Intersubjective Systems Theory

A Fallibilist's Journey

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Intersubjective systems theory is the view that personal experience always emerges, maintains itself, and transforms in relational contexts. It is held for reasons of personal inclinations, philosophical belief, and clinical conviction. As a clinical sensibility, it primarily includes an emphasis on the emotional convictions or organizing principles that systematize experience, the personal engagement of the analyst, and the refusal to argue about reality.

Key words: **intersubjective; system; psychoanalysis; fallibilism; reductionism; phenomenology; experience; contextualism; hermeneutics**

> We grace our beliefs by calling them theories. (Emmanuel Ghent)

Why is intersubjective systems theory so compelling for me? First, a few words are provided about this psychoanalytic approach. This theory examines the field—two personal worlds of experience in the system they create and from which they emerge—in human development and in any form of psychoanalytic treatment. Because of this focus, intersubjectivity theory also implies a contextualist view of development and of pathogenesis, describes the emergence and modification of subjectivity (the experiential world), and defines all these processes as irreducibly relational. The observational/participatory focus is the evolving psychological field constituted by the interplay between the differently organized experiential worlds of child and caregivers, patient and analyst, and so on. Informally, it means I am always trying not only to describe experience (yours, mine, and ours) in this temporal–relational context but also to understand in what relational contexts we became the people who participate and experience as we do.

This use of the terms *intersubjective* and *intersubjectivity* differs from some related ideas. In our usage (Atwood & Stolorow, 1984; Stolorow *et al*., 1987; Stolorow & Atwood, 1992; Orange, 1995; Orange *et al*., 1997; Stolorow *et al*., 2002) intersubjective describes the emergent relatedness between any two or more people and does not refer primarily to a developmental achievement. Daniel Stern's earlier work (1985), for example, names as "the intersubjective self" a stage and process of recognition of another's subjectivity as connected and responsive to one's own. This mutual recognition, also brought center stage in Benjamin's work (Benjamin, 1995), may be a late achievement in the intersubjective field of an analysis, especially in patients, such as those described by Guntrip (1969) and Kohut (1971). Mutual recognition intersubjectivity thus differs from our contextualist conception of an intersubjective field. Instead this mutual-recognition intersubjectivity may occur within an always already existing intersubjective world (Orange, 2008). I see intersubjective systems theory as one form of American relational theory—a variant more rooted in continental philosophies of phenomenology and hermeneutics.

There are at least three meanings of "why" involved as I attempt to explain my involvement

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Self and Systems: Ann. N.Y. Acad. Sci. 1159: 237–248 (2009).
doi: 10.1111/j.1749-6632.2008.04347.x

with intersubjective systems psychoanalysis. First, it can mean, "How did it come about historically?" as in the question, "How did it happen that a subway was built along Broadway in New York and not along Amsterdam Avenue?" This is a question about context and about history. I will call it the "why of influence," a question about what developmental circumstances, intellectual and personal, led me to embrace the psychoanalytic sensibility of intersubjective systems theory. Although I have generally regarded the writing of intellectual autobiographies as an exercise for 90-year-old philosophers, a collaborator with the authors of *Faces in a Cloud* (Atwood & Stolorow, 1993) can never avoid the question of the personal origins of theoretical preferences.

A second meaning of "why?" concerns the question of grounds, or reasons, for believing what I believe. Please note that we are speaking of belief, not of claims to unassailable knowledge. Granted, we psychoanalysts are devoted to the study of the emotional life and we value the intuitive and the imaginative. Still, it is incumbent upon us, I believe, to adopt and communicate reasonable beliefs about our work within a conversation in the "community of scholars," as American philosopher Charles Sanders Peirce would have said. Thus, the second part of this "why?" concerns why I find it reasonable to believe as I do and not otherwise. This means I must tell you, at least briefly, on what intellectual grounds I prefer intersubjective systems theory to the other psychoanalytic theories thus far developed. This is the why of reasons.

