Making Sense Together

The Intersubjective Approach to Psychotherapy

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The Centrality of Relationship

The history of psychoanalytic thought from Freud to the present has been characterized by the evolution of ideas and theories, their modification and revision, over time. Freud's first theory of psychopathology and treatment stressed the central role of childhood sexual trauma in the formation of neuroses. Most of Freud's first patients were young women with symptoms of hysteria (from the Greek for wandering uterus), which, in the late 1800s, was thought to be an exclusively female disorder. Through the use of hypnosis, Freud uncovered in these adult women repressed memories of childhood incestuous seductions by their fathers. He concluded that neurosis was instigated by some real-life traumatic encounter with another person, usually a close family member or friend. In modern terms, Freud was treating posttraumatic stress disorders.

What transformed this trauma theory of neurosis into an intrapsychic theory was Freud's growing conviction that what he had assumed were literal memories of real experience were
actually memories of childhood fantasies or wishes. Now, instead of accepting that his patients’ recollections of incestuous childhood sexual encounters were memories of real events, Freud proposed that his patients were remembering (oedipal) fantasies that they had as children. When this history is viewed in the context of today’s debate over false memories, it is striking how these issues are still being discussed 100 years after Freud originally introduced them.

Freud’s reformulation marked the beginning of the intrapsychic perspective, where the primary focus of psychoanalytic exploration is on the conflict between wishes and defenses within an individual isolated mind. Interaction with or relationship to another was considered to be inconsequential to the formation of psychopathology in the individual. Thus, instead of finding the source of psychopathology in disturbed relationships or interactions with external others, psychopathology was understood as growing out of the conflict between wishes and defenses within an individual isolated mind.

The intrapsychic focus in psychoanalysis continues to wield considerable influence today. However, starting in the 1950s, with the development in England of the British object relations theories of Fairbairn and Winnicott, new voices were attempting to assimilate back into psychoanalytic thinking the role of relationship with others. In America, Harry Stack Sullivan’s emphasis on the interpersonal roots of mental disorders was challenging the centrality of the intrapsychic perspective. Sullivan stressed the centrality of interpersonal relations in forming and treating psychopathology. An important step in the evolution and increased acceptance of interpersonal thinking occurred in 1988 with the publication of Stephen Mitchell’s *Relational Concepts in Psychoanalysis*. This book sought to integrate British object relations theory, interpersonal theory, and self psychology under the rubric of an inclusive relational theory.

Once theories of psychopathology shifted to include relational experiences, theories of technique and practice changed comparably. Many contemporary psychoanalysts now acknowledge the importance of the relationship between patient and analyst as necessary for beneficial therapeutic outcomes. However, specifically which aspects of the therapeutic relationship contribute to good treatment outcomes remain vague and unspecified.

Heinz Kohut (1959, 1966), a former president of the American Psychoanalytic Association, initiated a crucial development in theory. Kohut (1971) originally sought to expand the psychoanalytic understanding and treatment of narcissistic disorders. At the same time, he tried to remain true to his ego psychology roots by retaining its intrapsychic focus and instinctual drive theory. Patients with narcissistic psychopathology were formerly thought to be unresponsive to ego psychoanalytic treatment because they failed to develop the necessary transference neurosis (revival in the transference of the conflict from which neurotic symptoms derive). Kohut recognized that, while these patients did not form the traditional type of transference neurosis, they did develop what he described as narcissistic transferences. Kohut identified three characteristic transference configurations that narcissistic patients develop with their analysts: mirroring, in which the patient longs for the acknowledging and affirming gaze of an admired other; idealizing, in which the patient longs to connect himself to an idealized other and bask in the glow of her protective and admired qualities; and twinship, in which the patient feels a sense of oneness with a like-minded other. These three types of transference have become known as selfobject transferences because they describe three types of relationship that patients form with their therapists in efforts to satisfy previously unfulfilled selfobject longings. For Kohut, the selfobject transferences reflected the strivings of adults for the kinds of experiences a child needs to have with caregivers in order for healthy narcissism to develop. Healthy narcissism is characterized by realistic ambitions, a sense of agency and a belief that one is lovable. It is important to emphasize that for Kohut and sub-
sequent generations of self psychologists, healthy development, the development of a vital and cohesive self, requires relationships with early caregivers in which a child’s selfobject longings are met with attuned responsiveness. It follows, then, that self disorders result from persistent misattunement to the child’s selfobject needs.

While Kohut tried to integrate these ideas into an ego psychology framework, his emphasis on the importance of the external other for the mirroring, idealizing, and twinship selfobject transference experiences put the commitment to the intrapsychic perspective under pressure. The intrapsychic perspective views the other in the transference as a screen onto which patients displace or project their inner conflicts. Thus, the intrapsychic focus of analysis is on what goes on within the structures of the isolated mind of the patient. The actuality of the other is extraneous to the treatment process.

