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Main Article:

Connection and Disconnection: Value of the Analyst's Subjectivity in Elucidating Meaning in a Psychoanalytic Case Study

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Abstract

This article reflects on pivotal concepts of psychoanalytic practice and theory, applied to a single case study to create new meanings. Drawing from the concepts of transference, countertransference, and projective identification, the author presents the notion that the researcher's subjective reactions are created and induced by the subject of study precisely because this is one, and sometimes the only way available to the subject to communicate something that is out of its full awareness. In essence, some unconscious material can be expressed nonverbally by the subject by means of provoking visceral and bodily reactions in the researcher, or in some cases, psychic imagery such as dreams or fantasies. The material can be meaningfully interpreted by the researcher by receiving, containing, and sorting through these inchoate emotional reactions within self.

Index Terms: research context; subjectivity; psychoanalysis; transference; countertransference; projective identification; induced feelings; case study

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1. Introduction

Subjectivity has claimed increasing value as a tool of understanding in the human sciences. In contrast with the original idea that the researcher's subjectivity is a potential hindrance to understanding, it is now commonly accepted that it can also be a valuable instrument in the process of interpreting an objective social, psychological, or intrapsychic reality. However, it is my impression that the interplay between the

subjective experience of the researcher and the subject of study is often described in ways that do not imply an essential relationship between them. Instead, a parallel reality is implied which aids the researcher in the process of deriving meaning. An example of this would be the shared cultural or historical experiences between the researcher and the subject, which could facilitate *identification*, a form of grasping the psychological experience of the other. In this situation, understanding can be furthered by the psychological commonality of two separate realities (the researcher's and his subject's), but these realities do not influence each other.

Psychoanalysis offers a profound conceptual twist that implies the researcher's subjectivity may in fact be a creation of the subject of study which reveals an essential aspect of it. This relationship between the researcher's subjectivity and the subject of study is based on the underlying presumption that the researcher's subjective reactions are induced by the subject of study precisely because this is one, and sometimes the only way available to the subject to communicate something that is out of its full awareness.

The purpose of this article is to explain the psychoanalytic concepts that theoretically advance this argument and to illustrate their application to a single case study. It is my hope that the non- psychoanalytic reader may find parallels between the psychoanalytic process and the social, psychological, or intrapsychic research process, and also between the analyst-patient relationship and the relationship that develops between the researcher and the subjects of his/her research.

2. Psychoanalytic Concepts

The concepts that I will focus on are *transference*, *countertransference,* and *projective identification*. Bear in mind that these three processes are primarily unconscious. What render these concepts so useful to psychoanalysts, in the process of deriving some objective understanding of patients, are the controlled environment of the psychoanalytic office and the explicit terms of the relationship between the patient and psychoanalyst. However, they describe phenomena that are assumed to occur universally, intrapsychically and in any encounter between two or more people. Although other environments and types of relationships may not be as controlled, from an experimental point of view, these intrapsychic processes still occur and affect how we, as researchers, come to be in their presence and therefore, how we come to understand reality. For this reason, I believe that becoming familiar with these concepts may enhance any social or psychological researcher's understanding.

2.1. Transference

The phenomenon of transference was discovered by Sigmund Freud and became a fundamental tenet of psychoanalytic theory and therapy. Transference is defined as "the redirection of feelings and desires and especially of those unconsciously retained from childhood toward a new object" (*Webster's New Collegiate Dictionary*, 8th ed., 1976). It is the re-creation of the past relationship in the present one. A person may transfer impulses and feelings that he/she experienced towards persons in his past experiences in

addition to those that he/she experienced from these people of the past, or from these "objects" (Spotnitz, 1985). This re-creation of the past in the present is, according to Freud, an attempt to circumvent remembering and becoming conscious of some unconscious psychic element; however, it is through the re-enactment of it in the present that we can gain access to it and understand it (Freud, 1914/1958).