A third meaning of "why?" is "what for?" Why do theoretical differences matter? For what purposes, for example, do we think so carefully about our work? This question addresses the Aristotelian question of final causality, of course, but takes on a special quality when the "why?" concerns thinking. Heidegger's protests notwithstanding, I believe with the American pragmatists, and with Hans-Georg Gadamer, that thinking is inherently practical, that we think in order to be prepared to act. Afterwards, we reflect so that we may better understand how to act or not to act in the future. This is the why of purpose and of responsibility. This third form of "why?" is especially significant if one believes, as I do, that refusal by clinicians to think about theory, to examine and reexamine our beliefs, or to make choices among competing theories, means remaining unconscious about the presuppositions actually influencing our clinical work (Orange, 1995). In addition, making our theories explicit allows us to become aware sometimes that experience may be calling them into question.

Describing this fallibilist's[a] journey will, therefore, have three parts: (1) a personal story, (2) a series of sketchy arguments, and (3) a brief account of a clinical and ethical sensibility.

The Why of Influence

Personal history, of course, can lead one in various theoretical directions and does not provide logical grounds for developing or holding a theory but rather is suggestive of inclinations or leanings. I am relating something of my own personal history because my history has made it difficult for me to accept theories of innate aggression. These theories seem to me too simple to account for generosity and compassion and also seem to me to discount the frustration that results from actual deprivation and maltreatment. I was, therefore, first attracted to self psychology, which explicitly refuses instinct theories, and later to intersubjective systems theory, the latter for their phenomenology of personal experience, its thorough-going relational contextualism, and its resistance against all forms of reductionism. I believe our deepest convictions about ourselves grow primarily from the way we are treated as children and later and not from anything inherently wrong with us. The opposite idea would have confirmed my deepest organizing principles and

[a]Fallibilism is the recognition that we may always be mistaken, especially when we take our own point of view as the whole truth.

would have led me to despair, both personally and in my clinical work.

I was born into a troubled family that became a large one. As the oldest of 10 children, I was responsible for child care from my youngest years and for keeping a fragile family system running in many practical ways: cooking, laundry, cow milking, fire building, and so on. I envied children from smaller families; sleeping three, four, or five in a room, I could not imagine the solitude that allowed Descartes to develop his isolated-mind philosophy. In addition, I felt responsible for protecting my younger siblings, as much as possible, from parental violence and neglect. Each of us had nicknames; mine were "worthless" and "good-for-nothing," which were transformed, at an early age, into my personal "organizing principles" or shame-ridden emotional convictions about who I was and about how I should expect others to regard and to treat me.

To survive this situation, I became a bookworm and a church mouse. From the library, my only childhood refuge, I escaped into the convent, an even more rigid, authoritarian, and moralistic system than my family (Armstrong, 1981). There, however, I met some great women and found a reasonably good education. As an undergraduate, my love was for languages and literature, and my ambition was to teach high school. In those days, however, we had no choice whatever in deciding our college major. After 5 years teaching intermediate school, I was sent by my religious congregation to study philosophy because our college needed someone in that field. Fortunately, in spite of my serious doubts that I was intelligent enough for graduate school, I came to love philosophy and ultimately wrote a dissertation at Fordham on the development of the religious ideas of C. S. Pierce. From him I learned pragmatism, fallibilism, my conviction that the search for truth is an inherently communal project, and what I would today call perspectival realism. Probably the absolutisms of my family and the Catholic church made Peirce's fallibilism (and later self psychology's fallibilistic emphasis on exploring the analyst's contributions to clinical impasses) especially compelling for me.

During my years studying and teaching philosophy, I had left the convent and engaged in my first course of psychotherapy. This ended with my therapist's words: "What I still don't understand about you is why you are wasting your life in philosophy, when you would be such a wonderful therapist." At the time I had a teaching position in philosophy and a dissertation to write, so his words were unwelcome, to say the least. In the context of my mother's penchant for diagnosing her children, these words sounded like a curse.

But they intrigued me, and, with my dissertation defended, I began to take counseling courses at night to see if the shoe fit. I decided that it did and returned to New York to study at Yeshiva University's Ferkauf Graduate School where I found Beatrice Beebe, Jim Fosshage, Neil Skolnick, and, most important for me, Robert Stolorow. My dissertation there concerned the incoherence of eclecticism and of multiple-theory approaches to psychoanalytic theorizing. Next I joined the first class in the newly founded Institute for the Psychoanalytic Study of Subjectivity where my first supervisor was George Atwood, a man whose passion for clinical understanding has surely been the single greatest influence on my psychoanalytic work. George and I have collaborated now for 20 years as supervisors to each other, thinking partners, and friends. During the early years of working with George, his intense and deeply rooted interests in philosophy sent me back to philosophy myself. I begin to reread pragmatism and continental philosophy, especially Hans-Georg Gadamer's *Truth and Method* (1975/1991), and to write some articles that eventually became the core of my 1995 *Emotional Understanding* (Orange, 1995).

