Making Sense Together

The Intersubjective Approach to Psychotherapy

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Critics of intersubjectivity theory mistakenly assume that the therapeutic action is primarily found in the provision of empathy. Thus, they conclude, somewhat dismissively, that treatment based on intersubjectivity theory is superficial therapy because it is merely another version of the discredited corrective emotional experience. Because intersubjectivity theory does recognize the selfobject dimension of experience and the therapeutic benefits of new experience, critics tend to assume that therapy takes place strictly on the surface.

That intersubjectivity theory is indeed a depth psychology is evidenced by two of its central tenets. First, integral to the

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intersubjective perspective is the genetic point of view in which the principles that organize experience are understood to form in the early relationship with caregivers. Second, the intersubjective perspective recognizes that these organizations of experience exert their influence while remaining largely unconscious. The richness and depth of the intersubjective approach to treatment then derives from the way in which these developmentally formed unconscious organizing principles are identified, illuminated, and articulated. This chapter examines from the perspective of intersubjectivity theory how therapist and patient make sense of the patient's organization of experience.

Traditionally, psychoanalytic theoreticians have sought the therapeutic action of psychoanalysis in various activities of the analyst. The Freudian school has located the therapeutic action in interpretation, primarily of the transference (Strachey 1934), conceptualized primarily as cognitive processes whereby the analyst transmits new knowledge or insight to the patient. Relational theorists have emphasized that the therapeutic action resides in the new ways of relating that analyst and patient construct together out of their relationship. For self psychology, the therapeutic action is generally believed to derive from the provision of selfobject functions that mobilize thwarted developmental longings. From the perspective of intersubjectivity theory, the therapeutic action resides in the unfolding, illumination, and transformation of organizations of experience. One way in which new organizations of experience are formed is through the new experience of attuned responsiveness that infuses the therapeutic relationship. However, organizations of experience are also transformed through the identification, elaboration, and articulation of subjective experience that grows out of patient and therapist making sense together.

*Interpretation* is a term burdened with history. It derives from the classical literature where the focus was on making the unconscious conscious through attaching word cathexes to pre-conscious thoughts (Freud 1915b). Freud (1900) used *interpretation* (deutung) to describe his procedures for discerning the unconscious meanings of dreams and parapraxes. As Freud (1913b) explained, "The interpretation of dreams has as its object the removal of the disguise to which the dreamer's thoughts have been subjected" (p. 210). *Interpretation* here is being used in the sense of finding a solution to the puzzling mental phenomenon (Freud 1913a). In the sense that it is generally used, *interpretation* refers to the analyst's communication of the solution to the patient. The emphasis is placed squarely on the analyst's promoting cognitive insight by conveying new knowledge to the patient about the contents of the patient's unconscious desires or his defenses against knowing. Within this tradition, Arlow (1987) regards "the principal function of the psychoanalyst to be the giving of interpretations" (p. 69). From this perspective, the transmission of the analyst's cognitive insights into the mental functioning of the patient, through the verbal procedure of interpretation, is the principal therapeutic action of ego psychology, even if the insight forms in the mind of the analyst as an outgrowth of her relationship with the patient. There seems to be agreement that for the cognitive component to have therapeutic impact, it must resonate emotionally for the patient (Neubauer 1980).

From the perspective of self psychology, Kohut (1984) articulated a transitional position, retaining, at least in theory, the role of the analyst as objective observer, while simultaneously emphasizing the primary importance of understanding gained through an empathic bond. We have discussed previously the confusion in Kohut's writings between the use of empathy as both an observational stance and as a description of the relationship that facilitates therapeutic action (Stolorow et al. 1987). Kohut (1984) recognized that a therapeutic intervention consists of two interdependent steps: the analyst's empathic understanding of the patient, and communication of this understanding to the patient through explanation.

The two poles of the debate on the therapeutic action of
psychoanalysis are represented on the one hand by ego psychology, which emphasizes the transmission of new cognitive understanding, and on the other hand by self psychology, which stresses that the therapeutic action is to be found in the new selfobject experiences that come from feeling understood. Atwood and Stolorow (1984) have suggested that both are important and indivisible: “Every transference interpretation that successfully illuminates for the patient his unconscious past simultaneously crystallizes an illusory present—the novelty of the therapist as an understanding presence. Perceptions of self and other are perforce transformed and reshaped to allow for the new experience” (p. 60). In other words, whenever new cognitive knowledge is accepted by the patient as a meaningful formulation of his inner experience, the patient also has a new experience of feeling deeply understood. Therefore, interpretations work on two levels: the level of cognitive understanding, where new knowledge is assimilated, and the developmental level, where needed selfobject functions are experienced through the therapist’s attuned responsiveness. The tendency to dichotomize the therapeutic action into a cognitive component and an affective component is seemingly resolved by this stance that accurate transference interpretations convey both (Terman 1989). Nevertheless, the emphasis still seems to be that new cognitive knowledge provided through interpretation has therapeutic effect largely because it is packaged with the selfobject experience of feeling emotionally understood.

