

THE “SOMETHING MORE” THAN INTERPRETATION REVISITED: SLOPPINESS AND CO-CREATIVITY IN THE PSYCHOANALYTIC ENCOUNTER

Features of dynamical systems thinking can illuminate insufficiently recognized levels of psychoanalytic process. A central aspect of dynamical models is that changes in complex systems are unpredictable and arise out of the interaction of elements. Examination of the moment-by-moment micro-foreground, or local level, of psychoanalytic sessions led to the conclusion that indeterminacy and surprise are inherent properties of intersubjective systems. This indeterminacy, or *sloppiness*, comprises several interrelated features of the dialogue: “fuzzy” intentionalizing, unpredictability, improvisation, variation, and redundancy. Audiotaped transcripts of two analytic sessions illustrate how these sloppy features generate unpredictable and potentially creative elements that contribute to psychotherapeutic change.

In applying dynamical systems theory to psychoanalytic process, we have come to the view that psychoanalytic therapeutic interaction is an inherently sloppy process (Boston Change Process Study Group

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2002; hereafter BCPSG). This sloppiness arises from the intrinsic indeterminacy of the co-creative process between two minds. *Sloppiness* here refers to the indeterminate, untidy, or approximate qualities of the exchange of meaning between patient and analyst. This paper is an attempt to elaborate and explore this idea of indeterminacy, as well as its implications for the process of psychoanalysis. We will also ground this understanding of the sloppiness of moment-to-moment therapeutic process in observed features of a transcribed analytic session.

We will attempt to describe the process of psychoanalysis at what we have called the local level (BCPSG 2002). The local level is the second-by-second interchange between patient and therapist consisting of relational moves composed of nonverbal and verbal happenings such as spoken phrases, silences, gestures, and shifts in posture or topic. Each relational move at the local level is seen as revealing an intention to create, alter, or fine-tune the immediate nature of the therapeutic relationship. Any exchange will have a local level.

This approach permits a focus on what we think has been insufficiently recognized as happening in the therapeutic process. Many recent thinkers have been exploring interactive dimensions of the psychoanalytic process (see, e.g., Benjamin 1995; Hoffman 1998; Mitchell 1997; Ogden 1997). However, most relational thinkers have been concerned with the larger sweep of psychodynamic meaning and have not focused systematically on the moment-to-moment level (but see Beebe and Lachmann 2002). Examining process at the local level can be seen as a converging lens for viewing psychoanalytic process, an additional level of analysis that does not replace traditional psychodynamic descriptions at the more macro level.

New conceptual and descriptive approaches often require new terminology to capture ideas specific to them. As we began to develop our views of the moment-to-moment dimension of psychoanalytic treatment, it became clear that most of the established psychoanalytic vocabulary had strong conceptual links to the dynamic unconscious and the tripartite theory of mind. Using that vocabulary to refer to our somewhat different view of the varieties of unconscious processes often

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proved confusing rather than clarifying. We therefore found it necessary to introduce new terms into our discussion.

While our findings may have implications for psychoanalytic issues such as the reach of the dynamic unconscious, the relation between the imprecision observed at the local level and its technical handling, and the relation between what we regard as co-created spontaneous material and intrapsychic dynamic material from the past, such implications are beyond our scope here. For the moment, our approach and the descriptions that come from it will occupy our attention.

Despite the negative connotations of the word *sloppiness*, we view sloppiness as pervasive, inescapable, and inherent in the moment-to-moment level of all dyadic interaction. Rather than seeing this sloppiness as problematic, we view it as crucial to the generation of new possibilities for psychotherapeutic change. Although the sloppiness of the exchange of meaning introduces substantial uncertainty into the interaction, creating what usually are viewed as errors or mishaps, it paradoxically introduces new possibilities for increasing the coherence of the interactive process between analyst and patient. Sloppiness is potentially creative.

While dynamical systems models, which include the feature of sloppiness in one form or another, have contributed striking new insights in many areas of science (see Thelen and Smith 1994; Prigogine 1997; Edelman 1992; Freeman 1995, 1999), few theorists have considered how these models might be applied to relational processes in psychotherapy (but see Beebe and Lachmann 2002; Stolorow 1997). In exploring the implications of developmental research for psychoanalytic therapies, we have taken aspects of the dyadic, relational, and intersubjective perspectives on analysis and integrated them into a developmentally based dynamical systems view of therapeutic process. Dynamical systems models are especially well suited to dealing with complex systems with many interdependent variables. Such systems have self-organizing properties, resulting in discontinuous, nonlinear shifts in organization that are largely unpredictable. These shifts lead to the unanticipated emergence of properties that did not exist before.