As we have seen, for Kohut’s understanding of the selfobject transferences the experience of the other as a participant in relationship with the patient was vitally important. Kohut (1977, 1984), therefore, found himself moving away from the intrapsychic origins of psychopathology and back toward Freud’s earlier notions of psychopathology resulting from a failed relationship.

To describe the nature of the relationship with the other in the selfobject transferences, Kohut introduced the concept of the self-selfobject relationship. The construct of the selfobject was developed to explain how another person (an object) might lend certain of her psychological capacities to the subject who was deficient in these functions. For the developing child, the selfobject functions provided by the caregivers enable the child to develop a cohesive self-organization. Children and adults whose selfobject experiences were inadequate were thought to suffer from deficits in their self-organization. Kohut (1984) defined the selfobject as “that dimension of our experience of another person that relates to this person’s functions in shoring up the self” (pp. 49–50). He therefore spoke of the selfobject as an object who was experienced as providing those needed psychological functions that promote cohesion in the developing or deficient self.

While Kohut was originally concerned with understanding and treating narcissistic personality disorders, he gradually came to appreciate that all people, the troubled and the untroubled, need the sustaining function of selfobject relationships throughout life to help maintain a vital and cohesive self-organization. According to Kohut (1984), “Self psychology holds that self-selfobject relationships form the essence of psychological life from birth to death, that a move from dependence (symbiosis) to independence (autonomy) in the psychological sphere is no more possible, let alone desirable, than a corresponding move from a life dependent on oxygen to a life independent of it in the biological spheres” (p. 47). From this perspective, inadequate selfobject experiences with caregivers during early development are at the root of all psychogenic disorders. Accordingly, all these patients can be understood as suffering from varying degrees of disorder to their self-organization.

The function of selfobject experience has been expanded and clarified since Kohut’s original work. Since affects, as discussed in Chapters 1 and 3, are central organizers of self-experience, it follows that for intersubjectivity theory, “selfobject functions pertain fundamentally to the integration of affect into the organization of self-experience, and 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” (Stolorow et al. 1987, p. 66).

Here we have at least a partial answer to the question of what aspects of the relationship between patient and therapist promote healthy transformations. The selfobject function of “attuned responsiveness to affect states” is that aspect of the relationship with the other that promotes the cohesion, continuity, and positive coloration of self-experience. This allows for an expansion of the construct of selfobject functioning beyond mirroring, idealizing, and twinship that Kohut proposed. Now, all those
experiences with the other, whether verbal or nonverbal, that promote the integration of affect into the organization of self-experience are considered selfobject experiences.

Selfobject experience is a relational phenomenon. Concerned caregivers respond to what they believe are the needs of children; friends and partners do likewise for their loved ones; and therapists integrate their theoretical assumptions with their empathic gleanings in attempts to impart understanding to patients. Therapists strive to understand the world from the patient's perspective by listening for affect, recognizing unconscious organizing activity, and searching for personal analogues to the patient's presentation. This action of the therapist may or may not provide selfobject experience for the patient because the personal meaning to the patient is what determines the nature of the experience. A therapist attempts to provide atttuned responsiveness, and the patient organizes his experience of those efforts. Whether healthy transformations grow out of the treatment is a property of the dynamic system of the dyad—the relationship.

It should be clear that since selfobject experiences by definition are those experiences that promote the integration of affect and consolidation of self-cohesion, there could be no bad selfobject experience. There are, of course, bad objects and destructive relationships with these bad objects; that is, relationships that foster fragmentation and disintegration, retraumatization and rigid defensiveness. However, these would not be considered bad selfobject relationships. Selfobject relationships are, in their essence, growth promoting. They foster transformations of self-experience; that is, increased capacity for affect integration and self-cohesion. In Chapter 6, we refer to experiences that are organizing but are not transforming; that is they strengthen defensive organizations. These experiences should not be confused with selfobject experiences.

One of the fundamental assumptions of self psychology and intersubjectivity theory is that striving for health motivates much of human behavior, even what appear to be maladaptive behav-

iors. Striving for health can be seen in people's attempts to engage in new relationships that will provide what was developmentally missing but needed, that is, new selfobject relationships. It is to our patients' credit that they have not retreated into depressed or psychotic isolation but have persisted in seeking out needed selfobject experiences by risking a new relationship with the therapist, whom they hope will become the needed and wished for new object.

