Making Sense Together

The Intersubjective Approach to Psychotherapy

Peter Buirski, Ph.D.
and
Pamela Haglund, Psy.D.

JASON ARONSON INC.
Northvale, New Jersey
London
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,
the intersubjective sensibility, and the centrality of affect and relationship. These concepts form the foundation that supports informed practice. We believe that any approach to treating unhappy or troubled people must address itself to the root causes of the problem for which treatment is sought. In our experience, the vast majority of people who seek the services of psychotherapists have had, in their developmental histories, experiences of acute or chronic traumatic failures in attuned relating from caregivers. Such developmental failures are implicated in the broad range of psychogenically based psychopathology that our patients suffer from. In response to these compromised developmental relationships in childhood, our patients frequently came to organize their experience around convictions that they were the cause of the misattuned responses they received from these caregivers. They developed the invariant organizing principles that they were unlovable, undeserving, or unworthy of the attuned understanding they desired. Underlying these invariant organizing principles were the painful affects of shame and self-loathing that have been sequestered from conscious awareness. These organizing principles and accompanying affects play themselves out in maladaptive ways in the present. Because these affect states were both intolerably painful and experienced as disruptive or threatening to needed ties to important caregivers, they have been disavowed or dissociated.

The intersubjective approach to psychotherapy addresses itself to these maladaptive formative conditions in two main ways. First, through making sense together, the patient's invariant organizing principles are identified and articulated and the patient comes to understand himself and his formative history in a new light. Understanding of self in relation to others promotes the formation of new organizations of experience, and promotes affect tolerance, regulation, integration, and self-cohesion.

Second, the psychotherapy relationship offers the patient a new relational experience with the therapist (Shane et al. 1997), with whom the patient comes to feel deeply accepted and under-
understanding of the experience of the other is never pure or true, but is always shaped, influenced, or contaminated by our own subjectivity. The therapist's self-awareness is key in that it alerts the therapist to her inevitable impact on the patient's subjective experience. Since intersubjectivity presupposes no universal core dynamic, we try to listen with curiosity and an open mind to what the patient reveals, unencumbered by theoretical expectations. Each person, and his story, is unique, and the experience and meaning of the therapeutic work will unfold as a construction at the intersection of the two distinct subjectivities.

Attuned listening means attunement to the patient's affect states. As Stolorow has indicated, we do not so much put ourselves in the other's shoes as we try to find analogues in our own store of affective experience that resonate with the affective experience of the patient. When we think we have understood the patient's affective experience, we articulate our understanding, we put our understanding of the patient's affective experience into words that the patient may confirm, deny, modify, or embellish. Take for example, the patient who says, "I called the girl my mother wants to fix me up with and left a voice message for her but she hasn't called back yet." Based on our knowledge of the patient and our sense of his immediate affect state, we might say, "You felt hurt." This is not a question, but rather a statement of our own fallible but best guess. If we have got his feeling right, he will indicate feeling understood and proceed to say more about his experience. When we get the patient's affective state right, the patient has no end of things to say. It loosens a flow of associations that is truncated by the experience of misattunement. Therefore, free association is promoted by the experience of attuned responsiveness, not by silence. If we are slightly off base, the patient has the opportunity to modify our observation: "Not hurt, just disappointed." If we are way off base, the patient might correct us: "No, actually I felt relieved." In this example, the therapist sensed that the patient felt hurt. Rather than ask the traditional question, "How did that make you feel?" we believe that if you have a sense
of how the patient felt you should articulate it and thereby communicate to the patient that you understand his experience.

Embedded in this brief example are a number of important guidelines for furthering the therapeutic process. The first one is that the way psychotherapists inquire is opposite to that of lawyers. Lawyers are taught never to ask a question they don’t know the answer to. In this way, they avoid unexpected and unwanted testimony from coming forward and prejudicing their case. The psychotherapeutic process, on the other hand, is generally well served by therapists not asking a question to which they do not know the answer.

Take, for example, the following New Yorker cartoon.*

![Cartoon Image]

"And what do you think will happen if you do get on the couch?"

