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**Contextualist Sensibilities in Psychoanalysis: A Discussion of
Judy Pickles's Case Presentation**

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This article explores Judith Pickles's case presentation through the lens of contextualism. Key questions are posed: How can we account for the nature and origin of an individual's personal lived experience? What are the theoretical and clinical implications of our quintessentially human need to substantiate what we feel to be subjectively true and real? And what is the nature of therapeutic action? It is concluded that an ongoing, dialogic, inter-subjective playing with meaning reverberating across multiple experiential worlds is an essential ingredient in therapeutic action and the expansion of one's emotional horizons.

It is a pleasure to have this opportunity to share my reactions to Judith Pickles's case presentation—a clinical odyssey that underscores several key ideas and questions. They are, first, how do we account for the nature and origin of an individual's personal lived experience? Second, what are the theoretical and clinical implications of our ubiquitous need to substantiate what is felt to be subjectively true and real? And finally, what is the nature of therapeutic action? In light of Dr. Pickles's clinical material, I would like to examine these questions through the lens of psychoanalytic contextualism.

Dr. Pickles presents the story of a 42-year-old, deeply traumatized, and continually terrorized woman, and of herself, the clinician who patiently and bravely agreed to witness her patient's horrific experiences of denigration, humiliation, and abject abuse, and the emotional devastation that trailed in their wake. First and foremost, I am awestruck by the capacity and resilience of both individuals to remain committed to their analytic endeavor, to their focus on and continued hope for deeper understanding and, ultimately, transformation. Transformations here were hard won, altering both participants irrevocably. Keeping the above questions in mind, I will organize my comments around a few key junctures within the treatment process.

In the opening exchange, we witness the certainty and depth of Ann's self-loathing, of her having been damaged beyond repair, of her being, essentially, a "piece of garbage". Understandably, Dr. Pickles moves quickly to dispel her patient's belief: Clearly, Dr. Pickles experienced her as something other than garbage and naturally wanted to provide her with a different worldview, that her patient *feels* this way not because she is this way but because she was *treated* this way. Dr. Pickles rightly notes, though, that her attempts at providing an alternate view "threatened to repeat the trauma of usurping her experience of agency". This was a crucial juncture, as it centered not on the content of the patient's experience (I am and must be a piece of garbage) but on the disjunction in subjective worldviews, including the particularized meanings that disjunction had for the patient at that point in time.

We learn that Ann had become particularly sensitized to the possibility of having her own experience, including her sense of self that was partially organized around that experience, usurped: Better to be a piece of garbage than nothing at all. Much of Ann's experiential world appears to have been organized initially around just such experiences of usurpation, only previously in horrific proportions. We note that Ann attempts to reassert her subjectivity when she states, "But it *happened* to me, even if it wasn't my fault ... it wouldn't have happened if I weren't bad". We recall that on the heels of this exchange and Dr. Pickles's subsequent shift, Dr. Pickles witnesses the change in therapeutic ambiance to one more conducive to analytic exploration, to increasing the space in the relationship for a broader unfolding of Ann's affective experience. Furthermore, this exchange, particularly Ann's assertion here, speaks to the quintessentially human propensity for meaning making and for holding on tenaciously to a sense of substantiality about the meanings that are constituted via relational engagement. This

process is essential in developing and maintaining self-delineation (Stolorow, Brandchaft, and Atwood, 1987) and a “sense of the real” (Coburn, 2001), even if what is felt to be real is crushingly painful.

Stolorow and his colleagues have elaborated this concept also in the context of the vicissitudes of intersubjective conjunctions and disjunctions. What about this ubiquitous need for substantiating what each of us feels to be subjectively true and real? We all, as human beings, share the necessity (burden?) of having to organize our experiences of our selves and of the world in some identifiable fashion into specific, meaningful patterns, on the one hand, and yet cannot claim outright the achievement, or advantage, of having grasped the actual truth and reality of our existence in doing so, on the other hand. It is as if we are, or need to be, in the wrenching position of having to suspend our disbelief of our subjective world, as we do in the theater, while concurrently having to clutch at it tenaciously to carry out our daily functions, that is, in order to live, to feel that we are making sense of the world.

