TRANSFFERENCE
from an
INTERSUBJECTIVE-SYSTEMS PERSPECTIVE

ICP Ventura Saturday Series

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BRIEF DESCRIPTION OF INTERSUBJECTIVE-SYSTEMS THEORY

Intersubjective-systems theory is one brand of American relational theory that developed out of interweaving collaborations principally between and among Drs. George Atwood, Bernard Brandchaft, Donna Orange, and Robert Stolorow. Their framework is humanistic in nature and deeply rooted in continental philosophies of phenomenology and hermeneutics.

Abstractly and formally, this theory examines the field—usually, a dyadic field co-constituted by two personal worlds of experience in the relational system they create and from which they emerge—both in human development and in any form of psychoanalytic treatment. Because of this focus, intersubjective-systems theory also implies a complex contextualist view of development and of pathogenesis, explaining the emergence and modification of experiential worlds (subjectivity), and defining all these processes as irreducibly relational.

As observers, participants and therapists, this framework calls upon one to focus on the evolving psychological field constituted by the interplay between the differently organized experiential
worlds of child and caregivers, patient and analyst, and so on. Within this theoretical framework, “intersubjective” thus describes the emergent relatedness between any two or more people and, as distinct from the use of this term in the works of Daniel Stern (1985) and Jessica Benjamin (1995), for example, does not refer to developmental achievements. For instance, Benjamin’s mutual recognition intersubjectivity may, or may not, occur within an always already existing intersubjective system.

The foundational clinical maxims encoded in the intersubjective-systems theory include: 1) clinical attention to the emotional convictions patterning a personal world, often traumatically; 2) understanding the relational, or intersubjective, contexts in which such convictions take form, are maintained, or transform, 3) radical engagement with the patient; and 4) refusing, out of fallibilistic perspectivalism, any authoritarian claim or attitude of “God’s Eye” knowledge.

**WHAT IS “CHARACTER” FROM AN INTERSUBJECTIVE-SYSTEMS PERSPECTIVE?**

Below is a Blog post setting forth Robert Stolorow’s conceptualization of character. Please read and let’s discuss how it informs an understanding of transference.

What Is Character And How Does It Change?

Robert D. Stolorow

(Founding Faculty Member at the Institute of Contemporary Psychoanalysis)

Traditionally, in psychology, psychiatry and psychoanalysis, the term “character” has been used to refer to constellations or configurations of behavioral traits. “Anal characters” are said to be compulsive and perfectionistic; “hysterical characters” are described as histrionic; “passive-aggressive characters” show anger covertly by withholding; “narcissistic characters” are excessively self-centered; “borderline characters” form chaotic and primitive relationships and so on. How might character be understood from a perspective, like mine, that takes organizations or worlds of emotional experiencing as its principal focus?[1]
I have long contended that such organizations of emotional experiencing always take form in contexts of human interrelatedness.[2][3] Developmentally, recurring patterns of emotional interaction within the child-caregiver system give rise to principles (themes, meanings, cognitive-emotional schemas) that recurrently shape subsequent emotional experiences, especially experiences of significant relationships. Such organizing principles are unconscious, not in the sense of being repressed, but in being pre-reflective. Ordinarily, we just experience our experiences; we do not reflect on the principles or meanings that shape them. The totality of a person’s pre-reflective organizing principles constitutes his or her character.

From this perspective, there can be no character “types,” since every person’s array of organizing principles is unique and singular, a product of his or her unique life history. These organizing principles show up in virtually every significant aspect of a person’s life — in one’s recurring relationship patterns, vocational choices, interests, creative activity, fantasies, dreams and emotional disturbances. Psychoanalytic therapy is a dialogical method for bringing this pre-reflective organizing activity into reflective self-awareness so that, hopefully, it can be transformed.