2.2. Countertransference

Countertransference refers to those feelings induced in the therapist (or the receiving person), in response to the transference. Conceptually, the feelings aroused in the therapist (or the receiver) may be induced by an identification with early, unconscious self-feelings and emotional attitudes (feelings about the early self) of the patient or identifications with later, more developmentally advanced mental representations of objects of the past of the patient. Racker (1957) called the self-feelings *concordant identifications* and the object-feelings, *complimentary identifications*. In practice, what this means is that a therapist may be induced to feel the same feelings the patient struggled with in early life, or, in contrast, may be induced to feel the feelings experienced by people in the patient's early emotional life. In both cases, the emotional reaction of the therapist (or the receiver) is presumed to replicate some significant aspect of the unconscious emotional life of the patient.

The transference-countertransference realm of a relationship between two or more persons is always active and alive. Everybody has had the experience of inexplicably disliking another person, or being induced with feelings of sadness or hopelessness in the presence of another person. These are day-to-day examples of the transference-countertransference arena.

Even though casual interactions between people are bound to carry this element, it is difficult to tease out and understand because of lack of experimental controls. The relative constancy and predictability afforded by the analytic frame is what allows systematically isolating and studying the transference-countertransference phenomena. Arguably, some experimental controls could be put in place in the research design process so that these phenomena can be interpreted with an acceptable degree of certainty.

The concept of countertransference is the pivotal concept in the argument that the subjective experience of the researcher is a creation of the subject of study which reflects an essential aspect of its nature. However, not all feelings that are experienced in relation to the patient or the subject of study can be assumed to be countertransferential. In fact, they could be transferential creations of the researcher, which, if left unrecognized, could become a source of distortion of objective reality. Psychoanalysts are trained to scrutinize their feelings towards their patients in order to differentiate their own transference from their countertransference. They work extensively with supervisors and in their own analysis in order to tease out their own emotions from those that are induced in them by the idiosyncratic relationship with the patient.

The unconscious intrapsychic dynamics of our subjects cannot be directly observed. They can only be inferred from the external derivatives of thoughts, affects, and actions. In psychoanalysis, as in other psychological and social sciences, we rely heavily on verbal communication from our subjects to convey the status of all three derivatives. Through their discourse, we hope to gain access to the state of their thoughts, fantasies, affects, and even intended actions. In the practice of psychoanalysis, patients are encouraged to suspend actions in relation to the analyst—they are however encouraged to talk about their wish or impulse to act in the presence of the analyst (Rangell, 1997). In fact, it is believed that, the more a patient is able to suspend action, the more likely he/she is to express a meaningful aspect of his/her psychic state in words.

As psychoanalysts have progressively ventured to treat patients with more primitive psychic structures, they have had to learn to use other instruments, in addition to verbal communication, to gain access to the unconscious emotional experience of their patients. Emotional states experienced in the earlier phase of life, before language acquisition, are often inaccessible through verbal language. The earlier a patient's developmental arrest occurs, or the deeper a patient regresses, the less available language becomes and the more we need to rely on other forms of communication.

Within the perspective of early human development, some generally accepted assumptions are that the infant is first in a primary state of un-integration, in which it has no clear awareness of the self or the external world (Winnicott, 1949). The infant is also un-differentiated, meaning that with its mother it forms a symbiotic unit in which the boundaries of the infant extend to the mother and include her (Mahler, Pine, & Bergman, 1975). In this early phase, the body and the senses are the channel of communication. The states of tension and relief of tension experienced by the infant in response to the care and handling of the mother constitute the physical experiences in the body that form the building blocks for the psychic experience. In other words, it is assumed that the sense of self is originated in this early experience of the body (Winnicott,1945). These early bodily sensations and states of tension and relief of tension (previous to the acquisition of language) are elements of primitive communication that are "picked up" by the analyst in the countertransference.

The contertransference becomes a tool for understanding the unspeakable. In "the reconstruction of the inner realities of the undifferentiated period, the feelings induced in the therapist by the patient's transference feelings and behavior contribute additional—at times indispensable—clues to the early emotional history" (Spotnitz, 1985, p. 211).

