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Intersubjectivity

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PSYCHOANALYSIS might have ended up being the simplest to describe of all psychological treatments. Patients talk as freely as they want and can. The analyst listens carefully and intervenes when he or she has something to say that has a reasonable chance of being useful to the patient—useful because it ultimately illuminates some aspect of how the patient's mind works unconsciously. The patient, as subject, takes the analyst as object and through transference creates a phantasy analyst who will gratify wishes or be an obstacle to their fulfillment. The analyst, as subject, then takes the patient as object and applies the collective knowledge of the psychoanalytic community, in effect saying to the patient: "We know from psychoanalysis that the way your mind works to create these ideas and feelings about me and others is the following." Then the analyst offers an interpretation.

Gradually, however, in all schools of psychoanalysis, that picture underwent a significant change. The change involved adding another layer to a full account of the analytic process. In this new layer, labeled *intersubjective*, the patient and analyst are both subjects. An easy way to think of this is to use a tennis analogy. In the subject-object model—taken to a pure extreme—the analyst might be viewed as a tennis coach who watches the patient hit balls being served to him or her by a machine or by a neutral person across the net. The analyst observes and comments on how the patient plays, hopefully helping the patient understand why he or she hits the ball well, hits it poorly, or misses it. If the patient implicated the analyst in her or his performance, directing loving or hating feelings toward the analyst-object, the analyst-subject could interpret what was leading the mind of the patient (now object of the analyst) to think and feel the way it was doing. In the intersubjective model, the analyst is always on the court and is always hitting the ball back and forth with the patient, even though in a coach-student type of asymmetrical arrangement. The patient might see the analyst as being helpful or as hitting too hard, not trying hard enough, or not being interested enough, among other gratifying, anxiety-laden, or angry images of the analyst. The analyst, in this intersubjective model, is encouraged to consider the patient's view of the analyst not as being pure phantasy but as being a phantasy-observation mix or as existing on a continuum between phantasy

and observation. If the patient stopped an initial interview or a session during an analysis and said, "How did we end up talking about me in this way?" the analyst would not say, "Well, because your mind has revealed itself to work the way we are talking about it, just translated through my psychoanalytic concepts and vocabulary," but instead would say, "Well, because our minds working together have shaped a model of how your mind operates."

All psychoanalysts have become more aware of the intersubjective dimension of their work. For some, this means mainly paying attention to what is happening in the patient-therapist interaction (perhaps mainly as one source of evidence from which to build an interpretation about how the patient's mind is revealing itself). For others, it might mean prioritizing moments when there is palpable tension in the analytic relationship. For still others, it goes beyond focusing attention on and prioritizing "what's happening between us right now" to include techniques usually revolving around the analyst saying something about what the analyst believes his or her role has been in a clinical event (including disclosures of what the analyst understands about his or her emotional response to the patient and speculation about how he or she might have contributed to tension or momentary breakdown in the analytic relationship).

All three of these intersubjective perspectives have been fed not only by clinical experience and psychoanalytic theory development but also by research and theory occurring in the fields of infant development and neuroscience. I give just a few samples of thoughts about intersubjectivity currently circulating in those fields. These samples do not aim to do justice to these vast bodies of literature but only to whet the reader's appetite with brief quotes from those literatures that illustrate why they have piqued clinicians' interest.

In the field of neuroscience, the Italian researcher Vittorio Gallese (2009), reflecting on the type of brain cell that has come to be called a *mirror neuron*, suggested that such cells underlie a human capacity—embodied simulation—that offers "a model of potential interest" (p. 519) for why intersubjectivity might turn out to ground the human condition. Mirror neurons, which appear to allow us to actually produce, without motor activity, an internal facsimile of what we see someone else doing or experiencing (including what he or she is likely to be feeling), thus might be what provide the biological ground for Freud's (1926) hypothesis that it is only by empathy that we know the existence of psychic life other than our own" (p. 104).

In infant research, Daniel Stern (2004) argued that engaging in mutually coordinated mother-baby exchanges is something we are compelled to do from birth and therefore reflects "an innate, primary system of motivation, essential for species survival, and has a status like sex or attachment" (p. 97). As Winnicott once put it: "There is no such thing as a baby...if you show me a baby you certainly show me also someone caring for the baby" (alleged to have been said during a lecture; quoted in Abram 1997, pp. 2–3).

Summing up both the neuroscience and infant development evidence for an innate intersubjective dimension of human psychology, infancy researcher and psychoanalyst Robert Emde (2009) hypothesized: "The self is a social self to begin with....Moreover, research indicates that, from infancy, innately given brain processes support social reciprocity and the development" of a quality he calls "we-ness" (p. 556).

