Chapter 1, “The Myth of Isolated Therapy,” argues for widening the framework of psychoanalytic treatment to include the patient’s lived relationships.

Chapter 2 introduces key tenets of intersubjectivity theory, including its view of psychoanalysis, the structure of the subjective world, and development and pathogenesis.

Chapter 3, building on Kohut’s (1984) assertion of the persistence of self-object needs throughout the lifespan, describes the self-object yearnings and disappointments that underlie couples experience.

Chapter 4 describes the other side of the coin: the transferences that come to dominate relationships when partners regard each other not as sources of longed-for self-object experiences but as sources of pain and trauma that repeat pathogenic contexts from childhood.

Chapter 5 applies nonlinear dynamic systems theory to intimate relationships, drawing on the work of developmentalists (Thelen and Smith, 1994) and infancy research (Beebe et al., 1988, 1992, 1994, 1996).

The last five chapters apply intersubjective systems theory to clinical practice in a variety of treatment contexts.

Chapter 6 describes the empathic/introspective listening stance, which remains at the core of the intersubjective systems approach.

Chapter 7 provides a perspective on the way couples therapy proceeds, with particular attention to six general treatment areas: creating trust, fostering the capacity for introspection, making system interpretations, strengthening the holding environment, directly creating development-enhancing experiences, and strengthening attachment.

Chapter 8 describes a model in which individual and conjoint treatment is combined.

Chapter 9 applies the intersubjective systems approach to conjoint family therapy.

Chapter 10 describes an approach designed to interrupt the replication of pathogenic cycles through working with the caregiver in a variety of treatment contexts.

I have chosen as the epigraph for this book a line by Walt Whitman, perhaps the ultimate poet of inclusion. The self that Whitman sang of was a self that contained multitudes and yet was singularly his. The paradox that informed Whitman’s poetry is the paradox that lies at the heart of the approach to couples therapy described in this book: that we are never more ourselves than when we transcend our preconceptions of self and let ourselves be transformed through contact with another.

Richard and Beth were referred to me by their son’s therapist. Richard sought treatment to “see if his marriage of 20 years could be saved” after the husband of a woman who worked for him had called Beth to reveal his discovery of his wife and Richard’s affair.

Beth arrived at the first session in an advanced state of intoxication. Slurring her words, she disclosed that she had been drinking steadily for several weeks and was an alcoholic. The alcohol heightened her already bitter affect. She denounced Richard sarcastically every time he tried to speak, with comments like, “Why don’t you go tell that to cutie pie.” Richard, for his part, did not seem to show any real remorse for the affair, several times looking at me with a complicit look that seemed to say, “Do you see what I was up against?” He also took pains to tell me early on how many branch offices his business owned. From time to time, however, I saw another expression on his face: that of a scared and helpless little boy.

My nascent alarm about this case grew considerably stronger when, in the second week of treatment, Richard came by himself to announce that Beth was in the hospital with kidney failure. In addition to being an alcoholic, she was also diabetic. Beth returned to treatment the next week, somewhat chagrined but no less bitter.

It was tempting early in their treatment to protect myself from the vortex of their painful emotions by assigning them the diagnosis of a narcissistic/borderline couple (Slipp, 1988). This would have distanced me from the intersubjective field in the room, consisting of a woman in an acute state of...
fragmentation, exacerbated by the alcohol she turned to for relief; a scared man looking for the only kind of emotional supply that had ever been available to him—admiration for his professional (and sexual) accomplishments; and an alarmed therapist struggling to contain his sense of competency in the face of overwhelming emotions and Beth's life-threatening condition.

But such a retreat would have been a step away from the twin concepts that form the title to this book: that it is impossible to understand anything about people separate from their contexts, and that the underlying motivation for all people is the desire for a reliable emotional connection. Whatever the origins of Richard's so-called narcissism, it could not be understood outside of his experience in the relationship with Beth, nor indeed separately from the context of having talked to me on the phone and now being in my office. Nor could Beth's "borderline" condition be understood as anything other than a "phenomenon" arising in an intersubjective field—a field consisting of a precarious, vulnerable self in a failing, archaic selfobject bond" (Stolorow, Atwood, and Brandchaft, 1987, p. 130).