Early situations of consistent or massive malattunement to a child’s emotional experiences (situations in which the child’s feelings are ignored, rejected, invalidated, devalued, shamed, punished and so on) have particularly important consequences for the development of character as I have conceived it. One consequence of such malattunement is that emotional states take on enduring, crushing meanings. The child, for example, may acquire an unconscious conviction that unmet developmental yearnings and reactive painful feeling states are manifestations of a loathsome defect or of an inherent inner badness. A defensive self-ideal may be established, representing a self-image purified of the offending emotional states that were perceived to be unwelcome or damaging to caregivers. Living up to this emotionally purified ideal then becomes a central requirement for maintaining harmonious ties to others and for upholding self-esteem. Thereafter, the emergence of prohibited emotion is experienced as a failure to embody the required ideal, an exposure of the underlying essential defectiveness or badness, and is accompanied by feelings of isolation, shame and self-loathing. A person with such unconscious organizing principles will expect that his or her feelings will be met by others with disgust,
disdain, disinterest, alarm, hostility, withdrawal, exploitation and the like, or will damage others and destroy his or her relationships with them.

A second consequence of significant emotional malattunement is a severe constriction and narrowing of the horizons of emotional experiencing so as to exclude whatever feels unacceptable, intolerable or too dangerous in particular relationship contexts. When a child’s emotional experiences are consistently not responded to or are actively rejected, the child perceives that aspects of his or her emotional life are intolerable to — and unwanted by — the caregiver. These regions of the child’s emotional world must then be repressed or otherwise kept hidden in order to safeguard the needed tie. Large sectors of the child’s emotional experiencing are sacrificed, and his or her emotional world may thereby become emptied and deadened. Such sacrificing may also take the form of aborting the process whereby emotional states are brought into language. When this is the case, emotions remain nameless, inchoate and largely bodily, and psychosomatic problems may develop.

How does character — that is, the array of a person’s pre-reflective organizing principles and the corresponding horizons of emotional experiencing — change as a result of a successful psychotherapeutic process? In regard to psychoanalytic therapy, there has been a longstanding debate over the role of cognitive insight vs. emotional attachment in the process of therapeutic change. The terms of this debate are directly descended from Descartes’ philosophical dualism, which sectioned human experience into cognitive and emotional domains. Such artificial fracturing of human experience is no longer tenable in a post-Cartesian philosophical world. Cognition and emotion, thinking and feeling, interpreting and relating — these are separable only in pathology, as can be seen in the case of Descartes himself, the profoundly isolated man who created a doctrine of the isolated mind, of disembodied, unembedded, decontextualized cogito.

The dichotomy between insight through interpretation and emotional bonding with the therapist is revealed to be a false one, once it is recognized that the therapeutic impact of analytic interpretations lies not only in the insights they convey, but also in the extent to which they demonstrate the therapist’s attunement to the patient’s emotional life. I have long contended that a good (that is, a mutative) interpretation is a relational process, a central constituent of which is the patient’s experience of having his or her feelings understood. Furthermore, it is the specific
meaning of the experience of being understood that supplies its mutative power, as the patient weaves that experience into the tapestry of developmental longings mobilized by the therapeutic engagement. Interpretation does not stand apart from the emotional relationship between patient and therapist; it is an inseparable and, to my mind, crucial dimension of that relationship.

In a nutshell, interpretative expansion of the patient’s capacity for reflective awareness of old, repetitive organizing principles occurs concomitantly with the emotional impact and meanings of ongoing relational experiences with the therapist, and both are indissoluble components of a unitary therapeutic process that establishes the possibility of alternative principles for organizing experience, whereby the patient’s emotional horizons can become widened, enriched, more flexible and more complex. As the tight grip of old organizing principles becomes loosened, as emotional experiencing thereby expands and becomes increasingly nameable within a context of human understanding and as what one feels becomes seamlessly woven into the fabric of whom one essentially is, there is an enhancement of one’s very sense of being. That, to my mind, is the essence of character change.

