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## **Chapter 1: Subjectivity and Intersubjectivity**

Psychoanalytic theories of mind consist of comprehensive explanations of human behavior and motivation. Such theories seek to account for normal and abnormal development at both the population and individual levels, but these abstract and global ideas can seem distant from our personal, moment-by-moment, lived experience. Intersubjectivity theory has reformulated psychological concepts of why people act, feel and behave the way they do in terms that directly capture our internal and relational experiences. In writing this book we hope to communicate these compelling ideas and to facilitate the translation of these concepts into the practice of psychotherapy. In this chapter, we try to unravel the paradox that intersubjectivity presupposes subjectivity and subjectivity presupposes intersubjectivity.

A central organizing concept of intersubjectivity theory is that our experience of ourselves is fundamental to how we operate in the world. Our subjective experience is the phenomenology of all that one might be aware of at any given moment and much of what is out of awareness, as well. Over time, the complex interweaving of individual abilities and temperament, relational configurations with caregivers during infancy and childhood, and the lucky or harsh realities of one's life circumstances converge to form patterns. These patterns of experiencing oneself and the world describe our subjective, personal reality and become structured as our organizations of experience. In treatment we hope to understand these

patterns in the context of a relationship that becomes a new lived experience and the basis of new organizing patterns.

All psychoanalytic theories of personality begin with some conception of the central motivational constructs that underlie both normal and pathological human behavior. For example, Freudian theory sees human motivation as deriving from the instinctual drives of sex and aggression, while modern relational theories typically view motivation as springing from some need to create or maintain bonds to others.

Along with other modern relational theories, developments in self psychology and intersubjectivity theory point to the inadequacy of earlier psychoanalytic conceptions of motivation to explain human psychology. In work that has had a strong impact on intersubjectivity theory, Lichtenberg (1989) has observed that “...motivations arise solely from *lived experience*” (p. 2). Human motivations, whether for food, sexual gratification, or attachment (Lichtenberg posits five motivational systems) serve to promote, maintain or restore a fundamental sense of self-cohesion. “Lived experience is about how we human beings consciously and unconsciously seek to fulfill our needs and desires by searching in potential events for affects that signal for us that experiential fulfillment” (p.2).

By affects we are referring, in everyday language, to how one feels. Affects are emotions that refer to a subjective “state of mind or condition of arousal” (McWilliams, 1999, p. 103). As signals, emotions alert us to our needs and our desires and, along with our sensory perceptions and our beliefs and ideas, constitute the “stuff” of immediate experience. Emotions guide us and inform us about matters of survival, safety and satisfaction. We now recognize the important role of affects in organizing experience, and therefore, as the core of

subjective experience. From this perspective, the central motivational construct for intersubjectivity theory now stresses the role of affect rather than drive.

Lichtenberg (1989) further observed that “ The vitality of the motivational experience will depend initially on the manner in which exchanges between infants and their caregivers unfold” (p.2). He points us to the contextual nature of our emotions. Whatever our needs and the emotions associated with them, we initially experienced them in the earliest caregiving relationships. As Stolorow & Atwood (1992) make clear, “ The ‘affective core of the self’ (Emde, 1988) derives from the person’ s history of intersubjective transactions, and thus the shift from drive to affect resituates the psychoanalytic theory of motivation squarely within the realm of the intersubjective” (p 26.)

We have begun this book with a focus on affectivity, and will devote part of chapter 3 to the subject, because it is both a central organizing construct in intersubjectivity theory and the fundamental organizer of subjective experience. The generation, regulation and integration of affect occur within an intersubjective context, and we will trace the thread of affectivity as it is woven throughout intersubjectivity theory and treatment.

Psychoanalytic theories can be characterized by their distinctive domains of inquiry, treatment aims and investigatory stances (Stolorow, 1994). In the balance of this chapter we examine intersubjectivity theory from the perspective of its particular domain of inquiry, treatment aims and investigatory stance, and the central role of affectivity in each of these areas.

### Domain of Inquiry

Intersubjectivity theory is an evolving body of knowledge, the central focus of which is the psychology of human subjectivity. Unlike Freudian theory, which has its roots in the

medical sciences and takes as its object of study the interaction of mental and biological processes within the mind of the individual, intersubjectivity theory concerns itself with the field created by the interplay of worlds of subjective experience and personal meanings.