What we find so funny about the cartoon is the formulaic, actually ludicrous, question of the analyst. It is transparently obvious that this dog has been punished for lying on the furniture. Surely if the canine analyst knew anything about this particular canine patient she would have observed, “You are afraid you will be punished for getting on the couch.” Such an articulation would convey that the analyst understands the patient’s subjective experience. This would have the therapeutic benefit of making the patient feel understood and safe to reveal more of his experience.

We want to make clear that we are not advocating that therapists avoid asking questions, only that we avoid asking questions such as, “How did that make you feel?” when we have some sense of how the patient felt. The problem with the therapist’s asking questions to which she knows the answer is that such questions convey to the patient that the therapist does not understand him. Part of the difficulty is that some historical guidelines for therapeutic practice have become so ingrained in the public awareness that students come to training with preformed but antiquated ideas. For instance, it is a common belief that it is more therapeutic for the patient to verbalize the insight or come to the understanding himself rather than to have the therapist articulate it for him. This bit of psychotherapy lore derives from traditional psychotherapy approaches that view achieving insight as the therapeutic goal. However, we are not focusing on excavating the buried unconscious but putting one’s understanding of the patient’s subjective experience into words. Patients, like regular folk, may fail to express how they feel out of ambivalence, shame, embarrassment, fear of ridicule, the expectation of being misunderstood, or the paucity of language skills needed to express their subjective feeling states. By articulating the patient’s subjective state, the therapist conveys an experience of both acceptance and understanding. As we have indicated earlier, an important aspect of any accurate articulation is that in addition to new cognitive understanding, it conveys the selfobject function of being understood. Asking obvious questions conveys misattunement. Furthermore, for patients who have had little experience with another person’s being attuned to their affect states, putting a richly nuanced word to their affective experience may enhance their ability to express their feelings through

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language. In this way, therapists can teach the vocabulary of affective experience to their patients.

Another problem with asking questions is that it confuses the psychotherapeutic process with research. Research is all about collecting data. Most beginning therapists feel uncertain of what to say and also fear saying something hurtful. In such situations, asking formulaic questions or collecting tangential data may seem like a benign alternative. It serves to disguise the therapist’s uncertainties from herself and the patient.

While we do want to know about the patient’s life experience, especially his relationship with caregivers and siblings, often the information is useful only when it comes up in a specific context. Therefore, we find that it is not especially helpful to take a detailed history at the beginning of therapy. The facts or the vital data gain their therapeutic relevance from the context in which they emerge. For example, if the patient says, “My father used to work so much that I never saw him,” we would not ask, “What kind of work did he do?” This kind of question reflects tangential data collecting and is not process promoting. What is salient for the patient at this moment has to do with his feelings about his father’s absence, not whether his father was off mining coal or negotiating world peace. In some other context, the nature of the father’s work might be extremely relevant, but most likely to the extent that it bears on some affective experience, that is, the patient felt ashamed or proud of his father. We keep the dialogic ball in the air by attuning to the patient’s affective experience, not by collecting data.

Students of psychotherapy themselves often lack the vocabulary of affective experience. They have difficulty articulating the patient’s experience because they don’t have ready access to the words that most closely fit the experience. Therefore, it is important to be conversant with the exquisite affective nuance of words such as horrified, shocked, appalled, aghast, sickenèd, disgusted, revolted, dismayed, and so on. Too often, students like their

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patients, hide behind words such as frustrated, bored, and uncomfortable that disguise rather than elucidate affective experience.

Besides asking formulaic questions or collecting tangential data as attempts to ward off anxiety and uncertainty, beginning psychotherapists who are unfamiliar with the practice of articulating affective experience can sound quite inarticulate as they search for the right words to convey their impressions. This often leads to rambling, confusing interventions as the therapist struggles to buy time while becoming clear herself about what she is trying to say. This invariably improves with experience and supervision, but one guiding suggestion we have found helpful is that beginning therapists should try to keep their verbalizations to what can be said in one breath. In other words, be succinct. Verbalizations such as “Tell me more,” “Sounds like you felt insulted,” and “You felt unimportant” are, in effect, hitting the ball to the patient’s strength.

Let us examine the following clinical vignette:

Ryan, a 30-year-old man, begins his session complaining that his girlfriend has broken off with him because he has had several angry outbursts. While he recognizes the disproportion of his anger and the fear it generates in his girlfriend, he is mystified by her failure to value his genuine, unconditional love for her.