In this chapter I provide a brief account of the emergence of this intersubjective perspective into psychoanalysis. Starting with the introduction of the term *intersubjectivity* itself into the psychoanalytic literature by Stolorow, Atwood, and Ross during the 1970s and 1980s (Atwood and Stolorow 1984; Stolorow et al. 1978), the discussion then moves back in time to precursors of intersubjectivity in the writings of Ferenczi, Sullivan, Fairbairn, Winnicott, Klein, Bion, and Kohut. Then the chapter returns to the present for an overview of how this intersubjective attitude has increasingly informed analytic thinking across many schools of psychoanalysis.

Roots of the Term *Intersubjectivity* in Psychoanalysis

Although the roots of intersubjectivity might be traced to Ferenczi, Sullivan, Winnicott, or Kohut, its current life within psychoanalysis was launched by Stolorow, Atwood, and Ross between 1978 and 1988. While agreeing that patients come to analytic treatments with systems of meanings and organizing principles (that influence their thoughts, feelings, decisions, and relationships) formed during development, they argued that the source of these subjective psychologies is not mainly repressed wishes waiting to be discovered by analysis of anxiety and resistance through interpreta-

tion alone. Rather, they are prereflective meaning systems that, as Stolorow put it in 1988, are

> lifted into awareness through an intersubjective dialogue to which the analyst contributes his empathic understanding. To say that subjective reality is articulated, rather than discovered or created, not only acknowledges the contribution of the analyst's empathic attunement and interpretations in bringing these prereflective structures of experience into awareness. It also takes into account the shaping of this reality by the analyst's organizing activity, because it is the analyst's psychological structures that delimit and circumscribe his capacity for specific empathic resonance. (Stolorow 1988, p. 336)

What Stolorow was describing might be put in several related ways: the psychological phenomenon we call *consciousness* is the result of minds in interaction; that which each of us calls "my self" is a history of experiences created in interaction with others; it is "the recognition that the other person is central to the formation of the self" (Elliott 1992, p. 237, drawing on the work of Adorno and Marcuse); and the "pre-reflective" self is an accumulation of affective experiences, many of which have never been articulated (Socarides and Stolorow 1984). The ways in which this is and has been true for each patient will be a critical part of the analytic treatment of that patient.

The patient brings his or her idiosyncratic understanding of his or her self to the therapy. The clinician brings such a self-understanding as well but also brings a collective psychoanalytic and therapeutic self, shaped through immersion in the thinking of the community of clinicians known as psychoanalysts. Eventually, the two *articulate*—or, moving even further along the continuum from intrapsychic to intersubjective, we could say *create*—shared understandings of how the mind of the patient works unconsciously.

One might extrapolate from Stolorow that the fullest expansion of the patient's subjectivity would be helped most by the therapist being aware of how his or her subjectivity might block the patient from completing this task. Therapeutic progress, whether it unfolds during an hour-long interview or a 10-year analysis, derives from the clinician increasingly getting out of the way, using less theory, and learning to help the patient co-narrate (Spezzano 1993) the patient's story in his or her own way. If there are problems with the story, they will be exposed by this co-narrating. The process is less like a novice student of the Napoleonic Wars coming to see things more clearly by studying with a professor who (together with her or his colleagues) has been studying that series of events for years, and more like a novelist bringing a manuscript to a paid editor. They go over it again and again, sharing their different perspectives, asking different questions, agreeing that one way of telling the story makes most sense to both of them (or not) and repeating such processes over and over.

Early Precursors of Intersubjectivity

Ferenczi

Arguably, the first serious intersubjective analytic theorist was Sandor Ferenczi. He argued in the 1930s that patients often have had their egos' self-reflective capacities severely diminished by the constant shocks delivered by parents and other early caretakers. The part of the ego that could make good decisions was split off and saved, but that leaves the child reliant on external egos. In other words, the decision-making ego is split off; then it is imagined to exist in some other mind, and then one subjectively experiences oneself as reliant on those minds. Ferenczi wrote in his clinical diary (published in 1995): "Without any change in the external situation or in the ego's capacity for endurance, the return of the psychic situation can only result in disintegration and reconstruction" (Ferenczi et al. 1995, p. 182). Ferenczi, therefore, recommends "help through suggestion, when energy flags; shaking up, encouraging words" (p. 182).

This analytic attitude of "when you cannot break out of a psychic prison alone, we'll have to do it together" was first articulated by Ferenczi. Ferenczi emphasized the affective state one person evokes in another and, applying this emphasis to the therapy situation, theorized that symptoms emerge and hide, in part, because of unconscious and inadvertent safe and unsafe contexts for those symptoms created by the analyst. The patient's repressed and dissociated thoughts and feelings will continue to be expressed only in familiar symptoms and ways of relating until the analyst creates a possibility for them to appear in less disguised ways. As Borgogno (2004) concluded: "This was to be the task that Ferenczi would set himself: identifying in the affective life of the patient and taking upon his own person, and upon his own body, the possible passage of suffering that produced the symptoms" (p. 7).