This dynamical systems framework has several characteristics. First, the dynamic engine of the therapy lies in the self-organizing properties of analyst and patient together as a dyad. Second, analyst and patient contribute both individual tendencies and input shaped by others. These variables can at times be in opposition, and can at other times be

congruent or complementary. Third, the trajectory that will emerge from the interaction of the two partners is unpredictable and includes emergent properties that pop up from the interaction of the many variables. Fourth, the emerging trajectory will be sensitive to and constrained by the initial conditions of the relationship, including the relational histories brought by both partners. Such a framework includes a strong role for both organization and constraint operating within the system.

In addition to a dynamical systems framework, developmental research has pointed to the importance of nonconscious, implicit, procedural forms of memory. We have recently called attention to the importance of such implicit forms of representation in the relational arena and have termed these *implicit relational knowings*. This term refers to representations of the ways individuals relate to one another that are outside both focal attention and conscious verbal experience (Lyons-Ruth 1999; Stern et al. 1998; Tronick et al. 1998).

We do not reject the concept of the dynamic unconscious. Rather, we think in terms of a range of unconscious phenomena. Traditionally, the dynamic unconscious, construed as verbal or symbolic, and as unconscious only by reason of repression, is in psychoanalysis the only unconscious phenomenon considered “psychodynamic,” the locus of all affectively important representations. However, there is also implicit knowledge that is nonconscious, has no verbal or symbolic label, and does not require repression to remain unconscious (Stern et al. 1998). Because the implicit level represents goal-directed interpersonal action, with its strong affective valences and conflictual elements, this level is also rich in psychodynamic meaning, without necessarily being part of the dynamic unconscious (Lyons-Ruth 1999). However, further teasing apart the contributions of the implicit nonconscious and the repressed unconscious is beyond the scope of this paper. Here our task is to direct attention to the existence of the implicit level.

We find that framing the contribution of the past to the present in terms of implicit relational knowing offers several advantages. It provides a description of the past-present relationship consistent with current developmental and neuroscientific knowledge (see Lyons-Ruth 1999; Schore 1994; Westen and Gabbard 2002a,b). Cognitive neuroscience has repeatedly demonstrated the existence and separable functioning of two forms of memory, commonly labeled implicit and explicit, or procedural and semantic, memory. Developmental research has described the preverbal infant’s capacity for representing and anticipat-

ing patterns of interaction with others before symbolic or explicit forms of memory are functioning and long before any symbolic description of the interaction structure could be formulated.

While previous psychoanalytic theory has tended to equate non-verbal forms of representation with the preverbal functioning of infancy, current neuroscience makes clear that implicit forms of representation are fundamental to complex adult functioning as well as to infant functioning (see, e.g., Jacoby and Dallas 1981; Schachter and Moscovitch 1984). In addition, complex new learning occurs in adulthood through implicit mechanisms. This new learning is not mediated by translation of implicit knowing into symbolic or conscious form, even though words or images may be involved as part of the learning that is implicitly represented. Indeed, many forms of implicit knowing are about how to do things with words. Because implicit forms of memory are not initially encoded in words, the verbal form is not how the mind usually functions.

In addition, the concept of implicit relational knowing maintains a view of the dynamic unconscious (repressed) and nonconscious processing as central to affective and relational life, while freeing us from a model of the dynamic unconscious as the necessary or only way to understand the intrapsychic domain. It also frees us from the expectation that change necessarily requires verbal understanding in the sense of making the unconscious conscious. While most relational theories explain change as the result of the shared verbal understanding of patient-analyst transactions achieved after the critical interactions have occurred, our model proposes that affectively rich implicit processes can bring about change in interactive capacities in the moment (see Stern 2004). In some instances, these changes may not require that the interactants explicitly reflect on what has transpired.