In contrast to Kohut’s (1977, 1984) view of the curative process, which invoked optimal frustration and transmuting internalization, Bacal (1990) has suggested that the curative process involves a corrective selfobject experience. The notion here is that psychopathology results from archaic developmental longings being disrupted by a falling selfobject relationship with the caregivers. By restoring a needed selfobject tie, thwarted developmental longings will be remobilized in the safety of the attuned selfobject relationship. Hence, “the internalization of the cohesion-fostering selfobject tie constitutes the essence of what is the therapeutic, or ‘corrective’ experience in analysis” (Bacal and Newman 1990, p. 258).

Traditionally, interpretation derived from a one-person stance in which the analyst is the authority on the truth of the patient’s inner experience (Fosshage 1995b). As such, the term interpretation, as used in modern relational thinking, is anachronistic; it is a derivative of the myth of the isolated mind (Stolorow and Atwood 1992). Postmodern thinking emphasizes the construction of personal meaning. Intersubjectivity theory views psychoanalytic interpretation as “an act of illuminating personal meaning” (Stolorow 1994b, p. 43). Personal meaning is illuminated through the process of making sense together. Since our verbal interventions are directed toward putting into words the personal meanings of subjective experience, we propose that, rather than perpetuate the historical associations packaged with the term interpretation, we refer instead to the therapist’s “articulation” of her understanding of the patient’s subjective experience. Articulation specifically addresses the verbal component of putting into words the therapist’s understanding of the patient’s subjective experience as acquired through the empathic introspective mode of inquiry.

We would now like to further the discussion of the locus of the therapeutic action in intersubjectivity theory by pulling together the three themes in the debate: enhanced cognitive understanding, the experience of feeling understood, and selfobject functioning. We propose that illuminating personal meanings (new cognitive understanding) through making sense together (the experience of being understood) of the totality of one’s life experience has the selfobject function of promoting self-understanding, self-delineation, self-continuity, and self-cohesion. New self-understanding contributes to the construction of new organizations of experience and hence to structural transformation.

Patients respond to the therapist’s verbal communications in
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Orange (1995). Verbal articulations are an important part of the process that allows for the conscious recognition and reevaluation of archaic organizations of experience and the emergence of new organizing principles. By putting the patient's subjective experience into words, the therapist promotes self-cohesion and the integration of affect into experience.

Humans are meaning makers, and as Orange (1995) has pointed out, "The urge to make sense is distinctively human. . . . Healthy humans have a developing and lifelong propensity to reflect, to organize experience variously, and especially to wonder and to converse about meanings. . . . Psychoanalysis is a special conversation about meaning; it is an attempt of analyst and patient to make sense together of the patient's emotional life" (pp. 6–7). As humans we have a unique capacity for symbolic representation. At approximately 18 months of age the child develops the use of complex language, and with the acquisition of language, memory, communication, and organization of experience are irrevocably altered. Not only is linear, secondary processing acquired, but through the maturation of the frontal cortex and associational pathways, primary process representation becomes accessible (Lichtenberg et al. 1996). Levin (1991) discusses at length many possible ways of understanding the effectiveness of psychoanalysis (particularly transference interpretations) in terms of the emerging knowledge about functional neuroscience. According to Levin, metaphorical language, used spontaneously by a therapist, may serve as a bridge among multiple levels of neurological functioning. For example, an articulation framed as a metaphor may link modalities of touch, hearing, and sight; it can bridge past and present experiences simultaneously; it might connect affect with a narration of experience; and it could allow for associations among different developmental levels of cognitive processing (such as preverbal sensorimotor experiences, and, later, more advanced levels of symbolic representation). The ambiguity of the metaphor and its implicit comparison between that which is
similar and yet not identical allows for simultaneous multiple processing in the brain by which new associations and therefore new understandings can emerge.

Children suffering from alexithymia present another instance of the developmental imperative of putting words to feelings. By verbally labeling emotional experience, children can be helped to identify and think about their feelings, thereby promoting the organization and integration of affect. According to Reckling and Biuriski (1996), “Without the capacity to think about feelings, children will not develop the ability to identify and verbally express affect and will likely continue to express affect somatically. The caregivers’ inadequate articulation of their child’s affect states interferes with the child’s development of a capacity to desomatize and identify affects” (p. 85).