References:


**Excerpt from Peter Maduro’s 2016 interview of Robert D. Stolorow relevant to Transference from an Intersubjective-systems Perspective**

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). Key: “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-complexity 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.
Peter Maduro Work-Sheet with Respect to

Transference from an Intersubjective-Systems Perspective

With respect to any dyadic psychotherapeutic treatment relationship, co-constituted by Therapist and Patient, below are some questions we might consider on the topic of transference from an intersubjective-systems theory perspective.

When considering these questions, remember that intersubjective-systems is a relational affect theory: a theory focused on the human person’s emotional life and the relational contexts in which it takes form, is felt, and is maintained or therapeutically transformed. Despite its theoretical appreciation of the broad relational contextuality of emotional development and therapeutic action, entailing as it does existential, cultural, historical, socio-economic/political and other dimensions, its clinical perspective focuses on those emotional relationships, or “interaffective systems”, co-constituted by the emotional worlds of Caregiver and Child (developmental system) and Therapist & Patient (therapeutic system).

Basically, from within the intersubjective-systems framework, the Patient’s “transference” refers to the Patient’s relationally derived emotional and perceptual organization (experiencing) of the Therapist and the therapeutic process. Transference is thus a form and dimension of the Patient’s experiential organizing activity. On the first level, this organizing activity takes its distinctive shape from the Patient’s relationally/developmentally derived central organizing principles: the Patient’s central emotional convictions and perceptual filters --e.g., “I see myself as, and am, worthless”, “I will be emotionally exploited’, “my grief is hurtful to others”-- as rooted in his/her developmentally formative experiences, often traumatic, with others.

However, the Patient’s transference --as organizing process-- is inherently relational not only because it has developmental roots in relationships with important-others, but because one never organizes nothing --one never organizes a blank slate. Rather, there is always something in or of the Therapist, and/or the therapeutic situation, that lends itself to drawing forth one dimension or another of the Patient’s already-formed, developmentally rooted, organizing convictions, hopes, dreads, etc.

Similarly, the Therapist’s transference, called by some the Therapist’s countertransference, refers to the Therapist’s relationally derived emotional and perceptual organization of the Patient and their therapeutic process. Again, on one level, the Therapist’s transference takes its distinctive shape by virtue of being organized by the Therapist’s already-formed, developmentally rooted, central organizing principles --e.g., the Therapist’s central emotional convictions and perceptual filters that “I see myself, and am, responsible to keep others safe from pain”, “If I do not always-already know, understand, and have answers for those I care about, I am a failure”-- as rooted in his/her developmentally formative experiences, often traumatic, with others.
However, just as with the Patient, the Therapist’s transference—as organizing process—is relational also because it always takes form in the context of some feature of the Patient’s presence, personality-organization etc that lends itself to drawing forth one dimension or another of the Therapist’s already-formed, developmentally rooted organizing convictions, hopes, dreads, etc.

The “transference/counter-transference system”, namely, the system of emotional meanings co-constituted by the Therapist’s and Patient’s mutually and reciprocally influencing central organizing principles and associated transferences, is thus a particularly important—often complex—dimension of the therapeutic relationship.

Finally, as you consider the questions below, imagine a particular person in your practice as “the Patient”, and imagine yourself as “the Therapist.”

Now, finally, to the questions:

How Would You Describe the Patient’s Already-Formed, Developmentally Rooted Emotional Convictions and Perceptual Filters? How Would You Describe Your Own Such Convictions and Filters, as Therapist?

How would you describe the emotional convictions, or organizing principles, at the center of the Patient’s personality?

What “hopes and dreads” (Mitchell), or longings and anxieties, might most centrally and repetitively characterize the Patient’s emotional experience?

How would you describe the emotional convictions, or organizing principles, at the center of the Therapist’s personality?

What “hopes and dreads” (Mitchell), or longings and anxieties, might most centrally and repetitively characterize the Therapist’s emotional experience?

What Is/Are the Patient’s Transference(s) With the Therapist?

