WORKING
Intersubjectively
Contextualism in Psychoanalytic Practice

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Intersubjectivity Theory and the Clinical Exchange

> The person with understanding does not know and judge as one who stands apart and unaffected; but rather, as one united by a specific bond with the other, he thinks with the other and undergoes the situation with him.
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> —Hans-Georg Gadamer
> *Truth and Method*

By intersubjectivity theory we mean the psychoanalytic theory articulated in *Structures of Subjectivity* (Atwood and Stolorow, 1984) and developed in *Psychoanalytic Treatment* (Stolorow, Brandchaft, and Atwood, 1987), in *Contexts of Being* (Stolorow and Atwood, 1992), and in *Emotional Understanding* (Orange, 1995). An early formulation of this viewpoint said that "psychoanalysis seeks to illuminate phenomena that emerge within a specific psychological field constituted by the intersection of two subjectivities—that of the patient and that of the analyst" (Atwood and Stolorow, 1984, p. 64).

Intersubjectivity theory is a metatheory of psychoanalysis. It examines the field—two subjectivities in the system they create and from which they emerge—in any form of psychoanalytic treatment. Because of this focus, intersubjectivity theory also implies a contextualist view of development and of pathogenesis:

> Psychological development and pathogenesis are best conceptualized in terms of the specific intersubjective contexts that shape the developmental process and that facilitate or obstruct the child's negotiation of critical developmental tasks and successful passage through developmental phases. The observational focus is the evolving psychological field constituted by the interplay between the differently organized subjectivities of child and caretakers [p. 65].

Intersubjectivity theory intends to describe the emergence and modification of subjectivity, and defines these processes as irreducibly relational.

It is important to distinguish this use of the terms "intersubjective" and "intersubjectivity" from several related ideas. First, intersubjectivity theorists intend a relatedness that can exist between any two people as subjects. Thus, these terms do not refer primarily to a developmental achievement. Stern (1985), for example, describes a stage and process of recognition of another's subjectivity as connected and responsive to one's own. This mutual recognition may be a late achievement in the intersubjective field of an analysis, especially in patients like those described by Guntrip (1969) and Kohut (1971), and thus differs from our contextualist conception of an intersubjective field.

In addition, intersubjectivity theory differs from systems theory, as defined, for example, in the family-systems theory of Bowen and his collaborators[1] (Kerr and Bowen, 1988). Intersubjectivity requires subjectivity, or rather two or more subjectivities, and retains its focus on the interplay between differently organized subjectivities. We cannot work within the intersubjective field and simultaneously step outside the field to describe it, as family-systems theorists attempt to do, from a God's-eye view.

This impossibility may also account for what appears as psychoanalytic disinterest in empirical research. Positivist philosophers like Grunbaum (1984) and psychoanalysts like Spence (1993) find psychoanalysis unscientific, but they have misunderstood the essential nature of the intersubjective field. Even the best case studies can only feebly attempt to capture the feel of a particular intersubjective field, or of an analytic couple. We must examine the theories, prejudices, and assumptions that form our own subjectivity, but we can work psychoanalytically and understand psychoanalytically only from within the intersubjective field.

1. We show in a later chapter, nevertheless, that more process-oriented forms of systems theory are compatible with our point of view.

Third, for similar reasons, intersubjectivity theory differs from interpersonalism. Intersubjectivity theory concerns itself little with interpersonalist concerns like who is doing what to whom, with gambits and control. What interpersonalists call "participant observation" requires, we believe, maintaining an external perspective that interferes with "undergoing the situation" with the patient (Gadamer, 1975b). In our view, relational contexts are mutually constitutive: as students of aesthetics sometimes say, the writer creates the reader and the reader brings the writer into being. Intersubjectivity theory, although interested in the *experience* of interaction and agency, resembles more closely those currents in relational thinking that emphasize development (Bollas, 1987; Ghent, 1992; Winnicott, 1958) and conversation between differently organized and inevitably subjective perspectives (Aron, 1996; Orange, 1995).

On the other hand, intersubjectivity theory transcends the Freudian view of human beings. In classical theory we are self-contained bundles of better or more poorly harnessed sexual and aggressive instincts, some directed at "objects." Intersubjectivity theory sees humans as organizers of experience, as subjects. *It views psychoanalysis as the dialogic attempt of two people together to understand one person's organization of emotional experience by making sense together of their intersubjectively configured experience* (Orange, 1995).

BASIC THEORETICAL CONCEPTS AND THEIR HISTORY

Although intersubjectivity theory is a recent arrival on the psychoanalytic scene, its roots appear in early phenomenology. Like Freud, Husserl studied with the philosopher Brentano, who unrelentingly emphasized the experience of the intentional subject. Unlike Freud, who—at least intermittently—embraced

scientific empiricism, Husserl and later philosophers of subjectivity claimed that all experience is subjective experience.

The original authors of psychoanalytic intersubjectivity theory, influenced as well by personology theory (Murray, 1938) and by their own researches into the subjective origins of personality theories (Atwood and Stolorow, 1993), recognized in Kohut's work the more radical perspective needed. Though he welcomed and promoted exchange between psychoanalysis and the other humanistic disciplines, Kohut (1959) insisted that the entire domain of psychoanalytic inquiry is subjective experience. He implicitly rejected drive theory, along with metapsychological constructs generally. The only data for psychoanalytic understanding, Kohut believed, are those that are accessible by introspection and empathy. Intersubjectivity theory does criticize particular aspects of self-psychological theory, such as the concepts of transmuting internalization via optimal frustration and a preexisting nuclear self. Nevertheless, it completely accepts self psychology's most fundamental tenet, its definition of the sources of psychoanalytic inquiry and understanding as well as its conviction that self-experience is radically context-dependent—that is, rooted in specific contexts of relatedness.

In the early 1980s Bernard Brandchaft, who brought extensive and intensive understanding of British relational theories, began to make important contributions to the evolution of intersubjectivity theory. The phenomenological approach that emerged from the studies collected in *Faces in a Cloud* (Stolorow and Atwood, 1979), with its thoroughgoing emphasis on the development and maintenance of the organization of experience, thus moved toward a fully intersubjective conception. In this view, all selfhood—including enduring patterns of personality and pathology—develops and is maintained within, and as a function of, the interplay between subjectivities. Conversely the field itself consists of the relatedness between subjectivities. The people may be parent and child, siblings, analyst and patient, spouses, or other combinations. Intersubjectivity theory sees pathologies, from phobias through psychoses, in these terms. In other words, it radically refuses to place the origins or the continuance of psychopathology solely within the patient. This point of view, therefore, differs with drive theory in all its variants. Because self psychology and phenomenology have taught us to emphasize subjective experience, we also differ

with interpersonalists who locate difficulties in living in the patient's desire for control, in repetitive enactments of earlier relational patterns, or in disavowal of responsibility. Instead, we study the intersubjective conditions, or emotional context, in which particular subjective configurations arise and are maintained.

The principal components of subjectivity, in our view, are the organizing principles, whether automatic and rigid, or reflective and flexible. These principles, often unconscious, are the emotional conclusions a person has drawn from lifelong experience of the emotional environment, especially the complex mutual connections with early caregivers. Until these principles become available for conscious reflection, and until new emotional experience leads a person to envision and expect new forms of emotional connection, these old inferences will thematize the sense of self. This sense of self includes convictions about the relational consequences of possible forms of being. A person may feel, for example, that any form of self-articulation or differentiation will invite ridicule or sarcasm.

Within this perspective, we have attempted to rethink such fundamental psychoanalytic ideas as the unconscious. The "prereflective unconscious" is the home of those organizing principles, or emotional convictions, that operate automatically and out of awareness. They arise as emotional inferences a child draws from intersubjective experience in the family of origin. These principles may concern relatedness, as in "I must adapt to others' needs (moods, expectations, and so on) if I am to retain significant emotional ties." They may also consist in a fundamental sense of self, still intersubjectively configured: "I will never amount to anything," "I am always a burden," "I am worthless and good-for-nothing." Such organizing principles are sometimes direct quotations from parents who nickname their children "Mad Mary" or "Terrible Theresa" or "good-for-nothing." More often, these principles are emotional inferences drawn as the child attempts to organize some sense of self out of chaotic, traumatic, or more subtly confusing early and later relational experience.

We (Stolorow and Atwood, 1992) have also described a dynamic unconscious. This consists of emotional information, once consciously known, that had to be "sequestered," or forgotten, because it created conflict for the subject. In particular,

the memory would threaten the tie to caregivers on whom the child needed to depend. This form of unconsciousness is dynamic, as in Freudian theory, because the effects of such early experience, unavailable for reflection, continue to appear as repetitive troubles in an adult's life. Memories of parental cruelty that conflict with needed idealizations are obvious examples.

Finally, the "unvalidated unconscious" describes those aspects of subjective life that could never fully become experience because they never found a validating response in the emotional environment. Often aspects of one's talents and interests, one's character, as well as of the crises and quandries of one's emotional life have never found the recognition they needed to become fully real for the person.