Our position is not that verbal articulations of the patient’s archaic organizing principles are the primary or even necessary component of therapeutic action. We have certainly been impressed with Lachmann and Beebe’s (1996) demonstration of the importance of nonverbal interaction on therapeutic growth. What we are trying to emphasize is that putting into words the patient’s developmental dynamics has the function of promoting self-understanding—the understanding of one’s organization of experience in the context of one’s personal development. Such self-understanding promotes a sense of self-delineation, self-continuity, and self-cohesion. Understanding how one’s experience has become organized and the developmental context and constraints in which this organization took shape gives coherence to one’s life. For example, through verbal articulation, an adult male patient developed the awareness that his anger, which served as a shield to ward off hurtful disregard by his parents and formed a protective armor against a threatening world, while vital to his survival as a child, now functions to keep potential good objects at a distance. This understanding now provides the patient with a template against which to assess the dangers of new relationships, as well as a signpost to his self-protective behavior.

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He understands that when he finds himself enraged, behind his anger lurks an archaic conviction, derived from his invariant organization of experience, of his vulnerability to the presently perceived threat of retraumatization.

Building on our formulation that verbal articulations given in the context of a primary selfobject relationship provide important selfobject functions, we now turn to the question of the accuracy or exactness of interpretations. It is in just this arena that the different perspectives of historical truth and narrative truth collide.

Freud pursued historical truth. Using the archaeological metaphor, he sought to excavate the buried unconscious layers and unearth veridical memories of past experience. The important tool in excavating the past was interpretation or genetic reconstruction. According to Freud (1937),

The path that starts from the analyst’s construction ought to end in the patient’s recollection; but it does not always lead so far. Quite often we do not succeed in bringing the patient to recollect what has been repressed. Instead of that, if the analysis is carried out correctly, we produce in him an assured conviction of the truth of the construction which achieves the same therapeutic result as a recaptured memory. [pp. 265–266]

For Freud, the nineteenth century positivist, “an assured conviction of the truth” referred to his belief in the objectivity of truth, as opposed to the postmodern view of the relativity of the truth of personal meanings. In this vein, then, Freud stressed the therapeutic importance of the accuracy of the construction, even while acknowledging that the therapist arrives at the accurate construction through successive approximations.

As much as Freud stressed the therapeutic importance of accurate interpretations or constructions, he minimized the effect of inaccurate ones. As he clearly stated (1937),
No damage is done if, for once in a way, we make a mistake and offer the patient a wrong construction as the probable historical truth. . . . A single mistake of the sort can do no harm. What in fact occurs in such an event is rather that the patient remains as though he were untouched by what has been said and reacts to it with neither a "Yes" nor a "No". . . . If nothing further develops we may conclude that we have made a mistake and we shall admit as much to the patient at some suitable opportunity without sacrificing any of our authority. Such an opportunity will arise when some new material has come to light which allows us to make a better construction and so to correct our error. In this way the false construction drops out, as if it had never been made. . . . The danger of our leading a patient astray by suggestion, by persuading him to accept things which we ourselves believe but which he ought not to, has certainly been enormously exaggerated. [pp. 261–262]

Glover (1955) in his famous paper, "The Therapeutic Effect of Inexact Interpretation," published first in 1931, six years before the Freud paper quoted above, takes the opposite position. Glover's view is that an incorrect or inexact interpretation is utilized by the patient as a "displacement-substitute" (p. 356). Such substitutes act like suggestions; they may "bring about improvement in the symptomatic sense at the cost of refractoriness to deeper analysis" (p. 356).

Modern relational thinking discards the notion of historical truth in favor of a hermeneutics/constructivist approach (Mitchell 1993). As Mitchell summarizes it, "The patient's experiences, associations, and memories can be integrated or organized in innumerable ways. The organizational scheme arrived at is a dual creation, shaped partly by the patient's material but also inevitably shaped by the analyst's patterns of thought, or theory. The 'meaning' of clinical material does not exist until it is named—it is not uncovered but created" (p. 58).

From this perspective, it is meaningless to apply the criterion of accuracy or exactness to an articulation or construction. The therapist's articulation of the patient's subjective experience represents the therapist's experience of the patient's subjectivity, filtered through the therapist's subjectivity, which includes the therapist's theoretical system. It is an outgrowth of the context in which it forms in the mind of the therapist.

Thus, an articulation is not an expression of some objective truth about the patient's experience. It is the way in which the therapist has organized her understanding of the patient at this moment, in this place, in this immediate context. This particular understanding of the patient's organization of experience will necessarily be affected by changes in the context of the therapeutic relationship. Verbal articulations, within the hermeneutic/constructivist perspective, are not successive approximations of the truth about the patient's past but are constructions about the patient's current subjective organization of experience. The meaningfulness of the articulation to the patient depends on the selfobject functions provided by the formulation. We judge the clinical usefulness of an articulation or construction, not by its proximity to some criterion of truth, but by whether or not the patient finds the articulation personally meaningful. A personally meaningful articulation is one that leads the patient to new ways of organizing his experience, that is, new self-understanding that is growth enhancing.