In terms of episode 1, I can well imagine, considering several of the other exchanges between Dr. Pickles and Ann, that Ann was motivated to destroy herself, not out of the experience of an absence of her “right to live,” but rather, indeed, from her experience of needing to exert her right to *have* a life that she could direct in the fashion of her choosing. Although Ann clearly was immersed in profoundly unbearable emotional states, many of which centered on her father's invasive, incessant, incomprehensible torture and from which she wished to escape via suicide, she would not have been the first person to have killed herself, also, as a final attempt at garnering and asserting a true self-experience, one of self-agency, in the face of crushing usurpation. I would not presume this outright, but this view appears supported by the sequence of events occurring between Ann and Dr. Pickles. Abandoning the ritualized therapeutic stand of insistence and suasion, Dr. Pickles opts instead to impart a true self-expression of her own—“I cannot work this way!”—following which Dr. Pickles interprets, via her disclosure of her own emotional experience of hopelessness and helplessness, something of what *Ann's* own experience may have been like. Again, the theme of usurpation emerges. What we witness next is Ann's “softening,” not I believe an accommodative response, in this instance, but a reaction to her having had her need to determine the course of her life heard, felt, understood, and respected. I particularly like that Dr. Pickles, while having and sharing her intense emotions of fear, helplessness, and being held hostage, did not organize

her experience as being the result of the projection (as in “projective identification”) of her patient's disavowed affect states into her own mind for containment and metabolization. If anything, it was not Ann's utter helplessness that found its way into the mind of Dr. Pickles but, rather, a concomitant sense of her own self-assertion and self-agency that, while apparently at odds with that of her patient's, opened a space of negotiation between two highly discrepant worldviews. Here we witness, on one hand, a type of intersubjective disjunction in the form of “You are not garbage and must live” versus “I am garbage and must die,” while, on the other hand, we note a type of intersubjective conjunction in the form of “I recognize that I am trying to assert my need (to determine my future via self-destruction), which I know contradicts yours (you want me to live)” along with “I recognize that I am trying to assert my need (for you to reflect and to live), which I know contradicts yours (to protect yourself from any further pain and usurpation)”.

It seems to me that each participant learned here that they could negotiate with each other, not just their right to a life, but to the manner in which each would *direct* her life. In the midst of great fear and agony, each ultimately protected herself from substantial subjugation and usurpation—something that would have been repetitive for the patient—and, in effect, each found a beginning resolution to “I cannot live this way” and “I cannot work this way”. Here Ann was witnessing Dr. Pickles's asserting her need to maintain her own agency, to have her own voice. This exchange, among many others, is another excellent example of our need to substantiate what we feel to be subjectively true and real and to act accordingly. The ubiquitous need for this type of substantiation not only lies at the base of many therapeutic exchanges, characterized either by transformation or by impasse, or both, but also at the base of human life in general.

The experiential theme of usurpation is revisited throughout Dr. Pickles's work with Ann. Episode 3 is another striking example. Here we witness that Ann's experience of revisiting the physical vestiges (including pictures) of her horrific abuse, while certainly substantiating her felt experiences, also confirmed her profoundly organizing emotional conviction that she is (and will remain) a piece of garbage. Thus the “package” was instrumental in reconfirming one of Ann's central experiential themes that, in fact, she was inherently bad. I think Ann's difficulty was in trying to survive the gruesome results—the crushing and pervasive experiences of self and the world that evolved out of having had these explicit, conscious experiences to begin with. If Ann had difficulties trusting her own experiences,

she might have been less inclined to organize so profoundly her experiential world around her having been a piece of garbage. I think this is well illustrated in Ann's repeatedly defending herself from Dr. Pickles's discrepant view of her: "You're telling me how I should think and feel just like everyone else in my life". Here Ann once again assimilates Dr. Pickles as the usurping agent.