While fighting the temptation to protect myself with diagnostic labels, I also considered calling collateral therapeutic troops: residential substance abuse treatment and medication for Beth, individual treatment for both of them. It turned out, however, that Beth had already tried residential treatment and twelve-step programs without success, and that she had been seeing a psychiatrist for years, both for therapy and medication. Richard also had been in long-term individual therapy. Indeed, each partner blamed the other's therapist for exacerbating the marital problems. They both used their individual treatment as a source of weapons to hurl at each other with comments such as "My shrink's been telling me to leave you for years."

Against the press of these other options, I tried to bolster the central commitment of my work: to view a person's experience from within their subjective world, rather than from outside it (Atwood and Stolorow, 1984). Although the philosophical considerations that underlie this commitment (Atwood and Stolorow, 1984; Stolorow and Atwood, 1992; Orange, Atwood and Stolorow, 1997) have deeply moved me over the years that I have studied intersubjectivity, my consideration here was much more pragmatic. My clinical epistemology offered me a place to start working and offered the hope of establishing some kind of empathic bond in an intersubjective field characterized by real anxiety at the lack of any connection.

As I began to explore their individual experiences of the relationship, another dimension emerged—they both were attached to the relationship, and both held on to a glimmer of hope. Richard proposed a schedule of three times a week for sessions, and beginning in the third week of treatment this schedule was followed.

Because of the extremity of her condition, I decided to start with Beth. From an objective point of view, Beth looked quite disturbed—some of her thoughts were incoherent, and her attributions of intentionality to some of Richard's behavior seemed paranoid. Richard told me he suspected her years of drinking had caused organic damage. But an investigation of Beth's experience from within her subjective point of view yielded a different picture: the central theme that emerged was her complete feeling of betrayal—not so much from Richard's infidelity itself, but from the denial and lies that surrounded it. During the year of the affair she had come to distrust her own thoughts and feelings in the face of Richard's denials: "I would confront him with inconsistencies and he would convince me that I was making it all up."

Beth's sense of fragmented depersonalization began to make sense to me in this light. Richard's "gaslighting" (Beth's phrase, referring to the 1940s Ingrid Bergman–Charles Boyer movie Gaslight, in which a husband tries to convince his wife she is going insane) traumatically re-created the pathogenic developmental situation of a child whose "ability to sustain a belief in [her] own subjective reality was derailed because [her] perceptions contained information that was threatening to [her] caregivers" (Stolorow and Atwood, 1992, p. 95).

In the context of this profound selfobject (Kohut, 1971, 1977) failure, Beth's rage and attacks on Richard came to seem less an effort to punish or retaliate than a desperate attempt to shore up the reality of her affective experience. Shouting and attacking provided her, however momentarily, with a feeling that her thoughts and feelings were valid. I continually interpreted my understanding of the devastating effects of Richard's invalidation of her self-experience with comments such as "You're telling me that your entire world has been shattered" or "It sounds like you came to distrust your own perceptions." Beth's face, contorted with emotion, would visibly soften, and her outbursts would gradually begin to subside. From time to time she still needed to consolidate by denouncing Richard, but denunciation began to alternate with a calmer exploration of her experience of the marriage and the affair. About three weeks into the treatment, Beth announced that she had stopped drinking. I believe that my provision of a self-delineating (Stolorow and Atwood, 1992) selfobject experience, in which an individual's thoughts
and feelings are confirmed and validated, was a crucial part of her making a commitment to sobriety.

As Beth stabilized, Richard began to share his experiences of loneliness and frustration in their twenty-year marriage, but Beth was unable to listen to him without being provoked. She believed his only reason for describing these experiences was to justify the affair. Impasse: it was essential for Richard to begin to express his feelings, yet Beth’s capacity for empathy at this point in the treatment was limited. Empathy for Richard threatened to return her to a depersonalized, boundary-less state in which Richard’s reality supplanted her own. Although the lack of capacity for empathy often indicates developmental arrest, my commitment to view Beth within the context of her present relationship precluded this kind of diagnostic supposition. I interpreted my understanding of why she couldn’t listen to Richard, along with my belief that it would be necessary and important for her to do so at some point later in the therapy. Richard said that he could postpone talking about his side of things.

