TRANSFERENCE FROM AN INTERSUBJECTIVE-SYSTEMS PERSPECTIVE

Excerpt from Maduro interview of Robert D. Stolorow. Here Dr. Stolorow discusses his conceptualization of transference.

(For your eyes only: the record of this interview is pre-publication, so please do not forward this excerpt. “Q” indicates a Maduro question; “A” indicates a Stolorow answer).

A: So the concept of transference as prereflective organizing activity unites with the view of psychological structure as prereflective organizing principles and with character as the totality of prereflective organizing principles that shape a person’s experiences.

Now the advantage of thinking of transference as prereflective organizing activity is that it’s inherently contextual, because you can’t organize nothing. In order for something to be organized according to a prereflective organizing principle, there has to be something coming from the side of the analyst, for example, that is lending itself to being organized that way. So this conception of transference contextualizes it radically.
Q: And this is to say nothing of the fact that the organizing principles themselves are constitutively relational in so far as they are in part grounded in the patient’s history of experiences with others.

A: Exactly. So instead of seeing the patient’s transference experiences as displacements or projections onto the analyst as a blank screen, which is an incredibly self-serving illusion—that any other human being can be a blank screen for another human being—instead of that you’ve got all kinds of complex intersubjective exchanges taking place between patient and analyst, with various things coming from the side of the analyst lending themselves to the particular organizing principles that the patient brings to the encounter.

Now we found it very useful to distinguish two broad classes of organizing principles, or to put it another way, two broad dimensions of transference. One we call the developmental dimension, in which the patient longs for the analyst to be a source of developmental experiences that were missed or lost or aborted during the formative years. And the other we call the repetitive dimension, in which the patient anticipates, expects, fears, or actually experiences a repetition with the analyst of early developmental trauma—like the patients Bernie described in his paper on negative therapeutic reactions.

Each of these dimensions can be subdivided into multiple subdimensions, multiple developmental longings, multiple experiences of developmental trauma, and so on, leading to a multiplicity of organizing principles of both types. So both dimensions and their subdimensions are copresent in the therapeutic situation. But the therapeutic relationship tends to be dominated by one or another of them, depending on what’s coming from the side of the therapist and how that is lending itself to one or another of these dimensions.

So you’ve got a picture of multiple dimensions of experience oscillating between the background and foreground of the patient’s experience in response to the meanings of particular happenings within the intersubjective field. Now the same description also characterizes the analyst’s transference, which is no different from the patient’s—multiple dimensions of experience oscillating between the
background and foreground of the analyst’s experience in response to the meanings of particular goings on in the intersubjective field.

So you’ve got an extremely complex picture here of two fluidly oscillating experiential worlds, each with multiple dimensions of experience oscillating between the background and foreground in response to the meanings for each participant of particular happenings in the intersubjective field, and each of these multidimensional fluidly oscillating experiential worlds mutually influencing one another. Such a complex picture is not appealing to those who are looking for solid bedrock to stand on. There is no bedrock to be found here; just phenomenological contextualism all the way down!

Q: I was just thinking how the notion of “therapist as blank screen” effectively suggests the therapist doesn’t have any subjectivity that is part of the system. I could imagine a motivation within the “blank screen” theorist to de-complexify the relational field simply in order to make it more understandable. Maybe it’d be a product of the theorist’s “complexity dread” or some such affect. But anyway I digress.

A: Actually, I think that’s a very good point. It alludes to one of the things that creates an aversive reaction to our perspective in some people. George and I referred to the basis for that aversion as a fear of structureless chaos. The picture of the fluidly oscillating complexity of the intersubjective field can easily evoke that fear of structureless chaos.

Q: You’re alluding to a fear and aversion in some therapists for theory that doesn’t provide clear answers?
A: Particularly those people who need to feel that they’re standing on solid bedrock. The philosopher Richard Bernstein referred to that fear as Cartesian anxiety.

Q: Why did he call it Cartesian?

A: Because it’s the opposite of what Descartes was searching for—namely, clear and distinct ideas.

Q: Among the emotional demands of your phenomenological-contextualist perspective, you’re pointing to the way understanding the therapeutic situation in such complex, relational terms can evoke uncertainty anxiety, and thus require our tolerance of it in order to do thorough clinical work. In this regard, another feeling that I see in my own work, and in my supervision of candidates, is a kind of incompetence anxiety. I think it derives from holding clarity and distinctness as a personal, professional ideal since it sets the stage for feeling failure when what we see isn’t so clear and distinct. I know I can feel this when I expect myself to clearly understand the complex clinical exchanges in front of me. One consequence of this feeling of failure is that it undermines my tolerance of clinical complexity and ambiguity. It can be very painful, especially when I, or the supervisee I’m working with, is already in a mood of self-doubt for one reason or another. So that’s another thought I have, namely, the problem of incompetence anxiety or pain, and how it might inhibit one’s openness to the complexities of psychoanalytic treatment.

A: A good point, definitely.