Making Sense Together

The Intersubjective Approach to Psychotherapy

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SUMMARY

This chapter has presented an overview of intersubjectivity theory and the intersubjective approach to psychotherapy. We have examined subjectivity, the constitutive role of context on the subjective experience of both patient and therapist, and the intersubjective field constructed by the coming together of two subjectivities in a particular context.

The Intersubjective Sensibility

Students are drawn to the profession of psychotherapy for many, often complex, personal reasons. Therapists who themselves have been patients in therapy often give two psychodynamic explanations for their desire to become psychotherapists: the unconscious wish to cure oneself through acquiring deep insight and understanding of one's own personality dynamics, and the wish to cure one's dysfunctional family members. When graduate students are queried, many report that they have had their own prior exposure to personal psychotherapy and feel grateful for the benefits they derived. Applicants to graduate schools in clinical psychology often write in their autobiographical statements that they come from dysfunctional families and have experienced the healing effects of family counseling or substance abuse treatment.

In general, then, a common motive reported by many aspiring psychotherapists is the desire to help others and themselves. This is a sincere desire and a noble objective. Nevertheless, the desire to help contributes, ironically, to a mind-set that is
problematic for, or even antithetical to, practicing psychoanalytic psychotherapy effectively.

It seems paradoxical that the therapist’s desire to help may not actually prove helpful. Responsible therapists hope that the therapeutic relationship will enhance personal growth and self-discovery for their patients. Embedded in that desire to help others, though, is the assumption that the therapist does something to the patient so that the patient is fixed or cured. “Doing to” establishes the patient as the object of the therapist’s action rather than as a collaborator in a joint venture. This model of treatment grows out of a one-person psychology, where the patient is the object of study of a detached observer. In contrast, a two-person psychology views the relationship between patient and therapist as being central to treatment. According to Aron (1996), “The implication of a two-person psychology is that who the analyst is, not only how he or she works but his or her very character, makes a real difference for the analysand” (p. 50).

While the one-person view is consistent with the medical model, where the physician heals a patient, it is incompatible with the intersubjective perspective of psychotherapy. Stolorow has suggested that notions of one-person or two-person psychologies should not delimit intersubjectivity theory. According to Orange (1995), “Intersubjectivity theory sees human beings as organizers of experience, as subjects. Therefore, it views psychoanalytic treatment as the dialogic attempt of two people to understand one person’s organization of emotional experience by ‘making sense together’ of their shared experience” (p. 8). Psychoanalytic psychotherapy, from this perspective, is not a repair job, like fixing a leaky faucet, but a growth process, like the sprouting of a flower, that occurs over time, often over long periods of time. Psychoanalytic psychotherapy as making sense together, or exploring and illuminating personal meanings, is often experienced as an accompanied voyage of self-discovery for both participants. Unlike an airplane flight, where the navigator plots a course, sets a speed, and estimates the time of arrival, psychoanalytic psychotherapy is more like a hot-air balloon ride, where two participants climb into the gondola and go where the wind takes them. Neither participant controls direction or velocity. One cannot predict at the beginning exactly where and when one will arrive. This type of voyage is truly a voyage of discovery, of self and of self in relation to another.

We believe that empathically attuned listening and understanding are necessary prerequisites if true help is to emerge from within the psychotherapy relationship. When the therapist’s need to be helpful or to fix is activated, it disrupts and supplants the therapist’s focus on listening and understanding. We cannot emphasize strongly enough that what lies at the heart of psychoanalytic psychotherapy and the intersubjective approach in particular is the centrality of exploring and illuminating personal meanings, or making sense together.

The clinical problem with attempts to fix is not that they violate some abstract philosophical perspective about the mutual construction of experience, but that fixing precludes making sense together. In other words, fixing may both confirm existing core organizing principles in the therapist and prevent us from furthering the unfolding and illuminating of those organizing principles in the patient. Let us clarify this through the use of a clinical example. Suppose that a male patient complains of not being able to meet women. Fixing could involve the therapist’s suggesting such solutions as placing or answering personal ads. Much therapy time could be spent composing exactly the right wording and considering where such an ad should best be placed. However, the clinical issue of illuminating the personal meanings of the patient’s actions or lack of action might get misplaced. What, for instance, is the meaning of his aloneness? Might he feel so fundamentally defective that seeking a partner seems like an exercise in futility? Most patients of average intelligence could come up with the idea of placing or answering personal ads themselves. Certainly one doesn’t need to consult a mental health professional to get this advice. The bartender, the kindly old lady
on the bus, or his parents could make this suggestion. Nor, by the way, is there anything in our mental health training that qualifies us as givers of advice. What, then, is the meaning of this man’s inability to think of or put into effect some pragmatic problem-solving effort, such as placing or answering a personals ad? Might he believe that any woman who meets him would see through his outward facade and reject him? Perhaps what appears to be inaction might be a self-protective stance against the expectation of painful rejection. Before our hypothetical man can take problem-solving action, or be helped to take such action, his core organizing principle of inherent defectiveness needs to be addressed. If, during the course of psychotherapy, his organization of experience should be transformed so that he feels worthy and lovable, he probably would not need his therapist’s helpful suggestions as to how to meet a prospective partner.