It is worth noting that Richard’s capacity to forgo validation of his experience belied my initial impression of him as being highly narcissistic. Richard’s narcissism was not a fixed property of an isolated mind (Stolorow and Atwood, 1992) but a self-organization that was highly context dependent. It emerged in a specific developmental context, and flourished in a relationship dominated more by enmity than empathy. The intersubjective field formed by my careful investigation of Beth’s experience provided a different context, one in which Richard’s need to be center stage was assuaged by the implied promise that his turn would come.

When Richard’s experience of the relationship emerged, it became clear that his narcissism—his sense of himself as a highly successful entrepreneur, athlete and womanizer—was a thin veneer. Underneath this shield lay a world of self-experience characterized by constant perceived threats to his autonomy and hopelessness that he would ever get his needs met. Early in treatment, a model scene from Richard’s adolescence emerged, illuminating the origins of his self-experience. Richard had been playing basketball in the driveway when the mailman brought news of his admission to an elite Ivy League college. In order to preserve the experience from his intrusive mother, he just kept playing ball and didn’t inform his parents for twenty-four hours. His mother was terribly hurt and his father bitterly denounced him for upsetting her. This dynamic completely overshadowed any acknowledgment of his achievement. As therapy proceeded, this scene came to encapsulate his childhood history of domination by his mother’s needs and his father’s criticism.

Richard’s experience of his marriage was that Beth constantly attempted to control him to force him into meeting her needs and criticized him terribly when he did not succeed. He even felt that Beth’s wish to have him buy her presents for birthdays, anniversaries and holidays was an example of this. He wondered why she couldn’t appreciate what he provided for her every day. I speculated that there was a considerable amount of transference here, both maternal and paternal, and that his experience of Beth was being organized by his childhood experience of a mother who usurped his individuality with her neediness and a father who criticized him.

This material posed a theoretical challenge: whether to share with Richard the conviction that Beth’s desire for presents on major occasions was normal or to explore the meanings that these occasions had for him from within his subjective world. The latter course allowed for the depleted, fearful self that lay under his achievements to surface. It became clear that admiration was the only self-object experience that Richard could imagine; it was very hard for him to believe that anyone could resonate with his sad or depleted feelings. His resentment at gift giving hid a deeper resentment that the longed-for admiration came with the price of meeting others’ needs.

As this picture of Richard emerged, Beth commented, “I’ve always known this is true. I’ve always felt how much he needed to be admired for everything he did.” I asked Beth why then she took Richard’s actions as meaning he didn’t love her, rather than seeing him as loving her as best he could, given his limitations.

I was surprised at how readily Beth answered the question, and with the depth of understanding she expressed. “It’s because I was never allowed to comment on the fact that our mother was incapable of loving anyone.” Beth grew up in a large Irish family. Her mother developed MS when Beth was six, but Beth was sure her mother’s emotional remoteness predated her illness. Beth cited an example of her mother’s lack of caring the fact that she hadn’t even phoned her brother when his wife died. Beth had a ready answer as to why she personalized Richard’s lack of attention: “It’s because I’ve always felt that it was my fault. That way I didn’t have to violate our family’s denial about our mother.” These two childhood-derivable imperatives—to blame herself for not being cared for and to protect the secret of a
caregiver’s dysfunction—had ominous ramifications for her marriage. It is possible that behind Beth’s vociferous condemnation of Richard was a shaky commitment not to protect him anymore.

Without my taking a detailed history, both of the partners’ family of origin material had emerged. And increasingly, the treatment became focused on illuminating how these experiences had organized the field of the relationship. We began to explore the overlapping contexts of their experience: how Beth’s bitter denunciations reminded Richard of his father’s criticism, how Beth’s experience of being “gaslighted” ominously repeated the experience of having her experience of being unloved as a child constantly denied. As this occurred, a sense of collaboration slowly began to replace the bitterness and disappointment that had dominated the room.

The approach to couples therapy that this case illustrates grows out of the historical shift from an objectivist to a systemic, contextual epistemology in analytically informed psychotherapy. The requirement that a therapist “know” what is right for a couple is the epistemological cousin of the belief that a therapist should have knowledge, by virtue of his theory, of the contents of a patient’s mind. A couple’s reality is a systemic creation, and reality in couples therapy is a creation of the three-person system.