Focusing as it does on the patient's patterns of construing and making sense of his personal world, intersubjectivity theory attends to subjective experience. The therapist informed by intersubjectivity theory does not necessarily listen for personality structures associated with psychosexual stages of development, for derivatives of drives or conflicts, nor for unconscious motives, defenses or resistance. Through the intersubjective lens, patients are not viewed as trying to hide or dress themselves up. Rather, their presentations are seen as dynamic solutions to the universal problems of managing affect within their individual developmental contexts. By appreciating this adaptive solution and the complex system from which it emerged, the striving for health rather than the pathology of the patient's experience is affirmed. When the therapist responds from this perspective, the patient can feel more real to himself, more trusting in his perceptions and his own experience.

Before we can explore intersubjectivity, the complex field that is created when two or more individuals with their unique subjectivities come together, we must first examine the nature of human subjectivity. Intersubjectivity theory assumes that one's experience of oneself and the world is the fundamental focus of psychoanalytic inquiry. This assertion means that the personal ways in which we have come to view and experience ourselves, both privately, within our skin, and as we move about among others, are all that can be understood through the psychoanalytic dialogue. As straightforward as this statement seems, it is the basis for a theoretical revolution in psychoanalysis. No longer are universal assumptions about developmental imperatives and crises imposed on the patient's unfolding story. Gone is the

belief that the therapist holds a privileged, objectively “ true” perspective on the reality and meaning of the patient’ s experience. Rather, the overarching psychological construct is the validity and reality of the patient’ s perspective, his subjective experience.

Human subjectivity becomes organized into patterns based on repeated emotional experience within the child-caregiver dyad. The creation of such patterns, irreducibly imbedded in the emotional quality of formative life experience with parents and caregivers, constitutes the sense of subjective experience (Orange, Atwood, & Stolorow, 1997, p. 7). Such patterns are the scaffold on which the coherence and continuity of experience depend. Because this structure is considered essential to psychological functioning, Stolorow, Atwood and Brandchaft (1994) have included it in their understanding of an important source of human motivation. As they observe, “ the *need to maintain the organization of experience* is a central motive in the patterning of human action” (p. 35).

Human infants require sensitive care by others who take pleasure in their health, comfort and well being. Ideally, a system develops in which both infant and caregiver expect that the needs of the child will be met in ways that are satisfying to both. However, whatever quality of care is given, the developing child organizes those patterns of experience into expectations for the future. Without generating expectancies, experience is random and unmanageable, and every new circumstance would require new learning. Part of human adaptation involves the ability to organize experience into meaningful patterns. These patterns, or organizations of experience, contribute to the essence of subjectivity and the sense of a cohesive self.

Intersubjectivity theory recognizes that the therapist’ s understanding of the patient’ s experience is inescapably circumscribed by the therapist’ s own subjectivity. Therefore, while

striving to comprehend the patient' s view of the world through the patient' s eyes, the therapist must be tentative and non-authoritarian regarding what she believes she understands about the patient' s subjective reality. By holding this perspective of fallibility, the therapist facilitates the opportunity for expanding the subjectivities of both patient and therapist. That is, the potential for new patterns to emerge exists for both the therapist and the patient. For both therapist and patient, new patterns may develop in the organizations of their subjective experience when their archaically formed (that is, formed during childhood) organizing principles are disconfirmed in the treatment relationship.

Making subjective experience and its construction in intersubjective contexts central to the theory of personality and treatment is what distinguishes intersubjectivity theory from other psychoanalytic theories. In traditional psychoanalytic theory, the focus of attention is on the intrapsychic life of the individual. Psychological phenomena are understood in terms of the interaction and conflict between the three mental structures—id, ego and superego. According to Brenner (1982), one of the leading theorists of the modern Freudian tradition, “ The fabric of psychic life as we know it is woven of drive derivatives, of anxiety and depressive affect, of defense, and of superego manifestations” (p. 252). He then goes on to make the global yet questionable statement that, “ Compromise formations arising from psychic conflict comprise virtually all of psychic life which is of emotional significance to us” (p. 252). This kind of thinking illustrates what Stolorow & Atwood (1992) refer to as “ the myth of the isolated mind” (p. 7-28).