Striving for health can also be seen in people's attempts to avoid retraumatization. Let us take as an example the notion of the negative therapeutic reaction. Freud (1923) observed that some patients, when offered "correct" interpretations, got worse instead of better. This has been variously explained as the patient's wish to frustrate the analyst, as an expression of the patient's underlying masochism, or as a manifestation of an unconscious sense of guilt. However, if we examine the patient's "negative" reaction from the perspective of seeking health, we turn our attention to the perceived dangers the patient experienced or anticipated to be coming from the "correct" interpretation. One possible source of danger might be the therapist's misattunement to the patient. If the therapist believes she has made an accurate or correct interpretation but the patient gets worse or responds negatively, might it be that the therapist, who apparently steadfastly believes she is correct in spite of the patient's response, is actually quite wrong for the patient? The attitude betrayed in the label "negative therapeutic reaction" implies that the therapist is the sole judge of correctness and knows better than the patient what is good for him. It is presumed that the analyst's interpretation is correct and that the patient is to blame for his resistance to benefiting from the analyst's truth. This is, in itself, a major misattunement in that it fails to recognize the subjective correctness of the patient's response. The patient's worsening condition might not be a manifestation of resistance to the therapist's correctness. Rather, it might indicate that the patient is suffering from iatrogenic injury resulting from the
therapist’s failure to attune to the meanings the interpretation has for the patient. We would certainly hope that the therapist’s subjectivity and the therapeutic context include a theory that allows for the latter hypothesis to be explored seriously.

Some colleagues dismissively assume that being experienced as a selfobject means that we are being indiscriminately, dishonestly, and disingenuously warm, caring, nurturing, or attentive to our patients. In fact, what we try to do is relate in ways that are experienced by our patients as providing needed selfobject experiences. That is, we relate with our patients in ways that promote the recognition, articulation, and integration of discrepant affect states. In doing so, we attend to features that contributed to this patient’s particular organization of experience—those experiences that have undermined the development of self-cohesion. This includes providing the opportunity for a new reparative (selfobject) relationship, as well as opportunities to develop new self-understanding through the identification, articulation, and interpretation of unconscious organizing principles (see Chapter 5).

On a most general level, facilitating a potential new, reparative selfobject relationship involves maintaining a stance of attuned responsiveness to the patient’s affect states. In other words, we want to foster the experience of having one’s affects accepted and understood. Accepting affects does not necessarily mean approving or endorsing them, although it might. For example, if patients express hate for people of different ethnic, racial, or religious backgrounds, we can accept their feelings, tolerate their verbal expression, and explore the roots of the feelings without approving or endorsing the feelings (Ryan and Buirski, in press). On the other hand, if a patient describes a boyfriend who belittles, berates, and verbally abuses her, the therapist might comment, “He treats you badly” or “He treats you like you are stupid.”

Reflecting back to our discussion in Chapter 1, we cannot know, from our patient’s experience, how her boyfriend experi-ences his treatment of her, or how another woman might experience this treatment. We only know how this woman experiences him and we must address her experience. While objective reality is beyond either of our knowing, we do validate her subjective reality, which she desperately wishes for us to understand. It might be argued that the therapist should say, “You feel like he treats you badly,” thereby hedging on explicitly validating the patient’s view of reality. But it does not take long for patients, especially those who are getting better, to discern the analyst’s reservations and, consequently, to experience such interventions as implying doubts about the validity of the patient’s experience. It is important to remember that while we have doubts about anyone’s capacity to know the reality of another, we can nevertheless affirm the patient’s subjective experience.

Some might fear that by affirming the patient’s subjective reality we reinforce the patient’s defended or distorted view of the world—that we are undermining instead of supporting the patient’s reality testing. If reality testing refers to giving advice, providing education, training social skills, or offering the therapist’s perspective in place of the patient’s, we question whether such activity fosters good interpersonal judgment or the developmentally important ability to recognize the subjectivity of the other. Frequently, the patient’s early caregivers failed him in just this way—they disconfirmed and invalidated his affective experience and tried to substitute their own. Thus, by providing reality testing the therapist risks retraumatizing the patient by repeating early experiences of invalidation. We believe that people develop the capacity for affect attunement to another’s experience by having had the consistent experience of another being attuned to their own affective experience. If parents or caregivers deprive children of these experiences in childhood, then later reparative opportunities with attuned others or with a therapist can enhance the capacity for affect attunement. Let us examine a clinical example.
Marjory, a woman in her mid-forties, presented with a personality organization typically described as narcissistic personality disorder. Marjory had a powerful, dictatorial father whom she experienced as invariably critical and disapproving of her. Marjory’s mother, while affectionate, was intimidated by the father and never risked intervening in support of Marjory. Marjory had little capacity for self-examination and insight, and she showed little interest in understanding the subjectivity of others. During a long stretch at the beginning of therapy, Marjory complained of loneliness, but she found fault with and dismissed every person with whom she came in contact. She mistrusted their motives, felt that they were less cultured than she, read hostility into every interaction, and displayed a defensive grandiosity that always disqualified others for not being good enough for her.

Marjory’s therapist, rather than addressing her grandiosity and rejecting behavior, maintained a stance of attunement to her subjective experience. Instead of questioning her disqualification of others, the therapist attuned to her underlying feeling of having been disappointed by others. The following are examples of the therapist’s interventions: “Your father never appreciated you.” “It’s hard to find someone as well read as you.” “The women at work seem so superficial compared to you.” “Joe [her first date in years] only talked about himself and seemed unaware of you.” After many months of listening to her therapist validate her subjectivity, Marjory’s organization of experience began to change. Having experienced her therapist’s attunement to her subjective world, she began to be more self-reflective and aware of the subjectivity of others. While she still offered disparaging observations of people in her life, these were now accompanied by statements like, “I wonder if I am being too critical.” Her perception of her father also showed new understanding. She observed, “I wonder if he has to throw

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his weight around because he doesn’t really feel good about himself.”

