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**INSIGHTS FROM PSYCHOANALYTIC SELF PSYCHOLOGY  
AND INTERSUBJECTIVITY THEORY  
FOR GESTALT THERAPISTS**

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**INTRODUCTION**

This paper will examine gestalt therapy in light of clinical and theoretical insights from self psychology and intersubjectivity theory. These theories have stirred a great deal of controversy in the psychoanalytic community, and many practitioners claim that either one or both of the theories has revolutionized their approach to treatment. The theories challenge basic assumptions of psychoanalysis, and through these challenges, are moving psychoanalysis closer to humanism. Since gestalt therapy was born in part as a humanistic critique of psychoanalysis, insights from these theories offer a chance both to enrich our current clinical theory, and to stretch our own concepts to take into account psychoanalytic perspectives which have emerged since the basic concepts of gestalt therapy theory were articulated.

Any new theory brings with it a new way of understanding clinical phenomena. Self psychology and intersubjectivity theory offer clinical insights which any psychotherapeutic school might use. For instance, after one understands the concept of selfobject functions and selfobject relatedness, one never views clinical material in quite the same way again.

I see self psychology and intersubjectivity theory influencing gestalt therapy mainly in two areas. They reinforce and enrich our developmental perspective on psychopathology and therapy, and they enrich our understanding of contacting, its phenomenology, its psychic function, and its vicissitudes in the therapy process. Assimilating the newer psychoanalytic constructs may encourage a shift in emphases in gestalt therapy, moving us to focus on some of the less developed aspects of our theory.

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## **BASIC SIMILARITIES**

As both Kahn (1985) and Tobin (1990) have demonstrated, there are many basic similarities between self psychology and most humanistic therapies. The theorizing on "intersubjectivity" by Stolorow, Brandchaft and Atwood, which can be seen as an outgrowth of self psychology, has even greater compatibility. It is their thinking especially that I will be using in this paper.

The new psychoanalytic theories posit a holistic view of human nature. The holism is reflected in the centrality of "self structures" and "self-experience," which brings it close to our concept of organismic self-regulation. For our purposes "self-structures" can be translated as: "self-regulating capacities specifically pertinent to self-experience." When there are vivid, responsive, differentiated sequential gestalten, self-structures (or processes) are operating intact.

Self psychology and intersubjectivity theory focus quite radically on experience both in theory building and in the process of psychotherapy. Intersubjectivity theory even proffers itself as a "psychoanalytic phenomenology," because of its dedication to understanding both experience and the structures of experience. Both Kohut (the founder of self psychology) and Stolorow et al (the intersubjectivists) posit that a theory of human experience must be built upon concepts which are in principle accessible to experience (Kohut, 1959; Atwood and Stolorow, 1984 ). They extract and separate out the clinical theory of psychoanalysis from classical metapsychology which is inaccessible to experience. They endeavor to understand clinical phenomena not in terms of drives and mechanisms, but in terms of self-experience. The concepts of gestalt therapy, such as gestalt formation, awareness, contact, and organismic self-regulation are also "experience-near." While there is an important difference between "self-experience" and "self-regulation," in that the former is an exclusively psychological concept, the important point of agreement among the theories is the renunciation of metapsychology (drives, etc.) which cannot be checked against experience. Drive metapsychology is replaced by theory building which places primary emphasis on experience and the process (or structuring) of experience.

Intersubjectivity theory is especially compatible with field theory, as seen in the view of the nature of consciousness and unconsciousness. In intersubjectivity theory, experiencing emerges out of interactions within the intersubjective field, and behavior and experience can be understood only in the context of that field. Obviously, this perspective is compatible with our view that experiencing emerges at the contact boundary of the organism/environment field, although the concept of the intersubjective field is more specifically psychological than ours. Similar to gestalt therapy, Atwood and Stolorow (1989) point to the unconscious not as container of id impulses, but as a product of

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interactions in the field. The boundary between what is conscious and what is unconscious is fluid, and is dependent on context, specifically the conditions the intersubjective field.

Importantly, these theories share with gestalt therapy an emphasis on emotion and emotional development as central to the development of "self structures" or the capacity for self-regulation. Also, they share with gestalt therapy the view that resistances are not defenses and drives nor an attempt to sabotage one's own therapy, but rather are an expression of self-protectiveness or a self-striving, however disowned or unintegrated the expression.

Finally, all three are process theories, although gestalt therapy, self psychology and intersubjectivity theory differ to some extent on what processes are important in therapy. For instance, the psychoanalytic theories focus on developmental processes pertinent to the development of self-structures, and the theory of therapy describes relational processes and their impact on the development of self-structures (self-regulating capacities) in the patient. Gestalt theory focuses on the here-and-now awareness processes, using such lenses as gestalt formation and contacting to elucidate how the awareness process supports and refines self-regulating capacities.

## **PSYCHOANALYTIC CONCEPTS: BENEFITS AND CRITIQUES FROM A GESTALT THERAPY PERSPECTIVE**

I will define and describe certain concepts from self psychology, and critique them for their relevance and applicability to gestalt therapy. Since I view intersubjectivity theory as an outgrowth of self psychology, the reader may assume the concepts I describe also obtain in intersubjectivity theory . Where intersubjectivity theory differs from self psychology in ways relevant for our discussion (usually in ways which bring it even closer to humanism), I make specific references to the ideas of intersubjectivity theory.

As Stolorow et al (1987) describe, there are three essential contributions which self psychology makes to psychoanalysis:

- (1) the concepts of selfobject function and selfobject transference,
- (2) the unwavering application of the empathic-introspective mode of investigation as defining and delimiting the domain of psychoanalytic inquiry,
- (3) the central emphasis on the primacy of self-experience.(p. 15)

I will examine each of these contributions for its potential to enrich the theory and practice of gestalt therapy.