The myth of the isolated mind portrays the human mind as existing independent from the physical world and the world of others. For psychoanalysis, the myth of the isolated mind finds its expression in Freud' s view of the mind as a “ mental apparatus,” a drive-discharge,

tension-reducing machine. In ego psychology, the myth of the isolated mind is expressed in the value placed on the achievement of separation and autonomous mental functioning. The notion of the isolated mind not only finds expression in metapsychology but is deeply embedded in psychoanalytic technique. The traditional concepts of neutrality, abstinence, the purity of the transference field, the focus on regression, the idea that associations can be free, and the conviction that transference must be resolved before termination, are examples of the way that a fundamental assumption about the isolated mind can infuse and influence psychoanalytic practice. The unexamined acceptance of isolated mind notions even underlies education and training in psychoanalysis. It was once a common practice at institutes of the American Psychoanalytic Association that candidates in training were assigned to their training analysts. The myth of the isolated mind can readily be seen behind this practice: the assumption that analysts are interchangeable and that any skillful analyst can serve as the opaque screen onto which patients can displace and project their inner life. In this earlier theory, the notion was that the major function of the “relationship” between patient and analyst was to establish the working alliance. “Relationship” became a technique to be employed by one isolated mind upon another.

Much of post-Freudian theorizing has been, in one form or another, an effort to counteract this isolated mind construct. Winnicott’s (1965, p. 39n) famous dictum that there is no such thing as a baby without a mother and Sullivan’s (1938) similar idea that “personality is made manifest in interpersonal situations, and not otherwise” (p. 32) are examples of early formulations of the relational nature of the mind. The characterizations of traditional psychoanalytic treatment as “One-Person” in contrast to the “Two-Person” view of modern relational thinking and the systems view of intersubjectivity theory have been ways

that this paradigm shift has been conceptualized. Expanding on this multi-person direction in theory, Stolorow and Atwood (1992) hold that, “ The concept on an intersubjective system brings to focus both the individual’ s world of inner experience and its embeddedness with other such worlds in a continual flow of reciprocal mutual influence” (p. 18).

For intersubjectivity theory, then, psychological phenomena form, not in the isolated mind of the individual, but in an intersubjective context. This intersubjective context refers to the reciprocal experiences of mutual influence between two or more subjectivities. When two or more people come together in relationship, for instance the child and the caretakers or the patient and therapist, each brings his or her own world of subjective experience to the interaction. Together, they create a field, or a dynamic system, that contributes to the subjective experience of the other. Intersubjectivity theory takes as its domain of inquiry the field created by the interplay of these subjectivities. Thus, broadly speaking, intersubjectivity theory is a dynamic systems theory.

Beebe and Lachmann (1998) address the organization of a dyad in a systems paradigm, first by examining mother-infant interactions and then generalizing these findings to the therapy situation. According to their formulation, “ A theory of interaction must specify how each person is affected both by his own behavior, that is *self-regulation*, as well as by the partner’ s behavior, that is *interactive (mutual) regulation*. Each person must both monitor the partner and regulate the inner state” (p.482). Self-regulation refers to the person’ s capacity to regulate or control internal states, such as affectivity, arousal, or responsiveness. Interactive or mutual regulation refers to the extent that each person influences the other, though not necessarily to the same degree (what Aron [1996] has described as mutual but not symmetrical). The significant point is that, for infants and adults, the way one self-regulates

will impact the other, which will have a reciprocal impact on the experience of self. Infant research has demonstrated remarkable examples of mutual influence. In one study of EEG patterns of 10 month old infants shown a video of a laughing or crying actress, the infants' brains were positively or negatively activated in correspondence to the affect on screen (Davidson & Fox, 1982). This phenomenon of matching affective patterns holds true for adults as well: that perceiving the affective state of the other produces a similar state in oneself. As Beebe and Lachmann (1998) put it, "as two partners match each other's affective patterns, each recreates in himself a psychophysiological state similar to that of the partner, thus participating in the subjective state of the other" (p. 490). As you can imagine, this capacity for humans to match and mutually influence each other's internal affect states has important implications for the role of empathy in psychotherapeutic treatment.

In individual psychotherapy, the system encompasses the field created by the coming together of the subjective worlds of the patient and the therapist. While it is impossible to identify all components of the system since each system is unique, some of the likely shared components include the personal worlds of subjective experience of both, the situational and cultural contexts that encompass the system, and the interacting organizations of experience. Not surprisingly, the psychoanalytic theory of the therapist, with its assumptions and inferences, is an integral part of the context and impinges on the overall system. We will develop this further at a later point.

Individual therapy can be considered a dynamic dyadic system and a very complex one at that. The variables that might affect the system are too numerous and their interaction too complicated to thoroughly specify. Think of a pool table, where the path of the cue ball will be deflected by even minor contact with any other ball. Now imagine how such obvious

variables as the ages, genders, religions, race, and attractiveness of one might affect the subjective experience of the other. Given our exquisite sensitivity to the influence of others, we suggest that the powerful intersubjective field created in psychotherapy is a context in which both participants will inevitably be influenced and changed.

