The intersubjective field concept is a doorway to a dialogical sensibility. A dialogical attitude recognizes just how thoroughly and intimately any effort to understand another implicates both parties in the dialogue. The therapist’s task is to engage in a dialogue that stands the greatest chance of enabling the therapist to understand how our patients’ experiences—and ours—make perfect sense at this time in this situation together, even when our patients’ statements challenge our equilibrium or raise our defenses. In addition, many patients also struggle toward an engagement with their analyst not just as a repetitive figure (and not even as someone who merely serves their developmental needs). I think they strive for a more complex experience of the analyst in his or her subjectivity. Our ability to welcome them into our experiential worlds is often transformative in restoring a sense of dignity to emotionally alienated patients. An extended case example demonstrates these ideas.

**Key words:** dialogue; intersubjective systems theory; attunement; gadamer; buber

The point is to travel the way which lies between us. The obstacles from here and from there are the same, the distance is the same from me to him, as from him to me. [Letter from Hans Trub to Martin Buber, 1926 (Agassi, 1999: 163)]

Like many “second-generation” contemporary analysts who came of age in Los Angeles, my introduction to self psychology came by way of the writings of Stolorow, Brandchaft, and Atwood, especially their 1987 book, _Psychoanalytic Treatment: An Intersubjective Approach_. Unlike many, I came to the intersubjective systems theory of Stolorow and his various colleagues after years of study and practice in the world of humanistic psychology.

In the world of humanistic therapies—the world in which I first sought therapy as a patient—where there is a history of greater permissiveness regarding the transparency and responsiveness of the therapist, I had some vague hope, however tenuous and unarticulated, for engagement with a therapist who, in his or her willingness to speak openly with me, might help me overcome the emotional isolation and deadness that bedeviled me. I was not wrong. I remember a moment in my first therapy in which I was having some difficulty with my therapist. I tried haltingly to raise my concerns with him, and I could barely speak. He said, “It sounds like you think our relationship is so tenuous it cannot bear any strain or difficulty.” I was stunned. Actually, I had the sensation of a bomb going off suddenly under my chair. Did he say relationship? It had never occurred to me that he would consider us as being in a relationship together!

That sensation of being stunned by the bomb under my chair because he said we had a relationship remains a touchstone for me. It always brings me back to the core themes of my personal and professional development. I fact I have found, over the years, that clinical theory is not useful to me unless it finds some emotional resonance in my own world of experiences.

Those experiences have sensitized me to the primal importance of emotionally based
relatedness as a means whereby emotional integration occurs. Thus, it is probably easy to see why I would be attracted to theories that build on the notions of emotional attunement and selfobject ties as emotional processes themselves. In fact, reading the article “Affects and Selfobjects” [which later became chapter 5 of *Psychoanalytic Treatment* (Socarides and Stolorow, 1984)] was a sea change for me. I began to grasp how utterly intertwined our emotional lives are. There is no coherent emotional functioning without an intact selfobject surround. Once that notion began to take hold, there was no turning back.

But intersubjective systems theory offers another important point that was not really touched on in the original writings of self psychology—a point that is the ground on which I stand: the intersubjective field. The intersubjective field, which can be seen as an extension of the notion of selfobject relatedness, drives home the point that, first and foremost, our relatedness is irreducible. Our relatedness in our environment and with each other does not begin with us as separate selves, with relatedness being an “add-on.” Our very existence is utterly thoroughly context dependent, and our worlds of experience are emergent from our contexts, most especially our interhuman contexts. We have no experience that is prior to relatedness. As Merleau-Ponty has demonstrated in his writings on corporeality, we are born into a world “always already there” (Taylor, 1995). We come into being in relatedness.

The intersubjective field is not solely an epistemological orientation. The notion of the intersubjective field is a useful conceptual support to remind clinicians that anything we might believe that we know about what is transpiring in our consulting rooms is always coming from our situated perspective (Orange, 1995) and is—as the American pragmatist philosophers are wont to say—partial, incomplete, and subject to revision (Menand, 1997). Thus, an important clinical corollary of the notion of the intersubjective field is a commitment to continual self-reflection regarding our co-participation in the emotional lives of our patients.

The intersubjective field concept is also a doorway to a dialogical sensibility. That is, it is a small step from saying that our emotional lives are utterly interdependent, shaped within intersubjective fields of reciprocal, mutual, emotional influence, to saying that the quality of entire experiential worlds are contingent on the qualities of relatedness that we inhabit. I consider myself radically intersubjective in my orientation to my clinical work in that I view the clinical process as a continual conversation (either aloud or silently) about how my situated perspective is inhibiting or facilitating my patients’ development. I consider myself dialogical in the sense that I believe that certain qualities of engagement that are known as “dialogue” are most likely to be enriching and facilitative for my patients (and for me as well).

Martin Buber (1970) wrote about dialogue as something I call the “I-thou attitude” or “the dialogic attitude.” Buber writes about confirming the patient’s being and becoming, trying to enter fully into his world without judgment, and being present to meet and be met by the patient. Gadamer (1975/1991) refers to “undergoing the situation” together. He recommends that we take the most absurd utterances and try to understand them as the speech of a reasonable man. From an intersubjective perspective, I would add that the utterance emerges from our shared world. That is, in the clinical situation every utterance, every thought, feeling, sensation, every movement that happens in our consulting rooms is variably mutually influenced (and influencing). Nothing that happens arises pristinely from “within” the therapist or “within” the patient. Therefore, such thoughts as “this is merely my countertransference” or of the patient “this is projecting” will need to be discarded as remnants of an individualistic nonrelational sensibility. Instead, the notion of the intersubjective field leads to the following idea: “Something is going on between us that gives rise to the experiences the patient and I are having right now. Even if I cannot fathom
it yet.” My task as the therapist is to engage in a dialogue that stands the greatest chance of enabling me to understand how my patient’s experiences—and mine—make perfect sense at this time in this situation together.