### **Selfobject Functions and Selfobject Transferences**

One of the field theoretical gems in self psychology is its concept of selfobject relatedness. Self structure is developed and maintained through "selfobject" ties to other people. The term "selfobject refers to an object experienced subjectively as serving certain functions...a dimension of experiencing an object in which a specific bond is required for maintaining, restoring, or consolidating the organization of self-experience" (Stolorow et al, p.16). Goldberg (1988) goes so far as to define self structure as certain resources and experiences of the subject,as well as the subject's selfobject ties. A person serves a selfobject function for the subject to the degree that a particular type of tie to the person is experienced as helping the subject maintain a stable self structure.

For instance, in the case of a typical narcissistic personality, we see someone whose self-coherence is maintained only with the selfobject support of continuous mirroring of his or her grandiose sense of self. In everyday life, our sense of common purpose with colleagues or neighbors, or even the nation we live in, is a selfobject tie in that it reinforces our temporal stability and supports a positively toned sense of self-with-other.

Kohut described three major selfobject needs which became apparent to him in the transference in therapy; mirror needs, idealizing needs, and twinship needs. We all need some people to "light up" sometimes in our presence, and to prize us and our pride and expansiveness. We need to draw strength and soothing and calm from feeling at one with someone we can idealize. And we all need people with whom we can identify as like ourselves, to reaffirm that we are a human among humans, and welcome to be so.

The intersubjective theorists suggest that most importantly, we develop firm, responsive, flexible self structure (or processes of self-regulation) through identifying with, articulating and integrating our emotions, and that others serve selfobject needs to the extent that they forge an empathic tie with us through which we are aided in the process of emotional integration:

It is our contention that selfobject functions pertain fundamentally to the integration of affect into the organization of self-experience, and that the need for selfobject ties pertains most centrally to the need for attuned responsiveness to affect states in all stages of the life cycle... Kohut's conceptions of mirroring and idealized selfobjects can be viewed as very

important special instances of this expanded concept of selfobject functions in terms of the integration of affect. His discovery of the developmental importance of phase-appropriate mirroring of grandiose-exhibitionistic experiences points, from our perspective, to the critical role of attuned responsiveness in the integration of affect states involving pride, expansiveness, efficacy, and pleasurable excitement. As Kohut has shown, the integration of such affect states is crucial for the consolidation of self-esteem and self-confident ambition. The important early experiences of oneness with idealized sources of strength, security, and calm, on the other hand, indicates the central role of soothing, comforting responses from caregivers in the integration of affect states involving anxiety, vulnerability, and distress. As shown by Kohut, such integration is of great importance in the development of self-soothing capacities which, in turn, contribute vitally to one's anxiety tolerance and overall sense of well-being. (1987, pp.66-68)

When patients establish selfobject ties to the therapist, that is, when their needs and longings for these specific relational experiences emerge in the therapy, a selfobject transference is said to exist. The notion of a selfobject transference may enrich gestalt therapy in several ways. First, it delineates a psychological, subjectively based perspective on the interrelatedness of organism and environment. Whereas Buber claims there is no I without It or Thou, self psychology says self organization is contingent on at least a minimally responsive surround. One's psychic organization is dependent not only on the individual person, but on the nature of his or her selfobject ties. Despite our own strong belief that people cannot be defined as isolated entities but only in terms of their interactions in the field, this belief so contradicts the American exaltation of the individual's autonomy, that in therapy, with our emphasis on responsibility, we sometimes forget it. Self psychology is one more support for the idea of the inseparability of person and field, and provides intricate descriptions of the subjective experience of that relatedness, as well as descriptions of its psychic function in self organization.

Secondly, self psychology describes dimensions of the therapy relationship which provide extremely useful guides for working with contact. The view of transference posited by intersubjectivity theory is a most radical renunciation of the classical psychoanalytic view; it moves boldly into the here-and-now. In fact, a reading of Stolorow et al, suggests that their view of therapy need not even include the word transference. It can be described as a process in which two people focus on the experiencing of one of the people and how the relationship impacts that person. This position is very similar to that of gestalt therapy, and obviates the need to invoke the construct of transference. See how similar their view is to our own:

Transference, at the most general level of abstraction, is an instance of

organizing activity--the patient assimilates(Piaget, 1954) the analytic relationship into the thematic structures of his personal subjective world. The transference is actually a microcosm of the patient's total psychological life, and the analysis of the transference provides a focal point around which the patterns dominating his existence as a whole can be clarified, understood, and thereby transformed.

From this perspective, transference is neither a regression to nor a displacement from the past, but rather as expression of the continuing influence of organizing principles and imagery that crystallized out of the patient's early formative experiences.

(1987, p.36)

....Transference and countertransference together form an intersubjective system of reciprocal mutual influence. (p.42)

They assert, and gestalt therapy strongly agrees, that the patient's experience of the therapy relationship is influenced both by input from the therapist, and by the patient's process of attributing meanings to the events in the therapy. The implications for treatment of understanding the therapy relationship as an "intersubjective system of reciprocal mutual influence" are not yet fully articulated in the evolving literature of intersubjectivity theory, but in my opinion they will be moving closer still to the gestalt therapy notions of I-Thou dialogue.

Intersubjectivity theory makes a strong case for reliable affect attunement as the means whereby the affect integration necessary for self-development occurs. Gestalt therapy believes another element of relatedness is central to self-development, and that is the "interhuman meeting." In the meeting, attunement, while centrally important, is accompanied by the therapist's presence. By presence, I mean that the therapist is willing to be open to a kind of contact in which the patient can touch the therapist's subjective experience, both directly and indirectly. Quite often this occurs indirectly. But at crucial points in the therapy, for instance in efforts to address serious disruptions in a selfobject "transference," or at certain developmental thresholds, the patient may be intensely interested in, and require, access to the therapist's experiencing. In my view, self-development proceeds not only through the selfobject experiences gained through systematic affect attunement, but through the experience of the attunement coming from a discernible, personal "other." While there is nothing in intersubjectivity theory which militates against such things as therapist self-disclosure, their views are at present undeveloped, and their theory might be enriched by this aspect of gestalt therapy.

Below is a case example which demonstrates the mutual exploration of the "lack of fit" between discrepant perceptions of a shared event. The following example points to a

developmental process fostered by the patient's reaction to therapist self-disclosure. Exploration of our different experiences, coupled with attunement to the meaning of the difference for the patient, strengthened the selfobject tie. To me, it illustrates how our dialogical stance, sensitively pursued, can illuminate selfobject needs.

