

Three Relational and Intersubjective Levels in Integrative Psychotherapy

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Abstract:

The relational and intersubjective aspects of Integrative psychotherapy are essential components for achieving the goal of integration. The set of relational methods outlined in Integrative Psychotherapy, inquiry, attunement and involvement, provide a comprehensive guide for intersubjective treatment. Relational methods are important tools to help people with early relational failures, especially where those failures interfere with the development of intersubjective relating (Stern, 1985). This article focuses on three relational levels in an intersubjective context which contribute to integration: conscious verbal relating, non-verbal relating and non-linguistic or non-symbolized aspects of experience that are present in relationships.

Key words: Integrative Psychotherapy, intersubjectivity, relational psychotherapy, inquiry, attunement, involvement, individual psychotherapy.

Introduction

I have always valued the intersubjective aspects of Integrative Psychotherapy in clinical practice. The word intersubjectivity has been used in psychology with two main related meanings: a core developmental acquisition that allows social reciprocal interaction (Meltzoff & Moore, 1994; Trevarthen, 1980, Stern, 1985), and a paradigm of psychotherapy where the therapeutic relationship is seen as a co-construction (Stolorow & Atwood, 1979, 2004; Atwood & Stolorow, 1984). From my point of view, the set of relational methods delineated in the *Key*

Hole (Erskine & Trautmann, 1996; Erskine, 1997; Erskine, Moursund & Trautmann, 1999; Moursund & Erskine, 2003) provide an intersubjective paradigm of psychotherapy. The reflections presented in this article come partly from my practice of Integrative Psychotherapy in public mental health settings as a psychiatrist for children and adolescents, and also from the treatment of adults in the private setting of our Institute where training programs are also held for psychotherapists.

My work with children and adolescents with severe problems of communication and the ability to engage in reciprocal social interactions led me to focus on the use of relational methods to help them to improve their awareness of inner needs, urges, thoughts and feelings and their consideration of other people needs. Most of these children and adolescents lack proper development of their experience of a subjective self (Stern, 1985), were arrested at an experience of primary intersubjectivity (Meltzoff & Moore, 1994), and require mostly external regulation to tolerate their affects. The use of relational methods and focus on relationality with this age group is similar to our focus on the use of relational methods with adult clients suffering from early relational disruptions. Both require the therapist to be aware of his/her own experiences and the way these influence what is happening in the therapeutic relationship. This approach is different from other treatments I see every day in various public and private contexts where the client is an object to be observed, diagnosed and treated. Therapy takes place inside a relationship. As therapists, we are a “participant” audience. We participate in allowing ourselves to resonate with the other and answer in the context of a co-created relationship, and therefore work within a fully intersubjective realm.

Three Relational and Intersubjective Levels

Is it possible to achieve integration on your own? Experience shows that it is essential to have the presence of an “other” for integration to occur. It is very difficult for a person to undo, on their own, the fragmenting milestones of relational failures during childhood development. In psychotherapy, personal integration is achieved due to the presence of an “other.” However, just the presence of another person is not enough. That “other” must show a specific attitude and attunement for the integration to take place. The therapeutic relationship in and of itself must provide an answer to the individual’s needs for stimulation, relationship and structure. From this point of view, the therapist establishes a therapeutic relationship that helps provide acknowledgement of the person’s needs, helps restructure previous meanings, helps rewrite the story of his/her problems, and also offers an environment where body experiences are acknowledged and can

receive an answer. Therefore, in my clinical practice I pay attention minute by minute to three different relational levels in order to facilitate integration: the conscious verbal relating, the non-verbal relating and the non-linguistic and or “non-symbolized” aspects of experience, also known as the preverbal, never verbalized, implicit memories, presymbolic, subsymbolic, non-verbal, and/or procedural experiences, that are present in the relationship (Erskine, 2010, p. 8).

At the first level, I work with the conscious verbalizations of the patient, paying attention to how the demand for help is mediated by his/her script beliefs and conscious conflicts. Although verbal communication is really important in order to reach integration, it is not enough, and in some cases, it is not even the most important form of communication. Both client and therapist are working at the level of *verbal self*, as described by Stern (Stern, 1985).

