Subjectivity, Objectivity, and Triangular Space

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The author reviews his ideas on subjectivity, objectivity, and the third position in the psychoanalytic encounter, particularly in clinical work with borderline and narcissistic patients. Using the theories of Melanie Klein and Wilfred Bion as a basis, the author describes his concept of triangular space. A case presentation of a particular type of narcissistic patient illustrates the principles discussed.

The acknowledgement by the child of the parents' relationship with each other unites his psychic world, limiting it to one world shared with his two parents in which different object relationships can exist. The closure of the oedipal triangle by the recognition of the link joining the parents provides a limiting boundary for the internal world. It creates what I call a “triangular space,” i.e., a space bounded by the three persons of the oedipal situation and all their potential relationships. It includes, therefore, the possibility of being a participant in a relationship and observed by a third person as well as being an observer of a relationship between two people…

If the link between the parents perceived in love and hate can be tolerated in the child's mind, it provides him with a prototype for an object relationship of a third kind in which he is a witness and not a participant. A third position then comes into existence from which object relationships can be observed. Given this, we can also envisage being observed. This provides us with a capacity for seeing ourselves in interaction with others and for entertaining another point of view whilst retaining our own, for reflecting on ourselves whilst being ourselves. This is a capacity we hope to find in ourselves and in our patients in analysis. [Britton 1989, pp. 86-87]

Treatment of Borderline and Narcissistic Disorders

The theorizing that underlies these comments came from my experiences with borderline patients, from whom this capacity had been missing for long periods of time. Green (1997) sees borderline disorder and hysteria as distinct, and also makes the point— with which I agree—that borderline disorder is not a larval psychotic state. As will be evident from this paper, I regard the borderline syndrome as a particular form of narcissistic disorder, one that I characterize as hypersubjective or “thin skinned” (Rosenfeld 1987, p. 274). It has gradually become evident to me that what is missing in these cases is the third position described above.

I came to realize that my efforts to consult my analytic self were detected by such patients and experienced as a form of internal intercourse on my part that corresponded to parental intercourse. This, they felt, threatened their very existence. The only way I could find a place to think that was helpful and not disruptive was to allow an evolution of my own experience within me, and to articulate this to myself, while communicating to the patient my understanding of the patient's point of view. The possibility of my communicating with a third object was unthinkable, and so the third position I refer to was untenable. In such cases, the third object could be my theories, links with colleagues, or the residue of previous analytic experience.

As a consequence, it seemed impossible to sufficiently disentangle myself from the to-and-fro of the interaction to know what was going on. Any move toward objectivity could not be tolerated.

1 This passage is from a paper read at a conference on “The Oedipus Complex Today” at University College London, in September 1987.

Analyst and patient were to move along a single line and meet at a single point; there was to be no lateral movement. A sense of space could be achieved only by increasing the distance between us, a process such patients find impossible to bear unless they initiate it. In such situations, what I felt I needed desperately was a place in my mind that I could step into sideways from which I could look out at things. If I tried to force myself into such a position by asserting a description of the patient in my own terms, violence would follow—always psychically, and sometimes also physically.
Triangular Space

The crucial importance of the three persons of the psychic triangle has been emphasized by psychoanalysts of other schools and in other countries, particularly in France, notably by McDougall (1971), Chasseguet-Smirgel (1984), and Green (1997). In America, also, it is addressed by some of the writers on intersubjectivity. That ideas derived from psychoanalytic practice based on the theoretical background of the British Kleinian school could lead to similar preoccupations and illuminations as those from the French school and from the United States encourages me to think that we might be addressing a clinical reality that transcends country, culture, and theoretical framework.

The Influence of Primary Relationships

I personally arrived at the idea of triangular space and the third position from particular clinical experiences, and my theorizing was based essentially on Klein's (1928) concept of the early oedipal situation and Bion's (1959, 1962a, 1962b) theory of containment. Bion described the consequences for some individuals of a failure of maternal containment as the development of a destructive, envious superego, which prevents them from learning or pursuing profitable relations with any object. He made it clear that the inability of the mother to take in her child's projections is experienced by the child as a destructive attack by her on the child's link and communication with her as the good object.

I suggest that the idea of a good maternal object can then be regained only by splitting off the mother's perceived hostility to linkage and attributing it to a hostile force. Such a force was represented in various religions of the ancient world by "chaos monsters": in ancient Egypt, it was Apophis, who was "an embodiment of primordial chaos. He had no sense-organs, he could neither hear nor see, he could only scream. And he operated always in darkness" (Cohn 1993, p. 21).