Sullivan

Another forerunner to the intersubjective attitude (i.e., the notion of no such thing as stand-alone one-person psychic phenomena) is found in the writings of Harry Stack Sullivan. As early as 1937, Sullivan foreshadowed the contemporary intersubjective notion that "the subjective experience of each party is inseparable from that of the other" (Natterson and Friedman 1995, p. 129): "Information can arise only from explicit or implicit attempts toward communication with other persons. One has information only to the extent that one has tended to communicate one's states of being, one's experience" (Sullivan 1937, p. 17). As Gerard Chrzanowski (1977) summed up Sullivan's interpersonal psychoanalytic perspective: "Inherently human characteristics rest neither inside nor outside of the person. They are part of an ecolologic unit that can never be divided" (p. 115). This perspective led Sullivanian analysts to emphasize, intersubjectively, "What's going on here between us?" as a key question in all therapy sessions, at least as much as they emphasize, intrapsychically, "What's going on in the mind of the patient?"

Fairbairn

In the United Kingdom, W. Ronald Fairbairn's work ran parallel to Sullivan's in time (the 1930s and 1940s), but with more of an emphasis on showing how early interpersonal events lead to adult intrapsychic phantasies. Fairbairn had returned to Freud to ask why the affect of sexual excitement should be a source of universal anxiety and conflict. He argued that it was because to experience that affective state as pleasurable and to enjoy it unconflictedly, the child would need caretakers who showed excitement about the child's excitement. Even good mothers of healthy infants will have moments of anxiety, distress, depression, or anger when their baby tries to engage them excitedly. If there are too many such moments, the infant will withdraw into a schizoid state. Then, turning to Klein's emphasis on aggression as the source of anxiety, defense, and conflict, Fairbairn argued that if the child's aggressive excitement is met with rejection, the child will end up depressed, because in order to form a secure engagement with the mother, the child has to give up part of his or her emotional self: his or her anger. This is a significant loss and is therefore accompanied by depression. As Fairbairn (1941) summarized the dilemma:

> The great problem of the schizoid individual is how to love without destroying by love, whereas the great problem of the depressive individual is how to love without destroying by hate. These are two very different problems...it is the disposal of his hate, rather than the disposal of his love, that constitutes the great difficulty of the depressive individual. Formidable as this difficulty is, the depressive is at any rate spared the devastating experience of feeling that his love is bad. Since his love at any rate seems good, he remains inherently capable of a libidinal relationship with outer objects in a sense in which the schizoid is not. (p. 271)

Fairbairn (1952) took his understanding of the internal object relations of the depressive and schizoid personalities into the intersubjective realm at the developmental and clinical levels of psychoanalytic discourse. Developmentally, he thought that depressive and schizoid personalities result from actual excessive maternal rejection of, respectively, hate or love. He emphasized that the precursor to this intrapsychic maintenance operation is an actual interpersonal maneuver in which the child relates to the rejecting mother as though she were registering excessive hate or bad libidinal excitement from the child, and he suppresses his aggression and subdues his excitement. The actual affective self splits before the splitting is represented. So, at the clinical level of psychoanalytic discourse, the analysis of the schizoid personality has to include new experience of more recognition and acceptance of excitement about the analyst whenever that appears. Fairbairn saw (what he then believed to be all too frequent) interpretation of excitement about the analyst as damaging to the schizoid person's residual capacity to come out of hiding and feel/show excitement about others again. In a more general intersubjective sense, he made the interesting observation that the psychoanalytic method is (as we now label it) a third thing that is needed and will be used by the first two things—patient and analyst:

> In general, I cannot help feeling that any tendency to adhere with pronounced rigidity to the details of the classic psycho-analytical technique, as standardized by Freud more than half a century ago, is liable to defensive exploitation, however unconscious this may be, in the interests of the analyst and at the expense of the patient; and certainly any tendency to treat the classic technique as sacrosanct raises the suspicion that an element of such a defensive exploitation is at work. Further, it seems to me that a complete stultification of the therapeutic aim is involved in any demand, whether explicit or implicit, that the patient must conform to the nature of the therapeutic method rather than that the method must conform to the requirements of the patient. (Fairbairn 1958, pp. 378–379)

Winnicott

Donald Winnicott, too, focused on the maternal environment in which development occurred. He was especially interested in how well a mother/caregiver attended to what the infant showed interest–excitement toward and then facilitated the infant's doing what it wanted to do with what it found in its environment—his view of early creativity. He argued that psychoanalytic technique should enhance the patient's ability to recognize what he or she wanted to do and have (in the world and with others) and that the way to provide this help therapeutically was for the clinician to be used by the patient in ways the patient wanted. When these ways deviated from the psychoanalytic frame, Winnicott suggested methods that overlapped with those of Ferenczi (decades earlier): let the patient use you—that is, treat many (of course, not all) of the patient's requests and demands to be dealt with and related to in specific ways (not what you, the clinician, might ordinarily do) as opportunities to bring alive the patient's true self.

