Chapter 11

An Intersubjective Approach to Conjoint Therapy

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It is the repeated observation throughout the literature (Dicks, 1967; Framo, 1972; Bowen, 1978; Slipp, 1984; Scharff and Scharff, 1991) that spouses are bonded in marriage with similar unconscious conflictual hopes and fears. That is, they deeply hope that their sense of self will finally be accepted, affirmed, and encouraged while they also deeply fear that it will not be. From the self-psychological and intersubjective perspectives, this conflict is precisely the same for the patient entering treatment. As Stolorow, Brandchaft, and Atwood (1987) have noted, patients enter treatment “with hopes for an intersubjective context in which thwarted strivings for differentiated selfhood may become liberated ... and with fears that the violations of self-experience encountered in childhood will be repeated with the analyst” (p. 65).

THE SIX-STEP MODEL OF CONJOINT THERAPY

This chapter proposes a six-step model of conjoint therapy for empathically exploring marital conflict. As each step is presented, the key concepts of intersubjective theory upon which it is based are articulated. In

I would like to acknowledge my deep appreciation to Dr. Robert Stolorow for his critical feedback in developing the ideas expressed in this chapter as well as for his help in my maturation as a clinician. I am deeply indebted to “Bart” and “Tina” for consenting to my use of our work as an example of the intersubjective approach to conjoint therapy. Their actual names and other identificatory material have been altered to protect their privacy.
addition, the principles of practice found within each step will be illustrated through the case study of my treatment of a married couple, hereafter known as Bart and Tina.

The six steps of the model are as follows:
1. Shows how the therapist's attunement to each spouse's subjectivity instills hope, perspective, and the possibility for renewed growth
2. Articulates the pivotal importance of the therapist's assertion that neither spouse has a more correct version of reality than the other
3. Demonstrates how each partner's complaint arises from a developmental history of thwarted self-object yearnings, which emanate from malattunements and/or traumata in past self-object and self-self-object relationships
4. Illustrates how each partner's tendency to reenact his or her conflictual past is in the service of maintaining his or her sense of self-organization (That is, the clash between the inner imperative to strive to live in accordance with one's vitalizing affective core is in conflict with the imperative to conform to the emotional needs of one's caregivers.)
5. Discusses how enhancing each partner's capacity to be introspective in the presence of the other partner accentuates each one's sense of ownership of the relationship conflict
6. Facilitates each partner's capacity to attune to and support the other's introspection and personal growth

A momentary caveat regarding this six-step model is that it should not be seen as some fixed linear, or even hierarchical, progression. A better metaphor is that of the staircases found in the M. C. Escher print in which the top landing of the uppermost staircase paradoxically is the beginning landing of the lowest staircase. Hence, as our patients reach the sixth step of this model, they find themselves performing for one another precisely what the therapist does at Step 1, that is, demonstrating attunement to the other's yearnings and longings. These steps will be ascended many times throughout the course of treatment if not even within a single session.

**Step 1**

In the first critical step of the model the therapist demonstrates empathic attunement to each spouse's subjective experience by listening carefully to each one's concerns while titrating from their complaints those self-object longings that have gone unmet and noting the themes of disappointment each one reveals.

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1The Escher print that inspired this association is titled *Ascending and Descending* (Locher, 1971).
Several key elements of intersubjectivity must first be presented before the importance of this step can be fully appreciated. The first of these is the intersubjectivist view of transference as a self-organizing activity that, contrary to other psychoanalytic definitions, involves neither regression, displacement, projection, nor distortion and refers to how “the patient assimilates the analytic relationship into thematic structures of his personal subjective world. The transference is actually a microcosm of the patient’s total psychological life, and the analysis of the transference provides a focal point around which the patterns dominating his existence as a whole can be clarified, understood, and thereby transformed” (Stolorow, Brandchaft, and Atwood, 1987, emphasis in original).

While there can be multiple dimensions of transference, Stolorow and Atwood (1992) suggest that it can be most readily conceptualized as an unconscious organizing activity existing in two dimensions or consisting of two broad classes of organizing principles:

In one ... we term the selfobject dimension, the patient longs for the analyst to provide selfobject experiences that were missing or insufficient during the formative years. In the other, called the repetitive dimension, ... which is a source of conflict and resistance, the patient expects and fears a repetition with the analyst of early experiences of developmental failure. These two dimensions continually oscillate between the experiential foreground and background of the transference in concert with perceptions of the analyst’s varying attunement to the patient’s emotional states and needs (pp. 3–4, emphasis added).

In conjoint therapy two of the most powerful transference-prone relationships in a patient’s life—the marital and the therapeutic—coexist. Often the couple is locked into reciprocally antagonistic, repetitive dimension transferences toward one another while each spouse is experiencing the yearned-for selfobject in the transference toward the therapist. Indeed, the very success of his or her attunement makes the therapist the longed-for object of validation for each spouse, a role that, as will be discussed shortly, serves a critical function in restoring hope in the viability of the couple’s relationship.

4 Other dimensions include the following: (1) fulfill cherished wishes and urgent desires, (2) provide moral restraint and self punishment, (3) aid adaptation to difficult realities, (4) maintain or restore precarious, disintegration-prone self and object images, and (5) defensively ward off configurations of experience that one felt to be conflictual or dangerous” (Stolorow, Brandchaft, and Atwood, 1987, pp. 37–38).

5 Framer (1972), in particular, has used the concepts of family transference and countertransference to address the organization of emotional reactivity in a couple’s relationship and its linkage to their early object relations experiences.
Selfobject functions, of course, are evident when “an object that a person experiences as incompletely separate from himself . . . serves to maintain his sense of self” (Atwood and Stolorow, 1984, p. 39). According to Stolorow et al. (1987), “selfobject functions pertain fundamentally to the integration of affect into the organization of self experience” (p. 66). And in a point critical to this chapter, the same authors state that “the need for selfobject ties pertains most centrally to the need for attuned responsiveness to affect states in all stages of the life cycle” (p. 66, emphasis added). In other words, no amount of differentiation of self ever results in a self that does not yearn for selfobject relationships. Nor, as Kohut (1977) noted, would life be very interesting if we did evolve to such a state.