THE CLINICAL EXCHANGE

An intersubjective understanding of psychopathology and of unconsciousness has important consequences for psychoanalytic practice. Psychoanalysis will consist in the mutual creation of an emotional environment, an intersubjective field, in which it is safe to explore together those "regions" of unconsciousness that make up the problematic aspects of subjectivity. The interplay of transference and countertransference (or cotransference, Orange, 1994), the organizing activity of both patient and analyst within the analytic experience, makes up the intersubjective field of the analysis. The joint effort to understand both past and present organizing activity as a function of the experience of particular intersubjective fields means that past and present are always dialogically involved, implicitly at least; with those who cannot even try to understand the past and have no access at all to it, explicit dialogue between past and present may be many years ahead.

The intersubjective field of the analysis, made possible by the emotional availability of both analyst and patient, becomes a developmental second chance for the patient (Orange, 1995). New, more flexible organizing principles can emerge, now accessible to reflection, so that the patient's experiential repertoire becomes enlarged, enriched, and more complex. Under severe stress, old organizations of experience may return, but now a

person can recognize them and relativize them by reference to their origins in past relational experience.

In the remainder of this chapter we illustrate the clinical exchange from the standpoint of intersubjectivity theory. In our view, there is no distinct body of clinical theory or of "technical" recommendations to be derived from intersubjectivity theory. Rather, the intersubjective perspective introduces a more general characterization of all psychoanalytic work from within any specific clinical theory. Because each treatment includes an analyst with a point of view, different kinds of intersubjective fields develop in classical, interpersonal, or self-psychological treatments (Orange, 1995), as well as in each psychoanalytic pair. From a clinical point of view, intersubjectivity is not so much a theory as it is a sensibility. It is an attitude of continuing sensitivity to the inescapable interplay of observer and observed. It assumes that instead of entering and immersing ourselves in the experience of another, we join the other in the intersubjective space. Each participant in the psychoanalytic field brings an organized and organizing emotional history to the process. This means that although the analysis is always for the patient, the emotional history and psychological organization of patient and analyst are equally important to the understanding of any clinical exchange. (This idea is explained further in a chapter on cotransference in *Emotional Understanding*, Orange, 1995.) What we inquire about or interpret or leave alone depends upon who we are. The analytic process, as relational theorist Lewis Aron (1996) has explained, is mutually constituted but asymmetrical. One participant is primarily there as helper, healer, and inquirer. The other chiefly seeks relief from emotional suffering. (The Latin root of *patient* means to suffer, undergo, or bear. The word may also be related to the Greek *pathos*.) In the developmental process we call psychoanalysis, one is primarily guide and the other seeks to organize and reorganize experience in less painful and more creative ways. Nevertheless, each is a full participant and contributor to the process that emerges.

The following case material illustrates the ways in which the analyst's organization of experience interacts with that of the patient to form a unique and indissoluble psychological system. This analyst's theories, a particular amalgam of self psychology, attachment theory, and intersubjectivity theory, are

always present and formative. Even more, personal history shapes and limits any analyst's capacities for empathic-introspective understanding, and in particular, both expands and constricts the extent of emotional availability to any given patient. This means we must be much more self-revealing in describing clinical work than is typical in psychoanalytic writing. The case is presented not to show an example of optimal "technique." Rather we intend to demonstrate how conjunctions and disjunctions between the subjective worlds of patient and analyst sometimes facilitate and sometimes impede the process of treatment.

BACKGROUND

Kathy, a 33-year-old assistant professor of literature and women's studies, came to treatment after her most recent period of severe depression, for which she had begun to take antidepressants, which seemed to help, except that she often forgot to take them. Of Italian-American descent, she was much the youngest of three children of their mother, who had died of breast cancer when Kathy was 6, and a father who remarried when Kathy was 13. She lived with her boyfriend of several years, who wished she could have more fun and be less serious.

This is all we knew together when Kathy began treatment. No one in her family had been willing to speak about the past, and Kathy had not wanted to know more. But now she felt ready to ask why she fell into bouts of deep depression. She called and wrote to the hospital where her mother had twice stayed in psychiatric units, and, despite much bureaucratic bumbling, persuaded the records office to send her mother's discharge summary to her analyst. It finally arrived about three months into the treatment. By this time, her analyst had understood that Kathy's mother was the central figure that sustained her in her imagination. Reading the story of her mother's two attempts to kill Kathy filled the analyst with dread. What would happen now? What would be the impact of knowing that the central person in her life had tried to murder her? Would she want to kill herself? When Kathy arrived for her session, they decided to read the report together. Before they started, her analyst made sure the patient would not be alone after the session. The sense of

Kathy as the younger sister whom her analyst must protect probably began at this time.

Kathy's mother had been diagnosed with cancer when Kathy was still an infant, became seriously depressed, began to act "crazy," and after a suicide attempt, was hospitalized when Kathy was five. According to the hospital records—which did not make it clear who provided the information—the mother had intended to commit suicide twice, when Kathy was three and again at five, and tried to take her daughter along, that is, tried to kill her, so Kathy would not have to grow up motherless (as the mother had). On both occasions, Kathy had refused to take the pills (patient and analyst connect this with her difficulty remembering to take antidepressants). Perhaps, somehow knowing the mother would not commit suicide if she had to leave her daughter behind, Kathy was trying to save her mother by refusing to take the pills. Kathy had no direct memory of these incidents, but had terrifying nightmares and recurrent immobilizing depressions.

Later, Kathy's brothers told her that the mother often beat the middle child severely with a belt that always hung in the kitchen. Kathy remembers the belt hanging there—and that this brother tormented Kathy, who seemed to escape the mother's wrath. After the mother's death, the oldest brother cared for Kathy, but when Kathy was 13, this brother married and moved out, and their father remarried. An older male cousin who lived nearby molested Kathy almost daily for several years, when she was 6 through 12. Believing she was doing something terribly wrong, she felt she could tell no one. Kathy later moved, however, and in that process found and brought to treatment a diary written when she was 14. Here she had repeatedly written out her longing for "mommy," her awareness of the effects of the incest on her ability to trust boys, and her desire to be dead. She had not remembered any of this, or even that the diary existed. After this session, Kathy remembered bringing the diary, but had no memory of the contents, and seemed surprised when reminded.

The early years of treatment involved her analyst's frequently reminding Kathy of her own history—both recent and remote—which she seemed alternately to know and not know. She came in with a problem: "I can only have sex if I go away in my mind." Patient and analyst worked together on finding meanings—in this instance she had completely forgotten the incest and a rape

in her college years—and she went away feeling enlightened. Sometimes, as in this case, the symptom disappeared. Then she came in saying she was doing well and was wondering why she was in treatment. "Oh, but I had a bad Saturday—so depressed I couldn't get out of bed all day." Then the wondering and reminding process began again. If the analyst said anything to indicate that Kathy had a very rough start in life, she seemed surprised. "Oh, do you really think so?"

The analyst's history was both similar and different. The oldest, and thus the caregiver, of a troubled family of ten children, she had survived by hard work, reading, and dissociation. Like Kathy, she had difficulty remembering early troubles and connecting them to feelings in the present. A particular point of intersection was the analyst's having left home when her youngest sisters were three and five, and a strong sense of having abandoned them to a terrible situation. Kathy—who nearly died at those same ages—felt much like one of these younger sisters and evoked the analyst's caregiving and protectiveness. Though Kathy knew nothing of this history, she felt immediately that her analyst was a kindred spirit, in her words, "a wild woman." They developed their own humor together—the private jokes that are often part of specific intersubjective fields. Kohut might have called this a "twinship transference," and surely it was; the point is that the analyst's particular self-experience was an enormous contributor to the particular intersubjective field of this treatment, that is, to the way patient and analyst played and worked together. The clinical material is not dramatic, but the analyst's inquiries and responses—inquiry is a form of response that expresses the shape and limits of an analyst's emotional availability and understanding—were shaped by a particular subjectivity. They were not simple applications of any so-called rules of technique.

The disjointed quality of the conversation is common in work with very dissociative patients. This quality makes it harder for a reader to follow, but it also brings the reader into the emotional context of the experience with Kathy.

The main point about this treatment, from an intersubjective point of view, is that the analyst's awareness of, and struggles with, dissociation made possible the awareness of, and relentless work with, Kathy's. We might compare this empathic process to an analog search, in the sense that Kathy's demons (another

patient calls them the "trolls"), or automatic ways of organizing emotional experience, were already familiar to the analyst. A secondary point is that the analyst, historically situated herself, had to be emotionally available to go through Kathy's traumatic history with her. Then it became possible to help Kathy to integrate this history and its effects, and to develop a relatively continuous, cohesive, and valued sense of herself.

SESSION EARLY IN THE SECOND YEAR

Kathy: [Puzzled tone] I have been swinging in and out of depression—trapped—not as severe. Brian [her partner] has been really good. Strange not being there. Housework—Tim [brother eight years older] used to make chores so terrible. . . .

Analyst: [Searching for clues to the depression and the disjointed speech] Housework—can you tell me more about that?

Kathy: [Still puzzled] I don't know why I can't feel anything.