Apophis continually threatened ma'at, the female personification of order in the world. Mother as the source of goodness, like ma'at, is now precarious and depends on the child's restricting his or her knowledge of her. Enlargement of knowledge of the mother as a consequence of development and of the child's curiosity are felt to menace this crucial relationship. Curiosity discloses the existence of the oedipal situation. The hostile force that was thought to attack the child's original link with the mother is now equated with the oedipal father, and the link between the parents is felt to destroy her as a source of goodness and order.

I am suggesting, therefore, that the problem has its origins in the relationship to the primary maternal object in cases where there is a failure to establish an unequivocally good experience of the infant—mother interaction to contrast with the bad experience of being deprived of it. Instead of the natural, primary split of predepressive development, there is confusion. To arrest the confusion, an arbitrary split in mental life is imposed to enshrine the notion of good and to locate and segregate the bad. The essential structure of the oedipal situation lends itself to splitting of this kind. This can give rise to the misleading appearance of being a classical, positive Oedipus complex based on rivalry with mother for the love of father. The transference tells another tale. The familiar, split nature of the positive oedipal configuration—usually used to separate love and hate—in these cases provides a structure to segregate desire for subjective understanding and love from the wish for objective knowledge and a shared intellectual identity. I have come to regard these as the characteristics of narcissistic and borderline disorders.

Subjectivity and Objectivity

Here I am using subjective to mean the first-person point of view and objective as the third-person point of view. The philosopher John R. Searle (1995) distinguishes objectivity used as third-person description, which he calls ontological objectivity, from the use of the word to denote dispassionate judgment, which he calls epistemic objectivity. In this sense, it is the integration of ontological subjectivity with ontological objectivity that for some patients provokes catastrophic anxiety.

Rey (1988) described narcissistic syndromes as “a certain kind of personality disorder which defied classification into the two great divisions of neurosis and psychosis. We now know them as borderline, narcissistic, or schizoid personality organization” (p. 203). What sufferers of these various syndromes have in common is that they cannot, at least initially, function in analysis in an ordinary way, because they cannot form an ordinary transference relationship. Some remain aloof and detached; others are adherent, clamorous, and concrete in their transference attachment. But in neither of these is the analyst experienced as both significant and separate.

It was Abraham (1919) who discovered that some individuals who were not psychotic or manifestly uncooperative were extremely difficult to analyze because they did not, or could not, use the method of free association, nor could they
expose their subjective experience. Rosenfeld (1987) described such patients as “thick-skinned narcissistic” individuals, in contrast to “thin-skinned narcissistic” ones. In a book published just after his death, he wrote that there are those patients … whose narcissistic structure provides them with such a “thick skin” that they have become insensitive to deeper feelings… To avoid impasse these patients have to be treated in analysis very firmly.… When interpretations at

last manage to touch them they are relieved, even if it is painful to them…. By contrast … the thin-skinned patients are hypersensitive and easily hurt in everyday life and analysis. Moreover, when the sensitive narcissistic patient is treated in analysis as if he is the thick-skinned patient, he will be severely traumatized. [p. 274]

What I have suggested (Britton 1998) is that these two clinical states are the result of two different relationships of the subjective self to the third object of the internal Oedipus triangle. In both states, the third object is alien to the subjective, sensitive self. In the hypersubjective, the self seeks to avoid the objectivity of the third object and clings to subjectivity. The hyperobjective patient identifies with the third object and adopts a mode of objectivity, renouncing subjectivity.

What is quickly revealed in both cases is that analysis is a major problem for such a patient—and for the patient's analyst. Being in analysis is a problem—i.e., being in the same room, the same mental space. Instead of there being two connected, independent minds, there are either two separate people unable to connect or two people with only one mind. These two situations could not be more different from each other in analysis. What patients in both situations have in common, however, is the inability to function in an ordinary way and terror of the integration of separate minds.

In one group, the other is treated as of no significance; in the second group, the patient cannot commute without making the significant other an extension of him- or herself. In the first situation, the analyst cannot find a place within the psychic reality of the patient, while in the second, the analyst cannot find a place outside it. The first is hyperobjective, with narcissistic detachment, and the second is hypersubjective with narcissistic adherence.

**Hyperobjectivity and Narcissistic Detachment: Thick-Skinned Patients**

A case presentation follows in which the analyst was an outsider, that is, outside the subjective interaction with the object of desire and identified with an objective observer.