It is important always to bear in mind that while we stress subjective experience, such subjective experience is continually being constructed in the present out of the past experience of the individual and the current context in which she finds herself. “One’s personal reality is *always* codetermined by features of the surround and the unique meanings into which these are assimilated” (Stolorow and Atwood, 1992, p. 21). For instance, if the patient’s experience while growing up was of an aloof, demanding and critical father, then this particular set of experiences will contribute to shaping her view of herself and her expectations of relationships with others in the present. Furthermore, the specific ways in which the events, affects and bodily sensations associated with these experiences of “father” came to be organized and understood in their original context will contribute to the highly specific subjective meaning of new “father-like” contexts in the present.

You will have noticed that in the preceding paragraph we said, “if it was the patient’s experience...” rather than, “the patient’s father was...” The reason for this semantic distinction is that, from the intersubjective perspective, the tools of psychoanalytic psychotherapy do not permit us to know another’s “reality” in any objective sense. We cannot know how the father “really” was with his daughter; we can only know the daughter’s subjective experience of her father as she communicates it to the therapist today. This has on occasion been misunderstood as implying that intersubjectivity theory holds that there is no objective reality (Kriegman, 1998). This is certainly not the case. What intersubjectivity

theory maintains is that objective reality is not knowable or accessible through utilizing the empathic-introspective stance of psychoanalytic psychotherapy (Stolorow, 1998). One can learn all about the physical reality of a crème brulee by applying the principles and experimental techniques of physics and chemistry to analyzing its composition. But another person's experience of the crème brulee can be understood only from a report of her subjective experience of it. It was too rich, too sweet, and too thin—for her taste. Others might experience it differently. As therapists, we can never know what our patient's father was “really” like. After all, our patient's older brother, her mother, and the family dog might have experienced him differently. Thus, all that is knowable in psychoanalytic psychotherapy and therefore, its principal domain of inquiry, is subjective experience—the subjective experience of the patient and that of the therapist, and the intersubjective field created at the interface of these subjectivities.

The intersubjective emphasis on subjective experience is in contrast to the traditional psychoanalytic position that the therapist, by virtue of her vantage point and her training, has a uniquely objective view of the patient's experience. Such an objectivist stance assumes that the therapist can make observations about the patient's experience that are not colored by the therapist's own unconscious organizing principles (Orange, Atwood, & Stolorow, 1997). For the intersubjective theorist, all human experience is embedded in relational systems. One cannot escape the emotional impact of the person of the therapist on the relationship with the patient. The therapist's own unconscious organization of experience, as well as her theory of mind, must color her perceptions of and reactions to the patient. When the patient says that the crème brulee is too sweet, all the therapist can know is what “too sweet” means to her. Therefore, each patient/therapist pair is unique, formed within the intersubjective field created

by the coming together of their two unique subjectivities. The interfacing subjectivities converge around the idea of “too sweet” although neither knows exactly what “too sweet” tastes like to the other. It follows that the course of any treatment will be unique to the specific pair engaged in the process.

### Treatment Aims

According to Stolorow, Brandchaft & Atwood (1987), “The fundamental goal of psychoanalytic therapy is the unfolding, illumination, and transformation of the patient’s subjective world” (p.9). To approach this goal, the therapist who operates with an awareness of the intersubjective nature of psychological processes must provide an environment in which the patient’s world of subjective experience is able to unfold. This environment includes the ambiance of the setting, the empathic-introspective listening stance of the therapist, and the relationship created between the two of them. In addition to these factors, many unforeseen elements arising from the histories and the organization of experience of each participant contribute to the context. “...Analyst and patient form an indissoluble psychological system, and ...neither can, without violence to the integrity of the analytic experience, be studied alone” (Orange, Atwood, & Stolorow, 1997, p. 76). During the course of treatment, the attuned therapist explores and draws attention to the impact of these subtleties on the treatment. Essentially, the patient and therapist together create the environment in which a therapeutic dialogue can occur. It is through this dialogue that the patient’s story will unfold.

A second task of the intersubjective approach to therapy is to illuminate, to shed new light on, the patient’s subjective experience and the personal meanings the patient has made of it.