These articles evoked the interest of closet philosopher Robert Stolorow,[b] whose

[b]Robert has recently completed his own doctorate in philosophy with a dissertation on Heidegger, which formed the basis of *Trauma and Human Existence* (Stolorow, 2007).

encouragement helped me to write the book and who, on its publication, invited me to work with him and George. Bob has also become a treasured conversation partner and a good friend. This three-way collaboration has gone far to moderate my "worthless and good-for-nothing" self-experience, although of course, it returns several times a day to haunt me.

In the 1990s, my philosophical interests included extensive study of Wittgenstein, whose therapeutic conception of philosophy, language games, family resemblances, and forms of life became an important inspiration for a series of papers (Orange, 2002, 2003a, 2003b) and for a chapter in our last collaborative book (Stolorow *et al*., 2002). Together with my rereading of Gadamer's dialogical hermeneutics, Wittgenstein (1953/2001) has focused my attention on questions of language and meaning in psychoanalytic thought and practice. Most recently my philosophical studies have also focused on the work of Martin Buber, Merleau-Ponty, and Emmanuel Levinas.[c]

A final and closely related formative influence—engendered by collaborations and friendships with European colleagues—has been my return to learning languages. In 1997, I began seriously to study German, followed in 2001 by Italian. As you may imagine, learning languages in one's late 50s is no easy task, and the fluency achievable by younger people simply never comes. Nevertheless, at this stage of life, and perhaps because of the effort required, I have found myself frequently aware that I do not understand what I had thought I understood. I see that a language is a more-or-less untranslatable world of experience, culture, literature, music, and gesture. One of my Italian teachers, asked by students, "How do you say . . . in Italian?" often responded, "You don't. An Italian would not say that." Then she explained what an Italian might say in such a situation. Gradually this experience of learning second languages (one's "mother tongue" is learned quite differently, of course) has affected my clinical work and impressed me more deeply with the inescapability of the influence of one's own experiential world on the ways one understands. I have come to see, with Schleiermacher (1977), that misunderstanding is our basic condition and that understanding must be earnestly desired and sought.

Lynne Jacobs (Institute for Contemporary Psychoanalysis, Los Angeles, CA, personal communication, 2003) asked me an intriguing question about the why of influence. I have said above that Schleiermacher, Peirce, Gadamer, and Wittgenstein formed my thinking and convinced me of fallibilism, perspectival realism, the dialogic search for understanding, and so on. She wondered whether, instead, I was attracted to these thinkers because "they spoke to the yearnings/passion you have for genuine, nonrejecting, nonreductionist, fallibilistic dialogue." For a systems theorist or for a Gadamerian hermeneut, I believe, this cannot be an either/or question. My "senses of things," my personal and philosophical convictions, the beliefs that I grace by calling them theories, have emerged from a lifelong dialogue between and among the yearnings and leanings that my emotional and relational history has shaped, my readings and conversations with philosophers and psychoanalysts, and my clinical work. There cannot have been any unidirectional influence in this system. I have indeed sought out my intellectual influences, even though I experience them as having come to me as amazingly unexpected gifts.

Without making this a tidy story, therefore, I would summarize by saying that my life history, my philosophical and language studies, my clinical work, and my experience of collaboration have all conspired to lead me down the path of intersubjective systems theory, to whose reasons and grounds I now turn.

The Why of Reasons

For me, to explain why intersubjective systems theory is my psychoanalysis is not to

[c]These philosophers, along with Gadamer and Wittgenstein, structure my forthcoming book (Orange, 2009).

provide a set of unassailable or irrefutable logical proofs. Rather I will try to show that this point of view is the natural outgrowth of more basic convictions that I find reasonable to hold. Some of these convictions take the form of refusals to accept what has been urged upon me, but I will attempt also to give these ideas a positive form. A caution regards the interdependence of these ideas—they form a "web of belief" (Quine, 1978)—and thus can sound circular.