Let us examine what is to be gained by renouncing the temptation to fix and instead exploring personal meanings. First, let us speculate about the possible meaning of the patient’s asking for help. The patient may feel that he has never had others in his life who took an interest in him and offered him guidance in self-exploration, perhaps because he is insignificant and unworthy of receiving their attention. Thus, he might seek to repair a thwarted developmental longing for parental guidance through engaging the therapist as a new and better version of his emotionally absent or distant parents. While for this hypothetical dynamic, giving advice might be experienced as providing the longed-for parenting function, we would not know this if we had not first explored the personal meaning of seeking and receiving advice. Also, through the exploration of personal meaning we would facilitate the unfolding and illumination of the unconscious organizing principle that he feels unworthy of receiving attention.

A second possible organizing principle for this patient is that he feels stupid and doubts his own judgment. Thus, he turns to the therapist whom he believes is omniscient to find the answer he feels incapable of coming to himself. While providing advice might seem to foster or support an idealizing transference (which Kohut [1971] believed to be beneficial), there are several pitfalls to such a well-meaning stance. If, for instance, no one answers his personal ad, then we may have succeeded in leading him into an injurious situation, a replication of the misattuned parenting he had grown up with. But more importantly, we would have missed an opportunity to explore the unconscious organizing principle that his own judgment is untrustworthy.

A third possibility is that if we provide advice he himself could generate, as a competent and intelligent adult, we would be treating him as if he were a child. This might serve to confirm already-existing organizing principles that he is incompetent and child-like.

What activates the need to help in a therapist who is committed to listening and understanding? It is not uncommon for patients unsophisticated about the workings of psychoanalytic psychotherapy to come to treatment with the expectation that the therapist will solve or fix their problems. Such expectations often engage the therapist’s need to feel helpful or effective in ways that stimulate fixing interventions.

In general though, we have observed that the arousal of the therapist’s anxiety often precipitates a shift in focus away from listening and understanding and redirects it toward trying to fix or solve problems. Common issues that arouse a therapist’s anxiety are perceived evidence of increased suicidal risk, dangerous or self-destructive acting out, and outbreaks or intensification of symptoms. We are by no means suggesting that these anxiety-provoking developments be disregarded. Sometimes therapists must act quickly to make lifesaving decisions. However, often the therapist’s anxiety does not relate to imminently threats to the patient’s survival but to the subjective meanings that the patient’s communication carries for the therapist. For example, a patient reports that she has decided to marry a man whom she started dating last month, and invites the therapist to attend the wedding
at city hall the next week. The therapist has a number of choices as to how to respond. She might say something like “What’s the rush?” which obviously conveys a negative judgment that the patient is acting precipitously in making such an important decision and an implicit attempt to get the patient to slow down. An alternative that is more consistent with the stance of listening and understanding might be, “Sounds like you’ve made a major decision. Tell me about it.” While such an intervention might be more comfortable if the wedding date is set a year away, the therapist’s urge to act quickly may be no less precipitous than the patient’s. Sometimes we cannot forestall a patient from making what we predict to be the wrong choice. But how can we be certain that we know what is best for someone else? Can we be sure that this groom will wait around for us to make up our minds about his qualities as a potential spouse, or that someone more suitable will come along?

Consistent with the motive to fix is another dubious assumption that is often asserted in nonpsychodynamic approaches to psychotherapy. This perspective views the individual as made up of a collection of parts. Like repairing a car that won’t run, the therapeutic task for these approaches is to find the broken part and fix it. Perhaps the points, the plugs, the carburetor, the alternator, or maybe the computer need to be adjusted. These treatment approaches view people the same way, as a collection of parts, each of which is treatable independent of the others. Aggressive patients are referred to anger management groups, the premature ejaculators are sent to sex therapists, the phobics to systematic desensitization, and the depressed for a medication consultation. Some patients get some or all of these treatments concurrently. At some clinics, the patient may be in individual therapy, couples therapy, family therapy, and various support groups simultaneously.