Here is another example from an early therapy session with a woman in her late twenties where the focus of the therapist’s interventions was on maintaining attuned responsiveness to the patient’s affect states. The patient, Jill, had been talking to her therapist about friends whom she had not heard from in the months since she relocated. Jill feared that these friends had discarded her, and she reflected on what she might have done to cause them to be upset with her. She then associated to a current situation.

Patient: I’ve never told you how last week, how, you know, like everyone’s forgotten about me, and that I’m just not used to that. It’s not like I’m used to being the center of attention either, but it’s just that I’m used to having people around.

Therapist: Right now you feel like there isn’t anyone around for you. You feel like you’re all alone . . .

Patient: (Nodding and beginning to cry).

Therapist: . . . and even the people that are here, who you’re really wanting that support from, aren’t giving it to you.

Patient: (Nodding, crying, reaches for tissues). So, um . . . (shakes her head) and I feel kind of stupid bringing it up to her, you know, and I’m just like well . . .

Therapist: Tell me about feeling stupid bringing it up to her.

Patient: Well, I just kind of feel like she should realize . . . but maybe . . . you know when she moved here she came with her best friend . . . (begins crying harder and shrugs her shoulders).

Here, it might be tempting for the therapist to provide reality testing by addressing the unrealistic expectation that her friend
"should realize" how Jill felt—that her friend should read her mind. However, to do so would introduce the therapist’s agenda and make it more important than the patient’s. If our highest priority as therapists is to attune to the patient’s experience, then we would put aside our need to provide reality testing in order to be responsive to the patient’s affect state. This is one of those choice points in treatment where justifications could be given for selecting either path, but we advocate staying with the patient’s subjective experience in non-life-threatening situations.

**Therapist:** So, you’re feeling disappointed that she’s not more sensitive to you since she’s been through this herself, that you feel like you shouldn’t have to spell it out for her.

**Patient:** (Crying and nodding) Uh-huh.

**Therapist:** You want her to be more attentive to what you’re feeling.

**Patient:** Uh-huh, yeah, and sometimes I think she’s kind of just wrapped up in her own world. I mean, you know she . . . she’s married, and has her married friends . . . (starts to cry harder).

**Therapist:** And you feel unimportant.

**Patient:** Yes, and I mean also um, her husband was going to go camping this weekend . . . I can’t believe I’m crying about this . . . I thought we were going to spend the weekend together but she told me that she was going away for the weekend to spend time with this other woman . . . and all I could think was . . . (crying) I have to spend another weekend alone.

**Therapist:** And that’s really hard because she’s forgetting about you or discounting the plans that you had made, just the two of you.

In this example, the therapist focused on the patient’s subjective experience. The therapist was trying to communicate her attunement to and her understanding of the patient by articulating, putting into words, the patient’s subjective experience. There were suggestions in this vignette of possible organizing principles that may shape this patient’s experience: she feels unworthy and undeserving of the attention of others; she is fundamentally unlovable; she will always be alone. If this session had occurred later in treatment, or if the patient’s upset had been less pressing, the therapist might have identified, articulated, and explored the workings of these organizing principles as they emerged. But what we want to communicate with this example is that the therapist’s responsiveness to the patient’s affect state is a new experience for the patient. Jill felt understood and known by her therapist. Repeated experiences over time of feeling understood by her therapist would promote greater self-understanding, integration of affect, and an enhanced sense of self-cohesion and self-esteem.

If this incident had occurred later in treatment, Jill might have come in feeling angry with her friend for forgetting or discounting their arrangements. But Jill does not yet possess a consistent sense of self-worth and self-confidence that would support feeling justifiably angry or indignant—instead, she feels worthless and deserving of being discounted. We doubt that true and enduring self-worth will develop from being told that these are irrational beliefs and that she should think differently, or by offering palliative, reassuring remarks about how much she is really worth. Transformations in self-worth emerge within a selfobject relationship where the other endeavors consistently to attune to the subject’s affect states. In this way the therapist allows the patient a possible new experience of feeling understood, and simultaneously promotes self-understanding through the articulation of the principles that have organized her experience.