Hence, in keeping with Gadamer’s injunction, I try to grasp how the puzzling, or disturbing, or contrary experiences we are having could be so. I attempt to refrain from any temptation to evaluate that it could not be so, but instead I struggle to make sense—either in conversation or through silent self-reflection—until I can say, “Of course! Now I get it!” This is a phenomenological exploration done in a dialogical context.

Attunement and Dialogue

Now one thing that particularly interests me is that I do not think a therapist can get a concrete feel for the experiential truth of the radical interdependence of our emotional lives unless one also practices emotional attunement and listening from within the patient’s perspective. Other kinds of listening (for instance, “other-centered” listening or listening for what it is like to be in a relationship with the patient) cannot give one access to this experience because other perspectives evoke greater psychological distance and differentiation than the empathic listening stance evokes.

Attunement functions at two levels. On the one hand, it is the ground from which a sense of affect validity, articulation, and integration occurs. We have seen that such integration enhances and strengthens the patient’s sense of self to a great degree, expanding contacting possibilities. But the second level of communication may be even more crucial. Emotional attunement serves also as recognition of the wholeness of the patient. The therapist, in attempting to attune to the patient’s emotional life and to understand it in the context of this patient’s history and present life, is recognizing a unique and yet understandable person (Jacobs, 1998).

This insight gives rise to a particular ethical dimension of a dialogical sensibility. In a Cartesian perspective, the nagging question persists, “How can we come to know each other?” How can we come to know our patients? We have to reach across empty space, imagine, and reconstruct the other as an image in our minds. In the post-Cartesian world of the intersubjective field and a dialogical sensibility, our patients are found and become present with us through our co-inhabiting, our living with and within each other. Knowing, as in the Cartesian sense, becomes less important than undergoing a process of understanding, making sense together (Gadamer, 1976; Orange, 1995). Thus, our question changes from “How do we know each other?” to “How shall we meet each other?” We are less interested in the question of knowing, more interested in the meeting. This is the ethical stance of dialogical intersubjectivity theory.

As a clinician and as a patient, I have been interested in the potential usefulness of the therapist being available to be met by the patient. We are very familiar with the idea that the therapist reaches to meet and understand the patient. But sometimes it is important for the patient’s development for the therapist to be open to being met and touched by the patient. I wrote in Bacal (1998):

The impetus for my interest in this topic [of dialogue] derives in part from my own experiences as a patient, as well as from my experiences as an analyst. I kept encountering this simple experiential fact from my two analyses: that whatever deeply moving, facilitative selfobject experiences I had with my analysts, the transformative power of these interactive events resided—it seems to me—in the fact that they were offered voluntarily, by separate other people who willingly engaged their own subjectivity with mine, and used their subjectivity as a tool to serve my development. My awareness of this dimension—the otherness of the analyst—was crucial to rendering the selfobject experiences meaningful to me. (196)

A dialogical attitude recognizes just how thoroughly and intimately any effort to understand another implicates both parties in the
dialogue. The therapist can only attune to the patient from the depths of his or her own experiential world. I think patients often apprehend—if mostly subliminally—the significance of the fact that therapists must process their communications through their own subjectivity, and their successes as well as their struggles to be as accurate as possible are often affirming. In the mutual empathic engagement between patients and myself, patients help me to meet them. When I meet them, they are confirmed in two ways: as both a contributing other and an understandable other in the stream of human relatedness. This often restores a sense of dignity by diminishing the shame that usually accompanies emotional isolation or alienation.

The analyst as a person has various meanings to any patient, and I have seen many a patient benefit from the therapist’s openness to a kind of engagement in which the patient can touch the therapist’s subjective experience, both directly and indirectly.

Quite often the analyst’s subjectivity is revealed indirectly, through tone of voice, choice of language, focus of interpretation, etc. But at crucial points in the therapy, for instance, in efforts to address serious disruptions in the therapy relationship, or at certain developmental thresholds, the patient may be intensely interested in, and require, access to the therapist’s experiencing. From a perspective which asserts that all experience is embedded in a relational matrix, it seems almost self-evident that self-development proceeds not only through the experiences gained through sensitive attunement to the patient’s experience, but through the experience of that attunement coming from a discernible, personal other.

All analysts are aware that a specter of “otherness” hovers as a constant presence in the consulting room. But we are used to thinking of the power of otherness and its influences on the patient in two negative ways. First is the therapist’s “otherness” as a countertransference impediment when the analyst cannot decenter from her own perspective. Second, the patient is all too aware of the analyst’s predilection towards having her own responses, and that awareness can frighten and constrict the patient. The patient tends to expect that the analyst’s subjectivity will be perilously similar to the subjectivity of traumatizing caretakers in his life. But many patients also struggle towards an engagement with their analyst not just as a repetitive figure, and not even as someone who merely serves their developmental needs. I think they strive for a more complex experience of the analyst in her subjectivity. I think the deep gratitude we so often hear from our patients is a sign of their recognition that we are a separate center of initiative, we have our own aims and needs and organizations of our subjective worlds, and yet we volunteer to suspend our aims and needs where possible to make room for them. (Bacal, 1988: 200)

At any point in the therapy process, but especially at difficult moments, my task as the therapist is to engage in a dialogue that stands the greatest chance of enabling me to understand how my patient’s experiences—and mine—make perfect sense at this time in this situation together. For example, if I find that my patient and I are speaking in a deflected manner, it cannot be said merely that the patient is avoiding intimacy with me. We together have not found what will support more fulfilling engagement between us. Our way of being together is the best we can muster at this moment. When patient and therapist are thoroughly implicated in each other’s experiencing and behaving, it behooves us to recognize that we are participating, to whatever extent, in an emergent process that has more supports for avoidance, in that particular moment, than it has for more direct engagement.