Most dynamic psychotherapies, and the intersubjective approach in particular, view the individual as a whole, not as a collection of separately modifiable parts. The individual’s symp-

toms are understood to have formed out of the way his experience with early caregivers became organized. We view symptoms as having unique, idiosyncratic meanings for each particular patient. That, of course, is exactly what a symptom is—the manifestation of some underlying process, much of which is highly personal, and not a sign of any specific universal condition. A sign, on the other hand, is a concrete indicator of a specific disorder. Syphilis spirochetes in the blood are an incontrovertible sign of the disease syphilis, regardless of the meaning that being syphilitic has for the individual. In contrast, take the symptom of a high fever, for example. No specific condition can be diagnosed from the presence of a high fever. The patient might have cancer, an infected tooth, or sunstroke. High fever is not a sign of some specific disease; neither, on the psychological level, is depression, anxiety, or fear of strangers. They are symptoms, the meanings of which are uniquely personal for each individual.

Psychiatric diagnoses are based on descriptions of symptom clusters, not signs. The DSM-IV attaches labels (usually in Latin) to clusters of symptoms or behaviors. Labeling someone with dysthymic disorder tells you nothing about what has caused the affect state, only that descriptions of the patient’s behavior meet eight criteria. The symptoms a person may exhibit are unique to that particular individual, and so is the meaning they have to him.

Symptoms are like dreams. Let us take as an example Freud’s famous case of Serge Pankejaff, known commonly as the Wolf Man. Pankejaff is most remembered for a dream he had about wolves sitting in a tree. Any patient might dream of wolves but that doesn’t mean he has Wolf Man’s disease. To one patient, the wolf image might represent his father, to another his mother’s vagina, and to another the threat of the therapist’s ripping interpretations. In other words, having a dream about wolves provides us no clue as to etiology or the underlying psychody-

The intersubjective approach to psychotherapy views the individual as a whole. Symptomatic behaviors are understood to
have grown out of the particular ways this person has organized and made sense of his unique life experience and the idiosyncratic meanings that such experiences have for him. Any transformation that occurs to this organization of experience will have a global, not specific, impact on the patient’s manner of relating and behaving. The psychotherapeutic task is to illuminate the underlying organizing principles from which the behavior derives, not to modify the behaviors. We focus our attention on the process of unfolding and illuminating, not on hitting the targeted symptom. It is our conviction that the unfolding and illuminating of subjective experience will allow for the transformation of the principles that have come to organize that experience. Change results from making sense together. The process of making sense together is an irreducible context that includes the two subjectivities of the therapist and the patient, the unique field created by their mutual influence, and the specific understanding of the patient’s subjective experience that emerges through their work. Transformation follows from the experience of new understanding gained in a relationship with an attuned therapist.

The intersubjective approach does not target a specific symptom, such as self-consciousness. Rather, as the patient’s organization of experience unfolds and is illuminated and transformed in the therapy relationship, the patient develops new organizing principles that structure his experience.

Jack is a young man who feels very uncomfortable and self-conscious in the presence of attractive women. Throughout grammar school he was teased and ridiculed by the other children for his pronounced acne and his big nose. Feeling ridiculed in school was overlaid on the experience of having been repeatedly criticized by his mother, who found fault with any initiative shown by Jack. Jack organized these experiences around the notion, “I am defective and inadequate and if people, especially girls, get to know me, they will find this out and reject me. It is safest to avoid other

people.” During the course of therapy, as Jack experienced his therapist as understanding and affirming of his ambitions and tentative exhibitionistic strivings, Jack began to develop a different sense of his abilities. These new experiences of feeling mirrored and accepted by the therapist fostered the development of a new organizing principle: “I have something to contribute and am worth taking notice of.” Thus, having developed a new way to organize his experience, Jack’s self-consciousness diminished and he became more comfortable in social situations.

What is important is that reductions in self-consciousness are the outgrowth of new organizations of experience, which support increased self-confidence. This new organization of experience, a new mental structure, exerts its influence over the full range of interpersonal functioning, transforming self-consciousness into self-confidence in areas other than just with attractive women.

Still another unfortunate formulation that has influenced the practice of psychotherapy is the notion of ideal or proper technique. Since Freud’s day, it has been common to discuss the theory of psychoanalytic technique. However, the concept of ideal or proper technique, like the goal of helping or fixing, has had a constricting effect on the practice of psychoanalysis and psychotherapy. As Orange and colleagues (1997) see it, “The concept of technique includes the idea of rules of proper and correct procedure. The primary purpose of the rules of any technique is to induce compliance, to reduce the influence of individual subjectivity on the task at hand” (p. 23). Technique implies structure and conformity to rules. While Freud (1910a) may have felt that a body of rules was necessary to protect patients from “wild analysis,” such rules incline us to the belief that they suit the needs of all patient–therapist relationships. This is a kind of “one size fits all” approach to psychotherapy. But, as we have been arguing, each therapeutic couple constructs a distinct intersubjective field and a unique process, and the notion that
one size fits all cannot possibly apply. There are clearly better and worse ways to do psychotherapy, but there is no uniform technique that applies to all patients.