Of the variety of selfobject experiences that have been recognized, one form in particular warrants special attention. This concerns what Stolorow and Atwood (1992) have identified as the self-delineating selfobject transference. There are many
patients whose fundamental experience of themselves has been so undermined and invalidated that they no longer have any trust or confidence in their personal view of the world. They do not know how they feel or how they “should” feel. Often they preface an expression of feeling with statements such as “I must be crazy” or “You will think this is crazy.” A major selfobject function of the therapeutic relationship is to offset this profound experience of invalidation by identifying, articulating, and affirming affective states that have been disowned. In many cases, the patient has disowned or disavowed certain affect states that have threatened to disrupt needed relationships. For example, if the patient’s mother has been unable to accept her daughter’s anger and has threatened abandonment or withdrawal of love, the daughter might need to disavow her anger in order to maintain her needed tie to her mother. Chronic disavowal or denial of affect states can culminate in an individual’s losing touch with her sense of vitality, initiative, agency, and self-cohesion. The therapist’s identification and articulation of the patient’s disavowed affect states affirms their subjective reality and promotes their integration into consciousness. This is often experienced as a self-delineating selfobject function; that is, the therapist’s noticing and naming the patient’s immediate state enhances the patient’s sense of being whole, real, and alive. Such self-delineating selfobject functions, experienced in the therapeutic relationship, “serve to articulate and consolidate the patient’s subjective reality, crystallizing the patient’s experience, lifting it to higher levels of organization, and strengthening the patient’s confidence in its validity” (Stolorow and Atwood 1992, p. 35).

One of the factors that confound dialogue among the various psychoanalytic theories has been the tendency for representatives of diverse theories to use the same term to signify very different clinical phenomena. Such has been the case with the term transference. Freud (1915b) used the term to describe how powerful affects, like love or hate, that were originally experi-

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enced in relation to significant figures during childhood, can be revived and reexperienced in relation to the analyst during adult treatment.

Since the Freudian analyst maintained a stance of neutrality and abstinence toward the patient, the patient, by design, was thought to be shielded from knowledge of the person of the analyst. If the analyst was a neutral stimulus, then the source of strong affects must reside solely within the isolated mind of the patient. These strong feelings of love or hate for the analyst were understood to be manifestations of the patient’s distortions and misperceptions of current reality in terms of the past; thus, they constituted a transference neurosis. According to the theory, a patient displaced these feelings of love and hate from the original objects of childhood onto the analyst in the present. Being able to develop a transference neurosis was considered a precondition for effective psychoanalytic treatment because, through the establishment of the transference neurosis, the past was resurrected and brought alive in the present. Successful treatment meant the resolution of the transference neurosis and, thereby, the original infantile (oedipal) neurosis. The notion that transference represents a displacement of powerful affects from significant objects in the past onto the analyst in the present has, according to Stolorow and Lachmann (1984/1985), “perpetuated the view that the patient’s experience of the analytic relationship is solely a product of the patient’s past and psychopathology and has not been determined by the activity (or nonactivity) of the analyst” (p. 24). Intersubjectivity theory, as we shall see, offers a very different conception of the nature of transference in the therapeutic relationship. Therefore, it is legitimate to question whether, for intersubjectivity theory, the term transference should be retained.

From the perspective of intersubjectivity theory, “Transference in its essence refers neither to regression, displacement, projection, nor distortion, but rather to the assimilation of the
analytic relationship into the thematic structures of the patient’s personal subjective world. Thus conceived, transference is an expression of the universal psychological striving to organize experience and create meanings" (Stolorow et al. 1987, pp. 45–46). The idea here is that transference does not grow out of some biologically rooted need to repeat the past (Freud’s repetition compulsion), but reflects the patient’s attempt to make sense of the relationship with the therapist in the present in terms of the principles that have organized the patient’s experience in the past. Thus, transference is not solely an intrapsychic process generated within the mind of the patient. Rather, both patient and therapist contribute to the context in which the patient comes to feel what he feels. The patient tries to make sense of these feelings in terms of the themes that have previously organized his psychological life. If, for example, a patient experiences loving feelings for his therapist, we would not presume that these feelings derive from his unconscious love for an object from childhood being displaced onto the therapist. Nor would we understand his love merely as an irrational distortion of the present relationship in terms of the past. It is important to recognize that the patient would not have fallen in love in a vacuum. He will have spent many hours alone in a room with an attuned, accepting, noncritical person who is devoted to listening and helping him make sense of his feelings. This experience of attuned responsiveness to his affect states may be what he has always longed for but failed to experience with the significant objects of childhood.

For intersubjectivity theory, then, transference concerns the way experience is organized and meaning is created. Intersubjectivity theory recognizes that there is a selfobject or developmental dimension to all therapeutic experience. The selfobject dimension of the treatment describes the patient’s experience of a needed and desired new relationship with the therapist that fulfills selfobject longings that were unmet or inconsistently met during development. Through establishing a relationship that provides selfobject functions for the patient, the selfobject dimension of the relationship represents more than a technical development that sets the stage for curative interpretations. Rather, the selfobject dimension of the treatment relationship itself, once created, promotes psychological growth and transformation. Like Winnicott’s (1965) “holding environment,” the selfobject dimension of the treatment relationship provides the patient with a powerful relational experience of attuned responsiveness. Once established, the selfobject dimension of the treatment relationship can occupy the foreground or background of the patient’s subjective experience. Therefore, a central concern of treatment from the intersubjective perspective is that ruptures to the selfobject bond between patient and therapist be repaired so that the transforming aspects of the therapeutic relationship can be reinstated.