However, to allow oneself to be induced with very primitive emotional states is not an easy task. According to Spotnitz (1985), the main sources of resistance to experiencing countertransference are: "the need to not feel hate, the need to be liked or appreciated, the need to be right, and the need to be 'good'." The therapist (receiver) may "'barricade' himself, consciously or unconsciously, utilizing emotional neutrality as a defense against experiencing the feelings" (p. 232). The resistance to fully experiencing the feelings induced by the research subjects would hinder the researcher's subjectivity as an instrument.

Although countertransference by definition is unconscious, we strive to render it conscious through self-analysis, analysis of other sources of empirical data and external contrast (with supervisors, etc.). The receiver is often swept up by intense feelings that are difficult to make sense of, that often feel like they come from within, instead of from the subject of study. Spotnitz (1985) stressed that an emotional state that initially appears to be related to a blind spot in the analyst may prove of great value in reconstructing the patient's relation to a significant object in his early experience. This may very well be true for the relationship between the researcher and his/her subject of study.

2.3. Projective Identification

Melanie Klein (1946) described one of the primitive, preverbal mechanisms used by the mind in its active interaction with an incipient external world. This process, called projective identification, operates in the developmental level where there is still a profound blurring of boundaries between the self and the object representations in the mind. The mechanism involves the following sequence: first, there is the fantasy of projecting a part of the self into another person and of that part taking over the person from within; then there is pressure exerted via the interpersonal interaction such that the "recipient" of the projection experiences pressure to think, feel, and behave in a manner congruent with the projection; and finally, for therapeutic purposes, the projected feelings, after being "psychologically processed" by the recipient, can be re-internalized by the projector (Ogden, 1979). What I wish to emphasize about this mechanism is the active induction of feelings and impulses onto the recipient in an attempt to rid the self of its unwanted aspects and the result of the recipient being compelled to feel or act in a particular way.

Now, with these three concepts in mind, I will illustrate how my subjectivity was both utilized to develop new meanings and also, at times, interfered with my understanding of my patient.

3. Case Study: The Struggle Between Connection and Disconnection

I had been treating Ann psychoanalytically, as a requirement for my psychoanalytic training. We had been together for about a year when I undertook a single case study of her dynamics as revealed in the treatment as my dissertation research project (Hueso, 2011). At this point, I had become interested in what appeared to be a strong urge to connect to others and a less apparent tendency to destroy this connection. The data consisted of 70 process notes produced from memory after each session of the entire treatment, until its discontinuation. The notes included near verbatim reproduction of the patient's discourse, descriptions of any nonverbal behaviors, description of any contact outside of the sessions (phone calls, messages, etc.), and all relevant emotional reactions, thoughts, fantasies, dreams, or actions (such as forgetting a session) on my part, during or between sessions. The patient terminated her treatment while I was still working on the research project. Much of my understanding of the patient's dynamic in regards to her pull to connect and her tendency to destroy was derived from a retrospective analysis of the data.

From the universe of information, purposeful sampling of communications (i.e., the narrative of the events in her life or in the internal world of her psyche) or actions (i.e., missed appointments, body language, bringing a gift, etc.) that signaled affective forces of attraction, interest, love, admiration, connection, repulsion, rejection, distancing, indifference, destruction, or hate were highlighted. Oscillations or changes in intensity, valence or quality of these affects, and/or the direction in which these affects were aimed were noticed. Who was the agent or source of the affect, and who was the recipient was observed in each instance, as well as any shift in these roles. Any inconsistency between thought or action, and affect, or between discourse and the evoked emotional state was noticed. The story of external events in the patient's life, her descriptions of places, people, and the vicissitudes of her relationships was used as an empirical contrast to her relationships with the analyst and the analytic setting. As expected in a retrospective study, many readings and reiterations of analysis of the data progressively revealed new working hypotheses and further understanding of the dynamics. The data were analyzed both in terms of content (i.e., meaning and themes) and structure (i.e., use of language, flow and interruptions, shifts, and sequence). The content analysis yielded several repetitive themes related to the interplay between the urge to connect and the tendency to destroy. Data gained new meanings as the analysis of parts or concrete incidents and the whole of the treatment were superimposed.