If I find myself thinking that a patient may be “avoiding,” then in keeping with my theory I might wonder if I too am avoiding something, thereby diminishing the possibilities for good quality engagement. For instance, I might find myself thinking that my patient is avoiding responsibility for deciding whether or not to tell me a dream. She seems to want to tell the dream but she also seems to want me to ask about the dream so that I can be the one “responsible” for her telling the dream. Such an analysis of the situation is probably reasonable and a situation many of us can recognize. But it leaves out my participation. For instance, what do I want with this patient at this time that I am not getting? What selfobject wish of mine is not being
met? If I ask what I am avoiding, I might find that I dread the possibility of being blamed by this patient or of being poorly used. My awareness of a subtle rigidity in my posture—where I am nonverbally saying, “No, I won’t take the blame!”—allows me to consider that supports for more direct conversation are lacking between us, not within her (Jacobs, 2006).

Recently, in a peer supervision group with my analyst colleagues, I described difficulty working with a particular patient. The patient feels incredibly hungry for me to find a way for me to help her and equally despairing that anyone can help her. And, in a perfect example of parallel process, I went to the group saying I did not think anyone could help me with my difficulties. I kept referring to this woman’s style as like Teflon, refractory to influence. My colleagues noted that I seemed stymied and disrupted, and they asked me what my description of her (as “like Teflon”) and my disturbance was saying about how I was organizing my experience and how that might be influencing our sessions. I realized this woman’s despair had a form similar to my mother’s despair, in relation to which I felt helpless to relieve my mother’s suffering. So I became Teflon-like with my patient. I worried about intruding on her, by reaching frantically to rescue her as I had with my mother, and also I was protecting myself from the pain and frustration that I felt when I tried to engage my patient’s suffering. The familiar rejection I felt when I reached for my patient was daunting to me, and so I had tamped myself down. My own “cool” demeanor then mirrored her Teflon-like manner. So, in terms of co-implication, we were creating together the quality of engagement going on in the consulting room. We co-shaped the possibilities and we co-shaped the limits. My coolness was relevant to what was possible between us, just as hers was.

**Dialogue in Therapy**

There are various implications for therapy that derives from an intersubjectively based dialogical sensibility. Firstly, all phenomena that emerge in the therapist–patient dyad are, at least to some extent, expressive of the intersubjective field created by the patient and the therapist. Although patients and therapist each bring to the encounter a world of experience that has been shaped prior to their meeting, the way particular preformed repetitive themes emerge also reflects the unique system created by this pair. For instance, a patient who is exquisitely sensitive to rejection may feel rejected by the matter-of-fact way I announce plans to go on vacation.

Another implication, that of mutual emotional regulation, often occurs largely unnoticed but is ubiquitous and bidirectional. In fact, Sucharov (1998) has asserted that patients engage in efforts to regulate therapists’ affect states, through empathic interactions, as an integral part of the patients’ efforts to co-create conditions suitable for their developmental aims. Thus, one dimension of the process of mutual affect regulation is the patient’s effort—aware and unaware—to assist the therapist to regulate his or her states in a manner that creates a suitable working environment for the patient, while at the same time the therapist is engaging with the patient to help the patient regulate his or her affects in a manner most suited to the therapeutic process of the moment. Another aspect of the mutual regulation is that a therapist and patient “undergo the situation” together. In such a thoroughgoing, emotional, dialogical process, neither partner emerges unchanged. If the therapist is unchanged then the therapeutic process is probably severely limited.

I think, further, that the simple fact of being able to participate in mutual state regulation is a foundation for the development of a confident sense of human interrelatedness and is thus a response to some patients’ yearnings to be welcomed as a co-participant in shaping the subjectivity of an other. When a patient can find that the mutual regulation is a process that the therapist does not resist but in fact welcomes, it opens the door for further
development in such capacities as resilience, self-trust, and trust in relatedness, and openness to intimacy with others. But it is also something that, as therapists, we struggle with in our therapeutic encounters. In fact, when mutual emotional regulation breaks down, we are less likely to be able to have access to our own capacity to offer a receptive ear to our patients. The breakdown of the therapist’s capacity for dialogue is one component of a therapeutic impasse. Often, a therapeutic impasse begins to be resolved only after a therapist finds the supports to be able to reestablish an attitude that is infused with the dialogical attitude.

Case Example

It is impossible to describe the ongoing intersubjective mix-up—the shaping of our subjectivity, the mutual reciprocal affective influence in the clinical process, and the struggle toward dialogue—without doing some injustice to the holistic nature of affective experience and engagement. I find that the linear nature of words on a page frustrates my attempts to capture the simultaneity and multilayered quality of interactions in the therapeutic process. Nonetheless, I have tried, in the extended case description below, to illustrate a dialogical therapeutic process with a woman who longed to be welcomed into a shared emotional world.

Judy is a single freelance landscape architect in her 30s. We met three times weekly, for double sessions each time. She believed that our enterprise was her last chance to live without an empty hole at her center. She also believed that the means whereby her growth would occur was if she could “be herself,” fully and selfconsciously in my presence. The operative word about me in the prior sentence was “presence.” She was adamant that she needed a therapist who was able and willing to be available as a subject who could be met, a therapist whose subjectivity could be engaged. She hoped to discover that I was resilient enough to weather the storms of affect that would be stirred in both of us and still find a way to relate to her that was good for her as well as not destructive to me. This might confirm for her that it was possible to live in a world of “others” without having to deny her own sense of self. (I decided the gender and sexual orientation of the patient by a flip of the coin.)

