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Walking the Tightrope of Emotional Dwelling

George E. Atwood, Ph.D.
Clinton, NJ

Robert D. Stolorow, Ph.D.
Los Angeles, CA

This essay seeks to characterize an active, relationally engaged form of therapeutic comportment called emotional dwelling. Distinctive features of this mode of comportment are identified by contrasting it with corresponding formulations appearing in other theoretical viewpoints, including those of Freud, Ferenczi, Sullivan, and Kohut. Central in emotional dwelling is the therapist's capacity to enter into a patient's reality even while simultaneously holding to his or her own.

One of us (Stolorow, 2014) recently offered some formulations moving toward a more active, relationally engaged form of therapeutic comportment called emotional dwelling. In dwelling, one does not merely seek to understand the other's emotional world from the other's perspective. One does that, but much more. In dwelling, essential in the pursuit of our discipline's twin goals of healing psychological wounds and exploring human nature and human existence, one leans into the other's experience and participates in it, with the aid of one's own analogous experiences. In this essay, we seek to further identify distinctive features of this mode of comportment by contrasting it with corresponding formulations appearing in other theoretical points of view.

OBJECTIFICATION

The antithesis of emotional dwelling is the therapist's attitude of objectification. The most extreme forms of such an attitude are found in crude materialism and behaviorism, wherein the whole concept of the human being as an experiencing subject is abolished. But any way of relating that decontextualizes the experiences being explored objectifies them. Psychiatric diagnosis, for example, ascribes the content and form of the patient's subjective life to particular disorders inhering in an isolated Cartesian mind. Psychoanalytic character types (narcissistic personality, obsessional personality, schizoid personality, etc.), similarly, focus on the patterns of experience and conduct shown by a person seen in isolation from the relational surround. Even the concepts of intersubjective systems, theory can be applied in an objectifying manner, as, for instance, when the patterning of subjective life is ascribed to decontextualized "organizing principles" somehow operating within the mind.

Emotional dwelling, in contrast, recognizes the embeddedness of all experience in constitutive intersubjective contexts, including the one created by the act of dwelling itself. We are

Correspondence should be addressed to George E. Atwood, Ph.D. E-mail: ufpatw01@gmail.com

accordingly led to a view of psychopathology as no longer reducible to an array of discrete mental illnesses, conceived as located somehow within isolated individuals. Instead, the task of diagnosis shifts to the identification of recurrent patterns of disturbance or disequilibrium in complex intersubjective systems. The features of experience and conduct formerly regarded as symptoms of reified psychiatric categorizations or as expressions of decontextualized psychoanalytic character types then become understood as inseparable from the multifaceted relational fields linking the patient to other people, which include the participating presence of the observing clinician.

EVENLY HOVERING ATTENTION

Sigmund Freud (1912) famously recommended an attitude for the psychoanalytic clinician of "evenly hovering attention." His idea was that the analyst's sensitivity to the flux of the patient's experiences is maximally enhanced by a kind of floating, open attentiveness, unhampered by conscious preconceptions and purposes. He also suggested that this unguided following of the patient's free associations permits ideas and intuitions to arise out of the analyst's own unconscious mental activity, providing spontaneous insights into otherwise hidden meanings in the clinical material.

Emotional dwelling also aspires to have an openness about its approach to a patient's world, not assuming the presence therein of any particular content or psychological theme. This attitude of openness, however, is not one of suspending preconceptions but rather of searching for areas of *intersubjective resonance*. The analyst's understanding of the patient's felt situation depends upon an ability to find analogues in his or her own personal universe, emotional scenes, and moments paralleling the experiences being explored. Bringing such territories of correspondence into reflective awareness permits a participation by the analyst in the patient's subjective life as a kindred spirit.

PARTICIPANT OBSERVATION

Harry Stack Sullivan (1953) recognized that in psychiatry, as he practiced it, there are no wholly objective facts on which our knowledge can be based. He suggested instead that the scientific data of his discipline are gathered through a process of "participant observation." The instrument of observation is the person of the psychotherapist, who engages with his or her patients and takes note of the phenomena that appear in their reciprocal interaction.

There is a tension in Sullivan's thinking between objectivity and subjectivity, one that importantly distinguishes his understanding from that of emotional dwelling. One sign of this tension appears in the term itself: *participant observation*. It is virtually an oxymoron, the word "observation" connoting detached objectivity, and the word "participant" underlining the highly personal nature of the interaction and the collapse of the distance between the observer and the observed. A second sign of the tension in Sullivan's theory resides in an idea closely associated with that of participant observation: the notion of *parataxic distortion*. The patient is thought to distort the externally real in order to protect a threatened feeling of security, and Sullivanian

therapy, accordingly, has as one of its goals to free the patient from such distortions and thereby enhance the objectivity and accuracy of his or her perceptions of the world.