(1) It seems to me axiomatic, as it does to all relational theorists known to me, that personal experience takes form, is maintained, and transforms itself in relational contexts. It seems to me impossible that what we call experience could ever yet be experience without its interpretation by the explicit or implicit community.[d] I become I—with my characteristic ways of thinking, feeling, believing, and living with others—only within complexly nested and overlapping systems: infant caregiver, family, culture, religion, occidental lifeworlds (Husserl, 1936/1970; Merleau-Ponty, 1945/1962), and so on. How I experience myself and the otherness of the other depends upon these systems. It seems to me that when I bring my organization of experience to a relational situation, what I bring is a range of expectancies, emotional convictions, and ways I am prepared to respond or react. This range may be narrower or wider, depending on my whole life history in relational contexts and on what possibilities of therapeutic transformation have been available to me so far. Then this specific situation evokes particular aspects of my organized experience with more or less intensity, again depending on many particular aspects of the intersubjective situation. What I bring is just an enduring set of possibilities and leanings, nothing actual until I meet you. Whatever I experience in the situation with you is not something inside of me but rather it is my participation in the world we inhabit together. Levinas (1969) would have said that I become I only in response to the face of the other, the widow, the orphan, the stranger, in a word, to the destitute.

(2) All experience is interpretive and thus perspectival. This means no one and no group of people can take more than a partial view of anything. Our horizons of possibility of experiencing are limited, both spatially and temporally. This means that I have no God's eye authority to say that the patient is projecting or that I know an enactment is going on around here. Even a community's view, be it classical Freudian, ego psychological, Kohutian, Kleinian, Sullivanian, or systems theory, can only provide a partial access to complex systems. Our only possibility is to search together for understandings, always provisional.

(3) The inherent temporality of experience means that development and change—despite our longings for stability, reliability, and certainty—are as important as what endures. In the psychoanalytic situation, for example, mutually regulated experiences form unstable, though past-loaded, systems. These are always organizing and reorganizing themselves, both continually and in fits and starts. I am indebted not only to my philosophical studies and to my self-psychological beginnings but also to the pioneering works of researchers on early development (Sander, 1982; Fogel, 1993; Thelen & Smith, 1994; Beebe & Lachmann, 2002) for this understanding. At the same time, this conviction places me somewhat apart from those forms of relational theorizing that have tended to disparage a developmental emphasis in psychoanalysis.

[d] This view of experience need not exclude the kind of prereflective self-awareness or self-familiarity described by Zahavi F. M. (2003). *Selbstgefuehl: Eine historisch-theoretische Erkundung*. Frankfurt-am-Main: Suhrkamp; Zahavi (2005).

To think developmentally does not require a linear stage theory, nor does it necessarily infantilize. It simply refuses the atomism of the single moment. Instead developmental thinking, including Daniel Stern's version of the present moment (2004), can embrace the temporal situation—the warping of personal space-time—as meanings emerge and transform themselves.

(4) Human being is embodied spirit (Merleau-Ponty, 1945/1962). As I often say to patients and to myself—there is only one of me. My Cartesian mind does not take my material body out to ride my bicycle; rather, *I* go out for a ride. Nor do my brain mechanisms drive me to do this, even though the neuroscientists (not only their brains) may, in part, be able to explain why I am able to do it. (This is not, by the way, a claim for the primacy of personal agency. As a phenomenologist, I believe agency is one important form of personal and relational experience but that receptivity and responsivity may be even more basic.) Human being is describable in more mentalist or more physicalist language, but systems theories encourage inclusiveness of description and resist reductionism in all its forms (Orange, 2003a).

(5) Because of my perspectival realism (Orange, 1995), I see consciousness and unconsciousness as qualities of personal and relational experience, primarily as dependent on the conditions of relationality for individuals and communities (Stolorow *et al*., 2002). Thus, consciousness and unconsciousness are not locations; nor do they sharply divide experience. Often it is a question of more or less. At times, depending on many forms of context, I can tell you things about myself, about my patients, about those closest to me that I seem not to know at other times. Even Freud's dynamic unconscious was accessible within the psychoanalytic conversation, and his concept of "working through" is one of several that points to the incompleteness of the conscious–unconscious dichotomy. What relational and systems theories suggest, however, is that both are shifting properties of relational processes not of isolated minds or even of "mentalizations" (Fonagy, 2001).