Sessions with Judy tended to be intense and sharply focused. In the first few years of therapy, she often began sessions letting me know that the continuation of our treatment rested on whether or not I could “say the right things” in the current session.

In fact, she put me on notice right away. Everything about her in our first meeting warned of sharp edges. Judy was tall and thin, her hair was cropped very short, and her glasses were small and pointed on the sides. Her mouth was thin and tightly held, with a grimace suggestive of having just tasted spoiled food. She moved carefully and primly. She told me she was seeking therapy because she felt as though she had just jumped off a ledge and she needed a safety net. She had written her parents a longanguished letter in which she detailed their abuse, neglect, and ineptitude toward her and her two siblings and she wanted no further contact with them until she could work her feelings out for herself.

Judy had spoken with one other therapist. The therapist, a woman, had bathroom keys designated by color; blue for men, pink for women. Judy was upset by this but became even more upset when she raised her concerns about the possible sexist attitudes the therapist might have and the therapist appeared unconcerned and uninterested in reflecting on whether she might be being sexist. I suggested that Judy needed a therapist who would “take in” Judy’s experience, even when it was discrepant from the therapist’s perspective, and that she needed the therapist to be able and willing to reflect upon herself and upon her impact on Judy. If those conditions were not present then Judy could not feel safe. Judy concurred and said she was afraid she would just be put in a box and diminished.
Judy went on to describe her anger, especially toward men who do not seem to respect her boundaries. She was constantly being injured by the insensitivities of others. She described several interpersonal experiences where it was patently obvious to her that the only conclusion to be drawn about each situation was that people were insensitive and selfish in their interactions with her.

By the end of that first session, my body was rigid and tight. I was listening closely to every word she spoke. My comments had been careful and tightly reasoned, and I was tense and anxious about being able to be careful and finely honed in my interventions. This was the first of many uncomfortable reactions that were triggered by sitting with her. I was troubled by Judy’s close attention to the behaviors of others, in a manner that allowed little room for ambiguity, or the possibility of multiple meanings and interpretations of the same action. She decided for herself what particular behaviors “meant” about the character and motivations of the other person, and she acted on her conclusions in such a way that precluded the possibility of resolving misunderstandings with others (e.g., she might end the relationship with no further discussion).

I was tense for the first several months of our thrice-weekly therapy. Judy described herself as having a “tiny bull’s eye” inside her, and it was imperative that I be a sufficient marksman to be able to hit it. Interestingly, we came to understand that “hitting it” meant responding with my most authentic truth as best I knew it, whether I thought my “truth” was what she wanted to hear or not. She commented several times that I “seemed to be saying the right thing”—that is, she could trust my integrity and judgment—when I was honestly searching out my reactions to her various requests of me (requests ranging from providing information about the treatment process, to phone contacts, to information about my experiential world). Also very important was her awareness that I seemed to welcome the opportunity to expand our overt attention to my subjectivity as an integral and exciting aspect of our therapeutic relationship. In fact, as will become clearer below, my attitude of welcoming dialogue, even conversations that made me uncomfortable at times, served to affirm to Judy that she was embedded in an ongoing process of interrelatedness. Repeated experience of this particular dimension (my welcoming of our mutual exploration of my subjectivity, most especially my experience of the relationship with her) along with our exploration of such exchanges, enabled her to question deeply held beliefs that she was doomed to intractable isolation because she did not fit in among humans.

The first several months of our work together involved the gradual evolution of a sense of trust between us. Judy needed to test, and experiment, and look for ways to assure herself that I was committed to assisting her in being able to live authentically without devitalizing compromises. I needed to discover that there was room for me to be imperfectly attuned and to disappoint her longings and desires (to have “messy” contact sometimes) without each misstep threatening to abort the therapy altogether.

We came to understand together that Judy did not need me to be free of misattunements, even those that originated from my failures when my personal vulnerabilities led to problematic (sometimes defensive) reactions. Rather, she needed me to have them, to be responsible in my handling of them, and to use them to help her understand that she did have enough substance to affect other people. She also wanted to know how she affected me so that she could have clues as to what her impact might be on others.

I was a bit leery of being used in this way at first. I feared that my reactions to her would be taken as some “objective truth” to which she would have to submit. But as I experimented with being open about my reactions to her impact on me and to her ideas about others, she used my reactions in a variety of development-enhancing ways. She was extremely sensitive to my emotional process. Not only was she acutely aware of my mood changes, she
worried that each change was the beginning of a process of erosion of my willingness to engage with her. Once she felt relatively sure that our relationship would survive the exploration of whatever was transpiring between us, she frequently listened and responded sensitively to me when, in the course of the exploration, my own state of mind or my defensiveness became apparent. Her genuine interest—including a sense of fascination with how anyone’s mind works—and her sensitivity to me and to herself left me feeling both reassured that I was serving her developmental process and gratified by her attunement to me. My gratification was, in turn, surprising and pleasing to her as she struggled to understand why she believed she was too disgusting to allow anyone close to her. By my being open and not hidden, she felt reassured that she had not caused permanent damage. She trusted that I was telling her my personal truths, and these truths sometimes changed through our dialogue so that her sense of efficacy grew as well.

One of the “fields of play” for our reciprocal discovery process was in the area of my limits and how we lived with them. Judy lived in terror of accidentally tripping over my “invisible electric fence.” An electric fence was a limit that could not be acknowledged and discussed. It had been Judy’s experience that when she tripped over another’s electric fence they withdrew from her—usually abruptly and permanently—and she was left feeling alone, abandoned, and cold. One of Judy’s deeply entrenched beliefs was that, as she became closer to someone, eventually she would cross a boundary that would enrage the other person because they would feel violated and then they would leave her with no further discussion.