Stolorow (1992) suggests that there are two features that characterize a psychoanalytic psychotherapy process. First, psychoanalytic psychotherapy is concerned with subjective experience, the contexts that shape it, and the way such experience is organized. Second, the psychoanalytic psychotherapy process takes place within a relationship. The aim (or goal) of the psychotherapy process, as we indicated in Chapter 1, is the transformation of the organization of experience as it unfolds and is illuminated in the therapy relationship. Focusing on a concrete goal, such as symptom relief, detracts and distracts from the experience of the process. This is akin to Herrigel’s (1971) observation in Zen in the Art of Archery that to become an accurate marksman one must first renounce the wish to hit the target and instead immerse oneself in the process.

It takes a unique type of person to be drawn to the pursuit of psychoanalytic psychotherapy. If the therapist needs to control, is made anxious by ambiguity or uncertainty, must know where she is going and what lies ahead, relies on tools and techniques (the tricks of the trade) in order to feel competent, and relishes being treated as an authority, then psychoanalytic psychotherapy, and the intersubjective approach in particular, is not for her.

Working intersubjectively requires commitment to a particular stance or sensibility (Orange et al. 1997). There are many aspects to this sensibility, and psychotherapists must bring this sensibility with them to the beginning of each new psychotherapy relationship. This stance views the psychotherapy relationship as a collaborative venture of making sense together. What emerges in the process is coconstructed, that is, both parties contribute to the construction, although not necessarily in equal measure. If two people are baking a cake, one might bring the liquid and the other the cake mix. The cake can be thought of as having been coconstructed in that it could not have been made without the contribution of both parties, but the contributions of each may be quite different. Using another metaphor, let the patient be represented by an ice cube and the therapist by a glass of water. When the two are brought together, the water is cooled, the ice cube is warmed, and both are changed by the experience. In both metaphorical cases, each of the two elements is separate and unique and the process of their mutual endeavor changes each of them.

Another characteristic of the intersubjective sensibility is that neither party in a psychotherapy relationship is an authority on the mind of the other. By rejecting isolated mind notions and the myth of objectively knowable truth (Orange et al. 1997), the therapist remains open and willing to explore her contribution to the patient’s experience of the relationship. Working intersubjectively concerns making sense together, in contrast to the classical Freudian perspective that views the analyst as a scientist, an empirical observer of objectively verifiable phenomena. The Freudian scientist, through the stance of neutrality and abstinence, believes she will gain access to objectively verifiable facts about the patient’s unconscious motives, which are then interpreted or transmitted to the patient. The intersubjective approach, which focuses on the process of making sense together, immerses therapist and patient in the fluid and amorphous realm of the patient’s personal meanings.

The implications of this sensibility are that, as psychotherapists, we must take some responsibility for our contribution to the patient’s experience of being in relationship with us. This has profound ramifications for the way we diagnose and treat. Diagnostic labels tend to pathologize and blame the patient. The label “borderline” is typically applied to patients who are quick to anger, become abusive to others, and alternate between viewing others as all-good or all-bad. From the intersubjective perspective, we need to examine the context within which the patient’s actions coincide with descriptions of borderline behavior. If a patient who tends to idealize the therapist becomes suddenly angry and
abusive, is the patient showing his true borderline colors by manifesting splitting behavior? Or has something in the therapeutic relationship activated strong negative affects in the patient? According to Stolorow and colleagues (1987), “The psychological essence of what we call ‘borderline’ is not that it is a pathological condition located solely in the patient. Rather, it refers to phenomena arising in an intersubjective field—a field consisting of a precarious, vulnerable self in a failing, archaic selfobject bond” (p. 116). The patient’s precarious, vulnerable self-organization was structured in reaction to a chronic destructive caregiving environment, while the failing selfobject bond is an aspect of the present relationship with the misattuned therapist. The following clinical example illustrates what we mean.