Intersubjectivity theory draws heavily on the hermeneutic tradition (Atwood & Stolorow, 1984). Hermeneutics originally referred to the theory of interpretation of religious texts. It

has subsequently been applied to the interpretation and understanding of human subjectivity. When we investigate human subjectivity, our focus is on personal meanings. Man is a meaning maker and humans create meaning out of their subjective experience. Meanings made of today's experience influence the meaning made of subsequent experience. Therefore, we must expand our domain of inquiry to include not just subjective experience, but the meaning each person makes of her subjective experience and the impact of that meaning on further experience.

Meaning itself is a multifaceted phenomenon, emerging from within the treatment context. Any context consists of an array of factors that the participants--in this instance, patient and therapist--separately organize to make sense of their experience. So, as with the hermeneutic tradition in the interpretation of religious texts, in psychotherapy the meaning we seek to illuminate is dependent on the context. Simultaneously, features of the context are selectively organized within our subjectivity, conforming to prereflective patterns. In a continuously interpenetrating process, meaning influences subjectivity and subjectivity selectively organizes context. Illumination is a process of focusing and understanding the elements (affective, cognitive and relational) in the foreground at any given time.

For our patient who experienced her father as aloof, demanding and critical, it is not enough to understand that this was her experience of him. We must also be concerned with understanding the meaning she made of her experience with him: in other words, how she structured or organized her experience of herself in relation to her father. Did she consider herself to be uninteresting or unappealing? After all, father spent much more time playing with her brother and the dog. Might she have concluded that she was deficient or lacking?

After all, father seemed to set higher expectations for her brother. Could she have determined that she was worthless because father tended to dismiss or devalue her efforts?

Continuing with our example of our patient and her father, we said above that “all that is knowable in psychoanalytic psychotherapy...is subjective experience.” But one’s subjective experience and the meaning made of it are not static—they are active and evolving. The past is as we experience it today. In therapy, as self-understanding grows, as the patient develops greater self-cohesion and enhanced capacity to listen to others empathically, her experience of the past will change. In a dynamic system, when one part changes, the whole system is thrown into disequilibrium and subsequently forced to accommodate to what is new. In psychotherapy then, when the patient’s organization of experience changes, her relationship to others, whether in memory or in her present, also changes. In this way, subjective experience can be transformed and new meanings can be constructed. For example, the father who was characterized as aloof, demanding and critical at the beginning of treatment, might be experienced later as a well-intentioned and concerned man whose own harsh and impoverished childhood led him to prepare his daughter for the cruel world of his experience by promoting self-reliance and self-sufficiency in her.

We used the illustration of individual psychotherapy to examine the complexity of the intersubjective field created by the interaction of patient and therapist. But the context can multiply the complexity, like placing more balls on the pool table for the cue ball to engage. Let’s complicate the intersubjective field by introducing a supervisor into the therapy mix. In individual therapy done under supervision, the field would now include the impact of the supervisor on the system (Buirski & Monroe, 2000). Furthermore, if the treatment were audio- or videotaped, the system would expand to include the real or imagined listeners. We

can anticipate how the watchful eye or keen ear of the supervisor might impact both patient and therapist. However, the meaning that each makes of the experience of being observed might be quite different, depending on the organization of experience of each individual. For example, the patient might experience deep shame at revealing his flawed, devalued self-organization, while the therapist might fear being seen as hopelessly inept and uneducable.

In contrast to some other psychoanalytic theories that search for the presumed absolute or universal principles underlying human nature, intersubjectivity theory makes no such assumptions about the nature of human experience. We do not strive to fit a person's subjective experience into preexisting theoretical frameworks, like "id, ego, superego," "depressive and schizoid positions," or "stages of separation-individuation." Rather, these formulations are viewed as metaphors that may be helpful in understanding some people, some of the time. Instead, intersubjectivity theory concerns itself with the way in which people form patterns, organize or structure their experience. According to Atwood and Stolorow (1984), "the basic units of analysis for our investigations of personality are *structures of experience*--the distinctive configurations of self and object that shape and organize a person's subjective world" (p. 33).

To say that experience is structured simply means that people organize and give meaning to the recurrent patterns or themes that emerge from their formative relationships with caregivers and other significant players in their lives. These patterns or themes or structures of experience are now generally referred to as organizing principles because they function as the emotional framework around which self-concept and self-esteem are built. In the example of the patient with the aloof, demanding and critical father, she organized, or made sense of,

her experience by concluding that she must be fundamentally defective and unworthy of love. It is important to bear in mind that the concept of organizing principles contains both cognitive and affective components. For the patient in the example above, her organizing principles concern both the idea that she is defective and unworthy of love and the painful affects of shame and self-loathing that are at the core of this organization of experience.