Analyst: [Trying to find context] Just like the last two sessions—the first parts when you couldn't think why you were coming here.

Kathy: [More lively tone] I had an interesting conversation with my friend Jim last week. He thinks abused children blame themselves because normal children are naturally cuddly, needing touch, and he read that the touch receptors in the brain are especially sensitive when children are young. He thinks these natural needs are why we blame ourselves for however people touched us. What do you think of that?

Analyst: Well, we do know babies and children need to be touched and held. Do you mean if kids are hit or molested, they feel shame or blame themselves, like "you asked for it" because of their natural needs?

Kathy: Yes, maybe that's why you can't talk yourself out of it, or say it wasn't your fault, even when you know that.

Analyst: What mostly gives you that feeling?

Kathy: My cousin, I guess. . . . I wish I could remember my mother more, what she looked like, her facial expressions. I really don't remember much—I know she had

red hair, tons of freckles, and her body shape, everyone says, was kind of like mine. [The analyst guessed that this switch from the cousin to the mother connects with the sense expressed in her childhood diary. If her mother had lived, she might have been protected from the incest, so that when she remembered the molestation, she immediately tried to retrieve a connection to her mother.]

Analyst: But you don't have much sense of her personality, or how she was with you? [Trying to help her articulate the loss]

Kathy: No, I wish I could remember.

Analyst: How would that help?

Kathy: Then I could feel sad for the child that I was and not have to hear that voice: STOP FEELING SORRY FOR YOURSELF.

Analyst: Whose voice is that?

Kathy: That's just what I was wondering. How can I remember? I have such a hard time remembering. [Seemed lost]

Analyst: [Shifting into didactic mode, trying to help her become oriented—both analyst and patient were teachers.] Well, there are lots of ways—dreams, your writing and poetry, fleeting thoughts, and sometimes the stuff that goes on between you and me.

Kathy: What do you mean?

Analyst: Sometimes I will seem like someone who has been important to you, maybe someone who has hurt you, and that can be a way of remembering. I might say or do something that will trigger forms of memory.

Kathy: You don't hurt me. But I do sometimes feel: I don't need this. Why am I coming here? What is she talking about, that bad things happened to me? I'm just fine. Then later in the session we get into things. [A colleague pointed out to the analyst that Kathy was terrified of becoming attached to her, longing to do so, and deeply ashamed of this longing.]

Analyst: Why do you think that happens?

Kathy: I don't know.

Analyst: [Trying to prime the pump, as discussed in the emotional availability chapter of Orange, 1995, where the parent or therapist sends up trial balloons so that the child or patient can try them out. The analyst's contribution to this intersubjective predicament probably came from the expectation, a product of the analyst's own developmental context, that no one could possibly want to be attached to her. Slow to perceive attachment longings, she unconsciously avoided the attachment issue and missed some of the triggers in the transference for the dissociative phenomena.] Maybe being here with me—your "memory bank"—reminds you of when things were so overwhelming for you that you had to go away from yourself to keep from losing your mind. Or, more recently, when you had to go away during sex. What do you think?

Kathy: I think we are getting somewhere. Maybe I'm afraid of what I will feel if I don't numb out or go away before I come here. I want to remember, but I'm scared to remember. . . .

TWO YEARS LATER (AFTER A THREE-WEEK BREAK)

Kathy: How are you? How was your vacation?

Analyst: Good, very good. How have you been?

Kathy: OK, I guess. I don't know what's been going on. I can't feel anything. I don't know why I'm here. [Same discomfort as before] I think about cutting back on sessions because I'm OK. I'm really much better. I have decided I have to take the Zoloft. When I forget, I go way down again and can hardly get out of bed or stop crying. But I don't know what to talk about here.

Analyst: So the underlying trouble is still there? [She nods.] But we've lost contact enough these past weeks that you can't imagine or feel any way to work on it here with me? [The analyst again not picking up on how dangerous Kathy's attachment longings are to her and how they trigger the dissociative states]

Kathy: I don't even know what it is. I just get horribly depressed.

Analyst: So if you can just feel better, and keep out of being in bed all the time, things are OK?

Kathy: No, now that you say it that way. I'm still really worried about what happened at work. That was so terrible, and it's pretty recent too. [She had told this story just before vacation.]

Analyst: You mean your colleague who came on to you and you didn't know what to do or how to tell him no.

Kathy: [Very somber] Yes, I can't believe I didn't know what to do. I feel so embarrassed and ashamed. I just let things happen. I don't understand it myself, and even if I did, I couldn't explain it because that would be like making excuses, and there is no excuse for something like that. And I've let things happen like that many times before.

Analyst: So you're worried about how to manage with this colleague, but even more about what goes on with you that you let these things happen.

Kathy: Yes, I feel completely pulled in. I know somewhere in me that it's all wrong, but I can't use that knowledge at all when something like this is going on. [Sounding puzzled] I just mindlessly give in and feel awful afterwards.

Analyst: It reminds me of your dreams where your legs give out from under you. [Recurrent theme in her dreams, often when she was trying to get away from a dangerous situation, or when she was trying to challenge someone. They had often discussed this aspect of her dreams.]

Kathy: Yes, it is like that.

Analyst: As if you can't use the part of yourself that would walk out of a situation that's bad for you or that you've felt drawn into.

Kathy: So why is that? I just don't understand it.

Analyst: Well, let's think about other times in your life when you may have felt helpless to prevent what was going on, even when you felt something was terribly wrong. When you were small, you saw your mother running naked in the street, and another time saw her threatening your father with an ax.

Kathy: [Looking horrified] I had forgotten those things. But I don't connect them with this.

Analyst: OK. Well, what about how you felt when you were being molested by Anthony almost every day for seven years, and felt it was wrong, but didn't know how to make it stop, and had no one to turn to?

Kathy: [Nodding thoughtfully] Yes, it's like that. That's how it feels. I guess I need to work more on that, to tell you more about that, but it's so hard. I don't want to think about it.

Analyst: So much shame?

Kathy: Oh, yes. Well, I guess I'll have to keep coming here. I have to do this work. I can't keep on being like this. I just keep getting into trouble and letting people hurt me.

Analyst: So you will be here next week?

Kathy: Oh, yes.

She missed the next two sessions, but called to say she had not remembered until she was nearly home and it was too late. When she did come in, she painfully recounted some of what she remembered about the incest. She then remembered that the cousin had sometimes brought his friends to participate, and that she was sometimes pinned down. She believed that she would never again allow anyone to mistreat her sexually, and was quite exultant about this.

COMMENTARY

From an intersubjective point of view, all clinical work involves and takes place in the field formed by the interplaying of two subjective worlds. In this case, patient and analyst are similar, different, and complementary. Their related experience of dissociation both facilitated and impeded the analytic process. On one hand, the analyst's sensitivity to dissociative phenomena provided a comfortable and useful focus and interpretive lens or perspective. On the other hand, the analyst did not consider or recognize how dissociative processes were triggered in the transference by dangerous and shame-inducing attachment longings, because the analyst could not envision herself as being so centrally important to the patient—a legacy of the analyst's history of developmental trauma.

Though similar in dissociative tendencies, and in many tastes and interests, Kathy and her analyst differ in family position and in many of the ways they organize experience. The intersection allowed them to create a space where the unbelievable could be explored together, could be known in various ways, and could begin to be integrated. The analyst might be the big brother who did not abuse her and to whom she could turn in times of trouble, or the big brother she needed to avoid and who "makes her do work." Gradually they will be able to recognize and to reorganize Kathy's profound sense that attachment to an older woman is very dangerous. What they do together is a product of their experience in the unique intersubjective field they create together.

It might be argued that nothing in this treatment is unique to the intersubjective perspective. This is surely true. Intersubjectivity theory is not a set of prescriptions for clinical work. It is a sensibility that continually takes into account the inescapable interplay of the two subjects in any psychoanalysis. It radically rejects the notion that psychoanalysis is something one isolated mind does to another, or that development is something one person does or does not do. Working intersubjectively is exploring together for the sake of healing. Each particular analyst creates with each particular patient the opportunity—often, as in this instance, the first opportunity—to integrate and make sense of a painful and confusing life.

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Beyond Technique

Psychoanalysis as a Form of Practice

> Genuine creation is precisely that for which we can give no prescribed technique or recipe.
>
> —Barrett
>
> *The Illusion of Technique*

Many observers of psychoanalysis, as well as some of its participants, have thought that Freud was mistaken in taking his creative attempt to understand emotional suffering to be a science in the tradition of the exact sciences (Bouveresse, 1995). Fewer have noticed that Freud and his followers have also misunderstood psychoanalytic practice as technique. The two misconceptions are related, because both assume that all relevant variables can be controlled; ever since the articulation of the uncertainty principle in physics, we realize that this condition does not exist completely, even in the realm of material things. Practice, on the contrary, is characteristic of work with human beings with minds. The realm of the mental is thoroughly incomplete, indefinite, and open. It is the field of practice, or as Aristotle would have said, of practical wisdom. Although the classical principles of multiple function and of overdetermination respect this difference between matter and mind, as does contemporary relational psychoanalysis with its "postmodern" attitudes, the view of clinical work as technique has remained pervasive and seriously harmful. Our remaining chapters illustrate the alternative mode of thinking about clinical work that we propose.