If “the Patient’s transference” is defined as the Patient’s experience of the Therapist and therapeutic situation & process as organized by the Patient’s central “organizing principles”, AND as constituted and drawn forth by one or more features of the Therapist, and/or therapeutic situation, that lend themselves to evoking the Patient’s hopes/dreads, then
What “hopes” or developmental longings might you expect the Patient to consistently experience (whether or not consciously) in his therapeutic treatment? What is he or she likely to most deeply long for from his or her Therapist, and the therapeutic process?

What anxieties or dreads are likely to repetitively organize the Patient’s experience and expectations in respect of his or her Therapist, and the treatment process? What is he or she likely to be most afraid of and most sensitive to re-occurring in the Therapist’s way of being and therapeutically interacting with him or her?

What features of the Therapist/therapeutic situation are lending themselves to evoking one dimension or another of the Patient’s transference(s)?

What Is/Are the Therapist’s Transference(s) With the Patient and, With an Eye Towards this Particular Dyadic Intersubjective-System, How Do They Impact the Patient? How Do They Become Therapeutically or Traumatically Organized By the Patient?

If “the Therapist’s transference” is defined as the Therapist’s experience of the Patient and therapeutic situation & process as organized by the Therapist’s central “organizing principles”, AND as constituted and drawn forth by one or more features of the Patient, and/or therapeutic situation, that lend themselves to evoking the Therapist’s hopes/dreads, then

What aspects of the Therapist’s personal organization are apt to get mobilized or evoked by this Patient’s (i) developmental transferences (longings) and (ii) repetitive transferences (dreads of retraumatization)?

What aspects of the Therapist’s personal organization and associated transferences are likely to lend themselves to meeting the Patient’s particular longings, e.g., to understanding or seeing him or her well and promoting therapeutic transformation?

Which aspects of the Therapist’s organization and associated transferences are likely to lend themselves to evoking or confirming the Patient’s dreads or anxieties?

What features of the Therapist’s theoretical convictions and commitments, and derivative therapeutic style, clinical activity, or general attitude might lend themselves to meeting the Patient’s longings or evoking his or her anxieties?

If the Therapist is affiliated with a clinic, agency or other organization (e.g., Maple Center) that has its own personality, policies, aesthetic, reputation etc, and which, by virtue of such affiliation, is identified --in the Patient’s mind-- with the Therapist, what features of such organization might lend themselves to meeting the Patient’s longings or evoking his or her anxieties?
RECOMMENDED READINGS

WITHIN THE INTERSUBJECTIVE-SYSTEMS LITERATURE:

In order to deeply understand and integrate intersubjective-systems theory into your clinical thinking you would extend the learning garnered in Peter Maduro’s presentation by reading, or at least having at hand for reference, the following books -- each of which constitutes a central contribution to the intersubjective-systems literature.


Additional, Select Readings for The Chicago School Students


1 Introduction

The planned dissertation will consider collaborative knowledge construction in socio-technical systems from a cognitive psychology perspective to shed more light on the process of intersubjective meaning making (IMM) and provide it with adequate support. Will such comprehensive intersubjective collective intelligence systems make us more wise? Will they help prevent the kind of hatred and insanity that drove Breivik to enact this tragedy in the first place? I argue no; we should not confuse real-time environmental awareness with greater wisdom, compassion or decision-making ability.

Search within full text. Chapter. One natural route to the view that intersubjective spectrum inversion is possible is via the plausible claim that we can imaging the occurrence of intrasubjective inversion—a change whereby the different colors systematically look different to a person than they did before, although she is able to make all the same color discriminations as she did before, and sees things as having the. In philosophy, psychology, sociology, and anthropology, intersubjectivity is the relation or intersection between people's cognitive perspectives. Intersubjectivity is a term coined by social scientists as a short-hand description for a variety of human interactions. For example, social psychologists Alex Gillespie and Flora Cornish listed at least seven definitions of intersubjectivity (and other disciplines have additional definitions): people's agreement on the shared definition of an object;