### **Case Example**

Benjamin first came to me for supervision. At the end of the first session he requested that we meet for fifty minutes instead of my usual forty-five minute sessions. I regret to admit I acceded to his request without further exploration. I did have a sense that the request was very important for him. As I was seeing him just before my lunch break anyway, I told him I would agree to "trying out" fifty minute sessions as an experiment. (As time has gone by, I have come to see this event as a "symbolic enactment," a concept taken from self psychology. Benjamin needed some concrete example of the fact that his wishes had a place in our relationship, and he would probably not have stayed in consultation without being able to establish that fact initially)

Benjamin soon, but with great trepidation, decided he wanted to change our contract from supervision to therapy. After a few months, my schedule changed such that I did not want to meet for fifty minute sessions anymore. When I raised the issue with him he became enraged and accused me of being unfair, exploitive, etc. He said he would leave therapy rather than be treated this way. In the next session I was able to communicate to him my understanding of the significance of the issue to him. He lived in dread of being ruthlessly exploited by others who saw his needs not as expressions of his selfhood, but merely as obstacles which must be pushed aside. The five minute difference in sessions was a symbol to him that he would not be so exploited by me.

Benjamin readily agreed with the above formulation--actually it was something we arrived at through mutual exploration--and acknowledged that the five minutes was a symbol, and was actually unimportant as far as his experience during the sessions went. But he did insist that "understanding" the meanings did not obviate his need for the fifty minute sessions. I told him that the symbol and the needs it expressed were clear enough to me that I was willing to keep the sessions fifty minutes. After some reflection he suggested that we alternate, fifty minutes one session, forty-five minutes the next. He again said the time actually meant nothing, but the symbol was that if I could be trusted to take his needs into account, then he did not need to

be so uncompromising in his self-protectiveness.

In a much later session, he was exploring issues related to the fifty minute session, as he has done often. He was describing himself as a fair-minded person, and that he saw me as also fair-minded. He thought the agreement between us was a fair agreement. I told him that although I knew the agreement was important to him, I could not agree that the agreement was fair, in that I did not experience it as fair to me, despite his efforts to make it so. He was surprised by this, and asked me for my point of view, which I gave him. This included the fact that I made the agreement out of concern for his fears and his need for a concrete symbol that his fears and wishes would be taken seriously. He had assumed all along I was acting out of a "quid pro quo" sense of fairness. He was moved to discover that I might really do something out of concern for his needs. This led to more direct awareness of his strong desires to let down his guard and rely on me.

As previously shown, both gestalt therapy and the intersubjectivists would agree that the subjective world of the therapist is influencing the subjective world of the patient. The patient and I can explore together his views of the event, and his awareness of my views, and how that awareness influences him also. In Benjamin's case, it did appear to deepen a selfobject dimension of our relationship, although that was not necessarily my aim in speaking up. From a gestalt therapy point of view, this exchange enriched our contact, and also increased the patient's self-support for, and interest in, further deepening his contact with me. Thus, a developmental process was fostered.

Intersubjectivity theory offers other ideas regarding the therapy relationship which I have found quite useful. Stolorow et al suggest that the relationship (transference) has two dimensions: the repetitive dimension and the selfobject dimension. In the repetitive dimension we meet the "character defenses" with which we are all familiar. Now they can be understood as self-protective defenses brought to bear when something is occurring in the relationship which leads to a "dread to repeat," a dread that the therapist will hurt the patient in the same ways the patient has been hurt in the past when he or she has dared to reveal aspects of him or herself to others (again, one can see here how the defense is conceptualized as a protection against injury while one pursues one's development, not as a defense against a drive). As in gestalt therapy, self psychology believes such a "dread to repeat" is triggered by an actual interpersonal event in the therapy. It may seem insignificant to the therapist, but the meanings which the patient gives it make it significant.

In the selfobject dimension, a selfobject tie has been established and is said to be

working silently in the background to provide the support for self-exploration, or the selfobject dimension is in the foreground when the need to reestablish the tie emerges as the consequence of a rupture in the previously established tie. At such a time, attention is paid not only to the reestablishment of the tie, but to the function of the tie.

At times of rupture, the meaning of the tie to the patient's self-organization becomes apparent as the patient struggles with issues in two major areas, that of self-consolidation and self-differentiation. If the therapist can successfully "tune into" his or her impact on the patient, and help the patient understand, accept and clarify the trigger, the selfobject failure which occurred, and possibly the developmental (or "be-ing") striving which is being expressed, the selfobject tie can be reestablished, and the therapist, through such empathic attunement, provides a facilitative milieu for the development of more sophisticated self structures. The growing sophistication includes a maturation of the selfobject dimension of relatedness.

In my opinion, the intact selfobject tie can also be a foreground phenomenon, and explorations similar to that done to repair disruptions can also occur. It is a phenomenon which is perhaps more readily noticed and addressed in a dialogically based therapy such as ours (Stolorow, in a personal communication, agreed that although it is not spelled out in intersubjectivity literature, intact selfobject relatedness may become figural). An obvious example of an intact selfobject tie being in the foreground is when a patient feels grateful for an experience which leads to increased safety in revealing potentially shameful details of his or her life.

The selfobject dimension clarifies for us the self-regulating use of people, including the therapist. In gestalt therapy, when we see symptoms of a breakdown in the patient's self-support for contacting, we can use the notion of selfobject transference to try to understand not only how the contacting process has been ruptured, but what its meaning might be to the patient.

### **Dimensions of the Therapy Relationship**

There is, in fact, a third dimension of the therapy relationship besides the repetitive dimension and the self-object dimension: a dimension of "meeting the other." The selfobject dimension and the existential dimension are interconnected, and are both present in any contact episode. Daniel Stern's review and analysis of infant research confirms the gestalt therapy position that contacting is extant from birth. He confirms that some degree of boundary discrimination, which is the ground of contact, occurs even in newborns. But his work, and the notion of selfobject relatedness, require that we refine our understanding of contacting. Gestalt therapy tends to emphasize awareness of boundary discriminations ("appreciation of differences") when we describe contacting. While there can be no "other," no contact without such difference, often the foreground awareness of

differences derails the forming contact episode. Sometimes the differences must be a background on which exquisite and necessary experiences of unity or oneness stand.