Hence, a sense of self that emerges from good-enough attunement, that is, good-enough responsiveness to our affect states, strengthens our experience of cohesion (sensing the demarcation of our own boundaries in space), our experience of continuity (experiencing ourselves as relatively the same), and our sense of self-esteem. These three dimensions—cohesion, continuity, and self-esteem—represent a kind of continuum of health versus pathology, a theme to be developed momentarily.

Selfobject functions relevant to intersubjectivity include Kohut’s original tripolar system as well as four others (discussed in the following paragraph). Kohut emphasized the critical functions of mirroring the child’s experiences of pride, expansiveness, efficacy, and pleasure; of providing a source of idealized attributes, such as the caregiver’s wisdom, strength, and competence, especially at times when the child is flooded with anxiety, feelings of vulnerability, or distress; and of exhibiting a quality of twinnship, or “alter-ego-ness,” of confirming the child’s sense of being like others.

Emphasizing the critical role that integration of affect plays in development, Stolorow et al. (1987) expanded on Kohut’s original selfobject functions, adding four that they believe are also critical to optimal self structuralization. These include the selfobject functions of facilitating the capacity of children (1) to differentiate and articulate their feelings; (2) to synthesize their affectively discrepant experiences (i.e., integrating good and bad feelings pertaining to themselves and to others); (3) to tolerate strong affects and utilize them as an important source of information about themselves; and (4) to desomatize affect (pp. 70–73).

*A clear implication of this is the fact that a couple’s relationship inevitably involves each partner yearning for the other’s attunement to selfobject states—or, simply translated, to both their needs and feelings. Indeed, a mutual and unconscious system of expectations emerges that becomes the inevitable source of marital discord and also reveals the potential “cure.”*
Hence, a picture of an optimal marriage might entail two adults who, without too many disruptions, reciprocally share in admiring one another’s styles of expressiveness and expansiveness; take comfort in each other’s soothing; have a sufficient mix of common qualities, interests, and beliefs; encourage one another’s verbalization of feelings and experience; reckon with and tolerate inevitable disappointments; and utilize their own strong feelings as signals that indicate something to explore within themselves, instead of becoming fixated in blaming their spouse for their disappointment.

The therapist’s attunement to the selfobject dimension of each spouse’s transference also allows the therapist to begin to detect how easily disrupted each spouse’s sense of self becomes when an important selfobject function fails. This provides an early means of detecting how precariously organized each patient’s self structure is and helps determine the developmental level of the selfobject bond that each spouse has with the partner and that each will begin to develop toward the therapist. Indeed, Stolorow et al. postulate a severity continuum of psychopathology pertaining to disruptions in a person’s sense of self-esteem, continuity, and coherence. The least severe cases involve individuals with diminished self-esteem, which makes them vulnerable to experiences of self-loathing when they engage in activities demonstrative of their ambition, talent, or expansiveness. Moderately severe cases include those with diminished self-esteem and disruptions in self continuity or temporal stability; these individuals intermittently experience themselves as unreal or as either all good or all bad.

The most severe cases include those with the moderately severe characteristics along with disruptions in their sense of structural cohesion or self coherence. In such cases personal spatial boundaries are unclear, amplifying a sense of vulnerability and promoting the need to take extreme measures (e.g., self-mutilation) to reconstitute the self.

For couples in which the partners suffer more profound self disorders of the moderate to most severe degree, the consequences can be particularly threatening and include the following: delusional thought processes, abuse, abandonment, suicide threats, and self-destructive activities such as substance abuse. Partners with the least severe self disorders may dysfunctionally enact various forms of triangulation, by, for example, having an affair or incorporating one of their children or some other family member into their conflict.

The range of possible spousal dysfunctional adaptations is too lengthy to seriously address here. The point is that they all have their origins in the spouses experiencing one another as incapable of being (frequently the attribution is “unwilling to be”) understanding and responsive to the other’s emotional needs. What is essential, however, is that the therapist
help the spouses understand that each one's enactments are in the service of restoring or maintaining a sense of self and that selfhood is vulnerable to disruption when one repeatedly experiences rejection of one's selfobject longings. This latter point will be elaborated further under Step 4.

The success of the therapist's attunement in Step 1 will frequently have immediate and visible results. These can include a noticeable diminishing in the defensive manner in which each spouse relates to the partner and to the therapist. With somewhat greater relaxation, the couple can temporarily suspend their more concrete interpretations of behavior and may even be more receptive to alternative viewpoints. This experience tends to stimulate hope within the couple that they can be helped. First of all, new possibilities emerge when the same therapist who understands the husband's point of view also understands the wife's. This leads to each partner accepting that there may be something to the other's perspective. (This hopeful scenario is, of course, predicated on the assumption that both spouses truly want to make their relationship work. Cases in which attendance at marital therapy sessions disguises a covert effort by a spouse with "one foot out the door" to leave his or her partner may present considerably more resistance to the therapist's attunement.)

Part of the couple's heightened sense of hope also arises from the mobilization of their needs and longings in their transference to the therapist. Stolorow has suggested that a patient with idealizing transference longings may find in the therapist a hoped-for protective parent. Or the patient with a mirroring transference may finally experience a sense of being treasured. The hope of overcoming a sense of lifelong aloneness may arise in the patient with a twinship transference. Or the therapist may be experienced through his or her confrontations as "an idealizable, benign adversary," facilitating the patient's demarcation of self boundaries (Stolorow, 1994, p. 50).

Inevitably, these selfobject longings will be disappointed. What is critical is for the therapist to empathically acknowledge and explore their meanings, since such failures are inevitable. This topic will be addressed in far greater detail under the discussion of Step 6. Meanwhile the following discussion of my first session with Bart and Tina illustrates the key elements of Step 1.

