patients present to us or that we have constructed with them so that we and they do not become rigidly fixated to any one narrative construction” (1996, pp. 262-263). I think this coincides conceptually with Orange's description of fallibilism, “an attitude recognizing that what we ‘know’ or understand is inevitably partial and often mistaken” (1995, p. 43).

Stimulating a “Cartesian anxiety” (Bernstein, 1983), or what Stolorow et al. refer to as the “Tear of structureless chaos” (1994, p. 203), in the patient could or could not be reparative and constitutive for the patient, and it is left to the analyst and the patient to explore and make determinations about this when it is felt to be temporally and contextually useful.

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- **Transcendence**

This particular attitude toward one's personal subjectivity allows one to feel that one can know and assume something about the patient—something that is presumed to be real and true—via temporarily shedding one's idiosyncratic, subjective perspective. It can potentially position “the truth” and “the understood” in a less than dynamic and emergent framework. It can generate and help maintain a sense of certainty and conviction about the patient, for the therapist and perhaps for the patient, which may or may not be useful. This can be anxiety reducing, can provide a sense of accomplishment, and can sometimes even be transformative and constitutive for the patient, depending on the current selfobject needs evidenced within the intersubjective field.

It may be placed in conversational terms with the following: Now that I have reached a sense of certainty and conviction about something regarding this person, I must seriously consider sharing this with the patient to enhance our developing sense of shared reality; despite my certainty, I also need to consider tact and timing with the patient.

This stance implies that while one's organizing principles generally tend to shape and inform one's perspectives, once analyzed, they may be placed aside in order to capture a clear, “objective” perspective of what is being examined and explored (e.g., the patient, the patient's response to the analyst, and the relational field). It is akin to the type of subjectivity discussed by Slochower (1996). In her discussion of the analyst's holding function in relation to his or her subjectivity, she acknowledges the “centrality of the analyst's subjectivity in the therapeutic process” (p. 323). She speaks of the analyst's subjectivity, however, as something from which he or she may protect “the hyperalert patient” (p. 326) through choosing “to hold.” She feels that the analyst is capable of “suspend[ing] her own subjectivity when it is discrepant with this experience [i.e., the experience of the patient creating and destroying the ‘analyst-mother’ at will, in the Winnicottian sense]” (p. 327). Later, Slochower suggests that the analyst is capable of “temporarily set[ting] aside or protect[ing] the patient from her own [the analyst's] subjectivity” (p. 328). Her stance, using a Winnicottian perspective, adequately illustrates the “transcendence” attitude toward one's subjectivity. I am reminded here of the ubiquity of the mutual and reciprocal unconscious communication processes that continually unfold between two or more individuals and of how knowledge of these processes challenges our presumed capacity to cloak or otherwise set aside our personal subjectivities.

The transcendence standpoint, applied differently, reflects Kohut's
specific attitude toward countertransference and the obstructing influence of it on the analyst as an “observing instrument.” He states that “[i]f we want to see clearly, we must keep the lenses of our magnifying glasses clean; we must, in particular, recognize our countertransference and thus minimize the influence of factors that distort our perception of the analysand's communications of his personality” (1984, p. 37). In that sense, the cleaner the lens, the more clearly we may grasp the “reality” of the patient's experience. Technically, Kohut (1984) could more accurately be positioned, however, in the “embeddedness” stance, insofar as he was deeply aware of the necessity of not holding presumptions about the patient and of attempting to listen closely to what the patient felt was “true.”

Freud's empirical approach exemplifies the more polarized version of the transcendence perspective, substantially illustrated in “Analysis Terminable and Interminable:” “he [the analyst] must possess some kind of superiority, so that in certain analytic situations he can act as a model for his patient and in others as a teacher. And finally we must not forget that the analytic relationship is based on a love of truth” (1937, p. 248). Here, consistent with an archeological model, truth is not only objective and uncoverable, and once uncovered, static, but it requires conviction to propel it into the mind of the patient. Note Freud's emphasis on how “one of the necessary preliminaries to the treatment” involves “informing the patient of what he does not know” (1910b, p. 225).