I hope to show how this rigorous process of analysis helped me identify my "blind spots" and my resistance to knowing what was being communicated.

Ann came to treatment because she was experiencing a tormenting conviction that she had been infected with the HIV virus. She could not eat or sleep, and experienced "panic" each time the thought "took over." She had also experienced the obsession that she was pregnant with an unwanted baby that would have to be aborted. Both these fantasies symbolically expressed being invaded or contaminated, after having been in close contact with an "other." Ann expressed intense longing for closeness, as seen in these statements of hers:

> I'm not the most significant person for anyone in my life. Every person I know has a more important person than me in their life. . . . I want to have someone to cuddle up with and watch a movie. I want to give affection to someone, to receive affection, to look forward to seeing someone.

Her initial fantasy regarding the analysis was that of having found an ideal, all good and "providing" other. She valued our time together:

> This is such meaningful talk; this is important stuff.

In Ann's mind, I was endowed with competence and near superhuman power.

> There is a reason for what you do, and you are very careful . . . I feel almost like you can read my mind. . . . You corner me, you manipulate me . . . you have to get to me in order to be able to help me. . . . I know I feel better but I don't know why. I don't see what you do, it's a magic thingy.

We together, could surpass great obstacles:

> Sometimes I leave here feeling I've worked my brain really hard, I feel drained or tired, like something really significant happened . . . it felt wauwww!

Ann was willing to submit to this relationship in order to be helped:

> I feel very vulnerable, like the lid of my head is open and you have your hands in there, it's scary, I really am trusting you with a lot.

In turn, I felt interested, engaged, and thrillingly important. In short, in the transference-countertransference realm, we both shared the fantasy that we were together "as one," and powerful.

A closer look of this material suggests that I would be held against very high standards. Beneath Ann's apparent willingness to submit to the process, she was revealing I was being experienced as manipulative, penetrating, and dangerous. This perception was expressed in Ann's first response to my invitation to use the analytic couch:

> No, you could kill me from back there!

By the time I began my study, I had an intellectual awareness of Ann's negativity. I had also experienced quite a bit of discomfort sitting with her. However, my overarching feeling towards her was very positive. When I began the systematic analysis of my clinical data I was puzzled by the inconsistency between my emotional experience of Ann and her verbal communications. I had been blind to the aggression she had been verbalizing since the very early stages of her treatment. In fact, the data analysis stage proved to be lengthy and very painful, as I was repeatedly confronted with paralyzing feelings of incompetence and stupidity.

Early on in the treatment, Ann became very interested in learning personal information about me, especially whether I had children. She expressed that knowing these things about me would make her feel closer to me. In response to my unwillingness to provide this information, she became restless. I attempted to diffuse this tension by searching for what I thought would be a parallel experience we could discuss that would be, I hoped, inapplicable to our actual relationship. My conscious thought was that I could illustrate how knowing things about me could prevent her from talking freely to me. It is easy to see that my unconscious motivation was also to defend against her attempts to penetrate and violate me. I asked her how she thought it would affect a mother in treatment, to learn that the therapist was infertile; would this information prevent this mother from talking freely about her children? It felt uncanny when Ann responded that this was the fantasy she had about me, that I could not be a mother due to fertility problems. So, although I was attempting to circumvent an emotional issue of hers, I had clearly put my finger on it. Her underlying question was whether I was fertile? That is, she seemed to wonder if I could bear and nurture a "child" (her).

Ann had reported a dream in which she had gone to a pharmacy and, as she was standing in line, a celebrity asked her for some fire to light his cigarette. At the time, I did not find this dream meaningful, until I woke up one night with *Light My Fire* (a 1967 song by The Doors band) stuck in my mind. I had a distinct association with Ann's dream. I thought it was her wish to light my fire. She was communicating her wish to become my center, the source of my desire. She often expressed despair at the idea that she was not important enough to me: "Sometimes I worry that I am nothing more than work to you," suggesting her wish and demand that the other transcend some limit for her sake. Her demands had an extorting quality. Ann often described her compulsion to have sex during her recently terminated relationship:

> I wanted sex all the time, and I got angry if he didn't give it to me . . . I don't know how I didn't kill him! Maybe I left him sterile.