We have all probably encountered patients for whom belief in God is a profoundly organizing experience. Questions about the existence of God are irrelevant to the therapeutic enterprise. Belief in God helps organize these patients' experience of themselves in the world. Other belief systems have similar effects. Articulations, being constructed out of the experiences of both patient and therapist, are another form of belief system. The patient accepts the therapist's articulation of his subjective experience because the patient finds it to be personally meaningful and because it helps reorganize the patient's experience, or the patient may reject the articulation because it is experienced as
nonorganizing or at worst disorganizing. Such understandings or ways of organizing experience are not fixed but are subject to being superseded as newer understandings or organizations of experience are constructed.

Even though we are dispensing with the notion of true or accurate verbal articulations, we nevertheless believe that some articulations promote transformation of experience, while others might be organizing, but not transformative. Some misuses of interpretation or reconstruction can ultimately be hurtful to the patient’s development. Interpretations or constructions that move beyond a focus on illuminating the patient’s subjective experience, relational configurations, and affect (but aim instead to reconstruct memories of actual events presumed to have taken place in the patient’s past and reside in the patient’s unconscious) are potentially very destructive. Such an interpretation as “Your dream is the dream of someone who has been sexually abused by their father” is the type of destructive statement that purports to reconstruct some piece of real experience out of the cloth of subjective experience. One cannot derive objective reality from subjective experience. This is the flaw in the archaeological analogy. Freud believed that by sifting through the strata of the unconscious, one could unearth real artifacts of a patient’s buried past. Take for example Freud’s (1918) analysis of the Wolf Man’s dream (Buirski and Haglund 1998). Freud reconstructed that his patient, at the age of 18 months, had literally observed his parents having intercourse a tergo, three times, at five o’clock in the afternoon. That the objective truth of such a specific scenario could ever be known is highly doubtful. Objective reality can only be known through applying the scientific method of empirical observation, not from psychoanalytic exploration of personal meanings.

On a television news magazine program some time ago, a patient in past-lives therapy and his therapist were interviewed. The therapist reported that the patient, who had come for treatment because of his fear of water, had, under hypnosis, been regressed to a prior life. Under hypnosis it was uncovered that in the seventeenth century the patient had drowned in a shipwreck. The patient reported that recovering the memory of this prior life experience had been extremely helpful and he experienced relief from his fear of water.

Following the line of thought we have been developing, the recovery of the prior life experience offered the patient a new way of understanding himself and organizing his experience. We suspect that this new formulation functioned as an antidote, which we will discuss in greater detail in Chapter 7. As an antidote, this kind of interpretation, while organizing on one level, fosters defensive rigidification rather than promoting growth and self-development. It is organizing but not transforming.

Many of the ideas put forth in this chapter represent themes dramatically interwoven in the false memory syndrome controversy (see Harris 1996). While a complete discussion of the controversy is not possible in the context of this book, the relativity of “truth” in the co-constructed understanding developed in psychoanalytic treatment between patient and therapist must be considered. From the intersubjective perspective, the personal meaning of memories, fantasies, and experiences is the focus of analytic inquiry, and such meaning is not assumed to correspond to observable events, past or present. However, it seems imperative that patient and therapist explicitly discuss the subjective nature of their constructions. Harris (1996) formulates a position with which we concur: “We need to assert the importance of provisional knowing, of inquiry, and of creating climates of respect and support. . . . This attention to the potential for distorted listening does not rule out the importance of validating the patient’s experience where possible; but when the analyst moves beyond or beneath the experience of the patient, the grounds for doing so must be open for shared inquiry and meaning making” (pp. 183–184).

Verbal articulations always occur within an intersubjective
field, and the patient’s subjective experience of hearing them can be as complex as the therapist’s motives for giving them. They may be experienced as blaming or gratifying, loving or destructive, genuine or manipulative—depending on the particular intersubjective context. But for verbal articulations to generate meaningful cognitive and emotional understanding, they must be given within the context of a primary selfobject relationship. Verbal articulations promote the important selfobject functions of self-understanding, self-definition, self-cohesion, and self-continuity, as well as affect-integration and affect-tolerance. We hope to illustrate these points through the clinical material that follows.

CLINICAL MATERIAL

Hannah is a 36-year-old woman with a history of hospitalizations for suicidality who came for treatment to a clinic associated with a training program. Her current symptoms include head banging and cutting on herself. To illustrate the selfobject function of verbal articulations we have chosen to follow three themes over the course of the initial two consultation sessions. This will also illustrate the way in which thematic continuity is maintained through tracking their appearance across sessions. The cumulative effect of putting the patient’s experience into words appears to have helped make her past and her present more comprehensible to her, and therefore, we suggest, contributed to her understanding of herself in a way that enhanced a cohesive and continuous self-experience. While this is not a chapter intended to demonstrate the feasibility of short-term treatment, we have chosen only to use material from the first two consultation sessions in order to illustrate the power of verbal articulations delivered within the context of a quickly forming selfobject relationship.