A key component of the new paradigm is that psychic reality is fluid and context-dependent. If we cannot understand a phenomenon such as Beth’s rage separate from the developmental, relationship and treatment contexts that shape it, we must begin to rethink the boundary between individual and conjoint therapies. Does isolating a patient in individual treatment lead to a deeper or more profound cure? Does relationship therapy block access to the unconscious? How are we to understand patients without seeing them in their lived contexts?

We are fortunate to be living in a moment in intellectual history when the theoretical tools that can unify our understanding of individual, couple, family and group therapy are available to us. Intersubjectivity theory provides a conceptual link between two domains that have heretofore been seen as separate: the intrapsychic and the interpersonal. Dynamic systems theory provides a way of understanding a wide range of personal experience, from mental structures to repetitive interpersonal enactments in a couple, not as isolated, linear phenomena but as emerging from a complex and fluid system.

THE PARADIGM SHIFT IN PSYCHOANALYSIS

In their landmark opening chapter in Contexts of Being entitled “The Myth of the Isolated Mind,” Stolorow and Atwood (1992) make it clear that intersubjectivity theory both grows out of and extends the revolt against the dualistic, Cartesian thinking that has dominated Western philosophy since the Renaissance. “The myth of the isolated mind,” they explain, “ascribes to man a mode of being in which the individual exists separately from the world of physical nature and also from engagement with others” (p. 7). The image of a mind “separated from all that actually sustains life” (p. 12) is a heroic myth that serves the psychological purpose of disavowing the vulnerability of the human condition. In particular this myth disavows the fact that our lives are inevitably imbedded in the vicissitudes of our bodies, our relationships and the ever-shifting organization of our subjectivity.

The particular focus of intersubjectivity theory’s critique of Cartesian thinking are the mechanistic, objectivist assumptions that have underlay psychoanalysis since Freud. At their root is the assumption that there is an “objective reality” that can be known by the analyst and eventually by the patient” (Stolorow, Brandchaft and Atwood, 1987, p. 4). Intersubjectivity theory, in contrast, sees the observer as inextricably linked to the observed. Each patient/therapist dyad co-creates a specific intersubjective field (Atwood and Stolorow, 1984) out of which all meanings, transferences, interpretations and therapeutic outcomes emerge.

The challenge to isolated mind thinking from within psychoanalysis parallels the challenge posed by the family therapy movement. Beginning in the 1960’s with a critique of the portrayal of schizophrenia as an isolated mind phenomenon, rather than as a by-product of dysfunctional communication patterns in the family system (Bateson et al., 1956), the family therapy movement came to regard individual psychotherapy as an intrinsic part of the old paradigm that ignored the family contexts that maintained their pathology. Unfortunately, the family therapy movement, at least in its early manifestations, fell victim to its own hubris and epistemological blind spots. Early claims that family therapy alone could cure schizophrenia proved disappointing, especially in light of the widespread acknowledgment of the organic basis of it and other disorders. Furthermore, by failing to take into account the individual’s subjectivity, it failed to recognize the way that manifestly new-other experiences could be assimilated into old-self/old-other
configurations (Shane, Shane and Gales, 1997). The result was that new patterns of behavior or communication did not invariably result in lasting individual transformations.

Throughout the sixties and much of the seventies, the gulf between family therapy and psychoanalysis seemed uncrossable. By the 1980s, a number of theorists began to combine object relations theory and family therapy (Slipp, 1984, 1988; Scharf and Scharf, 1987). These theorists tended to privilege the view that fixed self and object representations, developed in childhood, controlled relationship and family systems.

At about the same time, psychoanalytic theory was undergoing a profound shift. Kohut (1984), who saw psychological life as influenced by the quality of relationships throughout the lifespan, challenged the view that psychological life is controlled by fixed structures that derive in childhood. Kohut’s concept of the selfobject (1971, 1977), in which the object’s functions of soothing, regulating or encouraging are experienced as part of the self, inherently challenges the isolated mind view of the separation of self and other. Self psychology views the analyst as inextricably contributing to the patient’s experience of self-cohesion, self-distress or fragmentation.

The relational school of psychoanalysis (Hoffman, 1983; Mitchell, 1988; Aron, 1996; Renik, 1993) also came to view the therapist/patient dyad from a systems perspective. These theorists emphasize here-and-now moments in which therapist and patient co-create meaning. As Orange, Atwood and Stolorow (1997) point out, however, these theorists tend to underemphasize the developmental contexts that shape those here-and-now experiences.