It can be said that the confirmation which occurs in an I-Thou dialogue is an expression of the twinship aspect of selfobject relatedness (In fact, I think self psychology underestimates the importance of mature twinship relatedness in its theorizing. Much more attention is paid to mirroring and idealization as specific forms of selfobject tie than to twinship.). One is confirmed as a human among humans, which is a mature form of twinship. Mirroring is vital to the I-Thou dialogue also, although mirroring is an incomplete term to describe the bold immersion in the experience of the other that occurs in dialogue. Generally, the idealization selfobject need is not honored directly in dialogue. If you accept the thesis that for some people there is such a developmental need, then you might be influenced to be more careful about insisting, in the dialogue, that patients see you in "realistic" proportions. Rather you will allow their picture of you to develop more complexity and "human size" over time.

This is an area that needing more thought and study, but at this point I am suggesting that in a healthy contacting process multiple dimensions of relatedness operate simultaneously (the notion of multiple dimensions of relatedness is not incompatible with the new psychoanalytic theories--see especially Stolorow, 1986--but their focus has been more on articulating the selfobject dimension, thus other dimensions of the contact process remain unexamined). Certainly the selfobject dimension is present in contacting, and while it may be necessary to prevent dissolution of self-functioning, the more complete realization of one's personhood is a by-product of the "existential encounter," more clearly an affirming meeting between two confirming others. The ground for such a meeting may be the selfobject dimension, but the selfobject dimension cannot take into account the "between," that which cannot be controlled or brought about by either party alone, or because one's selfobject needs are met. The "between" of which Buber writes is only possible when people not only wish to be confirmed, but when they reach to meet, and in so doing confirm, the other. In the therapeutic relationship, I think that at times the patient's interest in the subjectivity of the therapist is just such an attempt.

### **Empathy: Entering the Patient's Subjective World**

Let us turn to the second point, the introduction of the empathic-introspective mode of listening, and examine it for its potential to enrich of gestalt therapy . The empathic-introspective mode "refers to the attempt to understand a person's expressions from a perspective within, rather than outside, that person's own subjective frame of reference."(Stolorow et al, p.15) By now, most clinicians have been influenced by Kohut's approach to working with narcissistic patients, as well as our other patients. With narcissistic patients, we attend to their subjective world quite consistently, leaving "reality

testing" and other interventions which will insult them with awareness of our separate initiative lying fallow for a very long time. We do not rebel against the establishment of those intense selfobject transferences which wreak havoc with our own narcissistic needs.

Clinical experience has proven time and again the value of entering the therapeutic dialogue through immersing oneself in the patient's experience, and then communicating, both verbally and non-verbally our understanding of the patient's experience. Carl Rogers believed this process was the essence of therapy, and has described in fine detail the psychological processes by which it works, and is so necessary. For Martin Buber, this aspect of engagement was called "making present," or "inclusion." When one is made present by another, the other has imagined as fully as possible one's subjective world, with no judgement or attempt to influence it.

Self psychology has reminded us all of the value of imagining the reality of the other as fully as possible. Intersubjectivity theory goes a dramatic step further, by insisting that the dialogue is occurring between two people, both of whom, as participating subjects, have their unique way of perceiving the world and the therapeutic dialogue, with neither having a more direct claim to objective truth than the other. Such relativism reminds us to curb our tendency toward "moral therapy." Moral therapy holds that patients have unrealistic goals and wishes, and need to be aided to relinquish their immaturity in favor of mature understanding of the unrealistic nature of their wishes.

Existentially based therapies, such as our own, are prone to the error of moralism when we fall into aiming at authenticity and responsibility as righteous values. From the point of view of mutual dialogue where the subjective knowledge of each is equally valued (and where there is no such thing as "objective" knowledge), no wish is irresponsible, it is an existent. The meaning of the wish can be explored to illuminate the patient's organization of his or her self-experience. Often, a selfobject need is being expressed, that is, a need for a specific kind of relating which would foster self-cohesion or self-development. When this process of discovery, repeated time and again over the course of therapy, takes place through "making present," or entering the subjective world of the patient as fully as possible, two major things happen. First, the experience of seeing the event through the patient's eyes diminishes the therapist's likelihood of forming value judgments. Second, the patient's experience of being "made present," or the patient's experience of having another's empathically attuned immersion in their subjective world, enables the patient incrementally to build the emotional skills necessary for the self-regulating which we would describe as authentic and responsible.

This approach is entirely consistent with major tenets of gestalt therapy. It is in keeping with the paradoxical theory of change which says that by identifying with your current existence growth and change occur. Also, our belief in self-regulation suggests that if you allow the most immediate need to emerge, then the patients can move to get the

need met, and when they find it cannot be met, they can close the gestalt by mourning the loss if they are in the facilitative environment of contact with an accepting and attuned therapist. Thus, the three concepts of paradoxical theory of change, organismic self-regulation, and unfinished gestalten can be used to support a psychotherapeutic approach which views selfobject needs as central to self development, as self psychology does, and as I think gestalt therapy should.

A second interesting aspect of the empathic-introspective mode is its relevance for theory construction. Among those who have been influenced by Kohut, there is currently debate over whether the domain of psychoanalytic knowledge should be limited to that which is in principle accessible in subjective experience. Stolorow et al propose such a limitation, whereas Wolf, Shane and Shane, and Basch, among others do not want to be so limited.

Wolf's perspective is probably closer to our own, as he proposes an oscillation between "extrospective and introspective" methods, looking sometimes from within the patient's frame of reference, and sometimes from outside the patient's frame of reference (Stolorow et al, p. 5). I am not comfortable with the term "extrospective," and prefer instead to say that we gather data through the empathic-introspective method applied to both the therapist and the patient.