Another young woman had organized her experience around the idea that she lived under a black cloud that shrouded her life in bad luck. She was convinced that only disappointment and hurt would come to her if she reached for anything or anyone, and she was without hope for the future. After several years of treatment in which this organization of experience was identified and discussed, she met an attractive man at a local coffee shop. He expressed interest in her and they saw each other a few times and spoke occasionally on the phone. Eventually they began dating, and following their first sexual encounter, he suddenly stopped calling and did not respond to her phone messages. After many anxious days, she finally reached him by phone at his work, and he indicated that he no longer wanted to pursue the relationship. This was devastating for her. It fit perfectly, like a jigsaw puzzle piece, into her organization of experience. Hadn' t she always known that nothing good would come to her, that she was destined for hurt and disappointment? Who would want someone as loathsome as she? Let us imagine another woman with a different organization of experience—someone who feels self-confident and worthy of love. No doubt she too would feel hurt and disappointment at such a cold rejection, but this second woman would not find this experience to be a perfect fit in the waiting jigsaw puzzle. It might be viewed as a painful piece of bad luck but not a puzzle piece that fits seamlessly into a lifelong picture.

In both examples, these organizing principles and the affects at their core, though formed in childhood relationship with caregivers, get carried forward into the present and serve as a filter through which all subsequent experience must pass. One of the tasks of the intersubjective approach to psychotherapy, then, is to identify and articulate both the organizing principles and the underlying affect states that structure people's unique experience of themselves and others.

This brings us to one of the major current controversies in psychoanalytic thought: does psychopathology result from conflict or arrested development. The ego psychology perspective views neurosis as the compromise between conflicting forces or functions, operating predominantly within the unconscious mind of the individual. This intrapsychic conflict is understood to be occurring between the id, ego and superego. The principal locus of psychopathology is found in the forces in conflict within the mind of the individual and the internal management of this conflict.

In contrast, developmental arrest theories, like self psychology, might view psychopathology as resulting from a developmental history of insufficient or inadequate parenting in which the person was deprived of vitally needed selfobject experiences, such as mirroring, idealization and twinship, that promote the consolidation of a mental structure called "the self." From this perspective, the person is seen as suffering from developmental deficits in the structure of "the self." The developmental deficit perspective focuses then on what is missing (Atwood & Stolorow, 1997). And these defects in the structure of the self are understood to be the outgrowth of insufficient interaction with an external other.

While intersubjectivity theory values the importance of selfobject experiences for healthy development, "The concept of structure within intersubjectivity theory, by contrast,

refers to broad patterns within which experience repeatedly takes form, prereflective organizing principles manifest as recurring themes in the flow of subjective life (Atwood & Stolorow, 1997, p. 520). From the intersubjective perspective, psychopathology is understood as resulting from neither intrapsychic conflict nor developmental arrest in the formation of a structure like “the self.” Rather, psychopathology is thought to result from something that is present: the complex context out of which the person’s subjective experience became organized.

In addition to the unfolding and illumination of subjective experience, an important treatment aim of the intersubjective approach is the transformation of subjective experience. Transformation of archaically formed organizing principles does not mean that treatment leads to their modification. Successful treatment leads to the formation of new organizations of experience, new ways of understanding oneself and new expectancies based on these new understandings. If new structures, new ways of organizing experience, new organizing principles, are constructed during treatment, what happens to the archaically formed ones? They neither disappear, are forgotten nor are completely replaced by the newly formed ones. Rather, they persist, in weakened form, within the organization of the personality. In times of stress, in the absence of needed selfobject experience, old organizing principles may reemerge, reviving in the person old feelings of worthlessness or emptiness. The revival of these archaic affect states is referred to as either experiences of fragmentation, where prior attainments of self-cohesion begin to break down or experiences of depletion, where vitality affects cannot be sustained. Because the old co-exists with the new, it would be inaccurate to talk of cure. Successful psychotherapy leads to the formation of new structures: that is, new organizations of experience and new organizing principles.

The idea that what is accomplished in psychotherapy is the formation of new structures or new principles that organize experience is quite different from the idea that in psychotherapy people learn new ways of relating. If what happens in psychotherapy is that patients learn new ways of relating to others as an outgrowth of engaging in the transference relationship with the therapist, then psychoanalysis would be merely some variant of a social/learning theory.