**Bart and Tina (Step 1)**

Bart and Tina, each 28 years old, had been married for two years and involved in a close relationship for a total of seven when they came to their first conjoint session. Neither had been in treatment before. On the surface, their complaints seemed commonplace, focusing on sex
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and money. Exploration revealed that Tina felt Bart had no respect for her and only wanted her for sex and that she felt painfully reprimanded by him for her inability to maintain continuous employment in her line of work, the highly volatile entertainment industry. Bart defended himself by providing a detailed list of Tina’s lengthy stretches of unemployment. He indicated how burdened he felt as the sole provider and how thwarted he felt in his ambition to save money to buy a home in preparation for beginning a family. While taking umbrage with Tina’s statement that all he wanted was sex, Bart did underscore how deprived he felt over Tina’s withholding it from him.

Tina revealed that she had lost interest in having sex out of fear of becoming pregnant, a fear based on her belief that Bart would insist she have an abortion since they did not yet own a house. She also felt strongly that Bart really did not want to have children. She was quite certain that they meant nothing more to him than ornamental extensions of the "normal middle-class family." On top of all of this, she verbalized her grave suspicion that Bart would be an abusive father.

Adopting the premise that spouses yearn for their self strivings to be affirmed and encouraged while anticipating that they won’t be, I explored with Bart and Tina what they were wanting from one another and how these desires felt unmet. As they spoke, I listened carefully for the selfobject and repetitive dimensions of the transference in their relationship.

Accepting at face value Bart’s need to buy a house before starting a family, I explored with him what it would mean if this did not occur. What emerged in far greater detail than can be reported here was his dread of fear of providing poorly for his children and wife. There appeared to be a strong, closely concealed undercurrent of feelings of personal inadequacy, which included the anticipation of probable failure and unremitting humiliation. Bart’s pressing urgency that Tina remain employed (so as to help provide money) indicated that he tended to view her employment as a concrete antidote to his sense of an impending collapse of his own self-esteem.

Exploring Tina’s complaint unveiled her fear that Bart’s reluctance to support her between jobs would mean she would have to take full-time work that would make her unavailable for opportunities in her field. She worried that his pressuring her to take any job would inevitably lead her into a life of subjugation to work she would dread.

Attuning myself to each spouse’s fears helped me begin to see both their longings and their feared repetitions. Each seemed to yearn for the other to serve some idealized protective function but had come to expect that this yearning would be rejected. This fear left both spouses perilously vulnerable to disruptive affect states. For Bart this entailed a
dreaded fear of inadequacy and humiliation, for Tina anticipation of subjegation and abuse.

The couple were momentarily relieved by my interpretations and found especially important my formulation of the circularly causal linkage of failed selfobject functions. That is, Bart’s need for Tina to work to offset his fears of being an insufficient provider induced a fear of subjugation in Tina. Conversely, her need for Bart’s unquestioning support of her financially unreliable career induced in him the fear that he would be insufficient in his role as sole provider.

What was also glaring in this initial session was the fact that Bart and Tina seemed unable to tolerate strong affect states within themselves or from one another. Nor was there any evidence of their being able to differentiate and articulate their own feelings or to empathize with one another. A deeper understanding of why all of this was the case emerged during the history-taking sessions described in Step 3. Meanwhile, this initial session appeared to institute enough hope for them both to agree to return for two more assessment sessions. It appeared that my inquiry and interpretations conveyed to them both that their views would be valued, respected, and clarified.

**Step 2**

Critical to the second step is the therapist’s assertion that neither spouse’s version of reality is seen as being more correct than the other’s. This value is derived from the intersubjectivist acknowledgment of the ultimate validity of each patient’s experience, an acknowledgment that manifests itself in a tenacious commitment to the empathic exploration of each patient’s subjectivity as it occurs in the intersubjective field of the therapeutic relationship and, for purposes of this model, as it also arises in the marital dyad.

Nor, for that matter, does the therapist presume to know the correct version of reality. The treatment is optimally a three-way exploration of the two subjectivities of the marital partners through the partners’ own emerging self-understanding and through the interpretive analogues the therapist creates on the basis of what he or she understands. These analogues stem from multiple sources, such as “the analyst’s own childhood history, his personal analysis, his recollections of other patients’ analyses or of case reports by other analysts, his readings of great works of literature, his knowledge of developmental research, and his studies of psychoanalytic theories” (Stolorow, 1994, p. 45). And to this list I would include analogues from his or her own marital experience.

Adherence to this step cannot be overemphasized. Even though each spouse’s view is purely subjective, its validity must be acknowledged.
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if not, each will feel that his or her version of what is "real" is being
trivialized and will consequently face once again the traumatization of
being told that his or her experience is not valid. Furthermore, any other
view of reality imposed upon one spouse by the other or by the ther-
pist induces resistance, for resistance, as seen from the intersubjective
pective, is a means of protecting the self from repetitive traumatic
periences of being misunderstood.

This principle, that one spouse's subjective perspective is not more
valid that another's, is pivotal to this entire approach to conjoint therapy;
undoing repetitive transferences from past invalidating or traumatizing
devotional relationships hinges upon it.

Adherence to this principle is equally important in combating the
most common countertransference's problem of conjoint therapy, namely,
the therapist siding with one spouse over the other. In a sense, it is
inevitable that the therapist will find one spouse's point of view more
plausible, meaningful, interesting, attractive, seductive, or even intimi-
dating than the other (to mention just a few of the qualities that can
support his or her biased view). Illustration of an early countertransference
experience of mine with Bart and Tina will be shared briefly.

Meanwhile, the point cannot be overemphasized that when therapists
experience themselves as inclined to accept one spouse's version of
reality over the other's, especially when this becomes a fairly enduring
impression, they must deeply investigate what form of countertransference
reaction is occurring. The critical question becomes what in the
therapist's own self-observer organization puts him or her into a state
of intersubjective conjunction with one spouse and a state of intersub-
jective disjunction with the other (Stolorow and Atwood, 1992).

**Bart and Tina (Step 2)**

Throughout the course of treatment therapists are vulnerable to instances
of conjunction or disjunction that if left unanalyzed will result in a ther-
apeutic impasse. An example of a potential disjunction emerged in my
first session with Bart and Tina.