Limits that could be discussed were not a source of terror for Judy. In fact although they may be disappointing and hurtful, they were also relieving to her because they reassured her that I had my own center of gravity. This meant I would not build up resentments toward her as she used me in the service of her healing and growth because I would not make untoward sacrifices that would lead me to feel abused and then blame her for it.

Three examples stand out in my memory. These examples stand out to me largely because they also represent a confusion that I often experienced in my work with Judy. That confusion was the question of whether she was speaking metaphorically or concretely. Was she expecting a concrete action to address her current situation? Or was she speaking metaphorically, in which case the urgency of her need would subside as its meanings were addressed between us. My confusion was significant because, since I saw her as looking for actions to assuage a particularly painful state of mind that was also, unfortunately, a recurrent state of mind, I became anxious about repetitive demands for action and also about encroachments on my time and sense of freedom should I agree to participate in this way with Judy.

Over time I came to understand that my reactions to Judy’s action language contributed to the exacerbation of her demands for action in the treatment. This confusion in my mind over whether she was speaking concretely or metaphorically paralleled a confusion about whether I was being sought out as a function or sought out as someone to meet. The misunderstandings and misattunements with Judy, which led to our most serious disruptions, flowed from this confusion, and invariably I found with her that she had needed to reach me as a subject, even at times when I had little sense of myself as subject or little confidence that an expression of subjectivity would do anything other than harm her!

I came to understand that I kept a certain distance from her feelings in order to spare myself anguished confusion over what to do to respond to her suffering. Judy’s demands for action often led me to question some of my most fundamental (and sometimes unexamined) “standard operating procedures.” Standard procedures allow me to keep a relatively comfortable balance between the sometimes conflicting demands of my personal and professional life. Judy’s demands encapsulated her
insistence that my treatment relationship with her be a unique balance between my personal needs and my professional commitment to her. Her insistence reflected, I believe, an exquisite sensitivity to being treated as just “one of a crowd” and also an exquisite awareness of my tendency to rely on my standard operating procedures to an extent that occasionally blinded me to her uniqueness and the uniqueness of our relationship, thus leading me to objectify both of us to an extent intolerable to her.

**Example One**

The first example involved a time when she was moving into a house that she had just purchased. Whenever she did something positive for herself, she was plagued by awful visions of bloody bodies hanging from the ceiling or strewn about her apartment. We understood these images as an expression of her fear of being punished by envious family members whenever she took a positive step in her life. She dreaded the appearance of these fantasies when she moved. She was also afraid she would be assaulted by a fantasy of being surrounded by taunting siblings and parents who would threaten to suffocate her in her bed.

On the weekend of her move I was going to be out of town. We would also have to miss a few sessions prior to that weekend. On a Monday session she appeared to be especially panicked and insisted, urgently, that I reconsider my plans to be away. I was surprised by her vehemence and, in the course of attempting to understand the urgency of her request, I also said (defensively) that I would not reconsider taking my trip and that I had decided long ago that I could not afford to change such plans based on what work events were transpiring. She shouted back angrily, “I am not asking you not to go! But if you don’t even _consider_ it, then you don’t get it! You just don’t understand how terrified I am!”

I was surprised again, this time by her emphasis, not on the action of leaving or staying but on the subtler process of thinking about leaving or staying. I felt an immediate appreciation of her sensitivity to, and understanding of, the therapeutic process. I also recognized that I had, at one point, been so affected by the intensity of her suffering that I rued that I would be abandoning her at such a crucial time; but I had quickly and defensively pushed that thought away, thereby muting the resonant sorrow, compassion, and guilt that I had begun to feel toward her.

I responded to Judy that I agreed with her, that I had not fully appreciated the depth of her terror. I also suggested that my misunderstanding the intensity of her terror might be what led her to insist on some change in my behavior. I suggested she must need some concrete sign from me that I was not taking her fears lightly. She agreed and felt calmed by my attempts to set things on the right track again. The outcome of our discussion was that I would call her twice while I was away. It turns out she was not bedeviled by her visions. We both attributed her calm to the fact that she had felt more fully understood by me.

Subsequent exploration allowed us to develop more fully a theme from life with her mother, namely that her mother was generally passive and ineffectual; Judy had to insist on concrete behaviors in order to be taken care of at all, and yet, when her mother did react, she reacted hysterically. So although Judy wanted to see more visible signs of concern coming from me, she also feared I might overreact and become panicky myself. This latter fear helped us clarify one reason why I had underplayed the severity of her distress earlier. She had presented herself as troubled but “able to cope,” a familiar pattern from her childhood. And I, presumably like her mother, relieved that I could turn my attention elsewhere, was all too eager to take her presentation at face value.

In retrospect, I realize that her ability to distinguish between my actually changing my plans and my thinking about changing my plans released me enough from my guilt that I was able to be more open to her pain. In that way,
her statement served a regulatory function for me that benefited her. I have also come to appreciate that her first insistence that I consider changing my plans served an evocative function, stirring me out of my comfortable standard mode of operation so that she could have a more personal engagement with me—a much needed experience for her.

However, at the time, I remained vaguely disquieted. I recognized that I had been reluctant to allow myself to be affected by her distress and was unclear as to why. Ascertaining that she had balanced her distress by her posture of being “able to cope” was not completely satisfying. That accounted for a difficulty in recognizing her distress but not for my reluctance to recognize it. My reluctance, which was a reaction to the anxiety and confusion I described above, had been a constant influence shaping our relationship but became more understandable to me only after several more months of working together.