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In the opening remarks of session 1, responding to the therapist’s invitation to describe what brought her into treatment, Hannah begins:

Patient: (Describing her experience of hospitalization the previous year) Some issues within myself which are not resolved. I didn’t feel on kilter, not who I really am. Does this make sense? I feel hopeless. I get a black feeling inside myself that wells up, very black.

Therapist: Is it related to feelings that led to your hospitalization?

Patient: Yes, I think so . . . I have trouble differentiating what’s really happening. . . . I have difficulty expressing myself well and making myself understood.

In this summary of the first exchanges between therapist and patient, three themes have been articulated by the patient that the therapist will track and clarify with her over the two sessions: first, Hannah’s experience that she does not “make sense,” that she cannot make herself understood; second, her unstable sense of self, that she is “not who I really am”; and third, her description of a black feeling inside her that is connected with such extensive personal disorganization that she has required hospitalization in the past. Of course, these themes have been artificially separated in order to simplify illustration of the subsequent effect of the therapist’s articulations.

Hannah goes on to express her subjective experience of a lack of a cohesive self-organization in the absence of mirroring selfobject reflection. She presents a developmental dilemma revealed by repeatedly asking, “Does this make sense?” Through this question, Hannah raises the possibility that if the therapist can understand her, then perhaps she can grasp who she is. Tracking the theme of making sense, the therapist responds to her statement that she has difficulty making herself understood:
Therapist: You're awfully worried about making sense. Have you had the experience of being misunderstood?

[Here the therapist tentatively articulates what might be an underlying organizing principle: “People don’t understand me.”]

Patient: I find that I have difficulty expressing myself well, to get my meaning across.

[The patient blames herself for not communicating clearly.]

Therapist: You’re feeling that it’s your problem in communicating, rather than people’s problem in listening?

[The therapist articulates the patient’s experience.]

Patient: Must be.

Therapist: Must be (with a smile).

[The nonverbal communication conveys that both the therapist and the patient are leaving open to question that the patient’s problem is an inability to communicate clearly. Through the use of irony and humor, the therapist tries to depathologize the patient’s self-blame.]

At this point, though, Hannah identifies the problem as her failure to communicate clearly; she locates the difficulty in her manner of delivery and expression. However, as the therapist invites her to explore with whom and in what contexts she fails to communicate well, the patient reveals that the problem manifests primarily in close personal relationships, such as with both her present and former husbands and her mother. For example, with her mother and sisters who did not visit her during her hospitalization:

Therapist: You were hurt by that.

[Articulation of affect.]

Patient: I was hurt by that because I’ve pretty much gone out of my way for everybody, and . . . that’s my role in the family.

[Hannah identifies the context in which her organization of experience developed.]

Therapist: Your role is to help everybody else.

[Articulation of a second important organizing principle.]

Patient: Right!

[Said with surprise that reveals the novelty of being understood.]

Patient: I basically was (sighs), when people had problems they would come and dump them on me, and I would help them, or listen to them and . . .

Therapist: But nobody listens to you.

[Picking up the theme of the original organizing principle and articulating it again.]

Patient: Right. . . . At that point when I knew I was not together mentally . . . (She describes how her sister tried to get her to take care of her children and became indignant when the patient expressed unwillingness to take on that responsibility.)

Therapist: She wasn’t hearing you.

[Therapist stays focused on the theme of the organizing principle that underlies her subjective experience of the encounter with the sister.]

Patient: Right. Exactly.

Therapist: She wasn’t hearing what you needed.

[Articulated again.]

Patient: Right. Right. Exactly. I think I have a problem with my family. They don’t hear me. They definitely don’t hear me.

[At this point the organizing principle of people not hearing her appears to have been made conscious and is accepted by the patient. She no longer blames herself. We need to be alert to the possibility that her verbalizing of this organization of experience reflects superficial compliance with the therapist’s articulations.]
However, confirmation of the authentic meaningfulness of her understanding comes from traditional sources, that is, her next association. This spontaneous verbalization answers the question of whether she is merely agreeing out of compliance with the therapist.

**Patient:** I have a picture, as a matter of fact, that I drew in art therapy. It was really weird because I’m a little girl, kneeling. And my family . . . it’s just their heads, and they’re real huge, and they’re looking away from me. And none of them have ears.

**Therapist:** So they’re not hearing you and they’re not seeing you.

[Here the organizing principle is again articulated. In addition, the therapist is validating the subjective experience of the patient, thus fostering self-delineation through the promotion of trust in her subjective experience.]

From this point in the session, Hannah focuses in depth on her relationship with her current husband and how, in her wish to meet his needs she has lost some respect for herself. As she tried to communicate her experience to her husband, he did not respond. She feels unable to make things change, unable to stop the course that their relationship is taking.

**Patient:** I feel like I can’t talk to him, you know. I mean, you reach a point . . . At least I’ve reached the point where when I feel like it doesn’t matter what I say . . . There’s no point in trying to say anything.