This suggested both the wish to, and the fear of, having left him sterile. Ann's destructiveness was obscured by her self-reflective and empathic qualities. She expressed regret for the damage inflicted upon others. She was seductively sincere, funny, witty, and capable of acting in apparently loving ways. For example, when the analyst brought the analytic couch into the office, Ann phone called and left the following message in a celebratory tone:

> I reserve the right to be the first patient to use the couch!

Ann was very much in tune with me. She recognized the arrival of the couch was something I was excited about and looked forward to. In this session, she said:

> You can say that I was a very good patient; I was the first patient to use your couch; I didn't even turn to see you, except for once. I even baked you a cake.

Retrospectively, I came to understand that her gifts were bait. My response to them would be her measure of my love and appreciation for her. However, the covert stratagem was designed to prove I would fail at giving her the loving feeling she felt she needed.

The more she allowed herself to feel longing for me, the higher her frustration level would climb. Ann bombarded me with questions: What would I do if I met her outside the session? What did I feel for her? How would she know? I could just be "acting." She admitted to "Googling" me, and feeling frustrated at not finding anything. These interchanges were very tense. I experienced her as attempting to penetrate me. I became aware of my need to defend myself; I was stiff, anxious, and felt withholding. She seemed to be setting up this scenario where she would not be able to get her wishes gratified.

As I felt myself clamming up, I wondered if I was experiencing her early feelings of an intrusive mother who tried to penetrate her, or was I feeling the complementary feelings of her mother which experienced Ann as an aggressive, hungry, unsatisfied infant? The theme of penetration, violation of boundaries and transgression was frequent in her discourse in regards to her relationship with the outside world. She often complained of

others being controlling and demanding; she expressed the wish to escape their control through isolation or by breaking up the relationship. On the other hand, she pleasurably described numerous instances in which she perversely took advantage of others or violated them sadistically. These descriptions of her dealings with the outside world were later utilized as contrasting empirical data to help understand the dynamic in her relationship to me.

In a moment of heightened frustration during her therapy, Ann came into a session and, unlike her usual behavior she remained in a prolonged sullen silence. During this silence, she looked intently at family pictures that were displayed in the office by another therapist. She seemed angry that I would not reveal myself in this fashion. She continued to say nothing. Suddenly, I had the fantasy that Ann was reaching into my guts and pulling my insides out. This fantasy had the quality of a visual image. I remember feeling my heart racing. Later in the treatment I understood this event as a wish to rip me open, stealing everything from my inside. Soon after, Ann became very interested in my note taking.

> What do you write? What is important to you? . . . It would be a "dream come true" if someday you gave me something back, something you have learned about me . . . a conclusion of some sorts.

She reported the following fantasy in a provocative tone:

> It would be great to break into a psychologist's office and steal the records, it would be better than stealing the bank, you can then blackmail people with information.

Here again, she wished to have access to my creation—the notes. If she could not take hold of them, she would, in her fantasy, take them by force.

Being in a relationship with Ann required being capable of having diametrically different feelings in different moments. I cannot say that this was comfortable for me, nor that I succeeded at all times. It is entirely possible that my own desire to hold on to a positive relationship played a factor in my unwillingness to feel the full power of her aggression.

External sources were instrumental in raising my awareness of the inconsistencies between my emotions and those communicated by my patient. My personal analyst and my research advisor often cringed at my stories of my patient. Both seemed to wonder why I liked her. Once my advisor said: "I hope you hated her!" My response was sort of from my head, and given no other choice, I conceded. It rumbled in my mind: I knew I was supposed to be able to hate her, but I did not seem to be able to.