Gestalt therapy concepts are experience-near; that is, they are accessible to study through introspection and empathy (or the awareness process). For us the question of whether to use an experience-near perspective for theory building has long been answered in the affirmative. But the corollary to that debate which is quite relevant for us, is whether our concepts have greater clinical utility when elucidated from the perspective of an experiencing subject, or from an "outside" perspective.

Gestalt therapy has always defined itself as an experiential therapy. One of Perls' major critiques of psychoanalytic theory was that the psychoanalytic theory of his day reduced the experience of the patient to the status of epiphenomenon. For Perls, experience and experiencing should be the cornerstone of any theory of therapy and personality. But Perls followed Freud in attempting to articulate a theory that would be acceptable as natural science. By shaping the method of investigation toward "scientific" observation rather than introspection, he restricted his ability to carry the implications of his belief in the centrality of experience to its fullest development in gestalt therapy theory.

Natural science studies the observable properties and behaviors of objects; so-called "human sciences" focuses on subjective experience. The notion of human sciences was first introduced and defined by German philosopher Dilthey:

According to Dilthey, the human sciences are to be distinguished from the

sciences of nature because of their fundamental difference in attitude toward their respective objects of investigation: The natural sciences investigate objects from the outside whereas the human sciences rely on a perspective from the inside. The supreme category of the human sciences is that of meaning, which is something that exists within human subjectivity rather than on the plane of material nature. The central emphasis in the natural sciences, as Dilthey viewed them, was upon causal explanation; the task of inquiry in the human sciences, by contrast, he saw as interpretation and understanding. (Atwood and Stolorow, 1984 p.2)

From a natural science perspective, observable behaviors such as interactions with others are studied. From a human sciences perspective, the meanings to the experiencing subject are explored. In the human sciences, both subjects become intimately intertwined, as the attempt to understand one subject from a perspective within his or her experience necessarily involves the experiencing of the other subject (for instance, using empathy to enter the patient's experiential world). Dilthey (in Atwood and Stolorow 1984), drew a parallel to Buber's thinking. The mode of relatedness in the natural sciences is the I-It mode of subject-to-object. The mode of relatedness in the human sciences is the I-Thou mode of subject-to-subject.

Gestalt therapy has its feet in both camps. While its philosophical base is Martin Buber's philosophy of dialogue (its emphasis on "inclusion" compatible with the human sciences perspective), Perls et al take as their starting point not experience per se, but the "contact boundary." Certainly the contact boundary fits the definition of "experience-near," in that it is accessible to awareness. All experience occurs at the contact boundary, the meeting point of "self" and "non-self." But there is a major difference between studying events at the contact boundary from the vantage point of observer, and studying the experiences of the contact boundary from the perspective of the experiencing subject. In fact, what one is in contact with changes based on one's observational stance, therefore the "observed" contact boundary is a different contact boundary from that of the experiencing subject.

When Perls et al state that "psychology is the study of events at the contact boundary" (1951), they are taking a natural science stance, rather than saying that psychology is the study of experience, which is the human science perspective. Psychology does have many facets, and much of academic psychology is "natural science." But I think a therapeutic psychology which puts experiencing at the center of its clinical theory--as gestalt therapy does with its theory of awareness as the key to self-regulation--must necessarily take more of a human science perspective if it is to fulfill its potential to illuminate the nature of experiencing.

Sciences are defined in part by their method of study. Psychotherapeutic method

is dialogue. The task is for the two participants to illuminate and clarify the experiencing of the patient. All experiences which emerge are influenced by the experiential worlds of both participants. This becomes increasingly true as the relationship intensifies. As we know well from gestalt psychology, experience is always organized in meaningful wholes. The therapist's world of meanings is constructed, just as the patient's is. A natural science observational stance is impossible to maintain, given the intimate interactions of the therapist and patient.

In line with a human science perspective, gestalt therapy has explicitly adopted existential values. Martin Buber's philosophy, with its emphasis on inclusion and the I-Thou relation has been adopted not only as an embodiment of existential values, but especially as a guide to the nature of the therapeutic relationship. Gestalt therapy went outside of psychology to philosophy because of the limitations of psychological theories of the day. There was no clinical theory of the therapeutic relationship which recognized its primacy as 1) the irreducible unit of personal existence and 2) the ground of self-development.

But philosophy has certain limitations for a theory of therapy. Philosophies are inherently moralistic, and in their search for universals, tend to be experience-distant in their formulations. Buber has very few experience-distant concepts--"the between" is one--, but his moralism is clear throughout his writings. Note, for example, his credo that without Thou one is not fully human. For another example, we recall his insistence that the therapist at some point meet the patient with the "address of the world." These statements have ontic significance, but when transported unmodified into a therapeutic stance they become exhortations for a patient to "be a certain way." Moralism impedes psychotherapy by attempting to shape experience or behavior along predetermined pathways, thereby interrupting the unfolding of the experience of the patient.

Stolorow et al's theory of intersubjectivity posits a more purely psychological theory of the therapeutic relationship and its primacy in existence and development. The intersubjectivity theory can inform us more thoroughly of the psychological implications of our model of the I-Thou relation. There is great clinical value in developing a purely psychological description of what Buber describes philosophically.

At first I objected to developing a psychological perspective on I-Thou dialogue as reductionistic. The reduction of ontology to psychology violated the meaningfulness given in the ontology. I now believe that a psychological (as contrasted with a philosophical), understanding of the process which Buber describes does not "reduce" Buber's philosophy, but views the experiences of the events through a different lens. A psychological description should illuminate the I-Thou relation not in its ontological significance (a philosophical construct), but as such a relationship is experienced.

From the vantage point of a clinical approach defined methodologically by dialogue

between two people, the only thing that can be known is the experiencing of the two participants. Buber's domain of investigation was the same. But he was interested in extrapolating from experience to some ideas about what it means to be human. For psychotherapy, whose domain is the experiencing pair, and whose aim is the illumination of experiencing, the extrapolation which Buber made, while inspiring, guiding and hopefully accurate, must be seen from the perspective of a psychotherapeutic phenomenology, as a reification of an experience holding neither truth nor falseness. From a psychological perspective, ontological truths exist as a particular organization of one's subjective world, not as fact. The most we can know from a psychotherapeutic phenomenology is that this is the way someone ascribes meaning to his or her existence.