**Therapist:** He’s not going to hear you.

[The therapist articulates Hannah’s recognition that it is not her failure to communicate clearly, but her husband’s unwillingness to hear her that is the problem.]

Hannah moves now to exploring an area in which she does not feel hopeless: her relationship with her children. She contrasts these relationships to her relationship with her own mother, and again the theme of listening and being heard emerges.

**Therapist:** And they [her children] can listen to you?

**Patient:** Yeah. . . . That, too. That, too. I try not to be like my mom was. My mom was definitely, “Listen to me. Listen to me. Be my friend.” I try not to be that. I try to listen to the things they have to say.

The session ends with the following exchange.

**Therapist:** Do you have any thoughts about our meeting today?

**Patient:** Yeah. It’s intense. I don’t really talk about this stuff very much.

**Therapist:** It stirred up a lot of feelings.

[The therapist articulates Hannah’s affective experience.]

**Patient:** Yeah, pretty much. I get jumbled and I jump around . . . pretty much.

[Hannah reverts to self-blaming, the original organizing principle.]

**Therapist:** I think I’ve been able to follow you.

[The therapist affirms that Hannah has been communicating clearly and that he is available to provide attunement to her affect states.]

**Patient:** (Laughs) I appreciate that. It’s an accomplishment.

[Hannah concludes with a self-depreciating comment. Nevertheless, there has been a shift in her original organization of experience. The session began with Hannah’s conviction that she did not communicate clearly. This evolved into the idea that others do not hear her. Finally, with her therapist, she feels that while
she may be difficult to understand, that someone who makes an effort can follow her. She has moved from self-blame to an appreciation of the intersubjective context of her problem.]

The second session begins with the patient’s thoughts about the previous week’s meeting.

*Patient:* I thought about the part where we talked about me not being heard. And I think that’s pretty much true. Yeah, very much true. I don’t seem to have that problem communicating to people that I’m not in a close relationship with.

[Hannah has been able to hold on to the newly forming organizing principle that she can be understood, depending on the context.]

At this point the patient offers an extensive description of an incident earlier in the week in which she and her husband argued about the behavior of his 23-year-old son and the son’s thoughtless use of a car that is her only means of transportation. She relates the incident and her subsequent efforts to get support from her husband.

*Patient:* You know after a while when you try to talk to somebody and they’re not hearing you, you give up. What’s the point of even trying?

[Hannah has come a long way from her original position that she is unable to communicate clearly.]

*Therapist:* You feel it’s hopeless to get him to hear you.

[Here, the therapist articulates the affect of hopelessness that underlies the organizing principle.]

*Patient:* Yeah, because, it’s like, I’m in a no-win situation. . . . And he just doesn’t listen to me at all.

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From this point in session 2 the patient produces material that reveals her unwillingness to continue trying to make herself understood. Her first husband was physically abusive to her, and she associates her current attempts to assert herself with her second husband and stepson with the past violence. In further associations, she relates feelings of being alone and unsupported and in physical danger when dealing with her stepson.

*Patient:* I can never stand up for myself. It’s like that’s my lot in life. Do you know what I’m saying? And this has been my whole life. And I don’t want to be like that. It’s hell to live in your own home, and not be free. . . .

*Therapist:* So, the safest course is not to be seen, not to be heard.

*Patient:* That’s pretty much it. Which really sucks, because I feel like (crying and sighing deeply) . . . For a while I had been in a coma, for ten years or so. You know, I mean, my self. Because I started finally thinking of myself as a person instead of, “I need to do this for this person, this for this person, I need to take care of my mother, I need to do this for my husband, and I need to be there for my kids.” And I finally started thinking, “Well, I don’t do anything for myself.” And I started just taking a little time for myself. I felt like I was waking up, the inner me, who I am, not who anybody else needs me to be. I don’t know how to hang onto it (crying).

*Therapist:* It seems like in the face of [husband and stepson’s] criticism, it’s hard to hold on to who you are.

[The therapist articulates a new organizing principle, that safety comes from hiding what feels authentic to her. This marks the beginning of a conscious awareness of the conflict around self-delineation. To maintain her tie to the important object, she has to subvert her true feelings. We can see here that in a relatively short period of time, Hannah has moved from believing that
she does not communicate clearly, to the understanding that the people she has chosen to surround herself with do not want to hear her. She has become aware that it feels unsafe to express herself. The locus of concern has shifted from outside, that is, her husband does not hear her, to an emergent quality of their relationship. Hannah fears provoking him and jeopardizing her tie to him.

In the above interchange, the patient shifts from the initial theme of not being understood (the absence of attuned responsiveness) to the theme of not knowing who she is (the failure to develop self-delineation). The therapist has consistently put into words her immediate experience of not being heard and in doing so, has apparently identified one pervasive dynamic of her intimate relationships, a core organizing principle—that people close to her do not listen to her or hear her. By putting words to this organizing principle, the therapist has both provided an experience in which she does feel heard and understood, and simultaneously has provided her the understanding that while she has not felt heard or understood by important people in her life, it is not the fault of any deficiency in her ability to communicate. From this new position, she is willing to move into a slightly different kind of making sense, the area of thwarted self-delineation. Hannah has renounced her authentic sense of herself in order to maintain her tie to her husband, her mother, and other important people in her life.