In her reporting of why she feared that Bart might become abusive
(despite the fact that there had been no occurrence of abuse during
their seven-year relationship) Tina shared the following stories: One day
she came home and found Bart that had cut out a picture of his mother,
attached it to a piece of cardboard, and hung it by the neck with the

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3The term, as applied to this model, refers to the totalistic concept of counter-
transference, that is, covering all aspects of the therapist's feelings toward his or her
patients (Epstein and Feiner, 1983).
fireplace chain. On another occasion Bart found lying on the roadside the head of a large baby doll, which he then stuck on the trailer hitch knob of his four-wheel-drive vehicle. Later, embellishing upon this macabre image, he took red fingernail polish and painted streaks beneath its eyes to suggest blood flowing from them.

It was most disturbing for me when I explored with Bart his motivation to do these things, for he merely grinned sheepishly and giggled anxiously but could say little more than that they were all performed in jest. The day after this initial session I shared these anecdotes while consulting with a colleague. In a state of horror that surpassed my own he advised me to work with the couple until the husband’s inevitable precipitate departure, given his seeming paucity of insight, and then work with the wife in individual therapy to help her work through divorcing this “clearly disturbed” man.

There are those within psychoanalysis who would likely subscribe to this recommendation, particularly those who emphasize the role of instinctual aggressive drives, which would likely be surmised from these anecdotes as being under only minimal control in Bart. Fortunately, intersubjectivity does not subscribe to this but instead insists upon exploring the meanings of such apparent aberrations, no matter how alarming they may initially strike us as being. What I hope will become evident through further presentation of this case is the fact that Bart was indeed a far more sensitive man than any of the evidence presented thus far would suggest—so sensitive as to be able to detect (beyond his own conscious discernment), a trace of judgmental reaction from me. Clearly, neither Tina nor I was providing Bart with an optimal intersubjective context in which to explore the meaning of his actions. It was only from developmental background data that he supplied during subsequent sessions that I began to understand his behavior.

**Step 3**

While careful attunement and demonstration that neither spouse’s version of reality is the superior one help focus each partner on his or her own subjective experience, it is nevertheless important to show how each one’s experience arises in the context of the other. That is, for both spouses there is a developmental history of thwarted selfobject yearnings or failed selfobject functions that reflects malattunements and/or traumas in past self-object, and self-selfobject relationships. This is critical in helping spouses to clarify and correct any intentions inaccurately attributed to their own and to the other’s actions (or reactions).

During Step 3 we continue to observe how the couple interacts but
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t relationships. This is critical t any intentions inaccurately actions (or reactions), how the couple interacts but now also gather information regarding past self-object and self-selfobject relationships, from which we glean those invariant organizing principles that govern each spouse’s sense of self, principles that are both highly subjective and “prereflectively unconscious”—that is, they are beyond an individual’s normal reflection and can be made conscious only through inferences from his or her history of relationships and current interactions, and by observing how he or she relates to the therapist (Stolorow and Atwood, 1992).

At the end of the initial session (i.e., Steps 1 and 2) I explain that I would like to spend one session with each spouse to gather information regarding background, that is, relationships with members of the family of origin and of the extended family and with significant others. I ask that the other spouse also attend this session and participate as a “silent observer.” This technique is hardly unusual and, with some modification, is employed by other modes of conjoint therapy (see Bowen, 1978). The reason for having the other spouse as a silent observer is to provide an opportunity for him or her to hear anew his or her spouse’s life story, as well as experience the therapist’s empathic-introspective method of exploring this background. (This procedure anticipates later development of Steps 5 and 6.)

Occasionally, the silent spouse also provides a meaningful piece of omitted information. Although this momentarily breaks the stance of silence, important information can be revealed that the interviewed spouse might otherwise feel guilty about reporting (such as a complaint regarding his or her parents) but feels fine about having his or her spouse discuss. Any argumentation, however, is immediately stopped, and the couple is reminded that the purpose of the session is one of information gathering.

At the end of the session I ask the silent spouse to share how he or she felt while listening. Frequently, spouses who have just played the role of the silent observer say that they were quite moved and add (quite insightfully) that they either were unaware of or had forgotten this background information during their marital quarrels.6

Often, and for good reason, the assessment period is one of the calmest periods in the couple’s treatment. To begin with, both partners feel understood. Also, what is going on between them is making sense for the first time. Thus, the hope that began in the initial session becomes

6A scenario to which the therapist should be alert is the possibility that this background information might be used against the reporting spouse during fights. These assessment sessions are helpful in ferreting out how prone the couple might be to using each other’s backgrounds against one another. The therapist must quickly illustrate how destructive this will be, as it is anathema to any evolution toward Steps 4, 5, and 6.
somewhat more galvanized in these two sessions. Finally, since neither spouse necessarily expects any change during the assessment period, they both tend to feel less pressured. Reports in the next session of having done something pleasant together or of having had sex for the first time in a while are not uncommon. Of course, this state of calm is soon disrupted.

The culmination of the assessment is marked by the therapist’s sharing with the couple deeper, more complex versions of his or her initial hypotheses regarding each partner’s relational conflict with the other. (This statement anticipates the more detailed work of Step 4, where the couple’s conflicts are seen as the expectable collision of the spouses’ subjective invariant principles organizing their selfobject yearnings and their expectations (albeit unconscious) of repetitive malattunements.) Following this, each spouse’s goals for treatment are discussed. For couples evidencing anxiety regarding the duration of treatment, a trial period of three months is typically recommended, with an evaluation at the end to determine where to go from there. My experience, since I began adhering to these practice principles, is that the majority of couples stay in treatment for at least a year and a half and frequently for several years.

**Bart and Tina (Step 3: Developmental Background)**

Tina, the youngest of three children, had a brother and sister, nine years and seven years older, respectively. As the youngest, Tina was always treated as the baby, a position she rebelled against from an early age. The primary target of her rebellion was her overprotective, domineering mother. While Tina was apparently close to her mother up to the age of three, her nascent drive for independence only provoked her mother’s rage. As if to retaliate against Tina’s strivings, her mother would become emotionally closed down to Tina whenever she was not a compliant little girl. “My mother,” Tina stated, “is a woman who needs people to need her and becomes critical the moment we don’t. Even to this day, she ridicules my career, my figure, and my clothes.”