Intersubjectivity theory, as originated by Robert Stolorow and George Atwood in the late 1970’s and early 1980’s, developed parallel with Kohut’s self psychology, though the two theories have much in common. Intersubjectivity theory views the patient and therapist as a dyadic system in which the patient’s tendency to assimilate his experience of the therapist into pre-existing structures of experience and his accommodation of the therapist into a new sense of self and other oscillate between figure and ground. In a similar vein, Shane, Shane and Gales (1997) have categorized the patient’s shifting experience of the analyst into three modes: old-self/old-other, new-self/old-other and new-self/new-other. These conceptions of the therapist/patient dyad are readily applicable to couples.

Intersubjectivity theory is a contextual theory that includes both the developmental context and the context of the patient and therapist together in its attempt to understand and transform the patient’s inner life. It is this book’s contention, however, that an overemphasis on the patient/therapist system as the main subject of psychoanalytic inquiry has led intersubjectivity theory to ignore some of the most formative contexts of the patient’s inner life: the context of present-day intimate and family relationships, as well as the wider contexts of social, political and economic conditions.

Even as Stolorow, Atwood and their colleagues have deconstructed the myth of the isolated mind, they have not yet deconstructed the myth of isolated therapy. Similarly, while intersubjectivity theory has challenged the myth of the therapist’s neutrality (Atwood and Stolorow, 1984; Stolorow, Brandchaft and Atwood, 1987; Stolorow and Atwood, 1992), it hasn’t acknowledged as a myth the notion that therapy can be isolated from larger relationship systems, or that therapy is “contaminated” by the inclusion of these relationships in the treatment. There is a paucity of commentary in all of these authors’ case presentations on the patient’s present relationship contexts.

In limiting their exploration of the intersubjective field to the two-person models of child/caregiver or patient/therapist, these authors have not yet followed through on the promise set out in their first book (Atwood and Stolorow, 1984) in which they state that the concept of the intersubjective field can be readily extended to shed light on a wide range of human interactions, including intimate love relationships, family patterns, group processes and even intergroup relations. The concept of intersubjectivity provides a broad basis for a psychoanalytic understanding of human social life, bridging the gap between the analysis of individual subjective worlds and the study of complex social systems (p. 119).

Returning to the case of Richard and Beth, we see that without consideration of the relationship context, it is impossible to understand Beth’s subjective world. Indeed, her alcoholism, reactivity and “paranoia” were all connected to this experience of her having been “gaslighted” by Richard. The epistemological stance I took toward Beth (that it is impossible to understand her experience without consideration of the developmental context of her mother’s inability to validate her thoughts and feelings, the context of her relationship with Richard both before and after the affair, the context of her experience of Richard in the room and the context of our ever-shifting
transference/countertransference experience) was a crucial part of our therapeutic alliance. The empathic bond formed by my careful exploration of her experience in each of these contexts allowed her to have moments of increased self-cohesion, and to slowly begin to look nondefensively at her own role in the relationship.

RETHINKING THE BOUNDARY BETWEEN INDIVIDUAL AND CONJOINT THERAPY

Both Richard and Beth had been in long-term, individual therapy. During the course of these therapies not only did their relationship deteriorate, but their individual pathologies—Ann’s alcoholism and rage, Richard’s manic defenses against a pervasive feeling of emptiness—grew worse. Richard and Beth’s individual psychological organizations had become completely intertwined with a relationship system that assimilated those pathologies into fixed and relatively stable patterns of relating—at least until the revelation of the affair. Individual therapy had itself been assimilated to the relationship themes of blame and displacement.

This is not a unique predicament. The family therapy movement has always contended that an hour or even five hours of individual treatment a week would not be enough to overcome the family system’s pull toward maintaining old roles and behaviors. To use the terms of Shane, Shane and Gales (1997), the individual therapy’s attempts to create and maintain a new-self/new-other configuration take place in a relationship context that frequently reinforces the old-self/old-other configurations.

Richard’s individual therapist appears to have confirmed his worst fears about Beth. Whatever the therapist actually said, what Richard reported hearing was essentially “You can do better than this.” Even prior to the revelation of the affair, his sense of new-self/new-other with his mistress began to give way to some familiar repetitive patterns, and this influenced his decision to break it off and seek couples treatment.