We conceive of implicit relational knowing as a domain of relational memory that is constantly in the dynamical process of being reorganized with each new relational encounter. Though any two therapeutic partners have many intersubjective capacities, including capacities for interpreting relational intentions and the states of mind of the other, the capacity for creating shared implicit knowledge does not reside solely in either of them acting alone. Rather, as the therapeutic relationship moves along, shared implicit knowing and shared intentions emerge bit by bit from the co-creative relational overtures each provides the other. The dynamical dyadic system has emergent capacities

for creating new and unpredictable forms of shared implicit knowing in the interactants as new ways of being together are co-created in the treatment.

In summary, we make the following assumptions. Most of the affectively meaningful life experiences that are relevant in psychotherapy are represented in the domain of nonconscious implicit knowledge. This also includes many manifestations of transference. Therefore, much of what happens at the local level is psychodynamically meaningful, though not necessarily repressed. The fact that the dynamically repressed unconscious can also be an active influence at the local level is not our focus. We are simply calling attention to a different level of process.

In elaborating this dynamical systems model of the emergence of new forms of implicit relational knowing, we have come to focus on the moment-to-moment activity of patient and analyst. In previous work, we began by grappling with memorable moments that were “lit up” for both participants (Stern et al. 1998).

698 In subsequent work, we expanded our focus to include the quieter everyday moments of engagement between the two therapeutic partners at the local level of moment-to-moment interactions (BCPSG 2002). At this local level it became clear that change occurred in similar fashion both in the small, apparently unremarkable moments and in the “lit-up” moments of more noticeable therapeutic change. Because we believe that the local level is an important site of therapeutic action, we think that clarifying the processes and phenomena, including sloppiness, occurring at this level will illuminate additional facets of what actually happens in a psychoanalytic treatment.

Compared to the attention devoted to metatheory, that accorded the moment-to-moment level of therapeutic process has been scant. We believe this level of therapeutic activity has its own complexity, structure, and organization. It is at this moment-to-moment level that implicit relational procedures are enacted and evolve. However, our focus on the local level is not intended to imply that the background and metatheory of the psychoanalytic framework are not relevant as well. In fact, future work will need to focus on integrating the local level with the level of larger psychodynamic meanings and narratives.

**SLOPPINESS AND CO-CREATIVITY:
INTRINSIC TO THE THERAPEUTIC PROCESS**

A view of the therapeutic process as sloppy at the local level is a central observation of this paper. It has far-reaching consequences. Sloppiness expands the possibilities and variability inherent in the psychoanalytic dyad. And co-creation is the process by which sloppiness is capitalized on to generate order or shared direction in the interaction.

The analyst typically enters the treatment process with only a general and fairly abstract notion of where he or she might like to see the patient progress in relation to the resolution of conflict, the enlarging of areas of effective functioning, the reduction of anxiety, or the flexible expression of affect. Similarly, the patient begins with only very general ideas of where he or she might like to end up. Neither analyst nor patient can know in any specific detail what the two of them will need to do together to reach their goals. Indeed, both analyst and patient can only grapple with the immediate dilemma of what to do to take the next step in the interactive process. This grappling is, of course, the point at which all of the analyst's dynamic training and humanity come into play. It is here that the analyst's grasp of some healing direction, some selection of what to "recognize" in the patient's words and actions, will be operationalized. But this indeterminacy of the "how to" of therapy is inescapable, regardless of technical stance, and emerges necessarily from the irreducible fact that both patient and analyst are sources of independent agency and subjectivity and at the same time are constantly influencing each other.

The sloppiness of a therapeutic dyadic system emerges in part from a core feature of therapeutic interaction that we will refer to as *fuzzy intentionalizing*. When any two creative and independent agencies interact, a central problem they encounter is that while actions are observable, their intentions or meanings must be inferred. We would claim, along with Freeman (1995, 1999) and in line with current infant studies (Meltzoff 1995; Carpenter, Nagell, and Tomasello 1998), that this process of inferring intentions through parsing of actions is central to how the brain works, and to how we understand others. These inferences regarding the other's intentions are the raw materials from which one's own relational moves are partially crafted.