Emotional dwelling, in contrast, is occupied with apprehending subjective truths (Kierkegaard) rather than objective facts. In dwelling, we do not seek to correct the patient's experience and make no assumptions about external reality. While the patient's views frequently differ from those of the analyst, sometimes very dramatically, this difference is endured without judgment being passed as to whose reality is correct. Instead, the analyst searches for the standpoint from which the patient's perceptions and interpretations will show their own inner coherence and validity.

BECOMING THE PATIENT

In discussing the psychoanalytic therapy of those who have been subjected to an experience of soul murder resulting from traumatic abuse, Sandor Ferenczi (1932/1988) said,

> It is an unavoidable task for the analyst: … he will have to repeat with his own hands the act of murder previously perpetrated against the patient. In contrast to the original murderer, however, he is not allowed to deny his guilt. (p. 58)

He regarded it as essential that the analyst enter fully into the patient's personal world, feeling vicariously its suffering. Rather than approach the psychotherapy process guided by experience-distant theoretical ideas, Ferenczi urged his contemporaries to open themselves up to *becoming the patient*, viscerally undergoing the traumas that have occurred and that are resurrected in the analytic relationship.

The analyst, in joining the patient's reality and embracing rather than denying his guilt, may be catapulted into unbearable pain. Ferenczi provided little guidance as to how to survive this necessary suffering. One walks on a tightrope, and one can fall on one side or the other. If we fall on the side of complete identification with the patient's reality, we are indicted and condemned for being murderers, corroding our faith in ourselves as healers. If we fall on the side of protecting our own sense of personal identity—perhaps viewing our patients' experiences of annihilation as results of transference distortions as traditionally understood and our own feelings as products of patients' "projective identifications"—we are exonerated; but the result is to invalidate our patients and repeat their original traumas in full. The answer to the dilemma in an approach based on emotional dwelling is to stay on the rope, holding two differing realities simultaneously—something that is always exceedingly difficult to achieve. In clinical practice, one falls first one way and then the other, and back and forth repeatedly. This difficult oscillation, however, is inevitable along the only pathways to healing that can be found.

EMPATHIC IMMERSION

Traditional notions of therapeutic empathy have been pervaded by the Cartesian doctrine of the isolated mind. This doctrine bifurcates the subjective world of the person into outer and inner regions, reifies and absolutizes the resulting separation between the two, and pictures the mind

as an entity that takes its place among other objects, a "thinking thing" that has an inside with contents and looks out on an external world from which it is essentially estranged. Within this metaphysical vision, human beings can encounter each other only as thinking subjects, and something like empathic immersion—what psychoanalytic innovator Heinz Kohut (1959/1978) famously called vicarious introspection—is required to bridge the ontological gap separating their isolated minds from one another. In a post-Cartesian philosophical world, no such bridging is required, as we are all always already connected with one another in virtue of our common humanity (including our common finitude and existential vulnerability) and our co-disclosive relation to a common world.

Kohut's and others' contention that a therapist's empathic immersions can be neutral and objective is especially saturated with Cartesian assumptions. One isolated mind, the therapist, enters the subjective world of another isolated mind, the patient. With his or her own psychological world virtually left outside, the therapist gazes directly upon the patient's inner experience with pure and preconceptionless eyes. From our vantage point, this doctrine of immaculate perception (Nietzsche) entails a denial of the inherently intersubjective nature of analytic understanding, to which the therapist's subjectivity makes an ongoing, unavertable, and indispensable contribution.

The framework of phenomenological contextualism embraces the hermeneutical axiom that all human thought involves interpretation and that therefore our understanding of anything is always from a perspective shaped and limited by the historicity of our own organizing principles —by the fabric of preconceptions that the philosopher Gadamer (1975/1991) called prejudice. The claim that all analytic understanding is interpretive means that there are no decontextualized absolutes and universals, no neutral or objective analysts, no immaculate perceptions, no God's-eye views of anything or anyone—and thus no empathic immersions in another's experiences. This contextualist sensibility keeps our horizons open to multiple, relationally expanded possibilities of meaning. Analytic understanding is thus seen as forming and evolving within a dialogical context.

From our vantage point, therapeutic inquiry is a dialogical process in which each participant, in varying degrees and at different times, engages in reflection upon three interrelated domains—the meanings organizing one's own experience, the meanings organizing the other's experience, and the dynamic intersubjective system constituted by these interacting worlds of meaning. Furthermore, in this dialogical process each participant (far from entering the other's subjective world and leaving his or her own outside) continually draws on his or her own experiential world in search of analogues for the possible meanings governing the other's experiences. Empathic (-introspective) understanding is thus grasped as an emergent property of a dialogical system, rather than as a privileged possession of an isolated mind.