Let us examine an aspect of the treatment relationship from the intersubjective perspective where the present relationship with the therapist is assimilated into the ongoing organization of the patient’s experience. In this example, the selfobject dimension is operating as background when a potential rupture occurs.

Martin, a young man approaching 30 years of age, has been in treatment for two years with a male therapist. Despite his good looks and his high-paying job, Martin has been unable to establish a long-term relationship with a woman. Martin’s organizing principles include beliefs that he is inadequate, inferior, and doomed to fail in comparison to other men. Strong feelings of shame accompany these ideas. A few months previously, Martin bought a new Porsche that he pointedly pronounced as a two-syllable word—por-sha.

On those occasions when his therapist made reference to the car, he automatically used the single syllable pronunciation that he was familiar with (porsh), and Martin would
correct him. One session, the therapist again mispronounced the name, caught himself, smiled, and correctly pronounced the two-syllable word. Martin replied, “Touché.” This response surprised the therapist because it seemed that Martin felt wounded, clearly a potential rupture to the selfobject dimension. The therapist asked, “Did you feel I was mocking you when I corrected my pronunciation?” Martin said, “Yeah, I thought you were making fun of me.” The therapist replied, “I didn’t mean to sound that way. I was thinking, ’How often do I have to be corrected before I get it right.’ I thought I was making fun of myself.” Martin replied, “I missed that. I guess I just assume I’m being put down.”

As therapists, we need to be cautious about what we know of our own unconscious motives. By definition, if something in us is unconscious, then it is not easily or directly knowable to us. The therapist might unconsciously have been expressing his envy of the expensive sports car, or perhaps the therapist, who was Jewish, had negative feelings about the patient’s owning a German car. Just because the therapist was not conscious of feeling hostile or competitive does not mean he should disregard the possible unconscious motives behind his intervention. With this in mind, the therapist observed, “I can see how I came across sounding that way. You said you just assumed you were being put down. It sounds like you are very alert to being treated this way. Have you had the experience of being put down or mocked before?”

This observation unleashed a flood of associations. Martin began to describe how he was the object of incessant ridicule during elementary and middle school. He had a big nose, thick glasses, difficulty reading, and he was subjected to scorn and derision by the cool kids. While the therapist had some sense of Martin’s organization of experience, Martin had never, during the two previous years of treatment, been able to reveal the details of these experiences or the deep sense of shame that accompanied them. With tears in his eyes, Martin spoke of his empathy for the Columbine High School killers. He knew how those kids must have felt. He hated the jocks, too.

In this vignette, two aspects of the treatment relationship stand out. First, the selfobject dimension is operating as background. The patient feels trusting and safe in the relationship with the therapist until he is suddenly injured. However, because of the trusting nature of the relationship, the rupture was easily repaired and the patient retained ready access to his associations. In fact, as we discuss extensively throughout the book, the experience of being attuned to frequently has the effect of unleashing a flow of associations. When people feel understood, they have no shortage of things to share.

Second, at the moment of rupture (retraumatization), we can see how the therapist becomes incorporated into the patient’s ongoing organization of experience. Allowing that the therapist might have felt, and unconsciously conveyed, envy or resentment, Martin nevertheless experienced this as fitting seamlessly within his ongoing organization of experience. Because of his long and painful history of feeling the sword of ridicule, he readily accepted that yet another point had been scored against him: “Touché.”

A differently constituted patient might not have made an issue of pronunciation in the first place, or he might have accepted the therapist’s self-correction at face value, or he might have parried with a cutting retort: “You’ll pronounce it correctly when you own one.” But these alternatives were not available to Martin. He could only react with hurt to the therapist’s thrust because of the invariant way his experience had been organized.

A second dimension of the transference is referred to as the repetitive dimension, where the patient fears that the relationship with the therapist will repeat painful or traumatic experiences from the past. When the repetitive dimension of the transference
is in the foreground, the patient attempts to engage the therapist in a relationship that will forestall injury or retraumatization. An example of this occurred with Betty:

The oldest of five children, Betty's experience was organized around the belief that the only way to maintain a vital tie to her powerful but remote father was to anticipate his moods and act in a manner that pleased or placated him. Betty became exquisitely sensitive to her father's affect states and was quick to subordinate her needs in order to avoid displeasing and thereby provoking him. She developed a false self presentation (Winnicott 1965) characterized by cheerfulness and self-sufficiency.

In the treatment relationship, this dynamic configuration found expression in Betty's attunement to her therapist's needs and moods. She seemed constantly to be concerned that the therapist would become angry with her if she appeared needy or dependent. She might begin a session with the seemingly innocuous pleasantry, "How are you?" which really meant, "Am I a burden to you and will you reject me today?" When she became upset, she apologized for acting like a baby, and was quick to make demeaning remarks about herself, as if to beat her therapist to the punch. Betty was continually vigilant and intuitive in her observations. She would observe, "You seem tired today," which often accurately captured the therapist's self-state, and she was ready to leave the session if her presence was too taxing.