Gerri, a woman of 27, came for therapy because she had a history of chaotic, unstable relationships with friends and lovers. She developed close and intense relationships that, after a short period of time, she abruptly terminated because she became enraged with what she experienced as the other person’s unreliable and inconsiderate treatment of her. During the third session, the telephone rang and the therapist answered. The conversation was kept brief and within a few seconds the therapist returned her attention to the patient. Gerri, however, became enraged with the therapist and fired off a volley of verbal abuse that perceptively attacked the core of her psychotherapist’s professional self-image. “Your actions are unprofessional; you are unethical and should be reported; you shouldn’t be licensed; you need more supervision and personal therapy to get you to stop acting out with your patients; this is my time and you are using it to take care of your own business and I won’t pay for this session.”

From her therapist’s perspective, Gerri was overreacting to the degree of interruption and was responding in her charactero-

logical fashion of lashing out. This raises one of those choice points that frequently confront therapists. Whose subjectivity gets privileged in this situation? Should the therapist focus on her experience of being overreacted to and abused excessively, or should the therapist focus on Gerri’s experience of having been narcissistically injured? The therapist might have resorted to the personal safety and comfort of blaming the patient for the patient’s experience in therapy by pathologizing the patient and calling her names, like “narcissistic” or “borderline.” She might further have sought to reassure herself by hiding behind transferance interpretations involving projection or displacement (“You are treating me like your mother who was always uninterested and preoccupied when you wanted to talk to her”). However, even if such an interpretation would capture something of the patient’s formative experience, it would also fail to acknowledge, in fact would disregard or deny, the therapist’s contribution to the patient’s angry reaction. The intersubjectively oriented therapist would choose to privilege the patient’s subjectivity. Our reasoning is as follows: this is a patient whose personality structure is vulnerable and prone to fragmentation. In answering the phone, the therapist has provoked a profound narcissistic injury in the patient. (Clearly not all patients would experience the therapist’s answering the phone as so profound a narcissistic wound. But Gerri, by virtue of her history of chronic and persistent misattunement by caregivers, is uniquely vulnerable to failing selfobject bonds.) Gerri had entered therapy hoping for a new relationship that would fulfill her lifelong need for attuned responsiveness from a caring other. By answering the phone, the therapist’s behavior fit neatly into the patient’s organization of experience that she was not worthy or important enough for someone, her mother or her therapist, to respond to her emotional needs.

The therapist’s owning her error and affirming and validating Gerri’s subjective experience of devastating injury sets a reparative experience into motion. During the course of treatment, Gerri’s repeated experiences of attunement, affirmation,
and repair will lead to increased self-confidence, the capacity to integrate disruptive affects, the regulation and modulation of intense affect states, and trust in the constancy and continuity of good objects.

Rather than having before us a borderline patient (one characterized by intense and extreme swings in interpersonal relating), we have a patient with a precarious, vulnerable personality organization and a therapist who has failed to provide the longed for selfobject functions of attuned responsiveness. A differently organized patient with a more cohesive personality structure might respond to the therapist's transference interpretation with, "I'm angry at you because you are self-centered and inconsiderate, just like my mother was." The present is not being distorted or contaminated by the past, as in the traditional view of transference. Rather, the present relationship is being assimilated into the patient's invariant organization of experience. We will elaborate on this different conception of transference in Chapter 4.

In the above clinical example, Gerri responded in what might be labeled a "borderline" way to her experience of the actions of the therapist. Putting ourselves in this patient's shoes, we can appreciate that her angry and vituperative outburst was provoked iatrogenically by the injurious actions of the therapist. This patient is not a borderline. Rather, this vulnerable, fragile patient responds with rage when disappointed and injured by someone she wished would be attuned to her. Gerri's characteristic lashing out and her rage function to manage her feelings and ideas that would otherwise disrupt her sense of psychological integrity. Her organization of experience not only includes how she expects to be disappointed and hurt by others but her habitual ways of keeping herself psychologically intact when threatened. Gerri's attack is in fact a counterattack, launched in an effort to protect her sense of personal integrity, and, as self-defeating as her actions appear to others, they represent the best she has been able to develop to this point in her life. When not injured, she is not rageful. The patient is reacting within a specific context shaped by her invariant organization of experience and her therapist's behavior.

The therapist in this example recognized that she had injured the patient (while allowing that the patient was extremely sensitive—of course! That is why she was a patient in the first place) and proceeded to express her appreciation of how answering the phone had been experienced as uncaring and hurtful. The therapist apologized for her actions and agreed not to interrupt further sessions. Gerri warily accepted the apology and reassurance. Two years later, during a session, having forgotten to forward calls to her voice-mail, the phone rang and the therapist answered reflexively. The therapist instantly remembered the earlier session, realized that she had blundered by breaking her promise, cut the call short, and began to apologize. Gerri casually brushed aside the apology, saying, "Oh, it's OK," and continued on with what she had been talking about. Later in the session, at an opportune moment, the therapist reflected back on what had happened between them. How was it that what had so infuriated Gerri two years ago was no longer salient? Gerri explained how over the last two years she had come to experience and trust that the therapist was really "with me" and such a minor interruption did not disrupt that feeling.