This version of our meta-organizing principle may inhere in us a degree of certainty and conviction about the patient that potentially acts as a coercive agent directed at the patient, encouraging compliance, sequestration, and pseudo-health. At the least, if an analyst should arrive at a point of certainty and perhaps conviction about an aspect of the patient and chooses not to “induce [the patient] to remember something that has been experienced by him and repressed” (Freud 1937, p. 258), his or her withheld, “objective” opinions about the patient may nonetheless affect the patient via unconscious communications that occur on a millisecond-to-millisecond basis. This can occur despite the analyst's open invitations to the patient for continued exploration.

**Clinical Material**

The following clinical material illustrates a predominantly transcendent perspective or attitude, with occasional facets otherwise found in the embedded stance. This particular vignette is one in which the analyst's

*Dr. S's attitude toward his own subjectivity was varied. He accepted that although essentially tied to his own organizing principles and perceptions, he also felt that he was receptive to the affective and cognitive states of his patients. He believed he had potentially a direct, unfettered link to the psyches and experiences of his patients, and this link was accomplished and maintained through the medium of projective identification. By projective identification, Dr. S meant the process whereby a patient disavows cognitive/affective material by projecting it into the analyst and then somehow stimulating in the analyst the experience of the projected thoughts and feelings. Once stimulated, the analyst may then identify with that material originating in the patient and therefrom experience a disavowed aspect of the patient's psyche. This would occur apart from the influence of Dr. S's subjective perspective. Dr. S's invocation of the projective identification concept exemplifies the transcendence perspective. This was Dr. S's attitude toward his own subjectivity and his potential for occasional objective vision.*

*John's (the patient's) meta-organizing principle, or attitude toward his own subjectivity, alternatively, was more embeddedness oriented. He held his beliefs and convictions about the world rather lightly and often felt he would most likely never attain a clear, objective view of events, such as how others experience him. His perspective seemed to the analyst to be less a function of any philosophical regard for an entrenchment in one's subjective perspective, arrived at via intensive self-reflection, but more that of not having originally experienced an affectively clear, consistent, and responsive caregiver surround. As a result, John had not attained a sense of clarity and certainty about his subjective experience and perspective, especially in terms of how he affected others cognitively and affectively. He often withdrew from interpersonal exchanges, feeling bewildered, unclear, perplexed. His experience of others and the world in general as true and real was tenuous and derived primarily
from a physically unavailable father and an affectively disorganized mother, whose debilitating problems with
self-regulation occupied her mind most of the time. Much of John's experience of her centered on a sense of
emotional disconnection and sleepiness. This was particularly evident when his mother was intoxicated, which
she often was. John felt this to be an affectively dangerous and disorganizing situation and would often respond
with a dissociation of his feelings of longing for care, attention, and valuing by an other and ultimately with an
interpersonal withdrawal of his own.

* I am grateful to Dr. S., the analyst in this vignette, for communicating to me the ultimate development of and insight into the
experiences of both analyst and patient in this specific verbatim example.

In most of his sessions with John over a 3-month period, Dr. S continually experienced an undeniable sensation of
being drugged, sleepy, and perplexed. This self-experience was at times quite overpowering. He thought this was
something that most therapists feel at one time or another. Based on Dr. S's knowledge of John's history with his
alcoholic and abusive mother, and on his patient's proclivity toward what seemed to him like affectively sterile
communications, Dr. S believed that his self-experience of anesthesia and interpersonal distance evolved directly
from his patient's projective material and perhaps from other forms of state contagion.

On one particular day, Dr. S escorted John into his office and braced himself for what he anticipated to be yet
another onslaught of somnambulism and anesthesia from his patient. To Dr. S's surprise, which he contained,
John seemed amazingly awake and contactable. Dr. S thought: “He is struggling to hide something. He is
concerned that if he continues to make me sleepy and drugged, as he has been recently, I will tire of him, and he
will lose me. He is trying to be cheerful.” Dr. S nevertheless readied himself for heavy eyelids and another
difficult session.