The inferring of intention, or motivational direction, is a critical issue facing any two people interacting, but looms particularly large in

a psychoanalytic treatment because of the primary focus on motivational directions. When we use the term *intention* here, we use it in both a narrow sense (What is the other trying to do now with that comment?) and in a broader sense (What are the larger meanings or goals that contribute to the act or comment?). However, the relation between the observed action, usually a verbal action in the analytic setting, and the inferred intention is necessarily loose. The parsing and translating of action into intention or meaning often requires reiteration and redundancy in interactive sequences so that potential alternative “readings” can be evaluated and ruled out. This inference and evaluation process is occurring all the time, primarily at an implicit level outside of consciousness.

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The ongoing indefiniteness in the process of inferring intention or goal-directedness in the other’s activity lends inevitable sloppiness to the interactive process. Each partner is not only putting forth actions and inferring intentions; these actions and inferences of intention themselves have an effect on shaping the actions and intentions of the other as they emerge.

This sloppiness in apprehending intentions is one source of corresponding sloppiness in the interactive process itself. Sloppiness is inherent in the nature of human subjectivity. Over time, out of a process of negotiation, the intentions of each may become “recognized” by the other at an implicit level.

This ongoing process of fuzzy intentionalizing involves a great deal of variability and redundancy at the heart of the therapeutic process. This is necessary to allow the two partners to find fitted responses to one another that lead to the emergence of a joint direction in the treatment. The recognition process at the core of our view of therapeutic change capitalizes on sloppiness, with its variability, unpredictability, and redundancy, to achieve special moments of meeting that contribute to the emergence of a new shared direction for the dyad. We have discussed this implicit recognition process in previous work (Stern et al. 1998; Tronick et al. 1998; BCPSG 2002) and will return to it in more detail in the final sections of the paper.

SLOPPINESS AND CO-CREATIVITY

Because we find that sloppiness is intrinsic to moment-to-moment relating, we needed to grapple with how it might contribute to the generation of change. It is here that the concept of co-creativity comes into play. We think of co-creation as a self-organizing process of two minds acting together that takes advantage of the sloppiness inherent in the interaction to create something psychologically new. What comes into being did not exist before and could not be fully predicted by either partner. The many sources of confusion and surprise in any interaction create the potential for unpredictable elements to emerge and be elaborated in the dyad. Nonlinear dynamical systems as seen in dyadic interaction by their nature reassemble interpersonal and mental events in ways that are not predictable and that emerge spontaneously as a function of the interaction. Therefore, interactive processes make nonlinear leaps or qualitative shifts. For this reason, new intentions, feelings, and meanings are some of the creative products of interest in a nonlinear dyadic system. Although meanings, feelings, intentions are not usually thought of as created products that pop up unexpectedly from a dyadic process, they are arguably the most important and complex products that emerge from human interaction.

We use the term *co-creativity* rather than co-construction for several reasons. The latter has connotations inconsistent with a dynamical systems model. The word *construction* implies a directed process in which preformed elements are brought together according to an a priori plan. In contrast, with co-creativity there is no blueprint for assembly. Instead the elements assembled are themselves formed during the process of the interchange.

This creativity at the heart of the microprocess of therapeutic interaction is easy to overlook. At times it may even appear that nothing much is happening. However, at the subjective level there is a sustained experience of uncertainty and unpredictability as therapist and patient attempt together to apprehend and align their emerging intentions and initiatives in the service of a sustained shared direction in the interaction. Parenthetically, it must be mentioned that not every direction that could be co-created would be healing or constructive for the patient. But this is a matter of technique and of how therapeutic efficacy is conceived, topics beyond our scope here.

CO-CREATIVITY AND SLOPPINESS IN AN ANALYTIC SESSION

We will illustrate these features of relational systems and their essential role in generating therapeutic change by looking very closely at the line-by-line process of an analytic session, using material excerpted from three successive portions of the transcript of an audiotaped session of an analysis conducted by one of us. The full transcript appears below as an appendix. Because implicit relational knowing has often been misunderstood as referring entirely to the nonverbal aspects of the interaction, we felt it important to illustrate that these sloppy features of the communication are not confined to the nonverbal domain but are evident at the implicit procedural, or process, level of the verbal exchange itself. What an exclusively verbal transcript cannot capture is that many levels of communication, both verbal and nonverbal, occur simultaneously in any two-person exchange. The coherence of these communications within and across levels is crucial to their impact on the therapeutic partner.