Has the patient become less borderline? To avoid pathologizing one-person labels, we would formulate the change in this way: Gerri has become less vulnerable and prone to fragmentation. She has come to feel increasingly understood, safe, and trusting in her relationship with her therapist. Therefore, within the changed context, she did not experience the therapist's answering the phone as injurious. Having developed a more cohesive self-structure through repeated experiences of feeling understood by her therapist, the kind of actions that had formerly signaled a failing selfobject relationship no longer were experienced as hurtful. This reflected the development of a new
organizing principle: I am worthy of caring, attention and consideration.

This clinical example raises another fundamental assumption that intersubjectively oriented psychotherapists need to bear in mind as they begin a treatment. The typical intake procedure is satisfied to seek out the presenting problem that presumably brings the patient to therapy in the first place. However, we have become convinced that while patients might articulate very specific goals for therapy, such as overcoming some fear or acquiring new interpersonal skills, on a fundamental level all patients are seeking a new, reparative experience from the therapeutic relationship. That is, patients are at the deepest level seeking a selfobject relationship in which their thwarted developmental strivings can be repaired.

Lay people often disparage psychotherapy as a form of paid friendship. They argue that all a troubled person needs is a good friend (as if this is so easy for people with troubled interpersonal relationships to achieve). There is certainly merit to the idea that all people need good friends. Kohut (1984) argues persuasively that all people, including psychologically healthy people, have a lifelong need for selfobject relationships. But friendships are reciprocal in nature, whereas functioning as a selfobject is often a one-way street. Under the best circumstances, as a selfobject for the patient, the therapist should possess a cohesive self-organization in order to suspend her own personal longings while she attunes to the needs of the other. Aron (1996) has observed that mutuality but not symmetry characterizes the psychotherapy relationship. By noting the essential asymmetry of the therapeutic relationship, Aron is referring to “the important differences between patient and analyst in their roles, functions, power, and responsibilities” (p. 124). Unlike a reciprocal friendship, it would be inappropriate for the therapist to demand or expect that the patient take her needs and feelings into account, at least in the beginning phases of treatment. Eventually, as the therapeutic relationship matures and develops its own characteristic ways of noticing and opening up experience, we expect that the patient’s interest in and capacity for appreciating the different subjectivity of the therapist will expand. The use of the intersubjectivity construct to refer to such mutual recognition (the patient’s recognition of the selfhood of the therapist) is central to the thinking of the group of theorists that Teicholtz (1999a) calls the “moderate postmoderns,” such as Ogden and Benjamin.

Frequently, it is just those individuals with difficulties in sustaining reciprocal relationships who find their way to psychotherapy. Some come with an organization of experience that leads them to anticipate that this new relationship, too, will fail. While they hope for a new, attuned relationship unlike what they have experienced in the past, they nevertheless expect to be disappointed and injured, and to suffer retraumatization at the hands of this new/old object. Typically, these patients are described as resistant; that is, they are blamed for their ambivalence and their unenthusiastic embrace of the benevolent therapist. They tend to be diagnosed as having character pathology.

Some people, on the other hand, do come to the therapy relationship with a greater sense of hope. These patients generally receive more benign diagnoses of the Axis I variety (such as dysthymic disorder or anxiety disorders) because the therapist experiences them as more receptive, if not more idealizing. While symptoms of anxiety and depression are often clearly present, these less difficult patients also view the world through their characteristic organizations of experience, formed in the context of their early relationships with caregivers and operating in the present to maintain cohesion, continuity, and stability in the self-organization. For both types of patient, a therapist informed by intersubjectivity theory will come to understand the ways these patterns structure the patient’s view of the world and himself. As we discussed above, specific symptoms, whether benign, endearing, or distancing, represent only part of the whole picture of a patient. We understand very little of a person by a diagnostic description alone.
But we do understand that, for all patients, operating behind the initial reaching out to the therapist is a wish, however dim, that this new relationship will offer the opportunities for care and understanding that were unreliably and inconsistently met growing up. The wish that, in this new relationship, the developmental longings that were thwarted by misattuned caregivers would now, for once, be met with attuned responsiveness. As Stolorow and colleagues (1987) put it, “Patients enter analysis with hopes for an intersubjective context in which thwarted strivings for differentiated selfhood may become liberated” (p. 65). In other words, a fundamental conviction of the intersubjective perspective is that a striving for psychological health motivates all people, and patients are no exception. Profound implications for the practice of psychotherapy follow from this conviction. The implications apply to the process of treatment as well as to how the therapist understands all that a patient brings to treatment. So, from the intersubjective perspective, even the most self-defeating and outrageous characteristics of patients are thought of as their best efforts at staying safe and solid given the entire constellation of their personal history and individual qualities.