The reader may be puzzled by this idea that a therapist must have the capacity to hate a patient. I must clarify that having the capacity to openly experience and recognize all one's feelings is believed by many psychoanalysts to be the most powerful instrument that a therapist has to guide therapeutic responses to a patient (Winnicott, 1949). Through being aware of and using one's feelings, one can help the patient talk and bring his/her thoughts and feelings to consciousness, so that they can be integrated in more healthy

patterns of functioning. In this case, hate and destructive wishes had a driving presence in Ann's psyche. Therefore, these were important to bring to light, first in my own psyche, and later in hers.

Ann's intolerance for knowing her destructive impulses was echoed in my resistance to fully experiencing my own. This was an instance in which my own subjectivity, namely, my own unconscious dynamic interfered with my ability to fully apprehend Ann's psychological struggle. My own need to hold on to a positive, ideal relationship clouded me, driving me to oversee Ann's destructiveness. I believe that this too I had in common with Ann. My identifications with Ann prevented me from wanting to know how "crazy" or destructive she could be.

For Ann, connection was all encompassing. It was based on the fantasy of an all engulfing, all providing merger with the other. Being connected would require breaking down all boundaries between us. Hence her constant challenge of limits that separated her from me, her constant need to penetrate me. On the other hand, if she succeeded to be one with me, the connection would be too scary, and any frustration would be too devastating. Even more scary, would be to destroy the connection with this all engulfing love object by virtue of her own impulses—the destructive impulses of which she had an incipient awareness. At the time, Ann had only one way to deal with this dilemma: to get rid of all connection with the other, and to deny that she could even wish it. This predicament got enacted in the analytic relationship, where, as she became progressively more connected and dependent, she also became more frustrated with not being able to have the ideal relationship she wished for. As her longings were aroused, her destructive impulses were as well.

Ann struggled intensely with her destructive wishes. She attempted to disown them by "planting" them in me. By means of projective identification, Ann would be spared from having to acknowledge unacceptable qualities in herself. Furthermore, she could feel like she was my victim, therefore she was justified in her aggressions towards me. An example of this operation can be seen in Ann's ideas of what would get her "fired" from the treatment. She wondered how she could get rid of me, by setting herself up to be gotten rid of. She had the fantasy that if she "messed" with my children (which at this point she had become convinced I had), or if she "crashed" into my car, I would be forced to stop her treatment. These communications lend evidence to the idea that she had the fantasy of setting me up to be the agent of the treatment's destruction. In doing so, she could sweep over the fact that it was she who had brought this fate upon our relationship.

These fantasies informed me of her negativity and her proclivity to destroy our relationship. By this time, I was aware the treatment was in danger. I attempted to address her destructive impulses to no avail. Ann became cold, remote, and emotionally unshakable. She was refractory to engagement. By disowning her feelings, she gained absolute control over the treatment and the therapist. This strategy helped her to control acting on her destructive impulses, since she also had a certain degree of concern for the once loved therapist. Presumably, Ann had to rid herself of her relationship and attachment to me before she actually destroyed me.

In response to her stark disconnection, I was flooded with intense feelings. I experienced a massive emotional unrest. I felt rage of an intensity that I had never fully experienced before. I became paralyzed, as this was the only way I could keep myself from acting on my own destructive impulses. In addition to rage, I had intense feelings of humiliation and self-recrimination. Had I produced such a disaster? Had my incompetence brought this on? It must have been my fault! These self-attacking thoughts tormented me for a very long time, as if my mind had been invaded by a negative force that weakened me, that shamed me, that punished me. I could understand intellectually that this was an induction of Ann's re-created story with me, but I could not shake myself out of this spell. At this point, Ann had succeeded in projecting the rejected parts of her psyche into mine. She was spared feeling the torment, while I was left "contaminated" with these horrible feelings and impulses. I came to apprehend the state of mind she lived in and so intensely wished to rid herself of. I felt I had failed to give her anything of any value, and experienced intense doubts about my capabilities as a therapist. In essence, I felt infertile.

Her last contact with me was a phone call to request her therapy notes. This request induced in me intense feelings of being violated again, much like the image I had had of emptying my guts. If there was anything of any value, she wanted to be the one to possess it. If I was emptied out, she could negate that I had any good left to give. Then she could discard me painlessly. Leaving the other sterile would be her unconscious way to deny any dependency wishes towards him/her. Ann's unconscious wish to destroy and render the other useless seemed to figure more clearly.