Klein and Bion

Positioning Melanie Klein's theories as part of the evolution of an intersubjective view of human psychology and of psychoanalysis requires us to focus on her notion of *projective identification* (Klein 1946), which launched within Kleinian theorizing an attention to unconscious affective communication and therefore to intersubjectivity (although Klein herself did not move it from the intrapsychic to the intersubjective realm of experience). This thread or potential in Klein's thinking was realized by Wilfred Bion. The baby, as viewed by Bion, is subject to sensations and affects. These are experienced, revealed, and communicated as fragments of mental experience that he called beta elements. The mother has to take these in and metabolize them, using her alpha function. If she does this successfully and communicates her mental state back to the infant, the infant has the beginning of something he or she can, in turn, metabolize and, as cognitive development allows, reflect upon.

Kohut

Just as Bion developed his own theory out of his previous immersion in Kleinian theory, Heinz Kohut broke off from American ego psychology in the 1970s by arguing for therapy to be an experience in which patients regained access to healthy excitement and assertiveness about which they had become ashamed. In addition, he argued, when patients reject the therapist's interpretation, the first thought of the therapist should be that the interpretation had inadvertently rejected an aspect of the patient's self that the patient was trying to have known and accepted. Thus, breakdowns in analysis are best understood, at first, not as due to transference distortions but as empathic failures (which will happen in every analysis and should not be seen as something that wrecks a therapy but as an opportunity to focus on the patient's history of experience of empathic failures, right up to and including the analysis). For example, in his paper on the two analyses of Mr. Z, Kohut (1979) argued that the patient needed to hear the analyst say it was understandable that Mr. Z became enraged when he felt his analyst did not relate to him in the way he believed he was due. If the analyst does not find the emergence of specific bad feelings in his or her patients to be understandable, then the clinical problem is not simply the disturbing quality of the affect but also that the analyst does not understand the perspective of the patient well enough.

Contemporary Versions of the Intersubjective Attitude

Greenberg and Mitchell

Seeing these developments—variously thought about as intersubjective, interpersonal, and object relational—happening across a variety of psychoanalytic theories, Jay Greenberg and Stephen Mitchell (1983) pulled together the ideas of many theorists to argue that there were two main trends in psychoanalytic theorizing. In one, following Freud, the building blocks of the unconscious mind are endogenously arising wishes derived from sexual and aggressive drives. In the other, the building blocks of the unconscious mind are representations of relational experiences. Mitchell (1988) went on to theorize that "[m]ind has been redefined from a set of predetermined structures emerging from inside an individual organism to transactional patterns and internal structures derived from an interactive, interpersonal field" (p. 17) and that life and psychoanalysis are best

understood as what I would call team activities (Mitchell 1993, 1997). Mitchell's intersubjective attitude emphasized the need of each patient for a customized relationship within which psychoanalytic interpretations have an optimal chance to become useful.

The Barangers and the Bastion

During the same year, 1983, that Greenberg and Mitchell's book was published, in South America the attitude we are calling intersubjective was clearly articulated in the work of Madeleine and Willy Baranger and Jorge Mom (Baranger et al. 1983; see also Baranger 1993). The Barangers' theory of the bipersonal analytic field is a seminal contribution to intersubjective thinking. In this theory, the analyst and patient define each other—in other words, they give each other the roles they will play out in the analytic field. In this field, the two characters form a new psychic structure in which they, in turn, find themselves involved in a process that has a sort of life of its own, definitely dynamic and evolving, and having the potential for creativity (not just revealing and adjusting pathology). For this dynamic and creative process to emerge in its most positive form, the analyst must deal with a form of impasse they called the *bastion*:

> Each of us possesses, explicitly or not, a kind of personal countertransferential dictionary (bodily experiences, movement fantasies, appearance of certain images, etc.) which indicates the moments in which one abandons one's attitude of "suspended attention" and proceeds to the second look, questioning oneself as to what is happening in the analytic situation. These countertransferential indicators which provide the second look lead us to realize that within the field exists an immobilized structure which is slowing down or paralysing the process. We have named this structure the "bastion." (Baranger et al. 1983, p. 2)

So in the Barangers' view, we have not only the psychic structure of the patient and of the analyst but also a third psychic structure in the room. The bastion, running silent, only manifests itself indirectly. It surfaces through a jointly created enactment (a dramatic scene, if you will) played out by the two characters. In this drama, the patient and analyst play some other roles than patient and analyst (e.g., father and daughter, angry lovers), but in secret. Recognizing the bastion as an intersubjective creation and interpreting its existence and its impact on the analytic process are critical.