From the intersubjective perspective, as a result of forming new psychological structures, new organizations of experience, people acquire new expectancies of relationship and are therefore capable of relating in new ways. They are capable of relating differently because they experience themselves and the world differently. It is not so much that they have learned new relating skills as that, feeling differently about themselves and their place in the world, they have become more open to risk and more resilient in the face of injury. Thus, from the intersubjective perspective, psychotherapeutic success involves structural change.

#### Investigatory Stance

For Freudian theory, the investigatory stance concerned the analyst's adherence to a posture of neutrality and abstinence. Neutrality meant remaining opaque to the patient, offering little response to the patient. The analyst was expected to function like a projective screen onto which the patient displaced or projected his inner wishes and conflicts. This was the transference: the patient's distorted perception of the analyst in the present in terms of a significant relationship from his past. This formative relationship was thought to be a contributor to the patient's inner conflicts. By maintaining a stance of neutrality, the transference could be preserved from contamination by the actuality of the person of the analyst and, thereby, could be pointed out as a distortion residing solely in the mind of the

patient. Any feelings the patient had for the analyst were thought to emanate from distortions due to displacements or projections from the inner world of the patient and had nothing to do with the actual person of the analyst. For example, if the analyst communicated to the patient her personal feelings of care and concern for him, this would contaminate the transference. Since any future feelings the patient experienced for his analyst might have been instigated by the analyst's actions, the patient's feelings could not be attributable solely to transference, to the reappearance of feelings from his childhood being displaced onto the present.

Through the use of such techniques as having the patient recline on a couch, the analyst sitting out of sight and maintaining a stance of abstinence (not gratifying the transference wishes), and meeting at least four times a week, regression (a resurgence of ways of coping and experiencing from childhood) was promoted. This fostered the formation of a transference neurosis in the present. The transference neurosis represented a revival in the present relationship with the analyst of the original childhood neurosis. By resurrecting the original childhood neurosis in the transference, the analyst was able to gain access to the patient's past. Resolving the current transference neurosis, through insight gained from the analyst's interpretations, was thought to mitigate the original childhood neurosis.

Another important component of the Freudian investigatory stance was the notion that buried memories of childhood wishes and conflicts could be uncovered, brought to light, and made conscious by putting them into words. Thus, the emphasis was placed on the analyst's making verbal interpretations, primarily of the transference, and on the accuracy and timing of these interpretations. The analyst's verbal interpretations, explanations of the underlying meaning of the patient's behavior or fantasies, promoted insight. And insight and

understanding strengthened and extended the ego' s dominion over the drives and the superego.

We have provided this abbreviated review of the Freudian investigatory stance because it enables us to highlight how the Freudian techniques of treatment follow quite logically from the underlying assumptions of Freudian theory. That is, the Freudian view was that current neuroses were the outgrowth of repressed childhood conflicts. Observing analytic neutrality and abstinence and promoting regression would resurrect those forgotten childhood conflicts in the present transference to the analyst. These pathogenic childhood conflicts could then be interpreted and made conscious. In a similar manner, the investigatory stance of the intersubjective approach to treatment grows out of its assumptions about the nature of psychological development.

Let us review some of the assumptions underlying the intersubjective approach and examine their influence on the investigatory stance. First is the assumption that human beings, by nature, organize experience and the need to maintain this organization of experience is a crucial motive in behavior. This supraordinate motivational principle profoundly affects the investigatory stance that characterizes the intersubjective approach to treatment and differentiates it from other therapeutic systems. Rather than listening for derivatives of repressed impulse, defense or conflict, the intersubjective therapist' s focus is directed toward discerning those principles, generally unconscious, and the accompanying disruptive affect states, that organize the patient' s experience. In addition, the therapist strives to appreciate that much of what gets labeled as psychopathology represents attempts on the part of patients to maintain or restore their threatened sense of psychological equilibrium. Symptomatic behaviors, whether constructed out of concretizations, dissociations or other psychological

processes, are understood to serve the crucial psychological purpose of maintaining or restoring the organization of experience. They are dramatic manifestations of the patient's striving for psychological integrity, not compromise formations that attempt to garner disguised or distorted satisfactions. Therefore, an important emphasis of the intersubjective approach is the focus on the patient's striving for psychological health rather than on the patient's psychopathology, his propensity to repeat earlier maladaptive patterns. This, as we will see, has profound implications for the practice of psychotherapy. For example, a patient who tolerates an abusive relationship might be characterized as masochistic. That is, traditionally he may have been viewed as seeking out or needing to repeat hurtful experiences, perhaps because of the disguised sexual pleasure derived or out of an unconscious wish to be punished for guilt-laden desires. An alternative explanation that focuses on the patient's striving to maintain a precarious sense of self-cohesion might be that enduring the abusive experiences, rather than repeating, seeking, or desiring them, is the price the patient is willing to pay for maintaining a relationship that in other ways is experienced as self-sustaining. Possible organizations of experience underlying this patient's sense of himself in an abusive relationship might be that he does not deserve to be treated otherwise or that he will never have a different kind of relationship or that he could not survive without a partner, so he must settle for this current one.