At moments like these therapists might hear a multiplicity of themes worthy of articulation. The therapist must then choose from a wide range of possible interventions. Some therapists might focus on how threatened and vulnerable the girlfriend must have felt and believe they should address Ryan’s inability to attune to her experience. Other therapists might focus on Ryan’s excessive anger and feel the need to help him develop skills for containing and appropriately expressing his anger. These are both pertinent observations about Ryan’s relational style and might become the focus of the psychotherapy dialogue at some
point. However, the first response privileges the girlfriend’s experience—how Ryan’s anger must feel to her. The second privileges the therapist’s experience as the observing other—how an outside observer might feel about Ryan’s anger. What is it that should guide the therapist? From our perspective, we believe that the focus of the therapist’s articulations needs to be attunement to our patient’s subjective experience. This guideline would then be, “Remember who is your patient.” Ryan is our patient and we must remain attuned to him. While we might sympathize with his girlfriend’s fear of Ryan’s anger, it is for her therapist to explore the meaning of the relationship to her.

We want to communicate to Ryan our understanding of his hurt at being rejected and the meaning he makes of this eventuality. The therapist might put Ryan’s experience into words by saying something like, “You are left with the feeling that your love doesn’t matter to her.” Trying to articulate for the patient what is most salient in his experience locates the therapist as an understanding presence, seeing the relationship and the crisis from the patient’s point of view. Once such an articulation accurately captures Ryan’s affective experience, he will feel understood and freer to examine in greater depth other facets of the complex relational context, such as his anger. When addressing Ryan’s anger, we want to focus on his affective experience, that is, what precipitated his anger and not the impact his anger had on his girlfriend. We find that articulating the patient’s subjective experience, as opposed to highlighting the impact of his behavior on the other, allows self-protective defensiveness to recede and other, less easily revealed feelings and thoughts to come to the fore.

This introduces us to another important guideline for keeping the therapeutic dialogue going: avoid interventions that injure the patient. We suspect that the roots of Ryan’s fragile personality organization lie in repeated formative experiences of misattunement and invalidation. To make his psychopathology, like his inability to integrate his angry affects, the object of our attention would be to replicate his experience of being criticized and condemned. We would avoid saying, “Your anger frightened her,” for two reasons: first, such an articulation focuses on the girlfriend’s subjective experience, not his own; second, such a statement is likely to be experienced as blaming and shaming. Instead, we would suggest saying something like, “You got so angry because you felt so hurt,” which addresses his subjective experience. From our perspective, the salient psychodynamic issue is not that Ryan gets too angry, but that he feels too vulnerable to injury.

We appreciate that at some point it will be important for Ryan to understand the impact of his anger on others. We do not dispute that Ryan lacks this awareness and that psychotherapy will have fallen short should he never develop an appreciation of and sensitivity to the experience of the other. However, we view this as an outcome of the process of therapy and not a target we must try to hit. We believe that Ryan’s anger is an outgrowth of his sense of vulnerability and his susceptibility to narcissistic injury. Therefore, through our focus on attunement to his subjective affect states and articulating his organization of experience, we expect that he will gradually develop greater self-cohesion and affect tolerance, integration, and regulation. He will become more resilient, less easily injured, less affectively reactive, and, accordingly, less prone to angry outbursts.

If the therapist were to address Ryan’s inappropriate anger by interpreting it or its impact on others, she would risk repeating earlier traumatic relationships by inflicting narcissistic injury that could precipitate the kind of reactions in patients who then get labeled as “borderline.” This practice seems to us another form of blaming the victim because the insensitivity or disregard of their early caregivers has injured these patients in childhood. Ryan might get angry with the therapist, become verbally abusive, and perhaps even threaten to terminate therapy. To this the therapist could respond with an interpretation that Ryan is treating the therapist just like he treated his girlfriend. However, the therapist
will need to take responsibility for the fact that she has inflicted on Ryan the same kind of narcissistic injury that his girlfriend did. Now, if Ryan gets verbally abusive to the therapist, this is likely to narcissistically injure the therapist, making the therapist angry with Ryan. Fortunately, the therapist can restore her equilibrium by accusing Ryan of putting his anger into her via projective identification. So who is putting what into whom? This is the kind of scenario, perhaps in the extreme, that we aim to avoid by adopting a relational stance that prioritizes attunement to the patient's subjectivity rather than blaming, pathologizing, or otherwise injuring the patient.