Encouragement for Tina’s independence, however, did come from her live-in maternal grandmother, Edith, who died when Tina was ten years old. Ironically, Tina’s mother (herself the youngest of 14 children) was very dependent on Grandma Edith’s approval. Because she could not disapprove her own mother, Tina’s mom would permit Tina to do

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7There is nothing written in stone about having only two assessment sessions. Some couples need more. Indeed, one couple took ten sessions to provide the detailed history they felt they needed to present. They attended treatment for approximately six more sessions and terminated with a very satisfactory result.
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loose after my grandmother died, since both my mother and I lost the

ly upon whom we could rely.” Thereafter, all of the mother’s

esies and resentments surfaced, embroiling mother and daughter in

lict. Meanwhile, Tina’s father, a generally absent figure in her life,
told her that she had to do everything her mother told her to do or else

mother would die from a “burst blood vessel,” a statement that was

embolic of how fragile and reactive the mother was. Tina’s father

ther give in to his wife or flee to avoid prolonging their fre-

quent, passionate screaming matches. Mostly, Tina recalled that her

ther worked long hours, was seldom home for dinner, and hated his

From this Tina surmised that he also felt terribly inadequate as a

vider.

By her junior high school years, Tina’s independent streak could no

longer easily be suppressed. Fortunately, a benevolent bachelor

bor, whom the family called “Uncle Earline,” stepped in and took over

Where Grandma Edith had left off. He provided guidance, focus, and

ancial support for Tina to pursue her ambitions in music, art, and

lama. He even bought her a car when she turned 16 and created a

rust fund in her name, which she used to attend a private college. As

he was a close friend of the family and frequently spent his lonely

nings with them, the parents accepted these presents without pro-

t. Tina acknowledged, “My Uncle Earline and Grandma Edith were

ore father and mother figures to me than were my own parents.”

art also came from an intact family, with a brother four years his

er. He stated that between ages two and six his brother, David,
attempted to kill him several times. Subsequent to this, their parents

ought psychiatric help for David, but this did not entirely stop the

use, which several times ended with Bart suffering contusions and

acations and more than once being completely knocked out. He recalled

ny trips to the emergency room during his childhood and described

is head as a continuous “railroad track of scars.” The brothers’ last

ight occurred when Bart turned 14 and was finally big enough to be a

atch.

Although ineffectual in stopping the fighting, Bart’s parents did insist

on a code of manners, which meant that one must act “nicely,” that is,

ever show or discuss feelings of anger, fear, or humiliation. This code

was instilled by the mother in particular, the more dominant and disci-

inary figure in Bart’s life (his father was away from home a great deal

a traveling salesman). While not physically abusive, his mother would

ame Bart into behaving and was not above doing so with a thinly

eled aggressive tone. This was especially evident in a story Bart told

how during his adolescence his mother “mockingly” threatened that
if he ever contracted a venereal disease she would "cut it off with a
dull knife."

While Bart did not remember much about his childhood, he had vivid
memories associated with a congenital deformity that made his left leg
two inches longer than his right. This forced him to wear special ortho-
pedic shoes throughout grade school and interfered with his participation
in normal physical education activities. He recalled feeling deeply
humiliated until seventh grade, at which time an operation stunted the
growth of the left leg so that the right could finally equal it in length.
After the surgery Bart took to sports with a vengeance, compensating
for all his years of feeling so handicapped. This response exemplified
the behavior pattern Bart followed in adolescence: he worked hard at
everything he did. He was a decent student and worked part-time, sav-
ing his money so that he could learn to snow- and water-ski. He also
became active in a Christian social group. The emphasis during this
period was on getting away from his family and essentially raising himself.

The information on the developmental backgrounds of Bart and Tina
was indispensable to deepening my initial hypotheses regarding their
core conflicts. Clearly, the yearnings of both spouses for idealized self-
object functions were now more readily understandable. Although Tina’s
yearning for support of her natural talents and autonomy had been par-
tially fulfilled by Grandma Edith and Uncle Earnie, she also felt under-
mined by shame and guilt induced by a mother who functioned more
as a sibling rival and by a father whose own life was subjugated to a
career he hated. Bart, having had little experience in feeling protected
while growing up, compensated by rearing himself during his adoles-
cence. Nevertheless, beneath this exterior of seeming maturity was a lit-
tle boy, concealing his deformities and feeling terribly frightened that he
would not be able to provide for himself, his wife, and his future chil-
dren. It is not difficult to imagine that his contempt for both of his care-
givers and for his own yearning for their care could manifest itself in the
macabre presentation of his mother’s picture and of the bleeding-eyed
baby doll.

Step 4

Having helped the couple identify the thematic roots of their complaints
in their early relationships with caregivers, the therapist must now
demonstrate how each spouse’s conflictual past continues to be reen-
acted in the present. These conflicts arise from a childhood history of
repeated, complex selfobject failures, which Stolorow (1991) has
schematically conceptualized as having occurred in two phases:
In the first phase, a primary selfobject need is met with rebuff or disappointment by a caregiver, producing a painful emotional reaction. In the second phase, the child experiences a secondary selfobject longing for an attuned response that would modulate, contain, and ameliorate his painful reactive affect state. But parents who repeatedly rebuff primary selfobject needs are usually not able to provide attuned responsiveness to the child’s emotional reactions. The child perceives that his painful reactive feelings are unwelcome or damaging to the caregiver and must be defensively sequestered in order to preserve the needed bond [p. 15].

It is my hypothesis that this pattern of early relationships with caregivers is at the heart of most instances of unresolvable marital conflict and is evident in the reciprocal enactments that inadvertently create self-fulfilling prophecies of discord. By enactments, I am referring to those “recurrent patterns of conduct [that] serve to actualize the nuclear configurations of self and object that constitute a person’s character. Such patterns of conduct may include inducing others to act in predetermined ways, so that a thematic isomorphism is created between the ordering of the subjective and the interpersonal fields” (Atwood and Stolorow, 1984).