Example Two

Meanwhile, a second incident revolved around whether or not I would carry her phone number with me at all times. One time she had left an incorrect phone number on my answering machine so that, when I checked my machine remotely, I was unable to return her call. She asked me to carry her number with me. I reflected for a while and said I was reluctant to do so. I did not say so easily, as I worried that my refusal to take such a small concrete step to assuage her anxieties would plunge her into despair of being unable to affect me with the seriousness of her needs and anxieties. I told her I did not always carry my wallet with me and having to think about putting her number on my person whenever I was away from home or the office felt too constraining of my freedom. I wondered aloud if the number represented her wish that I carry her in my thoughts and in my heart even when we were not together and that, when I had not returned the call to her, it must have felt to her as though she did not exist in my mind anymore. She confirmed my guess. She also said this was a time when I had “said the right things.” She needed to see me be thoughtful about the impact on her of my failure to return her call. She did not actually need me to carry her number with me but had very much wanted to feel the freedom and sense of safety to be able to make the request and let me deal with its impact on me. She had in fact been anxious that I might feel coerced into acceding to her request and then become resentful of her forcefulness. She was gratified that I could turn down her request in a gentle manner that respected her need to make the request.

In this interaction, I gained more clarity regarding her use of action statements or demands as an effort to reach my emotions in a direct and immediate way. She seemed to hope to stir me up in a manner that would be difficult for me but she sincerely hoped I could work with my difficult stirrings in a way that would be fruitful for her. She was especially reactive, and felt more urgently compelled to reach for my fresh feelings in this way, when she had experiences with me where she felt “objectified” by me.

Example Three

A third example occurred as a consequence of the Northridge earthquake of 1994 in Los Angeles. On the day of the earthquake I canceled my session with her as my office was in shambles and needed to be set in order before I could see anyone. (I was also in shambles and needed to be set in order again!) We had our next session by telephone. She asked me at the start of the session whether I thought I was recovered enough from the quake to have a session, and I said yes. It turns out, much to my chagrin, that I was still distracted by the earthquake and its aftermath, was poorly attuned to her for much of the session, and neglected to warn her when there was only 5 minutes left
in the session (a ritual we had negotiated several months previously). When she arrived in person for her next session, she began with the following angry question, “Well, don’t you have something you want to say to me?” I looked at her quizzically, genuinely puzzled, and asked what she meant. She raised her voice and with angry panicked urgency lamented, “You just don’t get it. This proves it. Why aren’t you talking about having forgotten to warn me at the end of yesterday’s session? You are not with it. You are not ready to work. And I have to take charge to protect myself, AGAIN!” We spent the remainder of the situation working with this disappointment and its various meanings.

The next day she came in with a plan, which she announced to me. She could not bear being “dropped” by me and wanted to wait until I could hold her properly again, but she wanted me to return to my optimal level of functioning as soon as possible. To that end, she wanted to pay me for her sessions for the following week but would not attend the sessions. She wanted me to use the sessions to do whatever I needed to do to “right” myself so that we could continue our work. I could use the time to go sit on the beach, read, talk with friends, anything other than work, which might help me to recover. Attempts to explore together her feelings and thoughts were to no avail. I noted, with some sadness, that she was being driven to resorting to a familiar childhood pattern of “managing” her parents in an effort to get some modicum of effective parenting from them. She agreed but did not want to explore further. She was insistent that I take her plan seriously. Among other things she said that she did not expect an immediate answer from me, that I could think about it over the weekend and call her on Sunday. She said that she knew this was very unorthodox and she implored me to be open to considering her plan, that she could weather—with my help—my failures and could perhaps learn something about the durability and resilience that existed in our relationship. When I reached her on Sunday afternoon, she started the conversation by saying she had changed her mind herself. She recognized that these occurrences were “part of the process” and that she had felt so reassured by my willingness to consider her plan that she did not need to carry out the plan.

In all of the above examples there had been an intriguing misunderstanding between us. Judy had used concrete action language to describe what she needed from our therapeutic relationship. She insisted that I take her concrete ideas for various enactments (other examples have been calling her every day for a set period of time or helping her compose a letter to her father) at face value, even though she knew that her ideas were rich in symbolic meaning. I understand her concrete ideas as an attempt to create an experience with me that could open doors to evermore intimate relational experiences and to broadened exploration of experiences that make her feel exceedingly vulnerable.

However, her insistence on some form of action was usually initially unsettling to me. My consequent hesitation was then usually unsettling for Judy. Sometimes, as we negotiated our way through articulating the various meanings—especially the meanings about
what our relationship meant to her—of her concrete ideas and she witnessed my struggle to respond in a meaningful way, the negotiation and struggle itself seemed to constitute the very experience she was seeking. Our shared negotiations and her participation in my struggle to understand and respond were a process of mutual affective regulation and mutual shaping of each of our subjectivities. Her demand for an action tended to increase my anxiety. Then I attempted to forestall action but in such a way as to allay any increase in her already intense anxiety, and she attempted to clarify herself to me and convey emotional meanings to me in such a way as to reduce my anxieties about the sometimes unorthodox character of our therapeutic relationship.

In the examples above Judy had presented a concrete demand to me and I had reacted anxiously to the concreteness rather than to the metaphoric dimension of the request. It turned out that Judy was quite able to work with the request on a metaphoric level as long as she also experienced me as taking the concrete dimension seriously. Also, it appears that Judy’s request “escalated” into a concrete demand for action as a reaction to her belief that she was not being well understood in the first place. Both of these misunderstandings were relevant in the occurrence of, and working through, a suicidal crisis that occurred in our third year of working together.

Suicidal Crisis

In the weeks leading up to her revelation that she had decided to kill herself, we had many sessions that passed in almost total silence. She talked of feeling empty and like “nothing” inside. As she lay on the couch or sat with eyes closed, my thoughts would drift into a vague suspended state. At the time I told myself that I was merely feeling my way into her experience of emptiness. My mind drifted aimlessly, to the point that my thoughts were not particularly drawn to attending to Judy’s experience. A crucial difference between us, however, was that I found the experience to be a pleasant break from the pressures and responsibilities of therapeutic work, whereas she found the experience (I found out later) to be an excruciating confirmation that she really was nothing inside. My silence meant to her that I agreed she was nothing and she must now come to terms with that basic truth.