Richard’s experience of Beth as ruthlessly exploitative and unappreciative grew out of his childhood experience with his highly invasive and narcissistic mother. Moreover, the defensive structures that Richard developed as accommodation to this pathogenic surround—a belief that only grandiose feelings were worthy of mirroring and all other vulnerable feelings must be disavowed—contributed to the repetition of this childhood pattern in his relationship with Beth. Beth, starved for emotional contact in her own child-

hood, now found herself married to a man who habitually hid his own vulnerability and required constant mirroring of his achievements. A steady diet of this thin emotional gruel had led her to develop two responses—she either withdrew into her books or she became critical, self-destructive and demanding. In the relationship system, these responses only reinforced Richard’s worst fears of being tied to an unavailable but nonetheless invasive and manipulative other.

PSYCHOTHERAPY AT THE BEGINNING OF THE TWENTY-FIRST CENTURY

The current situation in psychotherapy resembles the parable of the blind man and the elephant. Each school is privileging the unique piece of psychological “anatomy” that they are touching: early self and object representations, the act of putting split-off or unacceptable parts of the self into another person, the influence of affect regulation by the primary caretaker, the evolution of constructed meaning in the therapy dyad, the influence of larger relationship and societal systems on the individual, the intersubjective field formed by the intersection of two differently organized subjective worlds.

One of intersubjectivity theory’s greatest accomplishments is its critique of the reification of these theoretical perspectives and their attendant metaphors into objective truths (Stolorow and Atwood, 1992) and accordingly of their transformation into enshrined techniques (Orange, Atwood and Stolorow, 1997). In spite of this recognition, the conception of psychoanalysis as a treatment modality consisting of one analyst and one analysand remains unchallenged.

It is the central tenet of this book that intersubjectivity theory contains the theoretical power to transcend this limitation. Intersubjectively informed analytic psychotherapy is a treatment modality that can, and indeed should be, practiced in a wide variety of individual, group and conjoint configurations. Therapists should use maximum flexibility in designing treatment protocols that “will lead to an awareness, deepening investigation, and gradual illumination of existing structures of unconscious organizing principles and their continuing contribution to the repetitive course that life takes” (Brandchaft, 1993, p. 228). When this investigation takes place in conjoint treatment the effects can be immediate: the alternative to the world these unconscious organizing principles create is renewed intimacy with the person sitting on the couch next to you.
Many issues in psychoanalysis have been discussed in terms of what Langs (1978) called the “frame.” It is in the name of protecting the frame that psychoanalysis has proscribed such things as therapist self-disclosure or the therapist’s contact with outside family members. As important as these considerations are, too often they have resulted in a priori assumptions as to what constitutes protection and what violation of the therapy situation. According to Orange, Atwood and Stolorow (1997), the frame should grow out of the process of therapy, rather than be something imposed on that process: “. . . we must take care to choose the frame for that particular painting, not buy the frame first and then attempt to create something or someone appropriate for it” (p. 24). Although there are specific intersubjective contexts where a relationship frame that excludes contact with outside partners is necessary to preserve a sense of integrity or safety, there is no reason to assume that this is a universal requirement. Indeed, in a case such as Richard and Beth, the frames around their respective individual therapies proved decidedly unsafe.

The cases in the next chapters will likewise support the following argument: treatment that (1) takes the context of present-day relationship systems into account in any attempt to understand an individual’s subjective world, (2) constructs a therapy frame that grows out of the process of the therapy, (3) includes whoever is relevant to the process of transformation, and (4) maintains a commitment to investigate the changing meanings that such a frame may evoke is preferable to one based on a rigid boundary between individual and conjoint therapies.

A UNIFIED THEORY OF PSYCHOANALYTIC THERAPIES

In their chapter entitled “Beyond Technique,” Orange, Atwood and Stolorow (1997) specifically challenge the idea that psychoanalysis can be conducted with a set of “rules of proper and correct procedure. . . . The primary purpose of the rules of any technique is to induce compliance, to reduce the influence of individual subjectivity on the task at hand” (p. 23).