(6) I believe in the uniqueness and unrepeatability of each human being and distinguish this carefully from the asocial conception that my collaborators and I have called the "Cartesian isolated mind." In every life there is an indefinitely large combination of relational and implicitly relational micro and macro events. From this myriad, each person continually self-organizes into a personality that can never be reduced to a formula or category. As I have said before (Orange, 2001), I inhabit my experiential world as it inhabits me. Most of what is wonderful, and strange, and difficult in life and art results from this always-emergent individuality—selfness when it is mine and otherness when it is yours. To claim that individuals are unique and can know themselves by a kind of intimate familiarity or *Selbstvertrautheit* (Frank, 1991) is not to return to the monism of the Cartesian mind.

(7) I believe that a fallibilistic attitude that holds theory lightly, and warns us never to be too sure, protects us against theoretical and clinical rigidity. As dogma, fallibilism is, as George Atwood often warns me, impossible to hold consistently "all the way down" because it would itself have to be brought into question. As attitude, however, it can keep us humble, unpretentious, and ready to learn.

It seems to me clear that intersubjective systems theory—especially understood as an intellectual and clinical sensibility—not only accommodates but also expresses psychoanalytically my philosophical beliefs outlined

above. Its focus is on the relational field constituted by two or more, unique, and unrepeatable subjective worlds of experience. Parent and child, patient and analyst, worker and manager, lovers, all constitute organic psychological systems, and the individual can never be understood apart from these systems.

Finally, intersubjective systems psychoanalysis suits me because it seems to include what I most value in other psychoanalytic theories without obligating me to accept those aspects I find unacceptable. Here is a very brief summary. From Freudian psychoanalysis I treasure the search for meaning as a way of healing troubled lives. From object relations theories I am indebted for the priority of relatedness in the formation of personal experience and for concepts such as the holding environment and transitional experience. To self psychology I am thankful for a clinical sensibility that places empathic understanding and developmental thinking at the center of its process and of its theory of curative efficacy. From American relational theory (Stephen Mitchell was my teacher for a year in my psychoanalytic training) I have learned how completely inevitable is the mutual participation in the psychoanalytic process and how to value and embrace this mutuality while also always living an ethical asymmetry (Levinas, 1981; Aron, 1996). For me all these gifts, and doubtless more, can be embraced by an intersubjective systems sensibility.

At the same time, my systems thinking allows me to eliminate the aspects of various psychoanalytic theories and practices that I find most problematic. I can, for example, reject reductionism of all kinds: overly-simple theories of human motivation, such as instinct theories, neuropsychoanalysis, and all authoritarian forms of treatment based on reductionisms. I can reject reifications, such as "the self," "the ego," "representation," "the mind of the other," or "the bad object," without giving up the experiences these ideas over concretize. Sometimes, of course, intersubjective systems theory can seem to make the opposite mistake—of being overly abstract and philosophical. Then I remember the words attributed to William James, John Dewey, Kurt Lewin, James Clerk Maxwell, and others: "There is nothing more practical than a good theory." It seems to me that our intersubjective systems theory allows me relentlessly to seek a dialogic form of empathic understanding with the patient, to acknowledge and explore our mutual participation in the psychological field we develop together, and thus to create what I have called a "developmental second chance" for people whose early and later lives have crushed and terrified them into aggressive and/or passive means of self-protection. I am allowed to witness their terrors and struggles and to support their emerging hope. This brings me to my third why, the pragmatic and ethical why.

The Why of Practice

Intersubjective systems theory, above all, both informs and results from my experience of daily clinical work and supervision. This aspect, however, is most difficult to articulate without seeming to discredit clinicians who think and practice differently. Probably analysts and other psychotherapists of every school can tell stories of patients untreated or mistreated by clinicians who think differently and who seem to be much better treated according to another approach. I try to remember that what patients tell me of their previous treatment is experience constituted by the intersection of at least three subjective worlds—the patient's, the previous therapist's, and mine—but I know that such stories have influenced me. I also know that when I read and hear psychoanalysts describing their work, I imagine myself as their patient and thus create yet another virtual intersubjective system. Recognizing that clinical style varies with the practitioner, I have tried to develop a theory and sensibility that, golden-rule-wise, I would want as a patient myself.

With this prologue, here are three short clinical stories that illustrate the negative shaping of my clinical spirit.