We appreciate that the point could be raised that Ryan needs to have his poor reality testing confronted. The desire to provide reality testing is common, especially in beginning therapists who worry that they are being negligent or irresponsible by failing to protect their patients from their self-defeating activities. If we were working from a cognitive-behavioral framework, we might institute some sort of anger management program for Ryan. However, as therapists working intersubjectively, we are more concerned with making sense of Ryan’s anger and the context in which it is formed, rather than in curtiling it; that is, focusing on the process, not the target. We believe that the therapeutic stance that will diminish Ryan’s inappropriate outbursts of anger involves focusing on promoting self-cohesion and affect integration.

Finally, another guideline that can be discerned from this example is that we let the patient set the agenda for the session. We do not assign homework and check that it has been done. We want the patient to feel free to explore his subjective experience, to speak his mind about the issues most salient to him. Invariant organizing principles are forever shaping the patient’s immediate experiences, and there is no risk that some important dynamic will be overlooked for long. A corollary to the principle that the patient should set the agenda is the guideline of not changing the subject; that is, the therapist should not change the subject to one more interesting or more salient to her. For instance, if the patient says, “I called my son last night,” the therapist should avoid such interventions as “What made you do that?” This question addresses the therapist’s curiosity, without leaving the opportunity for the patient to express his concerns. Perhaps the patient would go on to say, “My wife got so angry. She hates it when I give my attention to my son. She acts like I’m taking something away from her.” Clearly, why the patient called his son is not the important dynamic issue—unless he did it to irritate his wife. However, this too will become apparent when his need to discuss his feelings about his relationship with his wife becomes his priority. Rather, to the patient’s remark that he called his son last night, we encourage a response that allows for the unfolding of the personal meaning of that activity. There is no one right response, but many might provide an encouraging prompt to explore in more breadth and depth what made that call important enough to speak about. Some of the possibilities include being silent for a time, a simple “Uh-huh,” or “Tell me more about it.”

In addition to our attunement to the patient’s affective experience, we are also trying to grasp the underlying themes or organizing principles that shape his experience. Listening is guided by the idea that, whatever the current episode the patient is describing, it likely contains some expression of the patient’s invariant organization of experience. Sometimes an organizing principle will announce itself with trumpet flourishes: “No man that I want will ever want me!” The organizing principle behind this might be that the patient feels fundamentally defective and unworthy of the love of a desirable man.

Sometimes an organizing principle appears unheralded, hiding behind a trivial remark or a superfluous comment. For example, the patient makes the following remark: “Remember how last week I was talking about how mean my boss can be . . .” The patient seems to be concerned with the boss's aggression. However, for no apparent reason, the patient brings this into the
transference, the relationship with the therapist. Note the unnecessary word “remember.” This might be a meaningless throwaway word, or perhaps it touches on something meaningful for the patient. Why would the patient phrase things this way? Has this patient’s experience become organized around the notion that people don’t remember? Might the patient be saying, “Nobody really listens to me,” or “I am not important enough to be worth listening to”? This would then be a manifestation of the transference, of the extent to which the therapist has become assimilated into the patient’s organization of experience as yet another person who does not listen. So we might venture the following tentative articulation: “When you say ‘remember,’ I wonder if you think that I don’t remember?”

This articulation represents an exception to the guideline that the therapist should not impose her agenda on the patient. Investigation of the appearance of an organizing principle emerging in the transference temporarily takes precedence over the patient’s need to discuss his feelings about his boss. Of course, it is possible, even likely, that the discussion of the boss would turn out to center around the very same organizing principle (“I’m not important enough to be remembered or taken into account”). However, the therapeutic effectiveness of articulating the personal meaning of experience is enhanced when it occurs in the here and now, especially in relation to the therapist. While valuable understanding of the patient’s invariant organization of experience can be gained from focusing on important relationships in the patient’s life, the power is magnified when the focus is on the transference. This practice is consistent with the traditional notion that the central focus of analytic work is on the analysis of the transference. To reframe this from the intersubjective perspective, we offer the guideline that the optimum focus should be on how the therapist is assimilated into the patient’s invariant organization of experience.