Whether we refer to concepts derived from Buber's philosophy, academic gestalt psychology, or psychoanalysis, I believe that gestalt theory can be greatly enriched by a dedication to describing our concepts from a "within-subject" perspective. I think such theory development would be true to our roots as a phenomenologically based experiential theory.

The explanatory power of such concepts as the contact boundary will be greatly enhanced by more systematic attempts to elaborate them from the "inclusive" stance described above. I also think our therapy will become more precise as we attend to the differences between using an observational stance from outside the subject's perspective, and one from within the subject's perspective. For instance, we often use observational data, as well as introspective data, to assess the quality of the patient's contacting. Take for example, attention to a patient's contact functions. I have repeatedly witnessed our most skillful and experienced therapists assume that the quality of a patient's contact is poor because the therapist observes certain characteristics of the patient's behavior (e.g. "deflection"), or because the therapist feels little resonant energy, interest, etc. We tend to assume that if we feel "out of touch" with the patient, then logically the contact between therapist and patient has been disrupted. That assumption has moved us from the position of experiencing subject to outside observer. And the potential danger of intervening from that perspective, no matter how logical it may seem, is that we become arbiters of reality, and will tend to disclaim patient reports which contradict what we "know" to be "true," based on our logical beliefs about contact.

For instance, suppose the therapist says, " Gee, I feel out of touch with you now." And the patient responds, " I am surprised. I have a strong feeling of intimate connection with you right now, a sense of your deep involvement with me and what I am saying." Therapists who hew to the logical reality that the contact must be poor between them if one of them is out of touch, will also logically assume now that the patient is distorting or denying "reality."

This has at least two deleterious effects on the therapy. First, the patient's reported

perceptual experience is invalidated. After several such experiences the patient is very likely to comply with the therapist's ideas rather than suffer the indignity, hurt, or other painful affects evoked in the face of repeated disconfirmations. Alternatively, the therapy may become stalemated by the chronic disjunction between the therapist's beliefs about "reality," and the patient's insistence that his or her experience be taken as valid.

A second deleterious effect is that an opportunity to explore the patient's experience of the relationship is missed. The patient may be able to describe certain assumptions he or she is making about the therapist's listening stance which could reveal both certain fixed gestalten and the type of contacting experience that provides the patient a felt sense of intimacy with another. The mutual exploration of the lack of fit between the experiences of patient and therapist might also lead to shifts in the therapist's awareness. The therapist might discover that he or she was unaware of having been deeply immersed in the patient's words despite the more figural self-perception of being out of touch. Such a discovery will not be possible if the therapist approaches the exploration from the point of view that the patient's reported experience of contact is "mistaken."

This last point is important for gestalt therapists, who value some degree of transparency as vital for the patient's growth. A common assumption we make is that if the patient perceives (or experiences) something in relation to us which is discrepant from our self-experience, then the patient must be distorting. We again become arbiters of reality. In this case we insist we know ourselves better than the patient does, which may not invariably be true. The patient may be resonating with or reacting to something within ourselves which operates outside our awareness. Statements we make about ourselves, and agreements or disagreements with a patient's assessment of us, must be made as tentative statements of what we know to date, and cannot be used to gauge the accuracy of the patient's perceptions.

Finally, there is a heuristic value to a more systematic immersion in the patient's experience, namely that in my clinical experience, the patient is increasingly able to bring into awareness, and into the contact, more realms of previously disowned or otherwise sequestered self-experience. I have found that, in the context of a relationship where I systematically attune to the patient's experience, patients feel safer with me to explore sensitive topics, especially their painful emotional reactions to aspects of our therapy relationship.

The more realms of experience patients can bring into our relationship, the more resilient, cohesive and integrated their self-regulatory capacities--including, paradoxically, the willingness and ability to acknowledge the existence of a consensually determined reality--becomes. The two major foci of gestalt therapy are more fully developed: contacting and skill with the awareness process. The contacting is evident in the decrease in defensiveness, and increase in range of topics and affects which emerge. The skill with

awareness is evidenced in an obvious increase of interest in, and capacity for, self-reflection.

Thus again, I am arguing in favor of reworking our concepts to describe the experiencing subject rather than describe "observable reality." In the case of "contact," contacting would not be assessed by looking at patient-therapist behaviors, but the determiner of the quality of contacting would be the experience of the interaction for each of the participants. This might mean that each participant would legitimately rate a shared interpersonal event quite differently.

### **Developmental Deficit vs. Conflicts and Defenses**

A corollary to the emphasis on the empathic-introspective stance is greater attention to developmental requisites. It appears that attempting to understand phenomena from the point of view of an experiencing subject, rather than from the point of view of an observer, leads to a focus more on what one needs from the environment to sustain or develop, and less on what one is trying to "do to" another.

In my view most of the field of psychotherapy is shifting from a conflict and defense model of psychopathology to a developmental model. In many schools of therapy, the conflict and defense model holds sway, as a remnant of drive theory. In the conflict and defense model, disorder arises from conflicts between impulses, or between an impulse and the reality principle of the ego, and the resultant defenses against these conflicts. People are seen as wishing to retain infantile impulses, giving them up only reluctantly to conform with the demands of reality. In the developmental model, disorder arises when there is a poor fit between the needs of the developing person and the resources and capabilities of the environment, resulting in developmental derailments; a developmental process--e.g., the establishment of contact boundaries--has been thwarted.

Gestalt therapy has its feet in both camps again, largely without awareness. The influences of Fritz Perls and Wilhelm Reich lead us to view neurotic processes as avoidances, which is in keeping with the conflict and defense point of view. I am reminded of Perls' statement, thankfully honored more in the breach than in practice, that "The therapist's primary responsibility is not to let go unchallenged any statement or behavior which is not representative of the self, which is evidence of the patient's lack of self-responsibility."mine (1973, p.79) Actually, Perls' last book is quite interesting for how much of the material focuses on developmental requisites of self-regulation, and the respectful acceptance of needs which express one's growthful strivings. While on the one hand this book contains some of his boldest language of confrontation and attention to "manipulation," on the other hand the chapter, "Who is Listening?" is a touching, loving portrayal of the therapist as a "supplemental other," which dovetails nicely with the selfobject concept.