(1) One young patient had had no previous treatment but was the son of a social worker who had used diagnostic terminology and psychoanalytic jargon on her children. Having filled out the psychologist's questionnaire in the waiting room, he entered the consulting room for his first session. The therapist took the papers and began to read. Without once looking at the prospective patient, she murmured "Oh, this is bad . . . this is really bad." Before the end of the session, the psychologist offered this young man the option of working with her or of being referred to someone else. The patient, thinking at the time that "at least this is someone who seems to know something," stayed for a year. During this time, he was repeatedly treated as a case of one thing after another, despite his objections to the know-it-all (or in German, *Besserwisser*) interpretations and predictions of the therapist. By the time he left this treatment, his traumatized state of shock and confusion had worsened exponentially and he felt seriously suicidal.

(2) Another younger patient came to me with complex problems: obsessions, overwhelming feelings that she must harm herself immediately, and hearing voices. She found it almost impossible to trust anyone, least of all herself. I understood from the beginning that I was a frightening person but only gradually came to see why. In about the sixth session, she confessed, "I am so afraid you will say I am a borderline." "Why would I do that?" I asked. "Because that's what the hospital social workers told my parents," she responded. "And what do you think they meant by that?" I asked. "I don't know," she said, "but I think it's something really bad, and I want to know if you think I have it and if it's something that can get better."

(3) A third patient was being treated by a candidate in training at a prestigious psychoanalytic institute, on the couch, several days a week. Her mother had died of cancer when she was 11 years old, and no one had told her. She had no chance to say goodbye and only found out her mother had died when she overheard family members discussing funeral arrangements. This was one in a long series of traumatic relational experiences that had left her anxious and cautious. After a few months of analysis with this candidate, this patient began to wonder how deeply this analyst would be able to understand her experience, and asked her whether she too had lost a parent in childhood. The analyst steadfastly refused to answer and would only engage in analysis of the question. She refused to consider together the possibility that her patient's question might be reasonable and deserve an answer. The patient felt that she was being treated as an instance of a rule. After some months of this impasse and in despair, she left the analysis. Now an artist, she finds herself extremely cautious and unable to trust her own perceptions.

All of these patients, and many others, have trained me to think and practice as an intersubjective systems psychoanalyst. What these stories have in common, in my view, is their reductionism. Each reduces the patient to a case of something or an instance of a theory or rule. Each therapy is inadequate in a particular way—it fails to recognize the uniqueness of the patient's experiential world and the complexity of the influence of the so-called observer's participation in the psychological system.

In our view, there is no distinct body of clinical theory or of "technical" recommendations to be derived from intersubjectivity theory. Rather, the intersubjective perspective introduces a more general characterization of

all psychoanalytic work from within any specific clinical theory. Because each treatment includes an analyst with a point of view, different kinds of intersubjective fields develop in classical, interpersonal, or self-psychological treatments (Orange, 1995) as well as in each psychoanalytic pair. From a clinical point of view, intersubjectivity is not so much a theory as it is a sensibility. It is an attitude of continuing sensitivity to the inescapable interplay of observer and observed. It assumes that instead of entering and immersing ourselves in the experience of another, we join the other in the intersubjective space-time. 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. 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 that we name psychoanalysis, one is primarily respondent and guide while 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.

There are, however, chiefly three attitudes that characterize our clinical work: (1) a concentration on the emotional convictions (organizing principles) that pattern a person's experiential world, (2) radical engagement, that is, a self-reflective awareness of the clinician's constant and unavoidable participation, and (3) a refusal to argue about reality, that is, to assume an authoritarian "knowing" attitude.

The principal components of subjectivity, first of all, 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, sarcasm, exclusion, or loss.

The identification and working through of these emotional organizing principles is the daily bread of ordinary clinical work. Although much of the childhood experience may be easily remembered, the full power of the shaming conviction that one is defective ("the village idiot") comes to conscious awareness in dialogue with an analyst or therapist who can hear and respond. Such a therapist's very interest in the relational origins of such emotional convictions tends to call them into question and to open the possibility of experiencing oneself in other ways.

By radical engagement, secondly, we mean the self-reflexive awareness of our own implication in what we come to understand with the patient. Our own emotional history, clinical theories, gender, race or ethnicity, sexual orientation, various forms of embeddedness in larger cultural contexts, and attitudes toward difference will be present and influential throughout the intersubjective system that we form with the patient. Further, our very choice of psychoanalytic theory will be shaped by these same factors.