These enactments are based on the assumption that one’s spouse will rebuff, disappoint, or degrade one’s longings; that the painful reaction that one has to this cannot possibly be understood by the spouse; and that therefore one cannot expect any assistance from the other to help modulate, contain, or ameliorate one’s disruptive affect state. Finally, the beleaguered spouse assumes that any candid discussion of this will threaten the marital bond.

Of critical importance in Step 4 is the expansion of this unidirectional formulation into a bidirectional one. Recalling that a common theme of childhood experience is the necessity for children to perform selfobject functions for their parents, frequently at the sacrifice of their own self-strivings, we can begin to see how the very revelation of selfobject needs can provoke in each spouse a repetitive defensive reaction, one fraught with misattributions regarding the other’s intentions and potentially coupled with shaming, accusatory, and recriminating interpretations of the other’s behaviors. As all of this occurs, spouses become progressively more isolated from one another, each concretizing his or her version of their problems and assuming it is the accurate one. As this process becomes circularly reinforced and affectively amplified, the couple becomes even further polarized, with tenuous repairs to the relationship attempted intermittently while each spouse maintains a true-self position.

Nevertheless, we can see how each spouse’s self organization is restored. The partners are now on familiar ground, having recreated
within their marriage the essential constitutional factors of their upbringing. Although they each fall far short of attaining what they yearn for in terms of self striving and enhanced affect in their relationship, they do glean from their troubled interaction a kind of homeostasis in which known levels of self cohesion and feelings of continuity and worth are maintained.

**Bart and Tina (Step 4)**

As has been noted, Tina’s yearning was that Bart would encourage and support her self strivings just as Grandma Edith and Uncle Earnie had. What she expected, however, was a replication of her parents’ punitively withholding and critical styles. Having also been raised in a critical family, Bart was susceptible to taking on the very roles Tina most detested: those of the critical, constraining mother and of the affectively absent father.

This pattern manifested itself through interactions in which Tina, to use Bart’s word, would “blindside” him with some news and his subsequent startled reaction would come across to her as critical and rebuking. One such interaction was replicated each time she failed to discuss her plans with him in advance—and thereby lost the opportunity to secure his support and encouragement, a response that could only genuinely come from Bart after he had the opportunity to experience and explore his initial reaction (i.e., the one he was likely to have, given his own organizing principles).

While there are countless specific examples of this interaction, one illustration of it is as follows: In anticipating that Bart would not be supportive, Tina did not tell him when her last day of work would be. This resulted in Bart feeling “blindsided” when he learned that she was no longer working, particularly after he had started to feel some security about her employment. Not only did the news startle Bart, but it made him wary of when he would once again be struck with the same onerous news.

Although treatment began to break up this enactment, it resurfaced in one session when Tina, suffering abuse from her employer, informed Bart that she was quitting her job no matter what he said. This deeply hurt Bart, as it obviated his genuine support for her decision. Further, it threatened to preclude a scenario in which he supported her emotionally while she hung on long enough to look for another job before quitting, a scenario in which the true self needs of both spouses could be protected. As it turned out, our exploration of how Tina’s female boss’s style replicated some of the shaming behaviors of her mother, in combination with Bart’s supportive response, enabled Tina to confront her boss and to save her job.
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Because Bart came from an environment in which he was severely deprived of attunement, his longings were such a powerful source of shame that he was barely even conscious of them. What gradually became evident in treatment was his deep need to feel admired by Tina, to have her believe in him, and to have her be a source of security to whom he could turn without having to feel worthless. What he experienced, however, when his longings were not automatically accepted and met by Tina was the conviction that he was deficient, unwelcome, and undesirable to her. Given this anticipated selfobject failure, Bart continued to disavow his own feelings. Unfortunately, this left Tina bewildered and frustrated. At times it also panicked her, given her childhood experience of sexual abuse (which will be discussed in the next section). As she stated with considerable affect, “I’m scared because I don’t know what must really be going on in Bart’s mind.”

Meanwhile, Bart’s enactments inevitably produced the very humiliation that he dreaded. For example, his jesting to his male friends in front of Tina about the “nature of women” ultimately produced searing attacks from her. By quickly securing the politically correct high ground, she effectively made him feel like a “reprimanded little boy.”

In another episode Bart bought Tina some very glamorous and revealing clothes to take on a vacation and then packed only casual wear for himself. Insulted, she told him she felt as if she were a high-priced hooker with a college student. This comment devastated Bart since he had sacrificed the purchase of new clothes for himself in buying his wife something he felt (although his taste in clothes was miserably attuned to hers) would persuade her that he found her alluring and desirable.

We see in just a few examples that the very anticipation that one’s selfobject needs will be thwarted mobilizes a kind of preemptive behavior that can be experienced as an attack because it lacks attunement to the selfobject needs of the other. The irony in this is that both partners participate in bringing upon themselves that which they most dread. What is also most striking is the circular fit of these negative self-fulfilling prophecies.

For example, Tina’s fear of Bart’s criticism resulted in “blindsiding” pronouncements that then, having panicked him, produced the dreaded critical response instead of the yearned-for support. Conversely, Bart’s

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4 It is important that this discussion not be seen as a reiteration of projective identification, in which the unconscious intent of each spouse is to rid the self of an undesirable affect by “projecting” it into the partner and thereby inducing that mate to “identify” with the so-called projection. My position is that the yearning is to have the selfobject function met and the anticipation is that it won’t be. Hence, each responds in a defensive style, creating an intersubjective collision course in which the selfobject needs of neither spouse are fulfilled.
disavowed affect, itself a defense against the anticipation that his self-object longings would be rebuffed, left Tina bewildered and mistrustful both of Bart’s true motivations and of how supportive he would be to her. This all resulted in Tina’s misinterpretation of Bart’s meanings and in a response from her that evoked his worst fear, namely, that she would see him as inadequate (as, indeed, he saw himself).