This introduces yet another guideline for furthering the process. The archaic principles that have come to organize our experience are like the musical themes that flow through a symphony. While each life has many themes that wind through it, all these themes are not salient at any given time. One aspect of the process of psychotherapy, what in fact characterizes the process, is the way that organizing themes emerge, become an important focus of the treatment, and then begin to recede, allowing other themes to rise to prominence. What gives a sense of coherence and order to a psychotherapy process is the emergence and persistence of these themes over time. When an organizing theme has been sounded and is identified by therapist and patient, it becomes more easily recognizable as it reappears in new forms. The way a musical theme can be heard first in the woodwinds, and then in the strings, organizing principles may be heard first in descriptions of the patient’s relationship to his boss and later in the transference to the therapist. The theme gets developed, deepens in complexity, and then drifts away as another theme is announced.

Let us return to the patient above and to the theme that no one remembers him. If the organizing principle of not being remembered has been identified previously and seems to be in the forefront of this phase of treatment, then identifying this latent, underlying theme in the transference would take precedence over any specific content. While the specific life events the patient selects to relate may shift from one person in his life to another, the theme of not being remembered will likely be running through them all. It is important that we listen for the salient theme, track its embeddedness across the various events and relationships the patient describes, and shine a light on it: “Your boss doesn’t remember the good job you did,” “Your father forgot your birthday,” “Your mother sent you the same card this year as she did last,” “Your therapist needs to be reminded of something you told her last week.” These interventions are all articulations of the same underlying organization of experience. The clinical case presented in Chapter 6 provides a good example
of the way an organizing theme is identified and then tracked over the two sessions described.

In addition to identifying and articulating both the patient’s affective experience and the principles that organize his experience, another important psychotherapeutic practice involves elucidating the personal meanings made of subjective experience. While the accurate articulation of affective experience confirms the therapist as an understanding and attuned other, we will also further the transformative process by exploring and articulating the personal meanings the patient makes of his affective experience. Referring back to the example of the patient who was not being remembered, we want to explore the meaning the patient has made of his experience that he is not remembered. Or, put another way, what does not being remembered mean to him? If we try to make sense with the patient of the personal meaning to him of not being remembered, it might be uncovered that he has the unconscious conviction that nobody remembers him because he must be inherently empty, worthless, or otherwise undeserving of being remembered. This touches on the deepest and most painful level of subjective experience that is generally sequestered outside of awareness.

The transformative moments in treatment when the full impact of a patient’s hidden, personal meaning emerges are impossible to orchestrate. Certainly, being with another human being at such times transcends technique or even practice. Probably little can be taught about how to respond or intervene in these moments. Being with another person at such intense and intimate times calls upon the full psychological resources of the therapist. Her own stability and tolerance for her own and other’s affective intensity are important. Having had the experiences of being vulnerable and coming to new understanding in the presence of a trusted other is one possible way of enhancing one’s capacity for sharing them with patients. We encourage students and practitioners of psychotherapy to explore and expand their subjectivities in their own psychotherapy experiences.

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In contrast to those intense moments just discussed, at other points during the course of every treatment the flow seems to dry up, the material becomes vague and elusive, the patient seems distracted, the therapist feels bored and restless, or the patient seems to be avoidant and defensive. At these times, the patient is often described as being resistant. Traditionally this has meant that the patient is motivated to obstruct the therapist’s efforts to uncover his unacceptable unconscious motives. From the intersubjective perspective, resistance is a manifestation of the repetitive dimension of the transference. That is, these instances of disengagement in treatment are attempts by the patient to avoid retraumatization by the therapist. With this frame of reference in mind, a therapist might turn the light of introspection on herself and wonder what aspects of the context, including their interfacing subjectivities, have contributed to the emergence of the patient’s need to protect himself.