Techne is the Greek word for the kind of knowledge needed to make something (Aristotle). It describes both the explicit rules and the tacit knowledge (Polanyi, 1958) involved in a craft like carpentry or plumbing or surgery. Distinct from the art or science to which it is related, technique is often a necessary but not a sufficient condition for their full realization.[1] When we say that an artist has great technical skill, we are often damning by faint praise. We are contrasting superb technique with artistry.

Technique, as Barrett (1979) points out, resembles the kind of automatic decision procedure we expect from a well-functioning machine. In his words,

> All that we desire from a machine of this kind is that it go through the routines written into it. The last thing we want from it is that it be creative or inventive in any way. When your automobile starts to sound in the morning as if its starting up were a matter of improvisation or invention, it is usually time to trade it in [p. 23].

An ideal of modern science that has great influence in our field involves just such reduction of thought to a methodical testing of hypotheses. The creative process involved in generating the hypotheses themselves thus becomes an invisible adjunct to method and technique.

Freud, desiring that psychoanalysis command the respect accorded to the exact sciences in his time, declared that it was one.[2] He saw that scientific knowledge often carries associated

1. Gadamer (1975b) notes that where early hermeneutics viewed itself as a set of rules for interpreting texts, modern hermeneutics concerns the practice of understanding. In modern science, he believes, "the concept of technology displaced that of practice" (p. 556).

2. Freud, like so many modern thinkers after Descartes, believed in the unity of science. Descartes compared all knowledge (or science) to a house that needed a secure foundation, and to a tree that needed healthy roots. If the underpinnings were solid and certain, so was the rest of knowledge, including the realms of the productive and the practical. This meant that the same kind of truth and the same degree of certainty should be sought in all disciplines. Aristotle, on the contrary, like many contemporary thinkers, believed that each kind of inquiry has its appropriate degree of certainty, and in particular, that the exactness-requiring methods appropriate to the study of such disciplines as mathematics were unsuited for politics, ethics, or esthetics.

technical applications, and from the beginning he thought psychoanalytic work consists of techniques. He frequently referred to dream interpretation as a technique (Freud, 1900). Later, eager to protect the reputation of his young "science" from scandal, he elaborated recommendations for psychoanalytic technique. These concerned anonymity, abstinence, neutrality, and the use of the couch. Further elaborated by Freudians and Kleinians (Bergmann and Hartman, 1976; Etchegoyen, 1991), the recommendations became rules and persist as our collective "psychoanalytic superego" to this day. Despite the creative ferment and dissent in psychoanalysis from Ferenczi to the present, these rules have formed a psychoanalytic backbone and have often formed the "common ground," to use Wallerstein's term, among widely diverging schools of psychoanalytic thinking. If you use the couch, if you see patients four or more days a week, if you keep yourself neutral and anonymous, and if you also analyze defense and transference, then you are doing psychoanalysis. Only now is the wisdom, or the universal applicability, of some of these "technical" rules being seriously questioned.

But we are making a more serious and radical claim, namely that the whole conception of psychoanalysis as technique is wrongheaded—to borrow an epithet popular among philosophers—and needs to be rethought. Even in the so-called two-person psychologies, it relies on an assumption that one Cartesian isolated mind, the analyst, is doing something to another isolated mind, the patient, or vice versa. An earlier contribution (Stolorow and Atwood, 1992) provided extensive critique of isolated-mind assumptions in psychoanalysis. We claimed that "the development of personal experience always takes place within an ongoing intersubjective system" (p. 22).

> The intrinsic embeddedness of self-experience in intersubjective fields means that our self-esteem, our sense of personal identity, even our experience of ourselves as having distinct and enduring existence are contingent on specific sustaining relations to the human surround [p. 10].

We also argue that the instrumentalist idea of technique reduces suffering human beings to the mechanisms of classical metapsychology. This residue of positivist reductionism treats

people as brains or neural networks. (Given the persistence of this residue in the larger medical mentality, it is not surprising that the first response to any problem tends to be medication, a technical response to what is seen as a mechanical problem.) A later chapter illustrates some of the effects that this technical mentality may have on a person experiencing psychotic processes.

Despite these limitations, the idea of technique is firmly, if not rigidly, embedded in psychoanalytic discourse. A recent, cogently articulated exception, however, is the work of Louis Fourcher (1996), who writes of the problems inherent in the intellectualist conception of rationality found in most psychoanalytic writing:

> A dichotomy of knower and known is established that, in turn, requires a discontinuity of knowledge and action. Knowledge is therefore related to action only unilaterally through the objectification of the therapist's activity as "technique," or through the objectification of the patient's actions as expressions of some conceptual logic or "rule" articulated by theory. Techniques are presumed to be applied according to actions or interpretations dictated by theoretically organized procedural rules [p. 524].

The concept of technique, in other words, leaves us in a Cartesian dualism with an overly intellectualized concept of interpretation. Such interpretation then comes to be contrasted with, or at least seen as separate from, the emotional understanding that inevitably forms its context and gives it meaning in the psychoanalytic situation.

THE CONCEPT OF PSYCHOANALYTIC TECHNIQUE

A review of the extensive literature—too large to describe here—on psychoanalytic technique reveals an ongoing tension between devotion to rules and insistence on flexibility. The second emphasis owes its origin to the creative pragmatism of Ferenczi, whose maxim seemed to be, "if what you're doing doesn't work, don't blame the patient; attempt to guess what is going wrong and try something else." Unfortunately, such pragmatism, with

its admission of fallibility, made Freud and many later psychoanalysts very nervous, and Ferenczi's experimental spirit was lost to psychoanalysis until recently. Instead, most of us were taught Freud's "rules" with a few updates. There were "parameters" (Eissler, 1958), or special dispensations from the rules,[3] for people with special disabilities that made them unable to tolerate the rigors of orthodox psychoanalytic treatment. But these exceptions did not bring the rules themselves into question. Even Winnicott's importation of the spirit of child therapy did not seriously question the concept of technique.

In fact, although Bergmann is probably correct in claiming that psychoanalytic technique has not been a static entity and has developed, we argue that the *concept* of technique has persisted unchanged and continues to exert a deleterious influence in psychoanalytic thought and practice. Aside from Fourcher, we have found few psychoanalytic authors who question the appropriateness of "technique" as a significant term in psychoanalytic discourse. On the contrary, we find conferences and journal issues devoted to technique, and most recently Etchegoyen's (1991) monumental and thorough compendium on the topic has appeared.

Still, an intersubjective understanding of psychoanalysis must question this almost universally received idea. The concept of technique includes the idea of rules of proper and correct procedure. The primary purpose of the rules of any technique is to induce compliance, to reduce the influence of individual subjectivity on the task at hand. Even Kohut (1971), who taught us so much about listening to our patients, thought analysis should be a nonidiosyncratic science that could be taught to noncharismatic practitioners.

While someone may point out that rules are not necessarily bad, that they provide structure and even safety for whatever game is being played, we must question further. Is psychoanalysis the kind of "game" or human enterprise that is primarily capable of being played by rules? Winnicott's (1971) distinction between *play*, which can be studied for structure and rules, and *playing*, an open relational process, may be helpful here. Does

3. In the past, Catholics with health problems could obtain temporary dispensation from fasting or from the Friday abstinence from meat.

psychoanalysis perhaps belong to the second set of possibilities, to the realm of *playing?*[4]

Before answering this question, we should consider some reasons for seeing psychoanalysis, and psychoanalytic therapy, as a set of techniques. Most obvious, and probably an important consideration that led Freud to formulate his famous "Recommendations to Physicians Practising Psychoanalysis" (1912) and boards of professional conduct to formulate their codes of ethics, is the protection of the relatively vulnerable patient. Perhaps equally prominent is the desire to protect the reputation of the profession from practitioners who lack good judgment and good personal boundaries. Neither of these reasons for placing a "frame" (Langs, 1978) around the psychoanalytic process is negligible. But we must not equate the frame with the process. Even more, we must take care to choose the frame for the particular painting, not buy the frame first and then attempt to create something or someone appropriate for it.[5]

This leads us to consider a major shortcoming in the technical approach to psychoanalysis. It amounts to assuming that the same frame will be appropriate for every patient or for each analytic couple. Intersubjectivity theory claims that

> psychoanalysis seeks to illuminate phenomena that emerge within a specific psychological field constituted by the intersection of two subjectivities—that of the patient and that of the analyst. . . . [Psychoanalysis is] a science of the *intersubjective*, focused on the interplay between the differently organized subjective worlds of the observer and the observed [Atwood and Stolorow, 1984, pp. 41–42].

If this is so, then we must consider the probability that each analytic intersubjective field will develop its own process and change its own procedures as needed.

4. Recent papers by Lindon (1994, in press) represent a view of analysis as a nontechnical practice, freed of constraining theoretical dogma, rigidified rules, and the like.