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Despite the psychodynamically rich nature of the themes presented by the patient in these excerpts and our belief that the local level is connected to the level of psychodynamic meanings, we will not discuss these dynamics. While any therapeutic interaction could lend itself to a discussion of psychodynamics, it also has an organization at the local level, regardless of the particular analytic technique adopted. The negotiation of intention and direction will look quite different with different techniques, but such negotiation will always be present. And the reality of the features we are describing is not apparent unless one looks very closely at this moment-to-moment level. In fact it is lost at the narrative level. We will therefore demonstrate what we mean by sloppiness in the co-creative process as it occurs at the local level, relational move by relational move. We will illustrate the process of fuzzy intentionalizing, with its associated need for variability and redundancy. We will also comment on how these features of sloppiness are intrinsic to the creation of shared meaning.

To summarize the case history, the patient had come for analysis four years earlier for recurrent thoughts of suicide as her only way to assert herself in the aftermath of a history of familial sexual abuse. The Monday session to be described followed an extra session the preceding Friday that the analyst had proposed, having sensed increased dis-

tress in the patient during their last scheduled meeting. In the extra session, the analyst suggested that the patient might have felt coerced to come, but the patient had disagreed.

In the Monday session, the patient reported two dreams she'd had since the extra meeting. Together, patient and analyst used these dreams to enter territory that was new for both of them. In the first dream, which had occurred on Friday night, the patient was in a group therapy meeting that reminded her of a sexual abuse group she had actually attended. That group had disturbed her because, by emphasizing her victimization, it made her feel worse, not better. The second dream had occurred the night before, Sunday, and contained somewhat humorous material in which imperfections of the analyst made him seem more human and normally fallible, not someone totally in control of his life. Here the patient felt that the analyst, contrary to her previous notions, was much more like she was. The next day, the patient began the session sitting up rather than lying down and said that, uncharacteristically, she felt she had an agenda of her own. In fact, later in the session they began for the first time to talk about termination in a way that felt realistic and reasonable to them both.

How did they arrive at this new territory from having begun at a point of distress? Obviously the answer lies in the full history of both analyst and patient and their previous encounters, and is not attributable solely to the current exchange. However, we will confine ourselves to a line-by-line examination of the transcript rather than attempting to have the analyst explain and clarify in retrospect his internal process. Our concepts will be used to highlight aspects of the change process that occur at the local level of the interaction and that give rise to the more visible, macro-level changes experienced by this analytic dyad.

THE CO-CREATION OF INTENTIONS IN THE THERAPEUTIC PROCESS

In the first excerpt we will focus on the co-creative process and fuzzy intentionalizing in the therapeutic interaction. We will use an example from early in the analytic session in which the pair had been discussing the first dream about the disturbing group therapy session. On Saturday morning the patient thought of phoning the analyst to say that she felt differently about him than she had felt about the therapy group. However, she decided that she could wait until the next meeting to tell

him. Below, she describes the second dream (concerning the analyst's imperfections and her feeling more like him) as a contrast to that first dream. As can be seen, the analyst does not stay with her talk about the Sunday night dream but directs her back to the idea of calling him after the dream concerning the group therapy.

**FIRST EXCERPT: WHAT DREAM ARE WE
GOING TO TALK ABOUT AND WHY?**

Patient: So there are two completely different . . . the dream that I had last night left me feeling really connected to you, and you know it made me feel—I don't know, I guess closer to you, that you would tell me you were not perfect.

(She has presented two dreams with some discussion and analysis, but at this point she proceeds with the second one. Why? While there may have been many reasons for her choice—defensiveness, closeness in time, etc.—this is an example of the indeterminacy in communication regarding the direction the person intends to take, what we refer to as fuzzy intentionalizing. Was there more to learn from the first dream? We don't know, because what she talks about, the feeling of closeness in the second dream, is where she has taken us. And even within the choice she has made, she introduces some minor uncertainties, saying things like “I don't know, I guess. . . .” These declarifications could be resistances, show a reluctance to engage the topic, or suggest a real question about what she was saying. In any case, they add to the fuzzy intentionality, or indeterminacy, in inferring where the patient wants to go.)

Analyst: Uh-huh.