At the second level, I allow myself to feel impacted by aspects of unconscious experience mediated through the non-verbal expression of emotions. These experiences are also known as crossed transactions, ulterior transactions (Berne, 1961) and contact losses (Erskine, & Moursund, 1988; Erskine & Trautmann, 1996; Erskine, 1997; Erskine, Moursund & Trautmann, 1999). It is at this level that unconscious intrapsychic conflicts, which most often appear at times of stress, are relieved and expressed through symptoms, which usually are ego-dystonic. Symptoms convey a symbolic message and are therefore a kind of communication. As well, symptoms arise from conflictive experiences, put into language in childhood, but later fended off by means of defense mechanisms. Both client and therapist are working at the level of *verbal and intersubjective self* as described by Stern (Stern, 1985). At this level I work with the transferential and countertransferential matrix within the therapeutic relationship (Erskine, 1991; Martínez & Fernández, 1991; Little, 2006, 2011; Martínez, 2013; Martínez & Martín 2015a, 2015b). Childhood conflicts are expressed to the “other” in the therapeutic relationship, in the form of transference, whereby experiences and messages with a specific “archaic other” is projected onto the therapist. Such transference experiences often express unmet needs that were repressed, split or dissociated. In response, the therapist has to take into account his/her own script beliefs (Erskine & Zalcman, 1979; Erskine, & Moursund, 1988; Erskine, Moursund & Trautmann, 1999) and complementary or concordant countertransference (Racker, 1972), and the way these contribute to mobilize the client transference. This might be summarized in Table I where both client and therapist may be placed as Self or Other.

Table 1

Three Relational and Intersubjective Levels in Psychotherapy

Level	Self	Other	Process	Resolution
Conscious verbal relating	Conscious experience Verbal Self (Stern, 1985)	The other as interlocutor	Working through of shared meanings.	Rewriting the story
Non-verbal relating	Unconscious experience Verbal and Intersubjective Self (Stern, 1985)	The other as a projection screen	Working through of transference and counter - transference	Unconscious conflict resolution
Non-linguistic, non-symbolized relating	Body experience which seems to be outside of the relationship Nuclear and Emergent Self (Stern, 1985) Presymbolic Primary Intersubjectivity (Meltzoff & Moore, 1994)	The other as a unifying mirror and/or stimulus regulating other	Regulation of experience	Restructuring of nuclear and intersubjective Self

At the third level, I find myself resonating to the non-linguistic or non-symbolized experience of the individual which is expressed in relationships as procedural neurological patterns, which lay within the foundation and quality of body experience at every moment of life. Client and therapist are working at the level of *nuclear or emergent self* (Stern, 1985) in order to achieve intersubjective experience.

The term “non-symbolized” (Erskine, 2010, p. 8) encompasses the pre-verbal implicit memories, pre-symbolic, sub-symbolic and procedural self-regulating relational patterns, physiological inhibitions, styles of attachment and survival reactions. At this level, we cannot properly use the term “symbolic” experience, because these experiences lack the two aspects that are characteristic of symbols, as delineated by Saussure (1971) and, Piaget and

Inhelder (1975). Symbols are in the place of something. Neurological patterns may become signals, or indexes (Peirce, 1988) if they get to be meaningful for a significant other in a relationship who gives them a shared meaning. They also may become symbolized when the interpreter gives them words.

When chronic neglect or traumas overwhelm the capacity of the central nervous system to integrate experience, individual history and time become replaced by specific patterns of neuromuscular and vegetative reactivity (Lourie, 1996; Damasio, 1999; Cozolino, 2006). This level may precede intersubjective experience. Therefore, restoration at this level is possible through an attuned response to non-symbolized needs or body work (Erskine, 2008, 2014, 2015), which helps lead the client to new areas of intersubjective experience. The therapist has to be sufficiently open to resonate with the preverbal states that are recalled during this type of therapeutic process.

In order to reach deep levels and integration of archaic experiences in therapy, it is very important that the therapeutic relationship is open to the three levels described above, through the use of empathic transactions (Clark, 1991) and the Key Hole methods (Erskine, 1988, 1989, 1993; Erskine & Trautmann, 1996; Erskine, 1997; Erskine, 1998; Erskine, Moursund & Trautmann, 1999; Moursund & Erskine, 2003; Erskine 2008, 2014, 2015). Paying attention to relational and intersubjective levels in therapy is useful, beyond analysis and resolution of conflicts, to restore the feeling of continuity, cohesion, affectivity, agency and the availability to share of the Self (Stern, 1985). This way the person can achieve a more continuous and unified flow of his/her experience. It is possible as far as we become aware that the therapeutic relationship may provide in and of itself an answer to the needs of stimulation, acknowledgement and structure of the individual.

From Impasse to First Steps

Celia is a woman of 35. She has been in treatment with me for several years. She started treatment because of panic attacks and a sense of lack of agency in life. I remember being impacted in the first interview by her slowness in talking and moving. After a big improvement and the resolution of several relationship and professional conflicts we are now at an impasse in the treatment. I feel we are immobilized and I experience in my body a kind of restlessness during the sessions that I relieve by moving in my seat. One day Celia talks of her sense of being at an impasse for some months. She feels stopped and “paralyzed” in the treatment. She talks about feeling anxiety and strange sensations in her body and

sometimes having the urge to eat in an impulsive way to alleviate her body discomfort. Celia talks about an obsession with her twelve month old baby. "I am afraid that my child is gonna be dumb because he likes running instead of being quiet while I read tales to him." When I inquire about this obsession, she tells me for the first time that she was born with a congenital hip dislocation and that she had to wear a prosthesis twenty-four hours a day until she was three years old. It prevented her from walking. At the age of three she started walking but she couldn't play or do physical exercise at school like other pupils. She then used to read instead of jumping and running with her friends. Reading has become her favorite activity and a part of her current identity and profession since becoming a literature teacher.