Patient: I don’t even know what to be. I don’t know how to be.
Therapist: You want to please him.
Patient: Yeah. I don’t know. I’m too aggressive; I’m not aggressive enough. I’m subservient.
Therapist: It sounds like you feel that he doesn’t approve of you however you are. You never get it right.

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[The therapist, not too successfully, attempts to articulate her experience.]

Patient: Maybe that’s it.

[As we have seen, when the therapist succeeds in being attuned, this patient responds very enthusiastically. This response suggests more her compliance than her experience of being understood.]

Therapist: You’re always feeling disapproved of.

Patient: I guess not when I’m what he wants me to be. But I never know exactly. . . . It’s like, sometimes you get it. But that’s not me. Does that make sense?

Therapist: So he approves of you when you’re the way he wants you to be . . .

Patient: Right. Which is never consistent.
Therapist: It’s not always clear to you what that is.
Patient: Right. That’s right. Right.

[The therapist has been experienced as attuned.]

The patient moves with the analyst more deeply into her internal conflict around self-delineation and describes how she begins to lose her sense of herself in the face of conflict with her husband, especially conflict in which she feels she is not being heard.

Patient: My husband can tell me, “I know that it’s not just you,” but he’s not saying anything to his son, so it’s all just me. Does that make sense? He may say, “I know that,” but for him to only address me . . .

[This statement, questioning her capacity to make sense, is indicative of a fragmentation reaction; under the pressure of intense affect generated by her husband’s contradictory actions, she is suffering a disruption to her sense of self-delineation.]

Therapist: It’s like saying that you’re the problem. And you don’t feel strong enough to know inside that it’s not you.
Making Sense Together

[Here, the therapist is both validating Hannah’s subjective experience and affirming her struggle for self-delineation.]

Patient: Right. I don’t. For a while there I thought it wasn’t me. And now I don’t know . . . and I’m, uh . . .

Therapist: You get confused.

Hannah feels uncertain, again, as to the validity of her perceptions. In her associations, she returns to the experience she referred to in the initial exchange of the first session, the black feeling that wells up within her. In session 1 she identified this feeling: “It’s just a really awful, awful feeling. It’s awful to almost the point of feeling vile. Does that make sense?”

When she picks up this theme late in session 2 she relates:

Patient: I just have to hurt myself to feel better. . . . And I don’t like that . . .

Therapist: But that’s something you do.

Patient: Yeah. It’s like there’s nothing . . . It’s just a very alone feeling. It’s not like loneliness; it’s just totally alone.

Therapist: Isn’t that the black feeling you talked about last week?

Patient: That’s part of it. That’s not entirely it. It’s like a self-destructive thing. . . . It’s like, if I can make myself hurt enough, then I can quit feeling like that inside.

Therapist: Can you say something about how hurting yourself or injuring yourself makes the hurt inside go away?

Patient: (Lengthy pause) I don’t know if it overshadows it, or just makes it dissipate.

[Hannah explains that if there is enough pain, she begins to feel “fuzzy” and can gain equilibrium.]

Therapist: “Fuzzy” makes you forget how hurt you’ve been by your husband?

The Articulation of Subjective Experience

[The therapist articulates his understanding of her experience.]

Patient: Exactly. That’s it. That’s it. (And a little later) If I can make myself hurt enough, then I can quit feeling vile inside.

Hannah connects this pattern of physically harming herself to remove herself from painful feelings of hurt and estrangement with her previous material about not being sure of who she is. She asserts needs of her own that she should rightfully be able to present to her husband. This continues the theme of conflict around self-delineation.

Patient: It’s like, OK, once you’re a victim, you have this tattoo that says “victim” here (points to her forehead), and like, only weirdos can see it. . . . It’s like a magnet.

Therapist: It sounds like you feel that you somehow invite these attacks on you, but I think that must be because you’ve been attacked so much. And you’ve come to think it must be you.

[The therapist reformulates Hannah’s explanation that she is masochistically inviting attacks. He articulates an alternative perspective that addresses another organization of experience—that she blames herself for the mistreatment she has experienced.]

Patient: Well, yeah. (Pause.) I don’t have any other explanation.

[This is how her experience has come to be organized. It is hoped that in further treatment, she will develop new ways to organize these experiences.]

Therapist: You’ve never had a different kind of relationship.

Patient: In some ways all of my relationships end up, well maybe not, like, yelled at, and treated like I’m, you know, made to feel like I’m stupid and worthless,
but... Giving more than I want to give. Feeling forced into giving more than I want to give.