The significance of the assumption that all of us are striving for psychological health cannot be overemphasized. If there is one pearl of wisdom for therapists to use as a guiding mantra it is this: At the core of whatever a patient reveals is the hope of being accepted and cared for. Ironically, debilitating symptoms, disruptive behavior patterns, and disappointing relationships will all ultimately make sense as part of how the patient managed to remain psychologically intact in the face of barriers to feeling loved and accepted. One patient, seen over several years for crippling anxiety in work and social settings, eventually realized that the only time he felt sure of the love of his family was when they offered help after he left a job or could not function socially. For him, their enthusiasm for his “success” when he worked or socialized meant that they only loved him if he performed well. The only caring that felt authentic to him was what he experi-

enced from them despite his failures and limitations. On top of this wish to be loved and accepted for who he was lay fears and misunderstandings of other people and their motives that occasionally bordered on paranoia. Interpersonally, he tested the patience of lovers, friends, and his therapist by measuring their love for him by whether they stuck by him after he disappointed them.

Another important core assumption of the intersubjective perspective is that the therapist’s theory of mind is an integral part of the therapist’s subjectivity. Theory necessarily contributes to structuring every therapist’s experience. Our theories inform our understanding of normal development and developmental psychopathology as well as of how therapy works. Typically, analytic therapies search for the pathological motives behind behaviors. People are thought to be motivated by masochistic or sadistic urges, the desire to symbolically satisfy or deny oedipal strivings, and the pursuit of other antisocial or asocial expressions of sexual and aggressive drives. The fundamental assumption is that people are in conflict over their unacceptable impulses, that pressures for expression of drives and inhibition of that expression inevitably work in opposition. Thus, derivatives of the unacceptable impulse are sought and interpretive light is shone on them. The therapist’s stance is directed at uncovering what is being hidden or repressed. The patient is presumed to be concealing dreaded secrets, and the therapist is experienced as allied with the id, pressing for discharge, against the ego, which seeks delay (A. Freud 1936).

If, however, the therapist approaches human behavior from the perspective that people are striving for health, as opposed to defending against their unacceptable desires, then an entirely different quality of relationship is established. From this stance, we explore what adaptive purpose could be served by seemingly maladaptive behaviors. Mary, for example, is a patient who permits herself to be abused and humiliated by her domineering partner. The traditional stance would lead us to anticipate that
some masochistic motive is being expressed in this seemingly self-destructive behavior—perhaps seeking pain for sexual pleasure or possibly instigating an experience of punishment for some unconscious sense of guilt. Viewed from the perspective of health seeking, we learn that, however hurtful this relationship is, Mary believes that it is the best relationship that she has had or hopes to have. The pain is the price she is willing to pay to preserve the needed connection she experiences in the relationship. The relationship is not maintained because it provides the opportunity for pain or self-punishment. Rather, the treatment Mary receives from her partner and her view of herself in relation to him fit with a way of organizing her self-experience that derives from her childhood. This abusive relationship fits with Mary’s early solution to the problem of how to feel psychologically secure and valued in her family. She maintains her tie to her parents through attending to the needs of others at her own expense. Much of her psychotherapy will center on making sense of this current relationship in light of her historically formed organization of experience.

Going hand in hand with rejecting the myths of neutrality, objectivity, and other isolated mind notions is the need to maintain a stance of fallibilism, which Orange (1995) defines as “an attitude recognizing that what we ‘know’ or understand is inevitably partial and often mistaken” (p. 43). To be fallible as a therapist means to be tentative about the hypotheses we generate regarding why a patient reacts, thinks, feels or behaves in a particular way. It means taking the patient’s view of the treatment seriously and it means reflecting, again and again, on our own subjectivity and its possible influence on the patient. A stance of fallibilism leads us to reject such therapeutic goals as perfecting technique or formulating exact interpretations.