5. This frame conception of psychoanalysis may be responsible for the ongoing discussions of analyzability or suitability for the "rigors" of psychoanalysis. In recent years, a concern for treating those previously thought unanalyzable has opened many questions of psychoanalytic theory (Kohut, 1971) and led to widespread questioning of the traditionally restrained technique or method.

The alternative is to replicate massive structures of pathological accommodation (Brandchaft, 1994) in both patient and analyst. Once again, we must remember that the purpose of rules is to induce compliance, not to facilitate the interplay of subjective worlds and perspectives, nor to support the healing of emotional pain and the opening of new developmental possibilities. Each analytic pair, or intersubjective field, must find its own process and its own frame.[6]

A related problem with technical rationality as an approach to psychoanalysis is that technique is oriented to production of a uniform product. Psychoanalysis is not producing anything but understanding, and that must be particular and individual. Technically oriented thinking blinds us to the particularity of our patients, of ourselves, and of each psychoanalytic process. Emergence may be a better concept than production—the emergence of understanding, of relatedness, of stable and positive self-experience.

Developmental studies have taught us much about the importance of flexibility and attunement between infants and caregivers. Many of us were raised in the thirties and forties, under the influence of the *Better Homes and Gardens Baby Book*, according to which babies were to be fed and diapered on a rigid schedule and left alone between the designated times. Perhaps we replicate this kind of parenting with our patients when we think and speak about psychoanalytic technique. Even for analysts who consider themselves more flexible, psychoanalytic technique, or the "frame," constitutes a kind of default setting to which to return in the face of uncertainty, and which we pass on to our students and supervisees.

The most harmful aspect of technical rationality as applied to psychoanalysis, we believe, is its attitude of knowing in advance what to expect. One of us remembers being told by a supervisor years ago that with long experience one would no longer be surprised by patients, that the incapacity for further surprise was the mark of a mature clinician. What a loss! So many possibilities of experience for patient, analyst, and analytic couple are fore-

6. This does not mean, as some may fear, that anything goes. We all work within the ethical and moral limits of our profession, as well as within those we have found for ourselves. We should not need rules of technique to insure ethical practice, common sense, or sound clinical judgment.

closed by devaluing surprise and new experience. Making a routine procedure out of the analytic couch, for example, ignores the developmental importance of mutual gaze regulation and other forms of facial affective communication in forming possibilities of relatedness. We must, instead, retain a thoroughly exploratory attitude toward everything we do and create together in a psychoanalysis, and relentlessly seek the meanings, both individual and cocreated.

A fallibilistic attitude toward our work and toward our patients keeps us involved in a constant effort, comparable to mutual reattunement, to experiment and to readjust. Few of us will have the experimental courage of a Ferenczi, but we need his attitude of incessant searching.

EPISTEME, TECHNE, AND PHRONESIS

The philosophical hermeneutics of Hans-Georg Gadamer provides a powerful impetus for rethinking the notion of technique, which he also criticizes under the name of method (1975b). Method, or technical rationality, is part of positivistic scientific rationality and does not belong, in his view, to interpretive understanding. Instead, he suggests, the practical reason or *phronesis* of Aristotle better describes the kind of thinking we need in the human sciences.

Aristotle distinguished three kinds of knowledge and reasoning. *Episteme*, in his view, concerns universals. It includes mathematics and the most general philosophical questions. *Techne* is the kind of knowledge concerned with production. *Phronesis*, practical reasoning or, in Gadamer's translation, "ethical know-how," always involves both the universal and the particular. In the *Nicomachean Ethics*, Aristotle's main concern was to distinguish *phronesis* from *techne*, and he did so, as Gadamer (1979) points out, in three principal ways.

First, technique can be learned and forgotten, skills can be lost. Practical reasoning, on the other hand, is an interplay between the universal and the particular, involving thoughtful and reflective choice. We are always in an "acting situation" (Gadamer's term). Second, in *phronesis*, unlike production-oriented technique, there is no prior knowledge of the right means to any end. Indeed the ends and goals themselves emerge only in the process

of considering the wisest or most appropriate thing to do in this particular situation. Finally, and most important for our purposes, Gadamer (1975b) sees Aristotle's *phronesis* as a form of understanding (*synesis*). In his words,

> It appears in the fact of concern, not about myself, but about the other person. Thus it is a mode of moral judgment. . . . The question here, then, is not of a general kind of knowledge, but of its specification at a particular moment. This knowledge also is not in any sense technical knowledge or the application of such. . . . The person with understanding does not know and judge as one who stands apart and unaffected; but rather, as one united by a specific bond with the other, he thinks with the other and undergoes the situation with him [p. 288].

Instead of technique, we propose that psychoanalysis is a kind of practice in the Aristotelian sense. Practical reasoning is not concerned with the making of things without minds, but rather with relations between and among human beings. For Aristotle, practice, or practical wisdom (*phronesis*), included the realms of politics and ethics. Unlike technique, practice is always oriented to the particular. Practice embodies an attitude of inquiry, deliberation, and discovery. It eschews rules, but loves questions—questions about what is wise to do with this person, at this time, for this reason, and so on. Such wisdom can be learned, never on the basis of rules, but from the person who lives wisely. The Greeks seemed to understand that the question about the nature of wisdom could be answered fully only by pointing to the wise person.

We must ask, however, even as we grant that apprenticeship is the best psychoanalytic training, what learning it could consist in. What is this practical wisdom that we suggest as both end and means in clinical work? To answer, we must return to a basic premise or presupposition shared by Aristotle and intersubjectivity theory. *Human beings are by nature relational*. There is more to this assumption than meets the eye. It implies that our psychological life cannot be the life of the isolated mind; it must originate, grow, and change within the intersubjective contexts in which we find ourselves.

This premise requires us to ask not only what happened to this patient in what contexts of relatedness or experienced isolation

to bring about the suffering he or she brings to treatment. As contextualists, we must also ask what resources for healing are available in this analyst–patient pair. We must ask how our own history, personality, and theoretical allegiances affect the understandings we reach with this patient. This is the attention to particulars that Aristotle advocated, and it does not lend itself to rules. Granted, we all have our typical ways of getting started with a patient, but these begin to modify themselves from the moment the patient walks in, or even sometimes in the initial telephone call. Practical wisdom is antimethodical and antitechnical. It is irreducibly particular and relational.

Psychoanalytic *phronesis* includes an attitude of inquiry and thoughtful reflection—Aristotle might have said "deliberation"—to indicate the attitude and process of figuring things out. It eschews the presumption that we know in advance the "false idolatry of the expert" that Gadamer finds embedded in our technology-dominated world. We might apply to psychoanalysis his more general description of a dangerous "inner longing in our society to find in science a substitute for lost orientations" (1975b, p. 318). Perhaps the worship of science and technique in the history of psychoanalysis expresses a similar longing.

Let us now consider a time-honored "technical" question from within the gestalt of practice and from the perspective of intersubjectivity theory.

SELF-DISCLOSURE AND INTERSUBJECTIVITY THEORY

Earlier we explained that the notion of practice better describes psychoanalytic clinical work than does the venerable concept of technique. We argued that although technique is appropriate in working with things without minds, where more variables can be controlled and experimentation can be replicated, practice fits work with human beings. It is no accident that we speak casually of the practice of law and medicine.[7]

7. Aristotle (322 BCE) believed we should also consider ethics and politics to be practices, where what is needed is not rules of technique, but the ability to deliberate wisely.

The misapplication of the concept of technique in psychoanalysis is nowhere more evident than in discussions of self-disclosure. Only by conceiving psychoanalysis primarily as an empirical science that requires rigid controls over intervening variables could we imagine that self-disclosure could be regulated by rule or precept or even by "technical recommendation." Nevertheless, generations of analytically oriented teachers and supervisors have sought to protect the process from contamination by insisting that analysts remain anonymous, just as workers at computer-chip companies don white coveralls to protect their work. Consider the famous words of Freud (1912) for whom confiding in one's patients

> achieves nothing towards the uncovering of what is unconscious to the patient. It makes him even more incapable of overcoming his deeper resistances, and in severer cases it invariably fails by encouraging the patient to be insatiable: he would like to reverse the situation, and finds the analysis of the doctor more interesting than his own. . . . The doctor should be opaque to his patients, and, like a mirror, should show them nothing but what is shown to him [p. 118].

Later analysts likewise have been concerned to protect the "pure gold" of analysis from any impurity introduced by the analyst's personality; at the same time they recognized that such complete anonymity is impossible. Greenson's story about his patient who inferred that Greenson was a liberal Democrat is illustrative. Greenson (1967) asked how the patient, a conservative Republican, had come to this conclusion.

> He then told me that whenever he said anything favorable about a Republican politician, I always asked for associations. On the other hand, whenever he said anything hostile about a Republican, I remained silent, as though in agreement. Whenever he had a kind word for Roosevelt, I said nothing. Whenever he attacked Roosevelt, I would ask who did Roosevelt remind him of, as though I was out to prove that hating Roosevelt was infantile.
>
> I was taken aback because I had been completely unaware of this pattern. Yet, at the moment the patient pointed it out,

> I had to agree that I had done precisely that, albeit unknowingly [p. 273].