At any rate, on the Friday of her first announcement of her suicidal intentions, I had no idea what was happening. I knew nothing of what my silence had meant to her, little of what her silence meant to her, and I had not made an honest appraisal of my own flagging interest and its possible influence in the intersubjective field.

Our sparse discussions in between her bouts of prolonged silences had centered on three themes. One theme was her descent into depression and grief connected to her realization of how neglectful her parents were throughout her life. Another was her agony over feeling out of place in the world. Throughout our work together, we had often explored myriad and unrelenting prohibitions against her unique being in the world. Lastly, she talked of needing to enter into the “nothing space” because any other existence felt false to her at this time.

Now she said she realized she did not fit in the world but she no longer believed that she needed to try to fit anymore. She realized she was free to decide this world was not for her. She was free to leave it. She said that deciding that she was free to commit suicide was a rare experience of making an authentic choice. At first, I quietly affirmed the excitement and sense of vitality she felt at being free to determine the course of her own life. That seemed like a liberating breakthrough. She agreed and was pleased that I was not “in a lather” about her decision to commit suicide. She said she needed to ground herself in the realization that life was not right for her.

At this point, I thought that her new found freedom and autonomy, although it was being expressed so negatively, might lead her to
decide that if she could choose to die, she could also choose to live according to her own aims. In the past, she had often used action language and ideas to work out a symbolic issue. In the past I had taken her concrete action statements too literally. I thought that, by creating a space between us in which she could contemplate suicide, she was using another action statement to begin to work out themes relating to authenticity, freedom, and initiative—all crucial themes for Judy.

Judy went on to say that she was thinking of ways to disburse her belongings. She also said, seriously and with genuine concern for me, that she was concerned her father might sue me. In the course of this talk in the latter part of the session, I reiterated that I thought it was important to explore her thoughts and feelings regarding killing herself and that, while I was personally saddened by the seriousness of her belief that killing herself was the resolution of lifelong feelings of alienation, I knew we had to follow her explorations, wherever they took us. She seemed sober but heartened and grateful that I was not trying to talk her out of suicide. She talked a few times during the next sessions of her suicidal wishes, but mostly she spoke of examples of the alienation she felt and how nice it would be to be free of any struggle to fit in anymore.

By the Friday one week following her first mention of suicide, she was talking even more seriously of her intention to kill herself. I sensed she fully intended to follow through and I began to ask more detailed questions. She had set a date (10 days away) and she only needed to wait that long in order to set her will in order. She said she had a plan for how to kill herself, but she did not want to tell me what it was in case I had information about how messy such a plan might be. She did not want to be dissuaded, and she hoped her plan was a tidy one that would not “gross people out too badly.” I asked her to retrace with me how she had come to this decision. She became angry as she recognized I was becoming unsettled and less aligned with her perspective. She insisted she had been suicidal all of her life and she really wanted me to accept her wishes.

Judy spoke of how this choice seemed to her to be the logical culmination of our efforts to promote her singular autonomous existence and gave some examples of how our work together had encouraged her individuation. She also insisted that making the decision had ended her agony of trying to fit into life. She felt so much better now and calmer.

Her relationship with me had taken on an odd quality; it was as if she had drawn a steel curtain around herself to wall me out. I told her I thought that more was going on here. I said I shared her excitement over her realization that she was free to choose her existence but that if she killed herself she would no longer be able to exercise her exhilarating new freedom. I told her something did not feel quite right to me and therefore I could not feel sanguine about her decision to kill herself. I needed us to explore further.

Judy burst into tears of angry frustration and desperation. She practically shouted that she did not want to do any more exploring; “One explores when one has hope!” But the thin threads of hope that she had lived on were too agonizing, too risky, and there was so little return. She insisted forcefully that the only thing that could heal her was if I could be her mother, and I could not be her mother! Then, still full with emotion—mostly grief and despair—she told of a short story she had read over the weekend. The story involved a young girl and an insensitive and cruel mother. The crux of the story was how alone this girl was without her mother to turn to at a time of crisis.

I said to Judy that I thought the “nothing space,” which had preceded her thoughts of suicide, was perhaps the despair of being dead “inside” because there was no mother to be found, because I, too, had left her alone in her despair (her prolonged silent period had been preceded by deepening awareness of grief regarding her neglectful and exploitive mother). Judy said the “nothing space” felt like it was her (in a very concrete sense) and that my silence
had meant to her that it was okay with me that she was nothing. Thus, she was left with no hope and she would rather be dead than suffer the agony of risking by wanting more and yet have nothing come back to her.

Judy ended the session in a fury that I was fighting for her to stay alive. She asserted she just wanted me to leave her alone and let her go. She insisted that my efforts to prevent her from acting on her wish to kill herself were for me and for my interests, not for her and her needs. I said that I very much wanted her to stay alive for my own reasons but also very much because I had hopes for her as well. I was dismayed and quite concerned. I believed that Judy might well commit suicide. She had no apparent conflict or ambivalence about her wish. She experienced my conflict as an intrusion on her peaceful state of mind.

I have worked with suicidal patients before but never one who appeared so determined to be left alone to kill herself and never one who had so walled herself off from contact with me. I was confronted with my own existential crisis. I tend to believe that people have the right to commit suicide. Judy was firmly convinced of the rightness of her choice. She experienced my conflict as a painfully disappointing intrusion. I wondered if I was being blinded to her perspective by my personal anxieties about failing her and about having any patient suicide. And yet, my instincts led me to fight against her killing herself. I was fairly certain that her suicidal feelings were, in part, a reaction to some disruption in our relationship. Our last session, in which she iterated that she had interpreted my silences as confirmation that she was nothing, reinforced that opinion. Also, I just had the sense that this was an important transitional experience for her and, as such, it was temporary and her life would eventually feel rich with meaning for her.