Ogden's Analytic Third

Although the Barangers had suggested the notion of an intersubjective analytic "third" in the 1980s, it was Thomas Ogden (1994, 2004) who labeled it and conceptualized it as a normal part of analytic work. In Ogden's (1994) scheme, "[T]he analyst attempts to recognise, understand and verbally symbolise for himself and the analysand the specific nature of the moment-to-moment interplay of the analyst's subjective experience, the subjective experience of the analysand and the intersubjectively generated experience of the analytic pair (the experience of the analytic third)" (p. 3). What emerges into consciousness in the mind of the analyst during a session does not derive solely from the analyst's empathic reception of the patient's associations and the analyst's countertransference but also from "the analyst as a creation of the analytic intersubjectivity" (p. 8). The analyst has to treat that "motley collection of psychological states that seem to reflect the analyst's narcissistic self-absorption, obsessional rumination, day-dreaming, sexual fantasising, and so on" (p. 9) as also containing potential evidence about the unconscious psychology of the patient.

In other words, when we are interacting with another person, we cannot directly receive communications from the unconscious of the other, nor can our unconscious put anything directly into our consciousness. Everything is mediated by a third unconscious subject that, during analysis, produces associations in the mind of the analyst in which are hidden clues about both the workings of the unconscious of the patient and the workings of the unconscious of the analyst.

Benjamin's Intersubjectivity

Ogden's ideas, as is true of all the ideas covered in this chapter, are attempts to conceptualize the ways in which when minds interact, the result is not simply the sum of its parts. Yet those parts—the two subjects interacting—also continue to draw our attention, as clinicians and theorists, as well as the attention of the interacting subjects. Jessica Benjamin (1990) wanted to balance "the complementarity of intrapsychic and intersubjective aspects of self-development" (p. 33) by highlighting the critical importance to development and psychoanalysis of mutual recognition by the subjects involved in any interaction. She wrote: "The development of the capacity for mutual recognition can be conceived as a separate trajectory from the internation-

alization of object relations. The subject gradually becomes able to recognize the other person's subjectivity, developing the capacity for attunement and tolerance of difference" (p. 33).

The analyst and the patient will not end any analysis having a shared understanding of everything they found to be important. An equally therapeutic outcome, we might conclude, following Benjamin, is being at peace with the enduring differences about what aspects of the self of the patient and the self of the analyst have been revealed during the analysis, as well as living with the enduring differences in their stories about what happened (and what did not happen) in the analysis—especially moments when there was a breakdown in their relationship that might lend itself to ping-ponging blame but that, after a good analysis, will be seen as similar to a busted play in a sporting event: we tried to do X, but it did not work so well at certain moments. Otto Kernberg, for example, once said to an angry patient: "Do you think that you can tolerate our working together while each of us acknowledges to the other that our views are completely different?" (Kernberg 1982, p. 521). That question is being asked in all therapies and all relationships, according to the intersubjective perspective.

Natterson's and Friedman's Clinical Intersubjectivity

Similarly, Raymond Friedman and Joseph Natterson (1999) reminded us that analytic events, like all human events, are ambiguous and complex. Analysts need to be aware that the "recognition of co-responsibility is the enabling event for understanding and for constructive outcome" (Friedman and Natterson 1999). All therapies have moments where patients become concerned and/or angry about how some session, period of therapy, or entire therapy did not go as well as hoped or expected. This has always been as troublesome an aspect of clinical work as a patient finding analysis and/or the analyst to be libidinally exciting. An intersubjective attitude suggests that the initial approach to this is not so much "Where are these ideas and feelings coming from in the mind of the patient?" as "How has our working together led to these (sexually excited or angry) thoughts and feelings?" If a clinician is interviewing a patient in an initial meeting (whether in an emergency department or an office) and the patient becomes annoyed and claims the therapist is not "getting it," then the intersubjective attitude suggests that the failure to communicate is due to a mixture of how the patient is explaining the situation and how the clinician is translating and talking about it. With that attitude, the clinician would start with something like "Do you think you're having trouble expressing what's going on inside, or am I putting my own spin on what you're saying and in the process changing it too much? Or perhaps both?" Or he or she might say: "I'm having trouble understanding what you're trying to tell me, or if I am getting it, then my way of putting it back to you doesn't convey that I understand. That's adding frustration with me to the bad feelings you came in with."

In that scenario, the patient might be viewed as trying to use the analyst as an object, and the analyst is acknowledging that he or she has not been as pliable as the patient wants or needs. When one of us tries to use another in this way (wanting the other to be completely pliable to our imagined casting of them into a role), we are actually making the other less useful overall. The therapist knows that the patient is ultimately making him or her less useful by confining him or her to a limited role (even if at moments we might agree to be temporarily pliable in response).