Dr. Pickles's presentation for me invokes the question, how exactly might a contextualist sensibility inform our practice and our more general conceptions about subjectivity, transference, defense, and, especially, therapeutic action? In my view, it says that subjective experience is systemically constituted. Elsewhere I underscored that "one's personal, lived experience originates and continues to evolve from within a system or matrix of parts that cohere in some potentially recognizable fashion. Attributing personal experience to an individual mind alone thrusts us back into the theoretical quagmire of conceptualizing these perceptions and experiences as transference distortion. To say one is distorting reality decontextualizes the subject, effectively plucking him or her out of the subjective world in which such psychological phenomena coalesce and make sense" (Coburn, 2002, p. 656). I believe Dr. Pickles's sensibility in this area, along with that of her patient's, facilitated her initial strategic shift from attempting to counteract Ann's emotional conviction that she was a piece of garbage to an emphasis on the investigation and toleration of her patient's affective world. When Dr. Pickles did this, she necessarily shifted the emotional focus away from the relative veracity of perspectives about *who* Ann really *was* to one centered on the potential meanings of *how* Ann experienced herself in relation to Dr. Pickles and to the world in general. I believe this proved mutative for her patient.

A contextualist sensibility is well evidenced in the attitude that we, as an aspect of and in concert with all other aspects of our patients' surround, play an integral part in the coalescence of our patients' experiences and the meanings derived therefrom and that, as such, we wish to remain sensitive to the degree to which this may be emotionally salient or relevant to our patients. In other words, we can try to maintain a sensitivity that we are in this together and that at no point can we extricate ourselves from our patient's experience. This sensibility is germane to the work of authors such as Merleau-Ponty, Martin Buber, and Donna Orange. This is to be construed neither as claiming responsibility for another's experience nor as asserting that all of a patient's experience pertains to the analyst, nor that it does not. It is simply trying to take responsibility for the fact that we are present and

contributing and doing so in ways about which we can never claim absolute clarity or certainty. This also underscores an essential tenet of contextualism: Any facet of an individual's experiential world (a thought, feeling, dream, fantasy, conviction, etc.) arises always from the dynamic interaction between one's history, one's current state of mind, and one's environment. And the actual lines between the three are ultimately indeterminate.

To further extend this contextualist sensibility, it might be useful to bidirectionalize more explicitly the relational events that unfolded. For example, it is helpful to reflect on not just what the analyst does that may be instrumental in effecting change but also what the patient does. This highlights the chicken and egg problem of the origination of subjectivity and of subjective experience—a burden that can be relieved if we accept that “experiential worlds and intersubjective systems are equiprimordial” (Stolorow, personal communication, 2002). **Feuerbach (1972)**, who influenced Buber, also stresses the equiprimordiality of both participants in a relationship. Thus therapeutic action itself can be understood as a relational or systems event, one that is always systemically constituted, not the result of one person *doing* something to another. Personal experience and therapeutic action at the level of *explanatory* theory (as opposed to the *phenomenological*) are always of ambiguous ownership. In the language of complexity theory, emotional experience is always *distributed* across all the components of a complex adaptive system as opposed to belonging to or originating from one isolated component of that larger system.

In this light, we don't conceptualize therapeutic action as a series of interventions based on the generation of insight, the experience of attachment, or some form of integrative function (or even as an inextricable combination thereof), resulting in emotional changes in the recipient (the patient). Rather we see it as an ongoing intersubjective playing with meaning that reverberates across multiple experiential worlds, just as the play itself is an emergent property of those worlds. From a contextualist perspective, intersubjective play and the meanings that emerge therefrom are as distributed across multiple, interpenetrating worlds of experience as the reasons that bring patients to treatment in the first place. In any analytic dyad, the dynamics of therapeutic action and change, mapping from initial conditions and evolving to their current state, are so complicated and complex that we cannot account for the system accurately enough to be able to predict the outcome. If this were not so, Dr. Pickles could have been quite clear about each of her interventions, about how she chose to be with Ann.

Instead, she and her patient, *together*, struggled with each other, trying to make sense of their experiences together, trying to tolerate together what, in the absence of relationship, would have truly been intolerable.

I wish to thank both Dr. Pickles and Ann for sharing with us their tenacity and dedication to making sense of a life in the face of abject adversity, perplexity, and suffering, and for this opportunity to expand my own understanding of contextualism in psychoanalysis.

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