In this relational configuration, which emerged during the first few weeks of treatment, the repetitive dimension was clearly apparent. Betty's penchant for attending to the needs of others while asking nothing for herself led her to accept any articulation the therapist might offer as evidence of his brilliance and her stupidity. When the therapist said, "You seem to feel that you're a burden to me," Betty replied, "Yes, you have the patience of a saint." Brandchaft (1994) has described such behavior as pathological accommodation. Through bolstering her therapist's self-esteem and placing his needs above hers, Betty sought to avoid the threat of retraumatization that would come from incurring her therapist's displeasure. Such a stance precluded her experiencing a transformation of her organization of experience and was certainly not in her therapeutic interest. Nevertheless, the tie to the therapist was vitally needed, and she sacrificed her opportunity for emotional growth in order to avoid risking rejection.

Whether concerning positive or negative affects, the intersubjective approach addresses the organizations of experience that configure the relationship between patient and therapist. Let us examine an interaction from the treatment of Gerald:

During the therapist's August vacation in the first year of treatment, Gerald expressed the wish for some phone contact. His therapist agreed to a weekly phone session. During the second week, Gerald's mother died unexpectedly. He felt emotionally overwhelmed and alone and from the mortuary left a phone message asking his therapist to call. His therapist called and reached Gerald at his home that evening. They had an emergency phone session. An hour after the phone session, Gerald left another message asking if he could have the therapist's vacation phone number so he could reach her directly if he felt overcome with grief during the night. The therapist received the message and returned Gerald's call. She told Gerald that she was not available for night calls but would talk to him the next day during their weekly scheduled phone session. That night Gerald left an angry message saying that the therapist was just like all the other women in his life who were unresponsive to him and he never wanted to talk to the therapist again. The following day, the therapist left Gerald a voice message saying that she understood how
disappointed and angry he was but that she would like to talk to him and would await his call at the scheduled time. Gerald did call. He angrily told the therapist that he felt the therapist was rejecting him because his needs were too great, that the therapist must be angry with him for trying her patience, and that she must want Gerald to grow up and stop being so dependent.

Here we see a complex interpersonal encounter in which the patient has assimilated the therapist into his invariant organization of experience, that is, that he is too needy for any woman, that expressing his needs drives women away, and that no woman will ever give him the depth of love and attention he craves. There are clearly a variety of interventions available to the therapist, each informed by different theories. One possibility was for the therapist to interpret Gerald’s wish for the mother of childhood to be responsive to his every need. Another option might have been for the therapist to interpret Gerald’s wish to ward off separation anxiety by maintaining a constant connection to the therapist. Alternatively, the therapist might address Gerald’s need to control the therapist, or interpret his wish to ruin the therapist’s vacation because of his anger and jealousy. Still another option might be to interpret Gerald’s wish to get into bed with the therapist between her and her husband. Yet another option might be to share her feeling of irritation with Gerald’s repeated intrusions into her vacation. In the end, she chose to explain that from her perspective, what was important was that Gerald feels whatever he was feeling and be however he needed to be. He was not too needy, demanding, controlling, or angry for the therapist. The therapist wanted to work with him, and she would establish whatever boundaries or limits she needed for herself. She would tell Gerald what worked for her and it was not Gerald’s problem to figure out what those were and accommodate to them. It was difficult for Gerald to integrate that his therapist was not trying to shape, modify, or control his behavior.

The Centrality of Relationship

But this interaction became a focal point for ongoing work on these themes.

To repeat, the term *transference* derives from and is integrally related to the theoretical and technical assumptions of traditional psychoanalytic theory. Much of the traditional psychoanalytic theory of technique is an outgrowth of the traditional understanding of transference. Therefore, any change in the way transference is conceived will have profound implications for practice.

Let us reflect on some of the well-known aspects of psychoanalytic technique that derive their rationale from the traditional conceptions of transference and contrast them with the intersubjective perspective. Freud distinguished between those patients who were capable of developing a transference neurosis and those who suffered from narcissistic neuroses. Traditional psychoanalysts viewed the patient’s capacity to develop a transference neurosis as crucial to the consideration of suitability for psychoanalysis. Those patients who suffer from the narcissistic neuroses were presumed to be unanalyzable. This is essentially a determination based on diagnostic criteria pertaining to the patient alone. From the intersubjective perspective, suitability for treatment is not a function of the patient’s diagnosis, but is a property of the patient-analyst system. As Stolorow (1994a) puts it, of central concern to the determination of suitability for treatment is “the goodness of fit between what the patient most needs to have understood and what the analyst is capable of understanding. . . . I believe that, in principle, anyone with an intact nervous system is analyzable by someone” (pp. 152–153).