Most of us know the experience of wanting another person to relate to us in some particular way, but wanting them to do so spontaneously. Winnicott (1969) wrote a paper about this in which the baby is, in the end, happy not to have destroyed the mother's spontaneous subjectivity by its demands. The maternal object turns out to be a maternal subject as well—even better. However, we must develop to the point where we genuinely experience "even better" at the realization of the other as subject. Intersubjectivity, as a clinical theory, tries to explain how we can help patients learn to use the analyst-object's subjectivity, or perhaps more accurately, learn how to tolerate and even take pleasure in being part of a team of subjects co-creating psychological events that are partially gratifying (libidinally, aggressively, narcissistically) for all.

Fonagy's and Target's Mentalization

Patients enter therapy with varying degrees of ability to be such a psychological team player. As infants develop, they experience bodily sensations and the rudiments of emotions. They are stepping out onto the dance floor of life. Others help them get into a good rhythm, back away from them, bump into them, and step on their psychic toes. If the world of others already on the dance floor

ahead of them provides adequate help, infants end up regulating and expressing their affects in ways that facilitate good dancing. If not, they might become confused by their feelings, might name them differently than most of us do, might too quickly conclude that any bad interpersonal event (the kind that leads us to sometimes say sarcastically "that went well") is conclusive evidence of a bad self or a bad other, or might find it difficult to regulate their affective states.

Peter Fonagy and Mary Target (2007, p. 917) argued that 1) "the external world is not an independently existing 'given,' for the infant to discover, as is sometimes implicitly assumed. Infants acquire knowledge about the world not just through their own explorations of it but by using other minds as teachers"; 2) "the experience of external reality is invariably shaped through subjectivities"; and 3) "at first the infant assumes that his knowledge is knowledge held by all, that what he knows is known by others and that what is known by others is accessible to him. Only slowly does the uniqueness of his own perspective differentiate so that a sense of mental self can develop." There is a fundamental human paradox here. What anyone does when interacting with you is a crucial element in creating your reality. So when patients ask with frustration, "What are you doing? I don't want to talk about that. I want to be immersed in this thought or feeling," they (and I) are encountering the paradox of needing the cooperation of another person to maximize the subjectivity of themselves while being forced to recognize that the other person is at least partially engaged in the process of elaborating their own subjectivity.

Fonagy and his colleagues have termed this capacity—in which each of two people in the dyad remains aware that the other is representing the unfolding experience in his or her own unique way—*mentalization*. They (Fonagy and Target 1996, 2002; Target and Fonagy 1996) have been arguing that this capacity develops more in some people than others. Their introduction of this concept into the psychoanalytic literature was not the result of armchair theorizing. It grew out of their work with traumatized people who seemed to have significant difficulty intuiting others' thoughts and feelings, equated their internal states with external reality (e.g., if I feel really bad, then a really bad person must have just done a really bad thing), and related to others as though what they did was like a child in pretend play and thus would have no real impact on the other. Actions counted, but mental states or words seemed to be treated as something they could discount, devalue, or make irrelevant if the analyst tried to interpret.

Mentalization is another inherently intersubjective concept. It emphasizes not only that human interactions depend on the rapid negotiation of dueling representations but also that the ability to detect and negotiate these different representations is a developmental achievement that results from practicing with adults who are themselves competent at it. It is not simply a matter of developing a capacity and then practicing it with others. It is something one can only do with others from the start.

Hoffman's Dialectical Constructivism

This perspective has been developed in a unique way in the theory of dialectical constructivism created by Irwin Hoffman. For Hoffman, the experience of the patient is always contextual, including the context created by the spontaneous participation of the therapist. This participation is personal—that is, it is inevitably infused by and reveals the unconscious personality of the therapist and the therapist's emotional involvement, which will show itself unless deliberately restrained (which Hoffman does not recommend) because "the analytic situation lends itself to a high probability that our experience within our analytic role will include intense, responsive, passionate feelings, if we open ourselves to them as we hear the details of patients' suffering, their historical origins, and the often impressive, even heroic strivings of the patient, despite the obstacles, to survive, to live, and even to grow" (Hoffman 2009, p. 635). Because the unconscious sources of this participation by the therapist are not self-evident, both the therapist and the patient are free to look at them as one might examine a card on a projective psychological test such as the Thematic Apperception Test. The behavior of the analyst and the internal experience underlying it are inherently ambiguous. Everything that the analyst does and says—and also a moment when the analyst does nothing or says nothing, but might have—is open to interpretation by the patient. As Hoffman (1983) argued, this makes the patient a legitimate and necessary interpreter of the analyst's experience. The patient's interpretations of the analyst's experience are—as Hoffman's mentor, Merton Gill (1983), put it—always to be treated as plausible. Its plausibility is the analyst's starting point in taking it up with the patient. He does not mean to "assume the patient's interpretation of the analyst is the truth, the whole truth, and nothing but the truth." Rather, he means to "start out by treating it as plausible" and go from there.