This vignette shows that prominent analysts in the ego-psychological tradition recognized many years ago that unwitting self-disclosure of personal data about the analyst was inevitable and that full anonymity was impossible. Greenson's apparent chagrin, however, also illustrates the tendency of analysts to consider self-disclosure as an unfortunate side effect of analytic work, not an essential contributor. The patient must disclose everything; the analyst as little as possible. Recent work in relational psychoanalysis, encouraging exploration of the patient's experience of the analyst's subjectivity (Hoffman, 1983; Renik, 1993; Aron, 1996), has begun to remedy this one-sided view.

Intersubjectivity theory must be even more radical on this topic. It must recognize that within any particular psychoanalytic situation (Stone, 1961) or intersubjective field, two subjective worlds are continually self-revealing and attempting to hide. Even withholding is a form of communication. The question is what fundamental psychological convictions (emotional organizing principles) guide the content and manner of our revealing and hiding, both witting and unwitting, with a particular patient, and vice versa. Obviously the better-analyzed analyst will be better prepared to grapple with this question. The well-supervised analyst or therapist from an intersubjective or fully relational point of view will be better prepared to appreciate the importance of such profound self-knowledge. We can consider Ferenczi, who insisted on the thorough analysis of analysts, an important anticipator of intersubjectivity theory in this respect. Not coincidentally, he was also the first to challenge the psychoanalytic taboo on self-disclosure and to recognize that psychoanalysis is an intimate human practice.

The question of self-disclosure, however, continues to occupy analysts. This may mean we continue to struggle with compliance versus self-articulation (Brandchaft, 1994). Fidelity to our ancestral legacy of psychoanalytic rules often seems a crucial requirement for maintaining our ties with official psychoanalysis and our personal sense of identity as psychoanalysts. Reading and hearing the history of psychoanalysis, with its many incidents of excommunication and exclusion for the crime of being "unpsychoanalytic," makes such anxieties and conflicts more

than understandable. Conformity to the "rules of technique," which continue to cast great suspicion on any deliberate self-disclosure beyond one's carefully articulated experience of the patient, assures us, if we also conform to the other rules, that we really are analysts. In other words, the question of self-disclosure continues to be discussed, in part, because the psychoanalytic family requires of its members the suppression of spontaneity and self-expression.

But there is more. Self-disclosure of the deliberate kind remains a question because, as we mentioned earlier, psychoanalysis is a practice, not a technique. Psychoanalysis belongs to the realm of practical wisdom, not to that of techniques for the production of items or for the application of the findings of the empirical sciences, helpful and suggestive as these may sometimes be. People are not products to be shaped by techniques. Technique belongs to the realm of generality, mechanization, and routinization. The intersubjective field, on the contrary, is the realm of practice, the area of understanding, the particular interplay of particular subjectivities. This means we must address deliberate self-disclosure in psychoanalysis as a topic of serious questions and considerations. Wachtel (1993), in his textbook *Therapeutic Communication*, has made an extremely helpful start in his chapter on self-disclosure. Here let us note some important considerations that arise from an intersubjective perspective on psychoanalytic work.

Perhaps most fundamental is the question of meanings for patient and analyst. Neither disclosure nor withholding is neutral; each has a particular meaning in the context of a particular psychoanalytic treatment. Our primary concern, if we work within an intersubjective perspective, must be to understand with the patient the meanings of whatever is going on. If we believe this, then hiding our personal part in whatever is going on can only inhibit the psychoanalytic process. Of course the act of hiding, or not disclosing, will actually have a variable effect, depending on the patient's experience of this hiding, for example, as the withholding of intimate involvement, as respectfully staying out of the way, and so on. (In our next chapter we argue that there can be no neutrality in an intersubjective view of treatment.) For one patient, hearing that the analyst will be away for two weeks is more than enough. For another, there will be questions about where the analyst is going, whether the trip is busi-

ness or vacation, and so on. There is no neutral way to respond. In fact, to say more to the first patient would not be neutral either.

We cannot be more specific than the intersubjective principle allows. Suppose, as we could easily be tempted to do, we considered the wisdom of an analyst's self-disclosure to depend on whether it contributes to a sense of safety, for patient, for analyst, and for the intersubjective space itself. The intersubjective field would include the intermediate or transitional area—the space of illusion and playing, the space between—so helpfully articulated and illustrated in Winnicott's work. It would also include the subjectivities of both participants. Making the whole intersubjective field increasingly safe can permit exploration, inquiry, play, and the development of new or revised psychological organization. Thus, just as patients are constantly asking themselves if it is safe to say or feel this or that with this person, analysts express their own sense of personal and intersubjective safety as we choose how or what to say or not say to a patient. The question is how—not whether—to answer a patient's inquiry, for example. If we treat emotional safety as our fundamental criterion, then we must ask how particular forms of response affect the safety of the field. There is no routine, or default, procedure. With some patients, direct response to questions followed by inquiry about meaning seems to create the safety required for deeper reflection. With others, the exact reverse seems to be true. Some ask questions hoping the analyst will ask, "Do you really want to know that?" Then a discussion ensues, not only abut the meaning of the content of the question, but even more about its function, for example, to test the analyst's ability to protect the patient from retraumatization. Some patients are thankful for this kind of response. These patients are usually those for whom intrusion and boundary violation have traumatically reduced their ability to feel safe if the other person is known to them.

But the intersubjective perspective goes further. Certain patients may need to have the experience of feeling unsafe, for example, in order to recover in the transference lost memories of traumatic endangerment. We cannot conclude that any particular intervention is better or worse without exploring its particular meaning for this particular person in the context of this particular treatment.

Let us consider a specific example, one in which a pattern of self-disclosure on the analyst's part has developed. This example differs from those recently given of what is often called countertransference disclosure.

Tim came to treatment in his late 30s, depressed and expecting to fail at everything he undertook, professional or personal, despite a history of considerable success and large talents in more than one field. Although he described his family as close, it turned out that his parents' marriage was troubled and that he had become the parentified child to several siblings. Further, his parents were both prone to rages, and Tim was frequently berated in tirades from his parents in front of friends or siblings. Nothing he could do was good enough, so explosions were always imminent. His expectation of failure was understood as closely linked to his certainty that painful and destructive humiliation was always just around the corner.

Once Tim settled into treatment and began to feel understood, a curious pattern developed. At the beginning of each session he would ask how the analyst's weekend had been, or how she was. Initially, this seemed to be just a person who had been trained to be polite and whose "structures of accommodation" (Brandchaft, 1994) were strong. So, the analyst would answer briefly, "Fine, thank you," and attempt to shift the focus to the patient's concerns. But the shift would not come easily. He would ask more, or wait for more response, before he seemed able to move on.

The analyst considered the possibility that he was, in good parentified-child style, easily recognizable through the lens of her own history of parentification, attempting to take care of her. So she continued to answer briefly, without making an issue of the ritual, and took opportunities as they arose to study with him his patterns of compulsive caregiving. While some of these began to change for him at work and at home, this approach had no effect on the beginning of sessions, so the analyst concluded she had only partially understood. She was reluctant to point out the pattern to him, imagining he would feel shamed. Yet the merely polite responses were evidently also problematic.

It seemed time to experiment. Perhaps, the analyst thought, he needed her to talk about herself to him. So, one Monday, when he asked what she had done on the weekend, she said she'd mostly done chores, had done some reading, and had been to a concert. "What was the concert?" he wanted to know. And how

had the analyst liked it? After a somewhat more lengthy reply, they began to talk of his weekend, and he moved more easily into the work of the session. Since then, they have tended to "chat" for about three minutes at the beginning of each session. He has come to know a fair number of details about his analyst's interests and activities.

Now they have begun to discuss this interaction. Reflecting on the pattern they finally found together, they have concluded that he needs his analyst to be real in order to enter and stay with his own reality. If he cannot feel her as a real person with a life of her own, he feels unable to open up his own more vulnerable places. He needs to feel enough respect from his analyst to think she could trust him and talk to him. Their talking together about her interests and activities seems to make it safe for him to develop a sense of his own.

As they discussed this pattern, Tim further explained that he had always needed to check and see that the caregiver was in good emotional condition—not likely to explode—before he could venture into anything of his own, but had not realized how imperative this still felt for him. Otherwise, any indication of his own feelings and needs and concerns ran the risk of scorn and humiliation, with the consequent debilitating shame. The experiences of his adult life have only reinforced his sense of the necessity of these safety measures.

Still, to return to the earlier discussion, we do not suggest that safety, or propriety, or "the frame," or anything concrete is the ultimate criterion. From an intersubjective point of view, there is no "right answer" to questions about self-disclosure or other matters of what many call "technique." There are two people together, an analyst and a patient, trying to find understanding that will permit a reorganization of experience or perhaps a developmental second chance (Orange, 1995). Specific decisions about self-disclosures and other forms of analytic conduct need to be made on the basis of assessment as to whether their interacting meanings for patient and analyst are likely to facilitate these goals.