The critically important empathic connection is that each spouse’s dysfunctional interactional style is all in the service of maintaining a sense of self organization and preserving the relationship tie—for worse, if it cannot be made for better. Once it is apparent that a couple can begin to readily link their past object relational patterns to those operating in their current relationship, they are ready to make the important move to being more introspective in each other’s presence.

**Step 5**

During Step 5 I continue the work of the previous step, making the thematic connection between past failings and those experienced in the present. But now I also concentrate more on helping both spouses recognize whatever self-sabotaging function they are participating in that undermines their fulfillment of their own self strivings. At this point the therapy frequently looks like two individual therapies occurring simultaneously. This means shifting the focus from each spouse’s self-obstructive interactional style onto whatever affect states that person fears will arise by pursuing self-delineating goals, for example, such affect states as shame or guilt over the experience of being expansive and expressive. Obviously, spouses involved simultaneously in their own individual therapies may initially be more readily open to this exploration than those who are not.

This fifth step emerges from the work of the first four, in which the therapist’s persistent empathic, investigative, and interpretive stance has transference meanings for both spouses. This therapeutic activity establishes the analyst in the transference as the secondarily longed-for, receptive and understanding parent who, through his attuned responsiveness, will “hold” and thereby eventually alleviate the patient’s painful emotional reaction to an experience of primary selfobject failure. The selfobject tie becomes thereby mended and expanded, and primary selfobject yearnings are permitted to emerge more freely, as the patient feels increasing confidence that his emotional reactions to experiences of rebuff and disappointment will be received and contained by the analyst. Concomitantly, a developmental process is set in motion wherein the formerly sequestered painful reactive affect states, the heritage of the patient’s history of traumatic developmental failure, gradually become integrated and transformed and the patient’s capacity for affect tolerance becomes increasingly strengthened [Solorow, 1992, p. 9].
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The effect of such strengthened affect tolerance is the capacity of
both spouses to “own” their own role in the conflicts in which they are
likely to get ensnared. Bart and Tina evidenced the emergence of this
capacity, as the anecdotes in the following section indicate.

Bart and Tina (Step 5)

In a deeper exploration of her fears of Bart being abusive, Tina finally
shared in one session information she had not felt safe enough to reveal
in the original assessment sessions, namely, the fact that she had been
sexually molested at age five by a teenage boy, a member of a family
very close to her own. She had never disclosed this to Bart and had felt
understandably reserved about sharing it with me, especially since she
feared that my reaction might repeat that of her parents, which was to
dismiss the whole incident as a figment of her imagination. Indeed, her
parents had continued to see the family of the boy without ever men-
tioning the episode, although they no longer insisted that Tina play
alone with him. In her own self-exploration, Tina wondered aloud if this
molestation experience might not be playing a role in her “libidinal
numbness” toward Bart. Her willingness to share this memory in Bart’s
presence was enormously helpful for him, since the revelation put her
sexual inhibitions in a context larger than his obsessive belief that it was
reactive to his inadequacy. Furthermore, it created an opportunity for
him to sensitively respond to his wife, thereby softening some of her
resistance to him.

Another example of emerging self-reflection occurred when Bart
shared his fear that no one would be remotely interested in what he felt,
beyond using it to humiliate him. This fear, he speculated, had resulted
in his surrounding himself with friends who he was convinced would not
be comfortable discussing either his or their own feelings. Most impres-
sive of his speculations, however, was his suspicion that his automatic
assumption that no one cared about his feelings had created an erro-
nous self-fulfilling prophecy. Perhaps, he pondered, it was he
who would change topics the moment it seemed that either he or a friend
was experiencing any discomfort.

As gratifying as these revelations were to all of us, they were not likely
to have arisen outside the boundaries of my office, even though (with my
assistance) they did arise in the presence of the spouse. Nonetheless, this
was clearly a sign of emerging safety in the marital relationship, for as we
know, there is always the sense that what has been discussed in front of
one’s spouse can at any time be used against him or her. Optimal de-
velopment in this model of conjoint treatment, then, involves the next step,
Step 6, wherein each spouse is able to be empathically responsive to
the other’s painful reactions to inevitable selfobject failures.
Step 6

The sixth step involves the transfer of key aspects of the therapeutic function of the therapist to each of the spouses. First, each partner becomes an empathic observer and supporter of the other’s development. Second, each becomes able to empathically withstand and acknowledge the other’s inevitable upset over not getting a need supplied. Third, both recognize and acknowledge when they have failed to be attuned to their partner’s need or yearning. The transmuting of these therapeutic functions arises especially from the analysis of each spouse’s transference to the therapist.

In contrast to the reciprocal repetitive negative transferences that encumber the couple’s relationship, the by-product of the therapist’s empathic style heightens the potential for each spouse to initially experience an idealizing transference toward him or her. This, however, also sets the stage for inevitable growth-promoting de-idealization, as the therapist will be intermittently experienced as having empathically failed each spouse. Of course, the therapist’s empathic understanding of the spouses’ experience of these failures is central to restoring their sense of personal validity, not to mention arresting fragmentation and impeding resistive withdrawal.

When any form of acting out or resistance does become evident, it is essential that the therapist explore the patient’s experience of his or her empathic failure. Meanwhile, it is also necessary for the therapist to acknowledge the validity of the patient’s resistance, that is, to acknowledge that it is understandable that the patient feels impelled to retreat when feeling unsafe. For example, at one point Bart became anxious about the slow pace of treatment and began hinting about quitting. Wisely, Tina addressed this and thus stimulated an investigation of Bart’s resistance.