In one of Hoffman's (1994) case reports, a patient opened the hour by confronting him with the demand that he do something concrete and immediate to help her feel less anxious or she would quit therapy. She wanted Valium but didn't want the hassle of a psychiatric evaluation. Hoffman also believed going that route to get the Valium would be a burden for her. She had to go to work and school that day, and her functioning would be impaired by her intense anxiety. She confronted him with the question of whether he cared more about following good analytic form or helping her. He tried to get her to reflect on the pros and cons of his responding to her demand. Believing that the analyst is always co-constructing the patient's experience and that struggling out loud with such a dilemma rather than taking the position that analysts do not do such things, he asked her if she had an internist he might call. She gave him a name and number, as though that satisfied her, but while he was on the phone, right there during the session, she began to whisper to herself that what was happening was crazy because she could obviously have done this herself. The internist readily agreed to prescribe a tranquilizer.

Hoffman theorized that a projective identification was operative, but he hypothesized (in a two-person constructivist model) that it was his own. By refusing categorically, he would have been projecting his static version of an analyst-patient self-object representation. Agreeing to her demand, he argued, shook them loose from a projection he would have been initiating. He called her bluff and also challenged the force of his own internalized patient-analyst representation. The patient, in turn, was freed from her tendency to submit to the requirement that she do it the authority figure's way. As a result, and more important, she could freely—not forced by the analyst's interpretation—show an interest in the pros and cons of an interaction-enactment that she had initiated.

In addition, however, Hoffman was also unusually clear, among intersubjective theorists, in stating that the patient remains a distinct individual with an uniquely structured unconscious through which he or she experiences and responds to the analyst. Adding an existential note, Hoffman put this in terms of responsibility. In response to a mistake made by the therapist, one patient will quit treatment, whereas another will confront the therapist. If he had refused to call the internist and the patient had quit therapy, then that would have been her responsibility. Hoffman chose to view such actions not simply as inevitable expressions of each patient's unconscious psychology but also as a matter of choice and free will.

Dissociation

The intersubjective attitude often removes repression as the quintessential defense and replaces it with dissociation, a defense that, in turn, is usually viewed as having arisen because of a developmental breakdown or trauma in the patient's interpersonal world rather than mainly through intrapsychic conflict. Some experiences cannot be assimilated into the world as it is represented in the mind of the individual. This creates a different problem for the mind than those that repression attempts to solve. How will I express my aggression? What will I do with my sexual excitement? If ideas about acting out one's sexuality or aggression catalyze (defendable? manageable?) anxiety, then the idea can be repressed and the feeling can be preserved. So we say, "That wasn't my wish" or "I only meant" or "The frustration I was really angry about is," and we substitute another idea for the original wish, meaning, or frustration. When, however, an experience would force a complete destruction of the interpersonal world as one has represented it unconsciously, then the accompanying anxiety is catastrophic, and that world can be preserved only by dissociating, or splitting off, the experience (usually also a whole category of experience).

Arguably, the most comprehensive contemporary theory of trauma and dissociation has been created by Philip Bromberg (1991, 1998). In his formulation, each person's individual unconscious psychology develops and is organized by both conflict and trauma. Psychological trauma, even in a mild form (if any trauma can be called mild), always precipitously disrupts self-continuity by invalidating patterns of interaction that give meaning to life and tell each of us who we are. Trauma has a "this can't be happening to me" quality, so to preserve the "me" I have known myself as, I will split it off from the "me" to whom this is happening. The main reason why the experience cannot be reflected on and integrated into a new whole self is that the affects evoked by the experience are too intense. They disrupt the cognitive functioning that such self-reflection requires. Bromberg summed up this perspective in 1991: "Simply put, the patient is seen not as someone in need of 'insight' that will correct faulty reality but as someone in need of a relationship with another person through which words can be found for that which has no verbal language. As the patient finds words with which to represent his experience, he 'knows' himself" (Bromberg 1991, p. 419).

The traumatized patient who uses dissociation as a major defense will predictably find anything unexpected happening as severely disruptive. Events ranging from a missed appointment to an off-the-mark affective reaction in the therapist can trigger confusion, anger, an anxious need to get away from the therapist, and security-restoring thoughts about being free to leave the therapy. The last of these is an attempt by the patient to create an antidote to the inherent quality of trauma, emphasized by Bromberg as something from which there is no escape (e.g., "I couldn't leave my abusive or rejecting mother, but I can leave you").