The patient, Mr. B, was a successful writer who sought psychoanalysis after a period of marital therapy, at the suggestion of the marital therapist and with the prompting of his wife. After telling me this, he added with disarming frankness that his problem was intimacy: “I am no good at intimate relations, my wife tells me, and I’m sure she's right.” He also let me know in the consultation that he suffered from depression of a kind in which he would awaken sick with a sense of terror and despair about his own uselessness and life in general.

When Mr. B was young and still religious, he had believed that he was damned and beyond redemption, and that the usual religious remedies of confession, contrition, and so on would not work for him. When I suggested that he might feel the same way about analysis, he quickly agreed that he could not imagine its helping or changing him in the slightest—“but I have to try it if you are willing to have a go,” he added.

The problem of shared analytic space quickly asserted itself when Mr. B arrived for his first session. We had agreed on a time, and he accepted the analytic convention, as he saw it, of lying on a couch for fifty minutes. But he conveyed that he could have cooperated equally willingly if I had suggested that he stand on his head for fifty minutes. “Enduring things,” I suggested, “is something you know you can do without their having any effect on you.” He agreed with this, offering several convincing examples from his childhood of his fortitude's having protected him from being changed by regimes inflicted on him.

Once we got underway, the problem was mine. Although I could understand him without too much difficulty, I could not find a means of sharing Mr. B's mental space, of getting into contact with him. I was the outsider in this analysis. The patient would claim that he was not really involved in the analysis; he sympathized with me for having to endure such an unappreciative patient, when presumably, I would like to be thought important and to have my ideas appreciated. My needs, therefore, were worth his consideration, but he could not do anything about them. Pity was what he offered me as a decrepit old man whom he once described as the “West Hampstead worm.”
I was not empty minded, however, outside the realm of his attention. Mr. B had a gift for communicating to me what difficulties faced him and what anxieties troubled him, so that I was vividly aware of his very real suffering. If I drew attention to these, he politely scoffed at me for taking them seriously. He would then leave the session on an upbeat note of “Begone, dull cares,” and with a wave, would say, “See you tomorrow.” I was left, in other words, holding the baby.

This applied also to the patient's memories: to his recollections of cruel experiences, his revelations of painful humiliations and considerable deprivation. He treated my opinion that he had suffered an unhappy childhood as eccentric. If I then reminded him of recollections he had disclosed in the previous session, he would quickly say that he had a terrible memory and forgot everything from one day to another. So I was the only one who now knew of the existence of the suffering child.

My patient had gone missing. When I suggested to Mr. B that he had emptied his experiential self into me and then left the two of us behind, he responded by describing a story he had written. Although it had another title, he said that it “could have been entitled ‘The Story of a Missing Person.’” In the story, someone was exploring a residence and could not establish whether anyone lived there or not. An outline of the missing person's life and attendant details were visible as traces left behind, but there was no presence. The essence of the story was that of emptiness shaped by absence, the shape of a missing person.

In analysis as in his marriage, absence appeared to solve the problem of presence for Mr. B. However, it required a place from which to be absent. In order to be an absentee husband, one needs a wife; to be an absentee patient, one needs an analyst; to be a runaway, one needs a home to run away from. And to have a missed session, one needs to have a session arranged.

Largely through the use of my countertransference as a source of information about my missing patient, we were able to get some idea of the problems that led to Mr. B's psychic retreat to the periphery of his life. I found that, although I retained my usual analytic position of receptivity and inquiry, I could not achieve my customary sense of significance. I would be tempted to insert myself into my patient's field of psychic vision by assuming a role already assigned to me, often that of a coach or friendly critic. The price to be paid in the countertransference for remaining in my own psychic sphere was a sense of insignificance and loneliness. It was not difficult to see that this had been my patient's experience in the past and in his present working life, where he felt that he functioned on the rim of the world.

As a child, Mr. B had found a hideaway where he could be unknown to his family. His dreams made clear how significant this secret space was; it became the forerunner of other private spaces, culminating in the creation of the study where he worked. Here he created in his writing his own versions of himself and placed these replicas in a variety of contexts of his own choosing, which accurately mirrored his internal world. And a bleak and lonely place it usually was. I was to get insideknowledge of this forlorn terrain because it was where he placed me in the analysis. We met there, eventually, in a shared, moorland-like mental landscape that to me felt reminiscent of the place where Wordsworth (1904) met the leech gatherer when driven to despair by Coleridge's "Ode to Dejection." My impression was that the patient benefited from his analysis, and certainly he prospered; I would have liked to think that our encounters may have had a therapeutic effect on him similar to that which Wordsworth ascribed to the leech gatherer: “… to find/In that decrepit Man so firm a mind” (p. 157).