The traditional designations of positive (sexual) and negative (aggressive) transferences cease to be useful ways of conceptualizing underlying states. While it is obvious that some patients will experience positive, negative, sexual, and aggressive feelings toward their therapist, we do not assume, for instance, that a negative transference must be uncovered and analyzed before a treatment would be considered successful. When patients do
experience feeling toward the therapist, these are explored in terms of the organization of experience of both patient and therapist, and of the present context within which the relationship occurs.

Traditional psychoanalysts employed the couch and the stances of neutrality and abstinence in order to promote regression. Regression was thought to facilitate the reemergence of childhood neurotic conflicts in the present treatment relationship. Since treatment from the intersubjective perspective does not strive to revive the therapeutic relationship the patient's unconscious conflicts over unacceptable sexual or aggressive longings, we dispense with those techniques whose purpose is to promote regression and facilitate the formation of the transference neurosis.

Another aspect of the traditional psychoanalytic theory of technique that stems from the concept of transference is that the patient's positive or negative feelings toward the therapist must be resolved before a thorough termination experience can occur. As we have discussed previously, we reject the view that the patient's feelings for the therapist are neurotic distortions that form out of displacements and projections of the patient's inner world. From the intersubjective perspective, both patient and therapist experience termination as a suspension of face-to-face meeting. It is acknowledged that the relationship continues even though regular meetings do not. The model is one of separation, not death.

From the intersubjective perspective, no discussion of the intersubjective field can focus on the contributions of one (the patient's transference) without examining the coconstructive role of the other (the therapist's countertransference.) There has been much discussion in the psychoanalytic literature as to whether countertransference represents an obstacle or hindrance to the psychotherapy process or whether it is an important source of data about the patient, or both. However, framing the discussion this way perpetuates isolated mind notions. By viewing the intersubjective field as a dynamic system, the quality of the therapeutic relationship must be shaped by the unconscious organizing activity of both participants. If we broadly define transference and countertransference as manifestations of unconscious organizing activity, then, according to Orange and colleagues (1997), "It becomes apparent that the transference is co-determined both by contributions from the analyst and the structures of meaning into which these are assimilated by the patient. Transference, in other words, is always evoked by some quality or activity of the analyst that lends itself to being interpreted by the patient according to some developmentally pre-formed organizing principle" (p. 40). Taken together then, transference and countertransference "form an intersubjective system of reciprocal mutual influence" (Stolorow et al. 1987, p. 42). Transference and countertransference become qualities of the relationship formed by each unique therapeutic pair.

At this point in our discussion of the centrality of relationship we wish to address the profound importance of relationship itself to all that transpires in any particular treatment. Thus far, we have focused on aspects of the therapeutic dyad such as selfobject needs, selfobject transferences, and the intersubjective understanding of the interdependence of transference and countertransference—the cotransference. However, the whole of a therapeutic process, whether conducted from the theory of intersubjectivity or from any other theoretical perspective, is a relational context (a relationship) far greater than the sum of interpretations, functional analyses, homework assignments, gambits, assessments, attuned or misattuned responses, to name a small fraction of what therapists might describe as going on in the room. In Chapter 3 we noted that subjectivity is inevitably intersubjectively constituted. That is, our subjective sense develops, is maintained, and always refers to a relational context. So there is a certain irony in recognizing that the fundamental construct of this theory—the inescapable organizing influence of one's subjectivity—is itself formed through interplay with other subjectivities.
In our earlier discussion of sustained empathic inquiry and affect attunement, we referred to Kohut's efforts to clarify the concept of empathy by differentiating between the psychoanalytic investigatory stance, on the one hand, and a bond developed when the patient felt understood by the therapist, on the other. Once again, what at first seemed to be a logical sequence (the affective bond grew out of the correct understanding by the therapist of the patient's subjectivity) now appears to be more accurately pictured as a complex, ongoing, mutually interacting process. The patient seeks treatment hoping to escape the tyranny of the past, to be understood, and to experience himself in new and more satisfying ways. The therapist enters the treatment with her own ways of understanding, including her personal history, her self-understanding, her theoretical constructs, and her anticipation of what may happen in therapeutic relationships. These are a few of the elements that pull for organizational priority in the new relationship.

**SUMMARY**

Central to the psychotherapy process is a unique relationship created by each patient-therapist pair. The examination, illumination, and articulation of the dynamics of this relationship contribute to a transformational experience for both participants.

This chapter is intended primarily for beginning psychotherapists, although experienced therapists will find some of the ideas to be useful in their teaching and supervision. As we will discuss in Chapter 8 on conducting supervision from the intersubjective perspective, there are many important parallels between the supervision and psychotherapy processes. Learning the practice of psychotherapy is a complex, intensive developmental process that, like being a patient in psychotherapy, takes place over a long period of time. Unlike chess, where there are a finite number of allowable moves and the openings and endgames have been well documented, in psychotherapy there are an infinite and unpredictable range of possible beginnings, middles, and ends. No book can detail how treatment will unfold for a particular patient-therapist pair. However, what we can do is offer some practice guidelines for furthering and deepening the process of psychotherapy.

In the prior chapters we discussed intersubjectivity theory,