“How are you today,” John said.

“Fine thanks, and you?” Dr. S replied.

“Alright, I guess,” John said. “A bit apprehensive about a repeat of last session.”

“What about our last session, exactly?”

“Oh, you know, how I made you feel so drugged, and how I was drugging myself to escape my feelings, I
suppose.” [John's phrase, “I suppose,” does not draw Dr. S's attention here.]

“Yes, well, I think you did have rather strong feelings, and we've come to know how painful they are to
actually experience and talk about.” [Dr. S here is feeling rather affectively restricted in preparation for
his patient's anesthesia, but is also curious and inquisitive about his patient's emotional experience. Dr. S
does not inquire how John experienced him in their last session or in the present.]

John begins to appear sleepy, stating, “Yeah, I can feel it coming on already.” [This seems to be of no
surprise to either person.]

“Any ideas what brings this on at this moment?”

“Well,” John said, “no, but I was just thinking about my mother and her being so out of it so much of the
time. I remember when by Dad would be gone a lot and my Mom would just drink and smoke all the time.
I would just space out in my room, I guess.”

“Yes, and I think you continue to give me a good sense of what it was perhaps like for you—with all the
drugging, sleepiness, and withdrawal—trying to deal with your mother's absence. Perhaps you anticipate
my absenting myself, instead of remaining in contact with you.” [Dr. S reestablishes here his own
sense of certainty and does not make a mental or verbal note of John's lack of certainty (potentially noted in his concluding phrase, “I guess”).

“I'm sorry, it's hit again. I just can't stand this sleepiness. And now I'll probably drag you down with me.”

[John assumes here a more subordinate position and accepts, apologetically, that he is the perpetrator of the anesthetic experience. This proves to be another repetitive experience for John. Dr. S feels a stronger sense of conviction here about John and his dynamics surrounding the sleepiness.]

This clinical snapshot, reflecting Dr. S's assumption that his self-experience was exclusively a product of John's psyche, led Dr. S to conclusions about his patient and his patient's fears, and not necessarily about his own self and his relationship with John. He did not interpret his own anesthesia experience as his unique response, such as, perhaps, a narcissistic injury in response to John's pattern of relating, or, perhaps, a response to an admixture of intersecting personalities. Dr. S conceptualized that he had been used as a receptacle for and a metabolizer of John's disavowed affect, much in the way a Petri dish might be used for cultivating bacteria. This was distinct from conceptualizing his experience as a bidirectional, relational event between two people, such as affect attunement or a form of mutual regulation.

The content of Dr. S's meta-organizing principle—that his subjectivity is present but mutable and subject to transcendence—helped inform his anesthesia experience with John: It inclined Dr. S to view his own emotional absence as the borrowed property of his patient and as the logical outcome of his patient's history of abuse, numbness, and dissociation. Dr. S's perspective caused him to focus predominantly on the defensive characteristics of his patient vis-à-vis his patient's history and the anxiety usually presumed to exist beneath states of disorganization and dissociation. Dr. S concluded that the function of similar but separate experiences of dissociation in each was principally to provide insight into John's history, into how he continued to block possible transference feelings, and into what could be a much more colorful and adaptive affective life. Dr. S believed that John unconsciously intended Dr. S to experience the drugged state of mind, so that he might better grasp John's own experience. Within this framework, Dr. S did not consider that the dissociative anesthesia he was experiencing from his patient was perhaps not exactly consistent with the patient's experience, or that the patient's state was a direct response to an emotional state within the analyst (i.e., to the contribution of the analyst). He felt that his own subjective stance did not preclude a direct access to objective, affective states in the patient.

Dr. S's specific attitude toward his subjectivity vis-à-vis his patient in this vignette informs not just how he experiences his self and his countertransference, but also determines his level of conviction about what is true and real about the patient. His sense of certainty and conviction could have a positive impact on the patient, or it could be less than useful.