_Therapist_: They haven’t been reciprocal relationships where you got as much as you gave.

[The therapist articulates Hannah’s longing for a different kind of relationship that, because of the way her experience has been organized, she has no expectation of achieving.]

_Patient_: No. That’s like my M.O. (laughs). Yeah, it’s like, it’s almost like I seek that out, and I don’t... I don’t intentionally, I don’t. But I’ve noticed that I get into relationships with people I don’t like (laughs). That’s weird, I think. I think that if I met my husband now, and I saw how he is with me now, there’s no way that I would get married to him.

[First, Hannah takes pains to reject the formulation that she is masochistic. Further exploration might reveal that her masochism was interpreted to her in prior therapies; or perhaps, being intelligent and well read, she has come across this type of formulation in her readings. Second, she has become, in two sessions, more conscious of her deeper feelings. In the first session she described her relationship with her husband as “The best relationship I have ever had.” She now considers that this is not good enough. She is making tentative steps to develop new organizing principles such as, “I deserve better” or “I can have more.”]

Hannah develops this theme until, at the close of the session, she reveals an intense interest in writing and a wish to share her writing publicly at a small reading in a coffeehouse.

_Patient_: I don’t feel like I can go (to the reading) without him. I don’t feel like I can... I don’t even feel like I can approach him about that.

_Therapist_: But writing is something you feel good about.

[The therapist affirms her subjective experience.]

_Patient_: Yeah. That’s me when I do that.

[Here we see movement toward increasing self-delineation.]

_Therapist_: And you want to be able to go and read.

_Patient_: Right. I would love that. I would love to do a reading.

Hannah and her therapist have illuminated the personal meaning of much of what she revealed in the initial moments of the first meeting. By carefully putting words to Hannah’s pervasive experience in close relationships that she has not been heard, she has both felt heard and understands that others, such as her therapist, although perhaps not her mother or husband, can hear her. From that calmed and more secure position, Hannah’s feelings of identity confusion and self-fragmentation became available to be talked about. By attending closely to Hannah’s evolving subjective experience when in conflict with her husband, the therapist articulated the way in which she loses herself, subjugates her sense of identity, in her attempts to stay related to her husband. This articulation and the understanding conveyed by it then allowed the patient to begin a tentative exploration of the third theme, her emptiness and self-abusive behavior as symbolized by the “black hole.” As the therapist closely tracked Hannah’s associations, carefully putting into words the feelings and experiences she expressed, she found her way to a part of herself that felt real and positive—her ability to express herself in her writing and her wish to have her writing heard, her openness to trusting the hearing power of an audience. Clearly more working through of these themes would be expected to occur throughout the course of treatment. However, the work accomplished in these two sessions has given Hannah the language tools to pursue further understanding of these themes.
DISCUSSION

In the case material, Hannah appeared to revise her original conviction that she communicated unclearly. The therapist de-pathologized, reformulated, and contextualized this organization of experience. With her therapist's support and affirmation, she moved away from a view of her communication problem as solely residing in her, to an understanding that her problem arose in the intersubjective context of her close personal relationships. Once she grasped the pervasiveness of this organization, she presented several manifestations of enhanced self-understanding. For example, she asserted that she had legitimate needs in her marriage and that she believed that she had a right to present them to her husband and to have them acknowledged. This assertion appears to illustrate a more solid, cohesive, and delineated self-organization. Additionally, by the close of the second session she revealed that she would like to be "heard" by reading some of her writing to others in an organized setting. She fantasized doing this independently, without her husband, and explored the emotional and relational implications of such a move. These fantasies demonstrate a shift toward increased self-delineation. She understood that her concerns about her communications are historically rooted in the experience of not feeling heard. This connection between her childhood experience and the present supports a developing sense of self-continuity. She ended the second session in an optimistic state, one that suggested the possibility that her improved self-understanding might free her to explore new ways of experiencing herself.

Although the clinical material covers only two sessions, we believe that it illustrates the concept that verbal articulations promote the coming to consciousness of the organizing principles and the accompanying affect states that have shaped the patient's subjective experience. Together therapist and patient made sense of the patient's organization of childhood experience and the way these organizations of experience have shaped her present relationships. Through making sense together, the patient has acquired new self-understanding that promotes the transformation of subjective experience and the formation of new organizing principles.

SUMMARY

Among the selfobject functions provided by a therapist's attuned verbal articulations is that of self-understanding. Earlier discussions of the locus of therapeutic action of the therapist's verbal articulations implied that the benefit for the patient was either in new or enhanced cognitive understanding or in a selfobject experience of feeling understood. We propose that making sense together provides not only both of the previously mentioned experiences for the patient, but that, additionally, such articulations provide the potential for new self-understanding. For the patient, when the elusive past and the troublesome present become comprehensible, through language, in the context of a primary selfobject relationship, the possibility for new organizations of experience arises.