Judy called later in the day. She was enraged and desperately frustrated. She felt betrayed by me. She had thought I was on her side. Up until now she had given us one more week to work together. Now she was calling to cancel those sessions because she saw no point in speaking further with me. I tried to talk further with her but she refused. I told her I would not let it go at this, and that I would call her during the weekend. Now I was greatly alarmed.

I arranged a consultation with a trusted colleague. He was forceful in insisting that suicide was not in keeping with Judy’s developmental quest to be fully engaged in her relational world. He suggested I push relentlessly on the point that my agenda for Judy was aligned with Judy’s agenda as well. He pointed out that Judy was separating her agenda and mine because she could not imagine a relationship where her needs and my needs could be aligned.

My colleague pointed out that my own “maternal” needs to respond to her and to help Judy grow could not be met if she did not stay alive. He said I could not collude with her belief that there was no symbolic “mothering” available from me. She may have experienced me as failing her when I was so passive with her silence but that did not mean I was failing her in the same global way her parents did. He said that when Judy rebuffed me again I should tell Judy that I refuse to stand aside and let her die and that I should ask her what a mother would do in such a situation.

I was heartened by the conversation in two ways. First, my colleague was unambivalent about intruding on Judy’s peace of mind. Second, he pointed me in a new direction. When Judy had wailed that only a mother could heal her and that I was not her mother, I had taken that as a sign that she felt dropped and abandoned by me and I had merely attempted to attune to the horror of the experience of my failing her. I had not wanted to impose on her experience, even though my sense was that I was very much like “a good enough mother” for her. I had been afraid that I would violate her experience by doing so. Yet my colleague encouraged me to have confidence in how maternal my relationship with Judy tended to be. In a sense, he encouraged me be more literal and concrete in responding to her!
I called Judy. She started out guarded and angry and again talked of how betrayed she felt by my efforts to keep her alive. But as we talked, and I used the perspective I had gained from the consultation, Judy softened. She agreed to come back for a session on Monday and asked me to explain my perspective to her more thoroughly. We spoke again one more time over the weekend and she told me she felt better after our previous call, more like we were friends again.

When I saw her on Monday, the crisis had passed, although Judy was still in agony. She told me that she had put her decision on hold until she could form a better understanding of my perspective and until she could better understand her own experiences of the past several weeks.

Together we began to try to unravel what had happened. I had mentioned over the phone to Judy, when she was critical of herself for going to such extremes when she was upset and wondering if she was manipulating me, that perhaps she had been driven to an extreme measure in order to get my attention when she was confronted with my passivity. Judy explored this theme further in the next sessions. She talked of how hard it was to evoke a relevant response from either parent and also of how once she was able to make me notice her agony, she would turn off the alarm too soon. We both noted, in fact, that she had turned off the alarm again in this very session when she had told me at the outset that she would not kill herself for now. We explored a dialectic between us where she feared if she did not turn off the alarm I would withdraw but when she turned off the alarm she felt forgotten again as our normal routine resumed. We both noted that turning on the alarm did get my attention and that turning it off helped to create an exploratory ambience between us. This was her contribution to regulating my anxiety to facilitate my responsiveness to her needs—first her need to have her anguish well met and then her willingness to reestablish an exploratory atmosphere.

We began to speak of her dilemma in a familiar way between us—her tidy self and her messy self. I told her it was true, her tidy self was so convincing that I often lost track of the pain and despair beneath it. That led her to say that she knew her “messy self” would fight me, hurt me, insult me, reject me, and that she needed me to hang in there and keep pursuing her messy self. When I said at one point that I thought she was talking of handing me her baby to hold, she wailed that it was more like a pig or warthog than a human baby and that she was sure I would be repulsed.

We have since explored the many meanings of her “nothing space,” of my reaching out to her, of times when I do not reach out, of her tidy self and how it almost got her killed but is a necessary protection when I am unreliable, and other themes that wove through this crucial period of time. For about a month after the crisis, I called her daily. We both saw this as a safety net for her, so that her tidy self would not lull me back to sleep, and as an enactment of my willingness to go the extra mile for her if need be.

Judy's suicidal despair became part of a distant past as she became more directly her “messy self” with me. A special intimacy grew between us, a kind that only happens when people go to hell and back together. I am amazed at how strong our trust became. She trusted me enough to be really messy—overtly enraged, overtly depressed and despairing, thoroughly bitter, demanding. And I trusted that no matter what happened, she would return for another session, even when she said she wouldn't!

For my part, I learned to trust our discussions of her concrete wishes, my willingness to respond concretely to some of them, and my inability or refusal to meet others of them. It appears that the process of articulating, understanding, and welcoming the expression of the needs encapsulated in her concrete wishes, my willingness to struggle visibly to establish an authentic and unique relationship with her and her wishes, and my willingness to offer
alternative modes of connection between us offered sufficient reassurance to her of my commitment to our work that she was not only able to tolerate the disappointment of her wishes but also able to make therapeutic use of our dialogue in these situations. I also deeply trusted that my open revelation of my own subjectivity, in myriad ways from tone of voice to disclosure of problematic subjectivity to playful shared moments of humor, all set her on a path toward inhabiting an intersubjective world.

When she first began therapy with me, Judy said she wanted a place to be completely true to herself and yet where the other person would not have to compromise herself in order to provide room for her. We seemed to find that place between us, and subsequent contacts with her suggest she continues to develop in the direction of graceful, full-bodied, intimate engagement that she yearned for at the start of our work together.

**Conflicts of Interest**

The author declares no conflicts of interest.

**References**