Being somewhat unsophisticated about therapy, Bart was clearly disappointed that his wish for a magical cure—that is, that Tina would be catapulted back into his arms—was not being gratified. This wish, however, obscured a deeper affective issue, namely, that he was foundering in feelings of inadequacy, humiliation, and private self-retribution. His urgency became a meaningful index of how much pain he felt and how dangerous he felt it was for him to express these painful affects either to me, because he feared that I would resent his implication that I was a failure, or to Tina, because it would only confirm her negative image of him. Once this was disclosed, Bart discovered that these affects in fact were welcomed by me and were found to be both meaningful and helpful to our work and that, furthermore, Tina felt more intimate toward him since his vulnerability mitigated her fear of him.
key aspects of the therapeutic relationship. First, each partner represents the other’s development-empathically withstand and acquire not getting a need supplied. When they have failed to be present, the transmuting of these in the analysis of each spouse’s experience does become evident, it is a by-product of the therapist’s or each spouse to initially experience or her. This, however, also promotes de-idealization, as the potential for the therapist to be recognized, that is, to acknowledge feels impelled to retreat the point Bart became anxious about quitting, stimulated an investigation of therapy, Bart was clearly disinterested. This wish, how-
expressing a vote of no confidence in him. With my assistance, Tina was able to help Bart discuss his feelings of insecurity and diminished worth, areas of affect that before therapy had never been exposed. Reciprocally, Bart was able to be of much greater assistance to Tina when a recent Pap smear revealed some precancerous cells.

But trust in such reciprocity is easily lost in the beginning, particularly when one spouse is suffering from considerable stress. In this case, Tina’s growing anxiety over waiting for Bart’s insurance carrier to approve her receiving a recommended gynecological procedure escalated into panic and induced her to have it performed by a doctor not covered under Bart’s plan. The worst part of this was that she did not confer with Bart. Thus, once again he felt “blindsided” both by her actions and by the news of the expense of the procedure. Sorting out the fight that ensued demonstrates how the intersubjective model of conjoint therapy works, since this returned us to Step 1 involving the therapist’s empathic exploration of each spouse’s subjective experience.

Tina, feeling terrified about waiting to have the procedure performed, feared that Bart would not allow her to have it until the insurance company approved it. Bart, startled by her announcement that she had borrowed the money from her parents and had had the procedure done, asked angrily, “Why should I even bother to pay to keep you on my policy?” This retort, of course, confirmed for Tina her suspicion that Bart’s preoccupation was with money and not with her health.

In exploring Bart’s reaction, we uncovered his feeling that once again he looked like a “half-wit,” incapable of being supportive to his wife and appearing stupid and cheap to his in-laws. He protested, “I repeatedly get convicted for intentions that I don’t have!”

Tina realized from Bart’s response that she had once again engaged in a self-fulfilling prophecy. At the same time, we were able to focus with greater intensity on the kind of selfobject function she needed from Bart to help stay her panic and to prevent her from behaving precipitately and in a fashion that would undermine the very support she yearned for.

**CURATIVE FACTORS**

While the concept of cure in psychotherapy is hotly debated, there are discernible factors that indicate when treatment has produced an optimal outcome on conjoint therapy. These suggest that an enduring reparative motif has been created that empowers the couple to address inevitable conflicts and confrontations that emanate from expectable episodes of reciprocal selfobject failure. The mutative process of therapy occurs as the couple undergoes repeated reparations in treatment,
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that is, as the spouses cycle repeatedly through all six steps of the
model and thereby enhance their capacity to maintain a vital marital
relationship.

First, spouses learn how to deflate conflictual situations by learning
to focus on their own stake in the battle rather than on their partner’s.
They have learned to ask, in their own nonclinical words, the following
questions: What selfobject function am I needing from my spouse, and
how am I going about enlisting this? Am I doing so in a manner that is
known not to work? Is what I’m doing inflammatory, and am I only
putting my partner on the defensive? If so, what does this suggest about
the possible conflict I am having in articulating my feelings and in
asserting my needs or desires? In short, how am I involved in this, and
what can I do about it? Spouses must learn to focus these questions on
themselves rather than on their mate.

Progress to this point means that spouses have sufficiently mourned
the inevitable disappointment of their wish to have their minds read
and their needs automatically accommodated. This process is similar to
Winnicott’s (1971) notion of the essential and inevitable disillusionment
in primary caregiver relationships. Most importantly, spouses must suf-
ciently overcome impediments to asserting their needs in the relation-
ship. Obviously, movement in all of this can be greatly accelerated
when spouses simultaneously participate in their own individual thera-
pies. Indeed, sometimes this recommendation becomes essential when
progress halts each time a spouse encounters a core developmental
conflict.

Assuming that both spouses have developed a sufficient level of dif-
ferentiation and integration of affect to reflect upon, identify, and then
share what their stake in a particular battle is about, the couple is now
prepared for learning more about listening. This entails development of
the critical capacity to just listen to the other and accept the other’s ver-

tion. Each spouse has his or her own valid subjective experience of the
conflict; successful listening involves the capacity to say to oneself,
“This is how my spouse sees this. Period. I do not need to agree, but I
do need to listen and to try to understand, because this is how my
spouse experiences it.”

The emergence of the capacity to listen enables each spouse to be in
better attunement to the other’s needs and wants. Optimally, the needs
of each spouse are recognized as having their own subjective value and

10It will likely take a bit of separation to gain this perspective. Hence, a fight con-
tinuing beyond the time interval that has been determined to be productive for a
given couple should be considered dysfunctional, and the therapist should recom-
recommend that it be discontinued until each partner can figure out what the conflict means
to him or her subjectively.
are not evaluated according to some external standard. If one spouse’s yearning for praise and admiration is responded to by the other as a sign of being either selfish or childish, then the former will feel both ridiculed and dismissed. This inevitably shames him or her (a surefire way to inflict narcissistic injury) and induces withdrawal and/or retaliation. Furthermore, the injured spouse will likely be disinclined to respond to the other’s needs.

Ultimately, much intimacy is experienced in the attunement to the other’s needs and in the enjoyment of addressing them. This, after all, is the heart and soul of romance. But this quality can only be accomplished if individuals experience a sense of cohesion, of worth, and of at least having their own needs sufficiently respected, if not met.

Finally, all personal evolution in a relationship is linked to spouses’ increased capacity for attunement to one another and to their discovery of ways to be responsive without losing an individual sense of self. In the absence of this attunement and responsiveness, each spouse’s differentiation remains a potential threat to the other and therefore to the vitality of the marital relationship.

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