Dr. S's certainty about the origin and ownership of the patient's “projective material,” for example, the experience of anesthesia, conveys a message of certainty and clarity of knowledge about the patient's state of mind and perhaps even its etiology. This could potentially be a facilitative and constitutive experience for the patient—that the patient is being noticed and responded to with certainty and conviction (i.e., I have little doubt this is who you are). Despite his apparent sense of openness of mind and exploratory freedom, Dr. S does remain inwardly persuaded by what he feels is an objective truth about the patient. This he cannot help but convey to the patient in an unconscious if not conscious manner, and in fact Dr. S may deem it developmentally helpful to do so. Here, the potential for realizing a developmental advantage, however, hinges on whether Dr. S's “certainty and clarity of knowledge” actually correspond with the patient's experience. And in this case, it does not, as evidenced by the patient's anesthetic withdrawal and subordination to the analyst's perspective. In this context, the felt conviction of the analyst could be an invitation for patient compliance and, potentially, a foreclosure of any further, genuine exploration by the patient into the meaning of what looks like dissociation. As he necessarily did in the past, John once again must isolate and sequester what otherwise could be an expansion and continued definition of his own self through a continued, mutual, albeit ambiguous exploration of self and other with the other.

In this specific exchange, John experienced Dr. S's own anesthesia experience both as an affective withdrawal and detachment similar to his mother's response to John's attempts at deriving emotional contact and at organizing his
own internal world. Partly in response to Dr. S's unconsciously conveyed sense of conviction about the patient's state of mind, perhaps John experienced Dr. S as clearly delineating what John's subjective world must be like, as opposed to feeling invited to join in a mutual, shared struggle to ascertain his experience firsthand, in a collaborative fashion. A selfobject need and a potential selfobject experience were both missed, and the process of sequestration was bolstered.

It is important to note that this was not a situation in which Dr. S spoke self-assuredly as determiner and arbiter of the truth about John. Dr. S had verbally invited John to share in a mutual exploration of his impressions and associations regarding his own felt experience. Dr. S had by most standards provided John with an atmosphere of self and mutual discovery and of exploratory freedom. It was, however, Dr. S's essential experience of his self as certain, his attitude about his “snowledge” of the patient, gathered independently and unidirectionally from the patient, and his attitude toward his capacity to transcend his subjectivity, that ultimately facilitated an unconsciously conveyed sense of certainty and conviction about the patient to the patient.

Ultimately, Dr. S and his patient John loosened and unraveled their intersubjective disjunction through a gradual, thorough investigation of their discrepant, subjective perspectives and concomitant experiences of each other. It was primarily Dr. S's eventual shifting of his meta-organizing principle of transcendence, through continued self-reflection, toward a more embeddedness-oriented stance, that facilitated a development away from what had become a familiar, repetitive enactment for this particular analytic dyad. I wish to underscore that I am not arguing against the experience and communication of certainty and conviction in this or in any other context, even though at times they may be highly discrepant with or even antithetical to the type of affective responsiveness most useful to the patient at the time. Instead, I am calling to task the way in which one might potentially arrive at the personal experience of certainty and conviction vis-à-vis the patient, that is, via the attitude of transcendence.

Conclusions

The centrality and relevance of the analyst's subjectivity in the analytic context compel us to examine more closely the extent of its impact on our selves and on our patients. In this article, I have attempted to discuss and illustrate the impact one's meta-organizing principle—that of one's attitude toward one's subjectivity—has on one's experience of self, one's countertransference, and one's sense of certainty and conviction about the patient. Two specific attitudes were explicated in the hope of exploring the potential impact they may have on various facets of the analytic situation. I hope this provides a point of entry into further investigations of the impact that other attitudes toward our subjectivity, not discussed here, have on the analytic environment and also a way of helping elaborate the notion of context-dependent, context-driven experience.

References


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