What I think we learned in the analysis was the reason for Mr. B's self-exclusion. It protected him from being misperceived, or, in Bion's (1959, 1962a, 1962b) terms, from being the contained that would be molded into the container's definition of a self. On the edge, the patient could define himself as the outsider, as the man who would not fit in. The cost of this identity was exclusion. The passport to inclusion was to be defined by the other's presuppositions and preconceptions; the price for entry into the mind of the other was to be misperceived. The sacrifice to be made to secure a place indoors was to be caged within the limiting framework of the other's comprehension.

**Hypersubjectivity and Narcissistic Adherence**

What clinically characterizes this group of cases is their difficulty. These patients find life with others difficult; they find tolerating themselves difficult; they finding in analysis difficult; and, in a characteristic way, their analysts find working with them difficult. When analysts bring such cases for consultation, they almost always begin by saying, “I want to talk about my difficult patient,” or “I seem to have particular difficulty with this case.” It is often accompanied by a sense
of shame in the analyst, who feels that he or she has either let the patient down, or has become involved in a collusive analysis in a way that is hard to acknowledge to colleagues.

Of course, many patients pose considerable technical and countertransference problems, but the characteristic problem that leads analysts to use the word difficult with such emphasis is of a particular kind. It is the way that the analytic method itself is felt by the patient to be a threat, by virtue of its structure, method, and boundaries. The corollary of that in the analyst is a feeling of inability to properly establish an analytic setting. This impasse has been used by some analysts to promote as a superior analytic method an alternative strategy, which in reality was dictated by the patient as a necessary condition. This, I think, corresponds to the patient's belief, secret or not, that his or her atypical method of growing up was a more authentic way, and that those who were ordinary children (and who become more tractable analytic patients) are either victims of oppression or are collaborators.

While working empathically with the patient and validating his or her subjective experience in a way that the patient finds helpful, the analyst may begin to feel like a mother who does not really exist in her own right. The patient becomes reliant on this function and on the analyst as this receptive figure, but the analyst fears a loss of his or her own analytic identity. If, however,

the analyst asserts humor herself and produces objectively based interpretations, the patient will feel persecuted, leading either to masochistic submission or an explosion. The patient will then, one way or another, eliminate what the analyst says or eradicate those elements of difference in it. The patient may feel the need to remove his or her mind from the analyst's presence by psychic withdrawal, and some patients even find it necessary to remove their bodies in order to remove their minds, thus breaking off the analysis. Such individuals are inclined to leave one analyst or to stay in an impasse with another; the risks are of analytic abortion or interminable analysis. Subjective and objective realities are believed to be more than simply incompatible—in fact, to be mutually destructive.

Objectivity appears to be associated with visual gaze. There is a fear of being seen, just as there is a fear of being described. A child with such problems insipsychoanalytic psychotherapy serves well as an example because of the directness of the exchange with the psychotherapist. In a case I supervised, a seven-year-old girl was clearly very persecuted simply by being in the therapist's room, screaming whenever he tried to speak. Eventually, with the therapist's help, she managed to make it clear to him that if she blindfolded and gagged him so that he could not see or speak, but could only listen, then she would talk to him. When he was able to say to her that she believed his words would spoil and mess up her thoughts, she burst out, "They will, they will! So shut up!"

Such situations in their adult versions can evoke existential anxieties in the analyst because empathic identification with the patient seems incompatible with the analyst's objective clinical view of the situation and belief about what is necessary. Therefore, the analyst feels cut off from the theories that link him or her to colleagues and that bestow a professional identity. This problem also manifests in the analyst's difficulty in using general experience or general ideas, since such use appears to intrude on the singularity of the encounter with this particular patient and the uniqueness of the patient's psychology. Particularity seems to

be at war with generality in much the same way that subjectivity is with objectivity. In terms of the figures of the oedipal triangle, one might say that, when the analyst is able to follow and enhance the patient's emergent thoughts, he or she is identified as an understanding maternal object; but when introducing thoughts of his or her own, derived from general experience and analytic theories, the analyst is identified as a father who is either intruding into the patient's innermost self, or pulling the patient out of a unique, subjective psychic context into one of the analyst's own.

