

From:

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.

—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 collaborators¹ (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 misunder-

stood 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.

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

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

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 "pre-reflective 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 introduced 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 alarmed 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. 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, every-
one says, was kind of like mine. [The analyst guessed
that this switch from the cousin to the mother con-
nects with the sense expressed in her childhood diary.
If her mother had lived, she might have been pro-
tected 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 YOUR-
SELF.

Analyst: Whose voice is that?

Kathy: That's just what I was wondering. How can I remem-
ber? 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 col-
league pointed out to the analyst that Kathy was terri-
fied 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 emo-
tional 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 contri-
bution to this intersubjective predicament probably
came from the expectation, a product of the analyst's
own developmental context, that no one could possi-
bly 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.
So the underlying trouble is still there? [She nods.]

Analyst: 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.