I think gestalt therapy's view of personality development and personality functioning makes us much more a developmental theory than a conflict and defense theory. Our humanistic belief in strivings toward growth is the opposite of the conflict and defense belief that people want to avoid maturity if at all possible, and must be encouraged to give up infantile longings. There is such a thing as conflict, but I think we will be truer to our theory to view conflict as a subjective experience which is either acknowledged or denied. This is what the intersubjectivists propose. Given our adherence to the phenomenological method, I think their idea fits well for us also.

What is the implication of all of the above for the practice of gestalt therapy? In my own practice, my foreground has shifted. Where once I saw defenses and avoidances, I now usually see developmental strivings, however awkwardly or conflictually pursued. If I look at the same behavior from the two different perspectives, I arrive at two differing intervention styles as well. The defense model permits, perhaps encourages, confrontation. From the perspective of developmental strivings, confrontation is generally less appealing. There are exceptions. There are times when confrontation enables patients to become aware of, and honor, their selfobject needs. There are also times when a confrontation is experienced as meeting a selfobject need (see esp. Lachmann, 1986), as in the case of Benjamin I described earlier.

However, confrontation generally tends to be experienced as a lack of empathic attunement, and that is the experience which tends to lead patients to abort their strivings. Thus, I am applying new meanings or hypotheses to what I see, and I am much more likely to lead with an attempt to see the experience through the eyes of the patient rather than to be confrontive.

### **Case Example**

Let me describe a case where I was at first confrontive, and now regret it. By the way, I am not suggesting that adherence to gestalt therapy led me to handle the situation as poorly as I did. Rather, I am saying that however I came to make my mistake (there were characterologic sensitivities which influenced me, actually), self psychology helped me to better understand some of our own concepts so that I could reorient my work with this patient.

Pam, is a good story teller, interesting and articulate. For many months she wanted to tell stories of events in her life, large and small, and obtain my help in teaching her "how to cope." As time went on I began to assume that her stories were an avoidance of deepening emotional contact with me, and with her own experience. In fact she does carefully titrate her involvement with me. At times I asked her to explore her storytelling, and at times I confronted her on her avoidance. At one point I asked her to

experiment with telling no stories.

She felt quite hurt and angry at the suggestion. Three years later, despite progress in other areas, she is alternately defiant and apologetic about telling stories, and worries that I will reject her again. Recently, I began to see the stories from the point of view of developmental strivings. In one session, we explored how she seemed to organize her psychic life around her relationship with her quite domineering father. Influenced by the notion of selfobject ties, I began to see Pam's confluence with her father as an attempt on her part to regulate her sense of self-coherence. Without him to organize around, she felt lost, confused, empty. In that same session, she complained that organizing herself around her father left her feeling invisible in her own right. It then emerged that her stories were an attempt to say, "see, I exist," to claim some experiential space free from interference. In the next session she described how much she was a satellite to her father; when he wanted the TV channel changed, he would call to her. She would come from whatever corner of the house she was in, and change the channel. She experienced this as humiliating. Pam then remembered going into the kitchen to "hang out" with her mother, which was soothing. She then said it was similar to the soothing she felt in telling stories to me!

Now she is beginning, very gingerly, to deepen the contact with me through acknowledging her desires for my soothing support and my appreciation of her existence.

I hope I have illustrated here how her self-understanding--and hopefully, her self-development--was enriched as I shifted from confronting the avoidance to exploring the developmental need which was being expressed.

The above description is just one example of the usefulness of placing empathy (or Buber's term, "inclusion") at the center of our approach to therapy. It is the cornerstone on which the other elements of dialogue--therapist presence, and commitment to dialogue--stand. Without empathic underpinnings, no true dialogue can take place.

### **Primacy of Self-Experience**

The third major contribution of self psychology to psychoanalysis is the "central emphasis on the primacy of self-experience." By focusing on self-experience, the new psychoanalytic theories shift away from drive theory toward a "whole person" theory, and highlight subjective experience and the organization of the subjective experience as the

primary domain of psychoanalytic inquiry. Obviously, gestalt therapy made those shifts long ago with its assertion of the centrality of organismic self-regulation, and the awareness process as the key to healthy self-regulating.

The term "self-experience" is commonly misinterpreted to refer to a monadic, isolated "self." But for self psychology and intersubjectivity theory, self-experience is always a "self-with-other" experience, most particularly that of selfobject relatedness. Immersing oneself in patients' self-experiencing includes a constant articulation of their selfobject needs and experiences.

Obviously, a consistent focus on relational needs is closely aligned with the gestalt therapy emphasis on contacting as central to self-regulation. But there are differences in emphasis between gestalt therapy and the psychoanalytic theories. For instance, in attempting to understand the emergent experiencing of a patient, a gestalt therapist might try to identify what in the dialogic field influences the emergence of this particular figure. The added emphasis from self psychology is to define also what is needed from the therapist in order to carry the forming figure forward. The self psychological therapist might define what is needed, attune to the related affect state, and attempt to explore further the relational implications of the (selfobject) need. A gestalt therapist might, in the same circumstance, view what is needed from the therapist as an indication of a lack of the patient's self-support, and encourage the patient to experiment with ways to provide for themselves that which they are seeking from the therapist. Self psychology offers, in this case a more radical commitment to the inseparability of person/environment than gestalt therapy does.

It is in a corollary of the assertion of the centrality of self-experience that gestalt therapy and self psychology part ways most strongly. This is a difference in our view of human motivation. Both theories agree that self-development and maintenance is inextricably intertwined with others. Self psychology holds that a supraordinate motivation of human behavior is the development, consolidation and maintenance of self structure. In gestalt therapy, the notion of "creative adjustment" speaks to that motivation, but I think more fully than does self psychology. For there is more than maintenance and consolidation involved, there is growth and change as well. I know that is implied in "development and consolidation," but it is not really addressed in self psychology. In the self psychology conceptualization, people become reduced to aiming at themselves (aiming at maintaining the organization of their self experience). Gestalt therapy holds that organismic self-regulation is central, agrees that self-experience is primary (the experience of self-cohesion, continuity, differentiation, etc.), but that one is motivated toward maintaining self structure only when the smooth functioning of the self structure is threatened. Otherwise, the thrust of one's experiencing is toward "being," that is, living fully in the world of others.