So we have a defensively organized oedipal situation, with the fantasy of a totally empathic, passively understanding, maternal object, juxtaposed to an aggressive, paternal figure who is objectivity personified, seeking to impose meaning. While this defensive organization of the oedipal triangle is maintained, it guarantees that reintegration will never take place between the understanding object and the misunderstanding object—which would result, it is believed, in the annihilation of understanding.

In this hypersubjective mode, the positive transference expresses its energy not by penetration but by extrapolation. Its intensity is conveyed by extension. It encompasses the object and invests everything it covers with heightened significance. The physical person of the analyst—and, by extension, the contextual details of the analysis—are given great importance, including the minutiae of sessions, the analytic office and its contents, and so on. Patients may collect and retain physical remnants of the analysis, such as bills or paper tissues, which serve a function similar to that of religious relics.
The negative transference is equated with a penetrating third object, while feeling understood is attributed to the primary object. Both positive and negative transferences are at play: one craved and sought after, and the other dreaded and evaded. The desired transference is skin deep and enveloping. Its epistemological mode is empathy, its physical expression is touch, and its emotional qualities are erotic or aesthetic. What is dreaded most is the conjunction of the encompassing transference with the penetrating transference—that is, of subjectivity with objectivity.

- 58 -

**Malignant Misunderstanding and the Need for Agreement**

In chapter 4 of *Belief and Imagination* (Britton 1998), I explored the mental catastrophe that is anticipated as following the integration of two different points of view. From the transference, it seems that the basic fear is of *malignant misunderstanding*. By this, I mean an experience of being so *misunderstood*, in such a fundamental and powerful way, that one's experience of oneself would be eliminated, and correspondingly, the possibility of the self's establishment of meaning would be annihilated.

This represents, I think, the fear of a return to primordial chaos, which corresponds to Bion's (1959, 1962b) notion of *nameless dread*, which he posits as following a failure of containment. Bion gives two accounts of the production of *nameless dread* from a failure of maternal containment in infancy. In both these, the incomprehensible becomes the incomprehensible. One could say that there is a dread of the namelessness of everything. If this failure of understanding is experienced in early infancy as an attack rather than as a deficiency, a force is believed to exist that destroys understanding and eliminates meaning. One sees this repeated in the transference when the failure of the analyst to precisely understand the patient is experienced by the patient not simply as a deficiency of the analyst, but as an attack on the patient's psychic integrity.

When there is a desire for understanding coupled with a dread of misunderstanding, there is also an insistent, desperate need for agreement in the analysis and the annihilation of disagreement. I have come to believe that a general rule arises from anxiety about misunderstanding, which applies in all analyses: it is that the need for agreement is inversely proportional to the expectation of understanding. When expectation of understanding is high, a difference of opinion is intolerable; when expectation of understanding is fairly high, difference is fairly tolerable; and when there is no expectation of understanding, the need for agreement is absolute.

- 59 -

**Conclusion**

**Psychic Atopia**

I have asked myself these questions: Is there something in the *temperament* of some individuals that *predisposes* them to this particular development or response to trauma? Is there anything in the endowment of these persons that might encourage them to believe that an independently existing object will destructively misunderstand them? Is there an *innate factor* in the infant that increases the risk of a *failure of maternal containment*, and if so, what might it be?

In reply to these questions, I suggest that there may be an allergy to the products of other minds, analogous to the body's immune system—a kind of psychic atopia. The immune system is central to our physiological integrity and functioning; we cannot survive without it, and yet it is often the source of pathology. Is the same true of our psychic functioning? It certainly appears to be so in our social functioning, where the annihilation of the perceived alien is commonplace. The not-me or not-like-merecognition and response might fulfill a psychic function similar to that in the somatic. And just as the immune system sometimes makes for physiological trouble between mothers and babies, as in the familiar rhesus incompatibility problem, so, perhaps, might there be troublesome psychic immunity responses. Are there psychic allergies and is there sometimes a kind of psychic autoimmunity?

In the realm of ideas and understanding, we do seem to behave as though we have a psychic immune system. We are fearful about our ability to maintain the integrity of our existing belief systems, and whenever we encounter foreign psychic material, a xenocidal impulse is stimulated. Psychoanalysis made possible by the establishment of a shared mental space both exposes these difficulties and provides an opportunity to explore them.

**References**