(This may “mean” go ahead, but in a number of different possible ways: Because I'm trying to be with you. Because I have not yet understood enough and need to hear more. Because I don't have anything to say yet. Because I don't even know where you're headed. Because I need more time, maybe the other dream is more important. Any and perhaps all of these intentions could be in operation, making for a fuzzy mix. She gets the general idea because of convention and their past history of working together. Fuzziness is present but is not too broad or important here, yet.)

Patient: Um.

(She seems to be saying “I'm not sure where I'm going to go with this, either. Or if I do know where, I'm not sure I will go there. It's start-

ing to feel like I'll need some help." The analyst provides that help in the next line.)

Analyst: You actually thought about calling me on Saturday about this other dream.

(Here we have the first surprise, an example of the unpredictability in the sloppiness. The analyst exercises his own initiative and shifts the discussion to the other dream. In fact, not even to the dream but to what she thought of doing *after* the dream. Why? He seems to have radically altered the direction of things. Did he know why at the moment of doing it? The word *actually* stands out. It is either a request for clarification that she really did think about calling him, or a statement of his own surprise that she did. Or it could be related to his concern that he had coerced her into accepting an extra hour. In any case, his intentions are probably multiple, and not yet well formed. It turned out fine, but that does not mean he knew what he was doing at the time. The analyst's shift, his abandonment of the second dream, the one from Sunday night, is also surprising because the second dream appears to contain hotter transference material.)

Patient: Yeah!

(She works through some of the fuzziness by focusing on only one piece of unclarity. Yes, she really did think of calling him up.)

Analyst: Which would have been, uh, and the reason you were thinking of that, that kind of very real connection, was what?

(He is struggling here to find his way. He makes a number of incomplete and rapidly abandoned sorties to find and express his intention, an example of redundancy within his thinking. In so doing, he comes up with the phrase *real connection*, echoing words the patient had used in her first statement about the second dream: "really connected." He has recontextualized the phrase. He could be seen as starting to make a small and tentative bridge between the two dreams, or he might be talking about the reality of the connection between the two of them. This intention still remains fuzzy. But the phrase *real connection* is starting to become an enriched, co-created notion that will later help organize the session. The enrichment of this notion is a joint product of the sloppiness and of the attempts to find a joint direction and point of meeting in shared understanding.)

Patient: What are you referring to, the calling?

Analyst: Yeah, the calling.

(They trade attempts to reduce the uncertainty and discover/create

less fuzzy intentions. Here we also see redundancy and variations used to lock home clarifications.)

Patient: Well, because I had seen you on Friday and felt there was like a thread of consciousness that had flowed into that dream.

(She also vaguely senses some relation between the two dreams. Their fuzzy intentions are starting to converge. The sloppiness between them concerning which dream to discuss and the switching between dreams has made the relation between the dreams emerge as a theme. However, this was the original intention of neither patient nor analyst. It emerged from their collaborative attempts to clear up some of the indeterminacy.)

Analyst: Yeah.

Patient: It seemed kind of confusing to me that—I don't know how to say this exactly. It's like a throwback or something. To be dreaming about [the group therapist] and feeling that kind of pressure . . .

(Unsteadily, she goes back to the other dream, the first dream. There is a disjunctive going back and forth, another example of redundancy. In this context, the feeling of "pressure" emerges. It rises up as a new and interesting element, still fuzzy but well marked.)

Analyst: Yeah.

Patient: . . . is what I don't quite get—I mean I think . . .

(She is stumbling forward.)

Analyst: The pressure is there, isn't it? Here we come into the issue of coercion, being made to do something. And in this dream you really are being pressured to say something more. And I guess I wonder how did it, uh, connect to the fact that we had that extra session on Friday.

(He interrupts. Is he feeling a pressure, too, but with a different and as yet unclear intentionality? Improvisation enters here as he goes from the idea of pressure to that of coercion. They now have to work through the fuzzy intentions that will compose and clarify this notion. The coercion of the extra session has apparently been on his mind, contributing to his, but not necessarily her, sense of pressure. He is testing to see if there is a fit of intentions here.)

Patient: What it seems like to me is that—the dream was more connected to the idea of me feeling I have to measure up, come up with the right stuff . . .

(She says the fit with his idea of coercion was not good. The analyst was partly right and partly wrong. For the patient, the connection to the extra session was less important and is not picked up. What is

more important at this moment is that she is clarifying what pressure means—namely, to “come up with the right stuff.” The emergence of this crucial precision on her part was facilitated by the analyst’s misunderstanding, another harvest from sloppiness. Note again the repeated variations necessary to move to greater mutual clarity.)