Arguably, however, the core of traumatic experience—and the aspect of trauma that most strongly calls for an intersubjective focus on the part of the analyst—is an experience (or an accumulation of experiences) that remains beyond words in the mind. Therefore, a more complete account of trauma, dissociation, and intersubjectivity can be created by combining the work of Bromberg with that of Donnel Stern. Although we long emphasized the unconscious as a repository of repressed ideas, in 1915 Freud wrote: "The conscious presentation comprises the presentation of the thing plus the presentation of the word belonging to it, while the unconscious presentation is the presentation of the thing alone" (p. 201). The "thing" is not so much an idea as much as it is what Stern (1983, 1987, 1989) called "unformulated experience." Both Freud and Stern leave an appropriate element of uncertainty about exactly what internal unconscious experience is before it is formulated verbally in consciousness.

This notion, although true to some extent for all patients, is especially true for patients reintegrating traumatically dissociated parts (perhaps, more accurately, versions) of themselves:

> When a patient is finally able to think about a previously unaccepted part of life, seldom are fully formulated thoughts simply waiting to be discovered, ready for exposition. Instead, what is usually experienced is a kind of confusion—a confusion with newly appreciable possibilities, and perhaps an intriguing confusion, but a confusion or a puzzle nevertheless. Unconscious clarity rarely underlies defense. (Stern 1983, p. 71)

The technical implication is that patient and therapist will together create the story of this lost self. For example, the therapist will see what he or she believes as possibilities that the patient's way of narrating life events does not make clear but allows the therapist to surmise. Thus the intersubjective-relational therapist might be less concerned that a suggestion will bypass a defense than that lack of a suggestion will leave a lost version of the self out of the story. Such a therapist might say: "You haven't said this, but the way you tell that story led me to think that such and such could have been said, and it would have fit in perfectly."

Stern (1983, 1987, 1989) extensively developed this perspective through his writings on unformulated experience. Whatever any patient knows about herself or himself at any moment is not a static set of conscious, preconscious, and unconscious ideas but rather an internalized version of what the patient and the therapist have put into words together. That version cannot be simply a representation of a transcendent, fixed, and immutable truth about who the patient really is, but is a jointly created revision of the story about himself or herself with which the patient entered therapy.

Conclusion

Psychoanalysis has not, for better or worse, ended up with a single, universally embraced model of development, mind, and treatment, nor are its various schools mutually exclusive. None of the intersubjective authors talk to patients all the time as though those patients had no mind in which feeling and thinking were happening. They all do add some measure of "we" where "you" and "I" once prevailed hegemonically. In addition, they increasingly recognize that psychoanalysis tries to use what analysts know about affect (an immediate assessment of the state of the self in its interpersonal world; Spezzano 1993) and relationship (a constant conflict between the affective state of the self and that of all others in the subjectively experienced interpersonal world) to help lessen patients' suffering and increase their well-being.

KEY POINTS

- In the intersubjective model, the patient and analyst are both subjects.
- Although the roots of intersubjectivity can be traced to the work of Ferenczi, Sullivan, Fairbairn, Winnicott, Klein and Bion, and Kohut, its current life within psychoanalysis was launched by Stolorow, Atwood, and Ross between 1978 and 1988.
- According to Greenberg and Mitchell, there are two main trends in psychoanalytic theorizing: one in which the building blocks of the unconscious mind are endogenously arising wishes derived from sexual and aggressive drives; and the other in which the building blocks are representations of relational experiences.
- Mitchell's intersubjective attitude emphasized the need of each patient for a customized relationship within which psychoanalytic interpretations have an optimal chance to become useful.
- In the Barangers' theory of the bipersonal analytic field, the analyst and patient define each other, and the two characters form a new psychic structure.
- Thomas Ogden conceptualized the intersubjective analytic "third" as a normal part of analytic work.
- Jessica Benjamin highlighted the critical importance to development and psychoanalysis of mutual recognition by the subjects involved in any interaction.
- Raymond Friedman and Joseph Natterson reminded us that analytic events are ambiguous and complex, and recognition of co-responsibility enables understanding and helps bring about a constructive outcome.
- Mentalization, as conceptualized by Fonagy and colleagues, is the capacity to remain aware that each of us is representing the unfolding experience in his or her own unique way.
- According to Irwin Hoffman, the experience of the patient is always contextual, including the context created by the spontaneous participation of the therapist.
- The intersubjective attitude often removes repression as the quintessential defense and replaces it with dissociation.
- Arguably, the most comprehensive contemporary theory of trauma and dissociation has been created by Philip Bromberg.
- Stern emphasized that patients come to us with unformulated experiences, about which the patient and the analyst create a story. That story cannot be simply a representation of a transcendent, fixed, and immutable truth about who the patient really is, but is a jointly created revision of the story about himself or herself with which the patient entered therapy.