As a corollary to the assumption that humans organize their experiences into patterns and expectancies, a further assumption of intersubjectivity theory is that human beings are motivated to seek out those relational experiences that will promote and enhance self-development. If an adult regulates and integrates discrepant affect states, maintains a consistent sense of self over time and enjoys positive self-esteem, we speak of someone who

has achieved a measure of self-cohesion. Those relational experiences that promote or enhance self-cohesion and the integration of affect are referred to as selfobject experiences (we will have more to say about selfobject experience in Chapter 4).

Central to the investigatory stance of intersubjectivity theory is the empathic-introspective mode of inquiry. Historically, Kohut first introduced his formulation of the empathic-introspective mode of inquiry in 1959. According to Kohut (1984), “The best definition of empathy...is that it is the capacity to think and feel oneself into the inner life of another person” (p. 82). Since then, there has been a tendency in the self psychology literature to use the notion of empathy in two different ways. In the first case, empathy has been used to describe a way of responding with care and concern to another, as in, “John empathized with Mary.” The other usage of the term empathy is as a listening stance adopted by the therapist. Stolorow, Brandchaft & Atwood (1987) have proposed that reserving the term “empathy” for referring only to the listening stance could reduce the potential for confusion that results from the two different usages and meanings of the term “empathy”. In intersubjectivity theory, then, empathy refers to a method for learning about the patient’s subjective experience and empathic listening refers to the therapist attempt to understand the patient’s experience, to the extent that one can ever fully grasp another’s experience. They propose that we use the concept of affect attunement to describe the therapist’s responses to the patient’s experience. For example, when the therapist says, “It sounds like you felt hurt when your father forgot your birthday,” the therapist is communicating her understanding of the patient’s affect state, and by doing so, providing the patient with the experience of feeling understood, or attuned to. Thus the therapist’s affect attunement promotes the patient’s integration of affect (“I did feel hurt”) and is clearly a vital selfobject function. The empathic stance is the therapist’s attempt

to approximate the patient's inner experience and, from that perspective, respond in a way that the patient experiences as attuned.

Since the intersubjective approach focuses on the field created by the coming together of subjectivities of both patient and therapist, the “ introspective” component of the empathic-introspective stance concerns the manner by which the therapist attunes to her own internal processes. The importance of the therapist's introspective focus is on gaining and maintaining an awareness of the impact the therapist's person is having on the patient. In other relational approaches to psychotherapy, the therapist prizes her awareness of her experience, her countertransference, for what it tells the therapist about the patient's motives. In the intersubjective approach, the introspective stance is valued for two reasons: first, what it reveals of the therapist's impact on and contribution to the patient's experience, and second, introspection may provide the therapist with an emotional or experiential analogue that will provide both access to what that patient is feeling and a basis for providing an attuned response. Examine, for example, the situation of a patient who does not show up for his session and neglects to inform the therapist in advance. Attuning to her experience of irritation and annoyance, the therapist might interpret the patient's unconscious passive-aggressive desires to hurt the therapist; or, for those therapists with a more Kleinian bent, the patient's unconscious desire to make his therapist feel the way he felt when his parents forgot to pick him up after school and left him stranded. Rather than assume that the therapist's experience derives from the patient's angry motives, the intersubjective approach would lead the therapist to examine her own experience of the previous session (introspection) and explore the patient's experience of the therapist during the previous session. Might the patient's absence have been instigated by some experience of the therapist, like the patient feeling hurt or injured

by the therapist? This is not to suggest that anger might not be a reactive piece of the patient' s experience, but it allows for the focus to be directed to the intersubjective field constructed of the experiences of both patient and therapist to the previous session.

The above example highlights the importance of context for the intersubjective approach. For the Freudian system, the investigatory stance aims at uncovering the intrapsychic world of the patient. The aim of psychotherapy from the intersubjective perspective is to illuminate the contextual basis of experience, the patient' s and the therapist' s.

In this chapter we have tried to present 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.