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The Myth of Neutrality

The technical rationality dependent on objectivist conceptions of psychoanalysis is perhaps most evident and most harmful as expressed in the idea of analytic neutrality.

Scattered throughout our writings on the psychoanalytic situation viewed as an intersubjective system have been a number of criticisms of this idea. Here we gather together these criticisms and expand upon them, emphasizing in particular the illusory and defensive aspects of the doctrine of neutrality, as well as its intricate mythological underpinnings. We then propose an alternative analytic stance derived from intersubjective systems theory. We begin first with a critique of four conceptions of neutrality that have been prominent in the psychoanalytic literature. Two came from Freud, a third from his daughter Anna, and the last was proposed by Kohut.

Critics might object that in our portrait of the neutral analyst we set up a straw man, that critiques of, and alternatives to, the concept of neutrality already appear in the psychoanalytic literature (for example, Singer, 1977; Ehrenberg, 1992; Raphling, 1995; Renik, 1996), that relational-model (Mitchell, 1988) and constructivist (Hoffman, 1991) perspectives are already influencing analytic practice, and that only the most rigid among analysts would claim to behave in the manner we describe. Although these points may be well taken, we believe that the myth of the neutral analyst, with roots extending back through a hundred years of psychoanalytic history, continues to operate as a deeply embedded organizing principle, powerfully shaping analysts' perceptions of the analytic encounter and obscuring the intersubjective nature of the analytic process. In countless discussions with colleagues, students, and supervisees we have found that analysts

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and therapists are especially prone to make claims of neutrality when their patients' transference attributions threaten essential features of their sense of self (see Thomson, 1991). Additionally, we have found that often even relationally oriented analysts and therapists uphold neutrality as a revered, albeit unattainable ideal, deviations from which evoke shame or reactive shamelessness. It is for these reasons that we feel that a deconstructive critique of this ideal is warranted.

1. Often neutrality is equated with Freud's (1915) dictum that "treatment must be carried out in abstinence" (p. 165), typically interpreted to mean that the analyst must not offer patients any instinctual satisfactions. This technical injunction derived from the theoretical assumption that the primary constellations with which psychoanalysis is concerned are products of repressed instinctual drive derivatives. Gratification, according to this thesis, interferes with the goals of bringing the repressed instinctual wishes into consciousness, tracking their genetic origins, and ultimately achieving their renunciation and sublimation.

But in what sense can this stance of abstinence be said to be neutral? Surely not from the standpoint of the analyst who practices it, because for him or her abstinence is the expression of the deeply held belief system (some might say moral system) to which he or she adheres in conducting his or her analytic work, a system that includes basic assumptions about human nature, motivation, maturity, and psychological illness and health.

Furthermore, when one assumes a position from the *patient's* perspective, it is apparent that abstinence—the purposeful frustration of the patient's wishes and needs—could never be experienced by the patient as a neutral stance. Consistent abstinence on the part of the analyst decisively skews the therapeutic dialogue, provoking hostility and tempestuous conflicts that are more an artifact of the analyst's stance than a genuine manifestation of the patient's primary psychopathology (Wolf, 1976; Kohut, 1977). As Stone (1961) and Gill (1984) have pointed out, so-called regressive transference neuroses, thought by many to be a sine qua non of an analytic process, may actually be iatrogenic reactions to the indiscriminant application of the principle of abstinence. Thus an attitude of abstinence not only may fail to facilitate the analytic process; it may be inimical to it.

2. Closely allied to the rule of abstinence, and also considered by many to be an essential constituent of analytic neutrality, is

Freud's (1912) recommendation, consistent with his topographic theory, that the analyst "should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him" (p. 118). As Gill (1984) pointed out, the assumption that the analyst can remain anonymous denies the essentially interactive nature of the analytic process. Everything the analyst does or says—including especially the interpretations offered—are products of his or her psychological organization, disclosing central aspects of the analyst's personality to the patient. These impressions, in turn, are decisive in codetermining the development of the transference. Like the rule of abstinence, analysts' misguided belief that they can keep their own personalities out of the analytic dialogue itself produces transference artifacts that may be countertherapeutic.

3. A third conception of neutrality, invoked, for example, by Kernberg (Panel, 1987), is Anna Freud's (1936) statement that the analyst "takes his stand at a point equidistant from the id, the ego and the super-ego" (p. 28), a stance that she equates with one of "clear objectivity" and an "absence of bias" (pp. 28–29). Leaving aside the considerable difficulties involved in attempting to measure distances between oneself and hypothetical mental institutions, we wish to emphasize that this concept of neutrality, like the principle of abstinence, is rooted in a value-laden theoretical belief system—the tripartite model of the mind—and hence is not unbiased or neutral at all. Interpretations offered from this metaphorical point of equidistance encourage the patient to adopt the analyst's beliefs about the structure of the mind and, to that extent, they are suggestions.

4. The myth of the neutral analyst has persisted within psychoanalytic self psychology. Reacting against the equation of neutrality with abstinent unresponsiveness, Kohut (1977) defined analytic neutrality "as the responsiveness to be expected, on an average, from persons who have devoted their life to helping others with the aid of insights obtained via the empathic immersion into their inner life" (p. 252). While we find this a felicitous characterization of an aspect of the analytic stance, we cannot agree that it describes a neutral one. Like the principles of abstinence and equidistance, it is rooted in a theoretical belief system, albeit one that places the accent on the role of emotional responsiveness in facilitating the development of the sense of self. Furthermore, as Kohut (1980) recognized, "a situation . . . in which one person

has committed himself for prolonged periods to extend his 'empathic intention' toward another" (p. 487) is surely not experienced by the patient as a neutral one, meeting as it does deep longings to be understood.

Kohut (1980), however, contended that empathy "is in essence neutral and objective" (p. 483), and Wolf (1983) has suggested that Kohut's definition of empathy "implies an attitude of objectivity with regard to the patient's subjectivity" (p. 675). To expect that an analyst can be neutral or objective with respect to a patient's subjectivity, and thereby gaze upon the patient's experience with pure and innocent eyes, is tantamount to requiring the analyst to banish his or her own psychological organization from the analytic system. This, in our view, is an impossible feat, especially when the most powerful expressions of the patient's subjectivity are directed toward the analyst—hardly a disinterested party. What analysts can and should strive for in their self-reflective efforts is awareness of their own personal organizing principles—including those enshrined in their theories—and of how these principles are unconsciously shaping their analytic understandings and interpretations.

The four variants of the myth of the neutral analyst are closely intertwined with a number of other interrelated myths that have been influential in shaping the traditional analytic stance.

THE MYTH OF INTERPRETATION WITHOUT SUGGESTION

Following Freud's (1919) distinction between "the pure gold of analysis" and "the copper of direct suggestion" (p. 168), it has traditionally been claimed that what distinguishes psychoanalysis from other forms of psychotherapy is reliance on interpretation, especially interpretation of transference, as opposed to suggestion. The dichotomy between interpretation and suggestion is closely allied with the various notions of neutrality discussed earlier, because the neutral analyst, whether from a position of abstinence, anonymity, equidistance, or empathy, is presumed to be able to offer pure interpretation without suggestion.

As Gill (1984) pointed out, "every time the analyst intervenes he may be experienced as suggesting a direction for the patient to pursue" (p. 171). We suggest that this truism vitiates the

sharp distinction between interpretation of transference and suggestion. The commonly held idea that interpretation simply lifts into awareness what lies hidden within the patient is a remnant of Freud's topographic theory and archeological model for the analytic process (e.g., Freud, 1913). This model fails to take into account the contribution of the analyst's psychological organization in the framing of interpretations. Every transference interpretation—indeed, the concept of transference itself—is rooted in the theoretical framework that guides the analyst's ordering of the clinical data. Invariably, the analyst's allegiance to his or her guiding framework has roots in deeply felt personal beliefs and values (Lichtenberg, 1983; Atwood and Stolorow, 1993). Thus, each time the analyst offers an interpretation that goes beyond what the patient is consciously aware of, he or she invites the patient to see things, if ever so slightly, from the analyst's own theory-rooted perspective. To that extent, interpretations are suggestions, and it is critical to the analysis to investigate whether the patient believes he or she must adopt the analyst's viewpoint in order to maintain the therapeutic bond.

THE MYTH OF UNCONTAMINATED TRANSFERENCE

A common rationale for upholding neutrality in its various guises is the idea that noninterpretive interventions, such as gratifications or suggestions, will "contaminate" the transference so as to render it unanalyzable (Panel, 1987). The underlying assumption here is that transference can exist in a form that is "uncontaminated" by the activity of a neutral analyst. This assumption derives from the traditional conceptualization of transference, according to which the patient "displaces emotions belonging to an unconscious representation of a repressed object to a mental representation of an object of the external world" (Nunberg, 1951, p. 1). One of us (Stolorow and Lachmann, 1984/1985) has criticized this concept of transference as displacement.