Beginning therapists often have difficulty negotiating such phases in the treatment. At these times, we have found that it is often helpful to reflect on or observe some aspect of the unfolding process and not become mired in the specific content. For example, the patient discusses spending the night with her boyfriend but glosses over an implied sexual interaction. The therapist’s curiosity might be aroused by the patient’s avoidance of explicit references to sexual activity in her report of the evening. Among the therapist’s options might be to directly ask about the unspoken sex, saying something like, “Did you have sex?” However, we believe that this approach is problematic for two reasons. First, this is an intervention that grows out of the therapist’s unsatisfied curiosity. Here the therapist would be changing the subject to her area of her interest by directly confronting the patient’s discomfort and overriding the patient’s reluctance to be explicit about her sexual encounter. Second, this intervention reflects preoccupation with the content, as if what is therapeutically important are the details of the sexual encounter and not the patient’s reticence in discussing sex.
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losing what she craves and hangs on for dear life. It would not be helpful for the patient if the therapist was to align herself with the boyfriend’s experience, by interpreting that the more she clings, the more he feels suffocated and tries to disengage. We recommend that the therapist align herself with the patient’s struggle for health by depathologizing her self-criticisms and promoting confidence in her perceptions, as in an articulation such as, “You don’t seem to trust your experience that you’re not getting the emotional connection you need from him. You blame yourself for being too needy, but you’re not getting what you need.” Perhaps her needs are excessive (for this boyfriend) because her deprivation has been great. Her need for connection will not diminish because the therapist sides with the boyfriend’s experience of suffocation. Her needs will diminish when she feels understood and reassured that she is not intolerable.

Reframing is a technique that is utilized by a variety of psychotherapy systems, especially in cognitive therapies. We are not advocating reframing as a way to change negative thoughts into positive ones. Patients disparage their own affective experience, not out of some mistaken need to catastrophize but out of fear of, or repetitive experiences of, invalidation by significant others in their life.

From our perspective, by depathologizing the patient’s subjective affect states and affirming the patient’s striving for health, we hope to promote respect for the patient’s own subjective affective experience. By validating the patient’s affective experience, we promote self-delineation and affect integration. As a guideline, we believe it is affirming and supportive to uncover the kernel of health hidden behind the patient’s self-disparaging pathologizing.

Finally, we want to emphasize an important personal quality that tends to be overlooked when we enter into the practice of psychotherapy, that is, the personal courage that is required of the therapist. Psychotherapy, as a meaning-making process, does not follow universal laws. If we jump out a window, we know with
absolute certainty that the law of gravity will prevail and we will fall to the ground. When we jump into a psychotherapy relationship, we have no idea where we will land. It takes, not blind faith, but confidence in the method to make such leaps into the unknown.

It happens, on occasion, especially with more fragile patients, that we find ourselves concerned for the patient’s safety and well-being. Because psychotherapy is so uncertain an enterprise, we can never know for sure that patients who seem extremely depressed, potentially suicidal, or homicidal will not attempt to hurt themselves or others, or that patients who are under a great deal of emotional stress won’t decompensate, requiring immediate hospitalization.

With patients like these, therapists sometimes suffer crises of confidence. We doubt ourselves: Am I helping this person? Am I doing all that I could? Am I not doing something I should be doing? Patients who frequently interface with our subjectivities in this way get labeled “difficult.” We believe that what is meant by “the difficult patient” is the one with whom we suffer just such crises of confidence. When therapists subjectively experience stress and feel unsure of what to do or what should be done, there is a tendency to resort to what we can do. To manage our own anxiety or uncertainty we refer the patient for medication, recommend group therapy, or institute some other external intervention. Any of these interventions might be useful for a given patient at a given point in treatment. But we also resort to them, not just to help the patient manage his distress, but to manage our own. It never hurts to ask ourselves, Whose anxiety will be reduced if the patient takes medication—the patient’s or our own?

We believe that it takes great courage for therapists to face such crises of confidence by maintaining their trust in the method. Often when we feel the greatest internal pressure to do something external for the patient, the patient has the greatest need for us to maintain our confidence in him and the therapeu-

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tic process. Therefore, our final guiding recommendation is to trust the method. Maintain your commitment to the process of unfolding and illuminating the patient’s organization of experience and to responding with attunement to his affective experience.

SUMMARY

This chapter has distinguished between principles of technique and guidelines for practice. In contrast to technical recommendations, which have a one-size-fits-all quality to them, guidelines for practice emphasize the need to promote the unfolding and illumination of the patient’s subjective experience. Practice is context dependent and addresses the furthering of the process of treatment rather than the specifics of intervention.