There is something disengaged in the traditional conceptions of therapeutic empathy. Kohut was aware of this, and in his last lecture before he died he characterized empathy as a value-neutral investigative activity that could even be used for malevolent purposes. He suggested that the Nazis' practice of putting sirens on the bombs they dropped on London demonstrated an exquisite empathic understanding of the terror that would be evoked in those on the ground who heard them.

Emotional dwelling contrasts with Kohut's view of empathy. In dwelling, one does not simply seek to understand the other's emotional experiences within the other's frame of

reference. One leans into the other's entire emotional situation and participates in it. We have found that this active, engaged, participatory comportment is especially important in the therapeutic approach to emotional trauma. The language that one uses to address another's experience of emotional trauma meets the trauma head-on, articulating the unbearable and the unendurable, saying the unsayable, unmitigated by any efforts to soothe, comfort, encourage, or reassure—such efforts invariably being experienced by the other as a shunning or turning away from his or her traumatized state.

CONCLUDING THOUGHTS

A question may be raised about emotional dwelling as to its limits. How can one dwell with someone's experiences when they differ profoundly from one's own? On what basis can an analyst lean into a patient's subjective situation when the very horizons of possibility (Ratcliffe, 2015) defining the patient's universe depart significantly from the analyst's? Emotional dwelling does not require that the analyst have had identically the same experiences as the patient. It is necessary, though, that thematic analogues be found that will serve to bring their respective worlds into proximity, parallels sharing features in common allowing the analyst to imagine what it is like to be in the patient's situation.

An example appeared in some experiences one of us (G.A.) had during the early stages of his training as a clinical psychologist. A number of the patients he encountered in a psychiatric hospital made statements to the effect that the world was ending or had been destroyed and that they were dead rather than alive. The regular psychiatric staff viewed such statements as delusional, symptoms of a severe mental illness. He did not see them that way: The patients' words seemed to him to be direct expressions of subjective catastrophes that were being felt and lived. This perception in turn made possible in many instances a response allowing the patient to feel understood rather than isolated and pathologized, setting the stage for an eventual healing dialogue.[1] What made this understanding—this emotional dwelling—possible, in view of the fact that he had not himself undergone equivalent experiences of personal annihilation? The answer emerged following long reflection, years after these clinical encounters. Without realizing it explicitly, he had found an analogy in his own life history in a tragic and catastrophic loss that occurred when he was a child. His own early experience of the world ending as he had known it had assisted him in visualizing the experience in his patients of the world ending altogether.

It is our impression that the greatest difficulty analysts have in locating thematic analogues to their patients' experiences resides in areas of their subjective world that have been defensively walled off in order to avert unbearable conflict and pain. An analyst who has disavowed his or her own early experiences of disruption and loss, for example, will be unable to enter the forbidden zone and discover analogies therein to assist in grasping corresponding traumas in the lives of his or her patients. Those who are open to their traumatic histories, in contrast, can draw upon their entire emotional backgrounds as rich resources enabling them to dwell with the troubled souls who turn to them for help. We regard this opening of the analyst's life to the

[1] See the case of Anna in Chapter 9 of *Psychoanalytic Treatment: An Intersubjective Approach* (Stolorow, Brandchaft, & Atwood, 1987) for a detailed description of one of these early encounters.

search for thematic analogues to be one of the most important functions of the analyst's own personal analysis.

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CONTRIBUTORS

George E. Atwood, Ph.D., is Professor of Clinical Psychology (Emeritus) at Rutgers University and founding faculty member of the Institute for the Psychoanalytic Study of Subjectivity in New York. He maintains a private practice in Clinton, New Jersey, and is the author and coauthor of many books, including *The Abyss of Madness* and, with Robert Stolorow, *Structures of Subjectivity: Explorations in Psychoanalytic Phenomenology and Contextualism*.

Robert D. Stolorow, Ph.D., Ph.D., is a Founding Faculty Member at the Institute of Contemporary Psychoanalysis, Los Angeles, and at the Institute for the Psychoanalytic Study of Subjectivity, New York City. He is the author of *World, Affectivity, Trauma: Heidegger and Post-Cartesian Psychoanalysis* (Routledge, 2011) and *Trauma and Human Existence: Autobiographical, Psychoanalytic, and Philosophical Reflections* (Routledge, 2007) and coauthor of eight other books. He received his Ph.D. in Clinical Psychology from Harvard University in 1970 and his Ph.D. in Philosophy from the University of California at Riverside in 2007.