Only after Ann's unexpected termination did I feel the full fledge experience of her destructivity. It was, as she described, the breaking of an emotional dam:

> I make such efforts to stay guarded, to be in control, to not really give myself fully . . . the feelings overwhelm me and it's like a dam that gets thrown down and everything spills over.

My reading and rereading the session data led to new understanding after this event. I have been able to progressively extricate myself from the internal block, of knowing what was there all along. Even as I write this article, I have become aware of my wish to expose the case material in a fashion that would reflect a certain process of decomposition of our therapeutic relationship, rather than highlighting the negativity that this patient struggled with from the start. I believe this reflects my lingering wish to feel I was an important object to her, one that co-created this process. Even in my failure to help her, I prefer the feeling of being a special part of this relationship rather than an object that merely served to facilitate Ann's re-enactment. In contrast, I intellectually hold the belief that her interactions were unconsciously designed to mislead me, all along, so that a core aspect of her relationship to me—namely, her need to destroy our connection—would remain obscure. There is no way of knowing how the treatment might have progressed if I had had less resistance to experiencing all the negativity this patient brought into the office. Theory says I may have been able to help her manage these destructive wishes in more tolerable dosages. Maybe we would still be weaving the struggle between the wish to be connected and the urge to destroy, in each other's presence, in the consulting room, without having sacrificed the relationship.

4. Further Reflections

As the reader can appreciate, throughout the whole treatment and subsequent research process, I experienced intense inchoate emotional reactions and recorded distinct fantasies that I suspected were related to Ann's early life, but was not sure how. Ann appeared in my dreams, and waking hours. Over time, she took up increased space in my mind. In fact, this occupation of my mind, in a way that tormented me, helped me understand the state of mind she inhabited, that had caused her to come to treatment. Ann could never explain with words what I was able to understand through her inductions. My feeling Ann's feelings, in a visceral way was the process that bestowed me understanding of some parts of her unconscious, pre-verbal experiences with early objects. She had no other means of communicating this material, other than by repeating it in my presence, in the transference-countertransference realm.

Needless to say, I endured remarkable discomfort in the process of attending to the more emotional, disintegrated, subjective, and impressionistic data, especially when it did not quite fit a coherent picture. Remaining open to this sense of confusion and bewilderment proved its value in this study, precisely because the feelings induced in the process illustrated an essential quality of the patient's dynamic. The systematic contrast between my affective experience and the empirical data substantiated my interpretations. Over multiple iterations of analysis, my initially distorted understanding of my patient became more clear and objective.

Researchers in the social sciences are seldom afforded the continuity of the relationship, and the highly predictable environment that psychoanalysis offers. However, we can assume that transference and countertransference phenomena occur in the interactions between researcher and subject, and influence the ways in which they come to be in each other's presence. Through methods such as interviews and participant observations, the researcher impinges on the subject in unknown ways, and the subject may impact the researcher in unexpected ways too. Sometimes this impact can be inferred from the verbal discourse of both, the subject and the researcher, as the researcher develops the narrative of the interactions with the subject. But often the only indication of this unexpected effect can be inferred from the emotional, inchoate input registered by the researcher's subjectivity. Paying attention to the raw emotional inductions experienced during the research process, and to any tendency to dismiss, reject, or "barricade" these reactions, can prove invaluable to the interpretative process. Especially in research designs where subject and researcher have repeated contact, the transference-countertransference dynamic has an opportunity to reveal itself as a meaningful contribution to some essential aspect of the subject's unconscious dynamic.

The psychoanalytic concepts presented in this article can be extrapolated to social research in various contexts where human interactions are involved. Doing so would make a compelling case for utilizing subjectivity as a source of meaningful data in such contexts. Any resistance to using subjectivity as an instrument, whether arising from the fear of self-revelation or the apprehension that research quality may suffer, can be challenged by demonstrating the value of subjectivity as in the case described here.

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