In gestalt therapy, when the motivation of behavior is aimed at firming up self structure, that is a sign of disturbance in one's being-in-relationship. Gestalt therapy, based on field theory and on Buber's existentialism, holds that relatedness is a basic, irreducible fact of existence. People do not seek relatedness to maintain a self structure, but rather, self-realization is an occurrence of relatedness. It is true that relational disturbances do devitalize and disrupt self-functioning. And the path to restoring cohesive self-functioning is establishment of selfobject ties which firm up one's self structure. But the purpose of restoring self-functioning is to enable resumption of living-in-relation. In therapy there is a necessary focus on the disturbances in one's selfobject matrix as a major aspect of derailed development; so understanding and refinement of selfobject ties is a starting point for reestablishment of relatedness. It is not the end in itself, but rather a means toward multi-dimensioned, complex, full-bodied relatedness.

Selfobject relatedness may be needed all through life. But so are relations where one can "make present" and confirm another. The dimension of "meeting the other" is neglected in self psychology and intersubjectivity theory to date. They agree that self-development is intertwined with relations with others. But their psychology aims at the organization of self-experience rather than at living-in-relation. When one aims at the self, the other is missed in his or her elemental "otherness", and therefore self-development is limited.

### **Organismic Self-regulation: A Developmental Perspective**

Given the critiques listed above, I want to emphasize a major contribution self psychology can make to gestalt therapy. It broadens our understanding of organismic self-regulation, and provides a developmental process perspective. Selfobject transferences can be articulated by focusing on the need clarification phase of gestalt formation. Therapist and patient can clarify what the patient needs now, in this particular contact, in this particular intersubjective field, for reparative or growthful self-functioning. Contact means "approach toward an assimilable novelty" (Perls et al 1951). The assimilable novelty, that which is necessary for development, is at the boundary of self and other. Sometimes simply being able to articulate a need and have it empathically grasped is new enough contact. Even if what a patient "needs" is more self-support for something, one must ask what is needed from the environment, or from relatedness with another, for such self-support to develop or be utilized. Self-support is, at any rate, relatively dependent on environmental support; we are always engaged in a contacting process, so it is paradoxical that in a smoothly supportive environmental surround, one believes one is a relatively independent center of initiative.

For instance, a developmental perspective suggests that instead of viewing all boundary disturbances as defenses, they often represent developmental derailments. That

is, the disruption we see is an attempt to establish a selfobject tie, in however awkward a manner, through which the developmental path of the patient can be reestablished. Thus, instead of setting about to frustrate such an attempt, understanding the attempt and accepting its experiential validity may be providing just the contact (selfobject milieu) needed to set growth in motion once again, so that the disturbance will melt away as greater sophistication with one's boundary process occurs.

I have come to believe that a most effective way of working with boundary disturbances is not to label and explore the boundary disturbance itself, but instead to immerse myself in the patient's view of things which led to what I perceive as a boundary disturbance. If I can understand and appreciate the need (often a selfobject need) being expressed, the patient will come to firm up clearer boundaries as a next developmental step. It appears that the process of establishing the boundaries has been derailed by a lack of awareness of a need, or by a lack of entitlement to the expression of the need, and when the need is affirmed (although not necessarily met), the process of growth, including boundary development, continues.

### **Case Example**

In a supervision session, Carol reported she was angry that I had not been well "tuned in" to her during our previous session, had not read between the lines and responded to the vulnerability under her cool mask. We talked about her pain of wanting me to be able, willing, to read between the lines, and of my failure to do so. She then told of how she did that successfully with a client. At first, she denied she was sending a message to me in that, but then acknowledged thinking I should read between lines, and perhaps I did not care about her if I didn't.

I could have focused on clarifying boundaries. She wanted me to know she is vulnerable without direct contact with her vulnerability. I decided first to acknowledge, through empathic listening, the importance of her desire, and the cost of my failure to her. This brought out ideas of my lack of caring and a sense of self-diminishment. In the next phase she began to mention her growing realization that she does not (has not wanted to) know me. Thus she was able to clarify our distinctness when well attuned by me regarding her prior unfulfilled wish for attunement. She "grew into" clearer boundary process.

I believe we should emphasize more such concepts as organismic self-regulation and pragnanz, which suggests that any gestalt is organized as best as field conditions allow. One of the field conditions is developmental needs. A developmental need in

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longitudinal terms can be described in process terms as a gestalt pressing for closure. If the need expressed in the gestalt can be identified and accepted, the gestalt will close, and if one has faith in organismic self-regulation, development occurs.

Focusing more consistently on developmental needs is a movement away from the Reichian defense model of which Fritz Perls was so fond. In that defense model boundary disturbances are seen as an avoidance, and are to be frustrated. In the developmental model they are seen as best attempts at forward progress. Each view is useful at different times, or with different patients, and self psychology gives us greater sophistication with the developmental processes.

### **Summary**

Self psychology and intersubjectivity theory offer important clinical insights for gestalt therapists who wish to refine their understanding of the contacting process and its function in self-development. The concepts of selfobject functions and empathic attunement enrich our understanding of the psychic functions of contact, the experience of contact, and the multidimensionality of contact.

Our theory and clinical practice may be further developed by clarifying and exploring various gestalt therapy concepts from an observational stance within the patient's frame of reference. Intersubjectivity theory has developed more fully than we have the clinical implications of our shared belief that "reality" is always constructed, never known directly.

Finally, because of the essential compatibility among self psychology, intersubjectivity theory, and humanism, concepts from these theories may be used to build a gestalt developmental theory. We may also use the perspectives of these theories to enhance our developmental perspective by describing such concepts as contact, gestalt formation, and organismic self-regulation from the point of view of the experiencing subject.

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