Most necessary to a radical engagement in the intersubjective field, however, is the therapist or analyst's willingness to know and acknowledge deeply ingrained bias, an indispensible aspect of a fallibilistic attitude. Hans-Georg Gadamer's hermeneutic concept

of dialogic understanding significantly underlies my sense of the day-to-day and moment-to-moment process in psychoanalysis. For him any truth arises from the interplay of perspectives, each carrying its load of tradition and preconceptions:

> In reading a text, in wishing to understand it, what we always expect is that it will *inform* us of something. A consciousness formed by the authentic hermeneutical attitude will be receptive to the origins and entirely foreign features of that which comes to it from outside its own horizons. Yet this receptivity is not acquired with an objectivist "neutrality": it is not possible, not necessary, and not desirable that we put ourselves within brackets. The hermeneutical attitude supposes only that we self-consciously designate our opinions and prejudices and qualify them as such, and in so doing strip them of their extreme character. In keeping to this attitude we grant the text the opportunity to appear as an authentically different being and to manifest its own truth, over and against our own preconceived notions. (Gadamer, 1975/1991: 151–152)

Here we see several aspects of a hermeneutic attitude that contribute to perspectival realism (Orange, 1995) as a psychoanalytic epistemology. First, there is the assumption that there is something under discussion. For "the text" we may substitute the patient's history, the patient's suffering, a misunderstanding between patient and analyst, or the heating or cooling system in the analyst's office. This something makes its own demands on the discussion and requires us to identify and recognize our own preconceptions and thus "strip them of their extreme character." We are thus able to recognize our own view as a perspective so that the matter itself (or in German, *die Sache selbst*) can show up as other. In addition, of course, we may be able to hear our patients and colleagues as having access to realities that are hidden from us by our own perspective—this is what it means to be other, the "authentically different being".

And finally, understanding that each of us has only a limited perspective, giving only partial access to truth, requires us to engage with the patient in a search for what I like to call "emotional understanding." In Gadamer's words,

> 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. (1975/1991: 323).

We attempt, through conversation and dialogue, to make sense together of the experiential world, whether of trauma, exclusion, discrimination, or any other relational experience, of this patient and to find how past experience is organizing the expectancies for future experience. It requires a fallibilistic analyst who can suspend interest in "the facts," without denying the patient's perspective, and attend to emotional meanings, to create with the patient a system that supports understanding, respect, and further personal development.

What is needed is an ability to suspend attachment to the analyst's or therapist's perspective, personal and theoretical, as automatically or at least somehow superior and privileged in favor of the kind of listening that might "inform us of something." This is a fallibilist and hermeneutic discipline at least as rigorous and demanding as the abstinence and neutrality of former years. It is not antirealistic or constructivist in the more radical sense (Moore, 1999) but rather requires us to acknowledge the reality of worlds of experience that differ from our own. Intersubjectivity theory simply reminds us that we have no privileged access to reality. It gives up the search for certainty (including diagnosis and other timelessly demarcated categories) in favor of the search for understanding.

To return to the three patients mentioned briefly above, what guesses could I make about why these intersubjective systems–sensibility treatments seem to be going so well? Two of the three have been with me for several years, and each of the three has several sessions a week. Each comes from a family that could be informally described as seriously disturbed. Each has suffered extremely painful and debilitating

psychological difficulties. What each says to me in various ways is that "this works because you treat me as a person and not as a case of something, and because you don't pretend to KNOW, and because you don't hide behind your professional role with me. You seem to be really with me." Now of course all this could be described as idealization. I am no clinical saint, and with each of these patients there have been misunderstandings and struggles as occur, I imagine, in treatments conducted according to other theories too. An intersubjective systems clinician, however, presumes that she or he has participated in the making of the problem, that the patient always has something more to teach me. I thus begin the exploration with these presumptions in my background. The patient, unblamed and ever less shamed, then has more freedom to explore what he or she is contributing, and new understanding emerges in the conversation.

In closing, I will tell you what I said to the second patient: "If I ever call you a borderline, you may shoot me." It seemed to help.

Conflicts of Interest

The author declares no conflicts of interest.

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