The concept of transference as displacement has perpetuated the view that the patient's experience of the analytic

> relationship is solely a product of the patient's past and psychopathology and has not been [co]determined by the activity (or nonactivity) of the analyst. This viewpoint is consistent with Freud's archeological metaphor. In neglecting the contribution of the analyst to the transference, it contains certain pitfalls. Suppose an archeologist unknowingly dropped a wristwatch into a dig. If the assumption is made that anything found in the dig must have been there beforehand, some woefully unwarranted conclusions would be reached [p. 24].

We agree entirely with Gill's (1984) contention that "the notion that the transference can develop without contamination is an illusion" (p. 175). When transference is conceived not as displacement (or regression, or projection, or distortion), but as an expression of unconscious organizing activity (Stolorow and Lachmann, 1984/1985), then it becomes apparent that the transference is codetermined both by contributions from the analyst and the structures of meaning into which these are assimilated by the patient. Transference, in other words, is always evoked by some quality or activity of the analyst that lends itself to being interpreted by the patient according to some developmentally preformed organizing principle.

The contribution of the patient's transference to the production of the analyst's countertransference has found its place within psychoanalytic clinical theory. We are suggesting that the countertransference (broadly conceptualized as a manifestation of the analyst's organizing activity) has a decisive impact in shaping the transference. Transference and countertransference together form an intersubjective system of reciprocal mutual influence (Stolorow, Brandchaft, and Atwood, 1987). Neutral analysts, pure interpretations, uncontaminated transferences—none of these mythological entities can exist within such a system.

THE MYTH OF OBJECTIVITY

The notion of analytic neutrality supports the image of the analyst as a natural scientist making objective observations about the patient's mental mechanisms, especially the patient's transferences. Analysts embracing such an objectivist epistemology

interpret from a mythological platform with a God's-eye view of the true reality that the patient's transference experiences distort. Alternatively, reverting to a doctrine of immaculate perception, some analysts claim to make direct empathic contact with the patient's psychic reality as they enter the patient's subjective world through vicarious introspection. In either case, the assumption is that the analyst can make observations, either of objective reality or of psychic reality, that are not unconsciously shaped by his or her own personal organizing principles. This myth of objectivity denies the essential indivisibility of the observer and the observed in psychoanalysis, as well as the coconstructed nature of analytic truth. From an intersubjective or perspectivalist perspective, the analyst's perceptions are intrinsically no more true than the patient's. Further, the analyst cannot directly know the psychic reality of the patient; the analyst can only approximate the patient's psychic reality from within the particularized scope of the analyst's own viewpoint (Hoffman, 1991; Stolorow and Atwood, 1992; Orange, 1995). The implication here is not that analysts should refrain from using guiding theoretical ideas to order clinical data, but that analysts must recognize the impact of their guiding frameworks in both delimiting their grasp of their patients' subjective worlds and in codetermining the course of the analytic process.

A particularly irksome example of the myth of objectivity is the analyst who pronounces a patient analyzable or unanalyzable on the basis of an "objective" assessment of the patient's personality structure and psychopathology. Analyzability, we contend, is not a property of the patient alone, but of the patient-analyst system. What must be assessed is the functioning of the system, the goodness or badness of fit between the particular patient and the particular analyst.

THE MYTH OF THE ISOLATED MIND

An objectivist epistemology envisions the mind in isolation, radically separated from an external reality that it either accurately apprehends or distorts. The image of the mind looking out on the external world is actually a heroic image or heroic myth, in that it portrays the inner essence of the person existing in a state that is disconnected from all that sustains life. This myth, pervasive

in the culture of Western industrial societies, we (Stolorow and Atwood, 1992) have termed the *myth of the isolated mind* (p. 7). It appears in many guises and variations. One can discern its presence in tales of invincible persons who overcome great adversity through solitary heroic acts, in philosophical works that revolve around a conception of an isolated, monadic subject, and in psychological and psychoanalytic doctrines that focus exclusively on processes occurring within the individual person. The latter includes, for example, Freud's vision of the mind as an impersonal machine that processes endogenous drive energies, ego psychology's autonomously self-regulating ego, and Kohut's pristine self with its preprogrammed inner design. We (Stolorow and Atwood, 1992) have argued that the pervasive, reified image of the mind in isolation, in all its many guises, is a form of defensive grandiosity that serves to disavow the exquisite vulnerability that is inherent to an awareness of the embeddedness of all human experience in constitutive relational systems. All such images of the mind insulated from the constitutive impact of the surround counteract, to paraphrase Kundera (1984), what might be termed "the unbearable embeddedness of being."

The ideal of the neutral and objective analyst, impenetrable and sagelike, is just such an image, in that it disavows the deeply personal impact of the analyst's emotional engagement with patients and denies all the ways in which the analyst and his or her own psychological organization are profoundly implicated in all the phenomena he or she observes and seeks to treat. In order to dispense with the defensive invincibility and omniscience of the neutral stance, analysts must be prepared to bear the profound feelings of vulnerability and anxious uncertainty that are inevitable accompaniments of immersion in a deep analytic process. Letting go of metapsychological and epistemological absolutes and the security of standardized technique exposes analysts to the necessity of confronting the "Cartesian anxiety" (Bernstein, 1983)—their "dread of structureless chaos" (Stolorow, Atwood, and Brandchaft, 1994, epilogue).

Defensive functions similar to the ones we have been discussing played a prominent role in Freud's theory building. In our (Atwood and Stolorow, 1993) psychobiographical study of the personal, psychological origins of Freud's metapsychology, we found that Freud protected himself from awareness of the profound emotional impact of a series of early painful disappointments and betrayals by his mother by attributing his sufferings to his own omnipotent inner badness—that is, his incestuous lust and murderous hostility—a defensive translocation that found its way into his important adult relationships, including those with Fliess and with his wife, as well as into his formulations of clinical cases. This defensive solution, a form of defensive grandiosity, Freud also imported into his theory of psychosexual development and pathogenesis, a theory in which the primary pathogens were believed to be the unruly instinctual drives located deep within the interior of the psyche. In this theoretical vision, idealized images of the parents, especially the mother, were preserved, allowing Freud (1993), in a remarkable statement, to characterize the relationship between a mother and her son as "altogether the most perfect, the most free from ambivalence of all human relationships" (p. 133), and to apply the Oedipus myth in a manner that completely neglected the central role of the father's filicidal urge in setting the tragic course of events in motion. It is our belief that this same defensive principle fatefully shaped Freud's view of the psychoanalytic situation, wherein the *cordon sanitaire* that he wrapped around the parents he also wrapped around the presumptively neutral analyst, so that the patient's transference experiences could be seen as arising solely from intrapsychic mechanisms within the isolated mind of the patient, rather than being codetermined by the impact and meanings of the stance and activities of the analyst.

AN ALTERNATIVE: EMPATHIC-INTROSPECTIVE INQUIRY

If the notion of analytic neutrality is grasped as a grandiose defensive illusion to be given up and mourned, with what shall it be replaced? What is an alternative stance appropriate for the analytic situation recognized as a dyadic intersubjective system of reciprocal mutual influence, to which the organizing activities of both participants make ongoing, codetermining contributions? We (Stolorow, Brandchaft, and Atwood, 1987) have characterized this stance as one of empathic-introspective inquiry. Such inquiry seeks to illuminate the principles unconsciously organizing the patient's experience (empathy), the principles

unconsciously organizing the analyst's experience (introspection), and the oscillating psychological field created by the interplay between the two (intersubjectivity). Inquiry of this kind requires continual reflection on the inevitable involvement of the analyst's own personal subjectivity and theoretical assumptions in the ongoing investigation. Unlike the posture of neutrality, the stance of empathic-introspective inquiry does not seek to avert, minimize, or disavow the impact of the analyst's psychological organization on the patient's experience. Instead, it recognizes this impact as inherent to the profoundly intersubjective nature of the analytic dialogue and seeks consistently to *analyze* it.

We are well aware that the stance of empathic-introspective inquiry, like the stance of neutrality, can serve a variety of psychological purposes for the analyst. These should be a focus of the analyst's ongoing self-reflections. (See Atwood and Stolorow, 1993, pp. 189–190, for a discussion of some personal, subjective origins of our viewpoint.) We also wish to emphasize that there is nothing in the stance of empathic-introspective inquiry that advocates denial or obfuscation of the asymmetry of the patient-analyst relationship. The meanings of this asymmetry are to be investigated, not covered over. Nor does the stance prescribe any form of emotional responsiveness, participatory enactment, or noninterpretive provision on the part of the analyst. For example, although recognizing that the analyst is constantly unwittingly revealing his or her psychological organization to the patient (Renik, 1995), the methodology of empathic-introspective inquiry does not prescribe deliberate self-disclosure by the analyst. Instead, as we explained earlier, it enjoins the analyst to make specific decisions about self-disclosures on the basis of his or her best understanding of the likely meanings of such disclosures for the patient and analyst, and on his or her assessment, arrived at with varying degrees of collaborative input from the patient, of whether such interacting meanings are likely to facilitate or obstruct the analytic process—the unfolding, exploration, illumination, and transformation of the patient's subjective world. (See Stolorow and Atwood, 1992, chapter 7, for illustrative clinical vignettes).