As an alternative to technique, the authors describe an attitude of “practice” in which the question “what is wise to do with this person, at this time, for this reason” is continuously asked (p. 27). The discussion that follows opens directly into the kind of treatment modalities proposed in this book:

Human beings are by nature relational. There is more to this assumption than meets the eye. It implies our psychological life cannot be the life of the isolated mind; it must originate, grow, and change within the intersubjective contexts in which we find ourselves.

This premise requires us to ask not only what happened to this patient in what contexts of relatedness or experienced isolation to bring about the suffering he or she brings to treatment. As contextualists, we must also ask what resources for healing are available in this analyst-patient pair. We must ask how our own history, personality, and theoretical allegiances affect the understandings we reach with this patient (pp. 27–28, emphasis in original).

We must also include the patient’s intimate relationships and family ties in our consideration of resources, and we must further ask the crucial questions of how the patient’s outside relationships affect the therapy and how the therapy is affecting the patient’s outside relationships.

The concept of the intersubjective field, along with the therapist’s commitment to investigate that field through empathic immersion in the patient’s subjective world and constant introspection, lies at the heart of intersubjectivity theory. Moreover, it offers a way to extend psychoanalytic treatment beyond the individual to the couple and family modalities and even to create new modalities that will address ever-widening contexts of human experience.

In the last few years, intersubjectivity theorists have begun to embrace general systems theory as a way of understanding psychological phenomena (Sucharow, 1990; Orange, Atwood and Stolorow, 1997). According to Orange and her co-authors:

Dynamic systems theory is centrally concerned with the process of developmental change—that is, the generation of “emergent order and complexity: how structure and patterns arise from the cooperation of many individual parts” (Thelen and Smith, 1994, p. xiii). Because it accounts for the “messy, fluid, context sensitive” (p. xvi) nature, we (Stolorow, 1997) have contended that this framework is exceptionally well suited to serve as a source of guiding metaphors for psychoanalysis. We now suggest that it also provides a broad philosophical and scientific net in which all the variants of contextualism in psychoanalysis can find a home (p. 75).
Within this broad net, individual mental activity, the child/caregiver relationship, the patient/therapist relationship or adult intimate relationships are "subsystems or elements that constitute the whole" (p. 75). The capacity to think systemically does not come easily. Part of the difficulty is that viewing ourselves and others as operating within the bounds of a relationship system violates our cherished notions of autonomy and individuality. In order to overcome this dilemma, family therapy has often resorted to a reified view of the system as agentic, with its own needs for homeostasis, boundaries and so forth.

The phenomenological approach of intersubjectivity offers a way out of the dilemma. The intersubjective field exists not as a reified mechanism but as a way of describing the subjective experience of being part of a relationship system, for instance experiencing the system as being greater than the sum of its parts and having orders and structures that organize and thematize the member’s experience. The sense of ourselves as autonomous individuals becomes an important part of the intersubjective field, forming an ever changing figure-ground relationship with our sense of being caught up with or controlled by our engagement with others.

This book argues for a treatment that is inclusive, context sensitive and fluid in terms of which subsystem deserves attention. As Orange, Atwood and Stolorow point out: "One- and two-person psychologies have tended to be reductive and incomplete because they proposed comprehensive explanatory theories grounded in one level only of a living system hierarchy" (p. 75). Intersubjectivity theory has the potential to engage any of the subsystems with the depth, rigor and power that have been the hallmark of psychoanalytic treatment. The emphasis here on intervention at the relationship level is a response to the fact that conjoint treatment is vastly underutilized as the treatment of choice not just for marital discord but for a wide variety of psychological phenomena.

For therapists who came of age during the formative days of family therapy, the euphoria of rapid systemic change left an indelible impression. Although family therapy did not prove to be a panacea, the potential of new relationship systems to emerge, and the power of these new systems to affect seemingly intractable individual pathologies remains at the heart of the couples therapy enterprise. It is my hope that this book will be of use both practically and theoretically to my fellow therapists who are accustomed to working "where the rubber meets the road"—at the intersection of three or more differently organized subjective worlds. I am also hopeful that this book will encourage psychoanalytically oriented individual therapists to take the plunge and use their profound knowledge of the unconscious origins of psychological life in treatment modalities that actively support their patients' relationships. As the example of Richard and Beth demonstrates, there is an untapped potential in intersubjectively oriented conjoint therapy as a treatment for both individual and marital problems.