During the next sessions, Celia becomes more aware of the way that watching her son's psychomotor development mobilizes old body memories and sensations. She starts to observe her son's movements and delight in his growing psychomotor skills. Then she starts to follow her son everywhere and to run and jump next to him. At the same time, she explores her physical sensations at the therapeutic sessions and starts doing physical exercise for the first time in her life. Celia understands better the passivity she used to experience when needing to face life circumstances, desires, goals and especially regarding her relationships. She connects with an inner sense of physiologically being "stopped" and of having to adopt passivity and to disconnect from her body the need to move and look for stimulation in order not to feel body and emotional discomfort. After some months, she feels more empowered and more connected to her inner energy. Now she can put clearer limits on her husband's neglect and irresponsibility and enjoy her son's developmental stage.

Siegel (2006) has talked about the mutual resonance of body activation, of limbic areas and cortical representations about other's states in order to achieve increased integration during the therapeutic process. Celia's preverbal implicit memories and physiological inhibitions are now reactivated during the psychomotor development of her own biological child, and she brings to the treatment her own old childhood memories in the way of an impasse. This time, present day interactions, along with the role of the therapeutic relationship, are very important in order to facilitate the convergence of insight, awareness, transference and procedural relearning.

The Intersubjective Paradigm

In my experience, the intersubjective paradigm allows us to move the focus of psychotherapy from being not only centered in the resolution of conscious or unconscious conflicts, but also in the restoration of Self injuries, such as a failing sense of self agency, of continuity and cohesion of experience, a sense of emptiness, or a lack of affectivity. An intersubjective approach, differs from an “objective” analysis of the client, in that it underlines the difficulty for the therapist to become and remain “neutral” and “objective.” There is no way to separate the observer from the observed, for the role of “observer” modifies the observed field. This concept is now commonly accepted as a limitation of human knowledge, even within the traditional scientific method, as was shown by the work of the Noble Prize winning physicist Erwing Schrödinger who demonstrated that the results of some subatomic experiments were determined by the awareness of the observer registering them (Green, 1999).

The therapist is at most a “participant” observer in the therapeutic process. If we were not aware of this, we would be at risk of treating the client as a lonely mind about which we state some value judgments (Stolorow & Atwood, 1979, 2004; Atwood & Stolorow, 1984; De Young, 2003). An intersubjective approach analyzes the factors in the client-therapist dyad, which contribute to a co-constructed therapeutic relationship; a unique process beyond the canonic prescriptions of a given school of psychotherapy. This approach requires that the therapist takes into account his/her own script beliefs, his/her countertransference, and the way they activate the client transference. An intersubjective approach, which we as Integrative Psychotherapists share with other schools, also requires that the therapist is open to resonate with client experiences in order to work through the preverbal states that are recalled during the therapeutic process.

The therapeutic relationship is built together by the therapist and patient. Therefore, its characteristics depend on both participants in the process. As the Self only develops within a relationship (Erskine, 1991) the therapeutic relationship offers the person a chance to find words for his/her thwarted needs, leading to a fuller expression of the Self. The set of relational methods delineated in Integrative Psychotherapy provides a guide for intersubjective treatment, through the delineation of a set of clear, precise relational methods that make self restoration possible. These relational methods are made especially potent, through therapist attunement and involvement, and by the means of respectful inquiry applied once and again on deeper levels of experience.

Conclusion

The intersubjective dimension of Integrative Psychotherapy is very important in facilitating access to deep levels of experience. It requires the presence and attunement of the therapist in order to resonate with the client's experiences, and to work through transference and counter-transference. Three relational and intersubjective levels can be identified in the therapeutic relationship, which each correspond to three different levels of self and other experience. These are the conscious, unconscious and non-linguistic or non-symbolized aspects of the relationship, both from client and therapist. Each level may become more or less prominent in the therapeutic relationship at different moments. Being aware of these different levels of experience is especially important in treating relational failures from early development, where the therapy work often needs to account for preverbal implicit memories, pre-symbolic, sub-symbolic and procedural self-regulating relational patterns, physiological inhibitions, styles of attachment and survival reactions. An intersubjective approach may be useful in helping people with difficulties in social reciprocal interaction because of early relational failures that have prevented the full development of intersubjective relating.

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