Working intersubjectively is a collaborative venture of making sense together. The stance that best promotes making sense together is one of empathic-introspective inquiry. According to Orange and colleagues (1997), “Such inquiry seeks to illuminate the principles unconsciously organizing the patient’s experience (empathy), the principles unconsciously organizing the analyst’s experience (introspection), and the oscillating psychological field created by the interplay between the two (intersubjectivity)” (pp. 43–44). We develop our thoughts on empathy and on the empathic-introspective stance more fully in the following chapter. However, within this oscillating field there is much room for misperception and misunderstanding. For example, our subjectivity may interfere either with the capacity to listen or with our understanding of the patient’s organization of experience. Remaining fallible necessitates that the therapist maintains an appreciation for the complex and highly subjective filtering of what both the patient and therapist think is going on.

Nevertheless, working from the intersubjective perspective, like other forms of dynamic psychotherapy, requires a great deal of training. A necessary complement to the acceptance of fallibility is the capacity to manage one’s sense of uncertainty. Psychotherapy is a very ambiguous and confusing process. Experienced therapists often feel adrift and anxious about how and where the voyage is going. Like a kayaker paddling through strange rapids, you may not be familiar with the waters or with what lies around the bend. However, if you know how to maneuver your kayak, keep it upright, and right it if you get swamped, then your anxiety and uncertainty are more easily tolerated. Course work and supervision, as well as one’s personal psychotherapy, all enhance this process. Being a psychotherapist requires lifelong learning.

Every treatment is different because with each new patient, a new and unique intersubjective field is created. Thus, while there are guidelines to follow, such as professional ethics, there are no absolute rules of the game. For example, how many sessions a week constitute a proper analysis? The question of session frequency as a measure of the psychoanalytic validity of a treatment was raised early last century and continues to be debated to the present day. Abraham Kardiner (1977) reports that Freud always
saw his analytic patients six days a week. However, when Kardiner and five other foreign students arrived in Vienna hoping to be trained and analyzed by Freud, Freud had only thirty hours available, time enough for only five of them to be seen. Anna Freud reportedly figured out that if five patients are each seen for six hours, which totals to thirty patient-hours, then six patients can be seen for only five hours, which totals to the same thirty patient-hours. Therefore, if each student gave up one session a week, the one hour saved from each of five patients would allow for a sixth patient to be fit in. So the six sessions per week analysis became five sessions per week, and nowadays many analysts consider that a proper analysis can occur in four, or three, or even two weekly sessions. Some argue persuasively that a psychoanalytic process should not be defined at all by structural factors like frequency of contact (Fosshage 1997a, 1999, Stolorow 1994b).

Clearly conventions change and there is nothing sacred or scientific about the frequency of sessions. The same can be said for the duration of a session. The fifty-minute hour has, for many analysts, now shrunk to forty-five minutes. In this way therapists have countered currency inflation with session length deflation: more sessions can be fit into the day. Now, then, if we set the length of a session at forty-five minutes, is this some immutable boundary that must never be violated? As we have seen, the length of the therapy session is set, not just with the best interests of the patient in mind, but also in accord with what suits the therapist. Are we not permitted to go over a few minutes if the patient is in great distress at the end? The answer to this question, as to so many other questions concerning analytic rules, must be, "It depends."

At this point, we would like to comment on the notion of eclecticism in psychotherapeutic theory and practice. We often encounter colleagues and students who would like to take the most applicable aspects of diverse theories and techniques and mix them according to the needs of the patient. We agree with Greenberg and Mitchell (1983), who in describing the two major psychoanalytic traditions, the drive/structure model and the relational model, observe, "A fundamentally different understanding of human development directs the two models toward equally incompatible approaches to the therapeutic action of psychoanalysis" (p. 390). Each theory of mind has its own unique worldview and its own distinctive perspective on the origins of psychopathology from which it derives its principles of therapeutic action. While one can be a little bit empathic, empathy is not a technique but a sensibility. The therapeutic effectiveness of the empathic-introspective stance derives its mutative power from a commitment to the consistent, not occasional, application of this sensibility.

**SUMMARY**

Here are some important prescriptions for the unsettling attitude we advocate for therapists: Do not give in to your need to act helpfully. Remain flexible, fallible, and uncertain. Know that however you try to avoid influencing your patients, you inevitably influence and are influenced by them. Apart from ethical standards, there are no hard-and-fast rules to guide your work. Sometimes even the unquestioned and most universal practices have potentially detrimental consequences for treatment and ought to be handled with great sensitivity to their meanings for the patient. Finally, the patient's symptoms and behaviors, no matter how self-defeating or incomprehensible to the observer, represent his striving for health and psychological stability.

The basic orienting perspective for those practicing intersubjectively is on making sense of the patient's subjectivity within a particular context, as it is influenced by the person of the therapist. In subsequent chapters we address specific ways to enhance the therapist's capacity to understand the patient's subjectivity and how to respond, once the patient's perspective is grasped.