Analyst: Uh-huh.

(Having been put back on her path, he is watching and encouraging this unexpected unfolding.)

Patient: . . . than the feeling of [being] coerced into coming here. Somehow there’s a difference somehow in there from sort of making a link with . . .

(She is refining the precision and stumbling forward. The level of sloppiness seems to have momentarily increased again. She is alone, with another, and out of this sloppiness they are co-creating something novel and something with greater clarity.)

Analyst: Yeah, uh-huh.

(He is urging her to continue to find her way, their way.)

Patient: . . . feeling coerced to coming here on Friday, which I didn’t feel, at least consciously. Because what I was feeling had more to do with [the group’s] asking me—it was like I had to be sicker than I felt. And I think that’s frequently a part of what my mind-set is when I come here, that there’s some sick part of my mind that I have to access . . .

Analyst: Uh-huh.

Progressively, out of the sloppiness, patient and analyst have co-created islands of intentional fittedness and shared direction. Through the same process, of using the co-creativity of sloppiness, these islands then coalesced to make larger spaces of shared implicit knowing. In this way the analytic pair stumble forward from the patient’s feeling that she had to be sicker than she was, the feeling that emerged from the dream of the group therapy. This is a way station toward her greater sense of agency, seen most clearly the following day, when she began the session sitting up.

To sum up our understanding of this set of transactions at the level of implicit process, the patient has recently articulated her recognition of the need to claim her agency. She decides *not* to call her analyst Saturday morning. Then she brings two dreams in which she is connected to another person: in the first through her sexually abused, sick self, and in the other through her competent, equal-to-the-analyst self. In the ensuing dialogue patient and analyst discuss the dreams and the

patient's associations to them from the point of view of symbolic meaning. In addition, however, they are on the local level simultaneously working on the development of the patient's agency through the implicit, moment-to-moment interactions we call co-creativity. (The analyst's contribution to this task is to give the patient the opportunity to clarify what is her own experience, to not merely accept his direction, an illustration of technique in the scaffolding of the patient's agency.) In a sloppy process of trying to find a fit with each other, they negotiate shared intentional directions and local-level meanings. Although this might be viewed as merely facilitating the patient's developing agency, our view is that such facilitation is part of the co-creative process that led to changes in her sense of agency.

Out of this activity, more complex symbolic meaning and intentionality emerge. These more complex meanings include that of the patient being connected to another person through a positive sense of self, equal, while at the same time being aware of angry, helpless self-experience—"the sick part of my mind"—that she is still struggling to manage. The intentions that emerge include the beginnings of her own agenda and the confidence to assert it.

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How does the co-creative, sloppy nature of the local-level process operate in this segment to contribute to change? It is in the implicit jockeying back and forth, patient and analyst checking out at each step how much each can contribute and respond to the emergence of a new shared direction, that a new shared meaning is co-created (this, rather than change in symbolic meaning leading the way through shared understanding of the patient's dreams and associations). As patient and analyst search for a fit with each other, while at the same time referencing their own agendas, they are co-creating a shared intention. This new intention reorganizes and recontextualizes each of the old agendas in the process of its emergence (for related data on the recontextualization of previous perceptual experience by new experience, see Freeman 1995).

It should be noted, however, that the problem of arriving at a shared direction is more complex than simply decoding the ambiguous communications of the other. The deeply relational nature of the human mind (Bruner 1990; Dilthey 1976; Husserl 1930; Lakoff and Johnson 1999; Modell 2003; Feldman and Kalmar 1996; Stern 1985; Vygotsky 1934) means that an intention or motivational direction is not simply a thing in one person's mind that is conveyed to the other. Instead, joint intentions or directions for the next steps in the relationship are co-created, negotiated

between partners on a moment-to-moment basis. What we usually think of as solely within the person is not internal and fixed but is continually co-created in interaction with another. Each partner is both putting forth actions and inferring intentions, which have an effect on shaping the actions and intentions of the other as they emerge. Not only is the communication of intention by each partner ambiguous, but those communications are constantly shifting and adjusting based on the feedback of the partner and the possibilities sensed by each of finding a shared direction for their exchanges. The expression of a relational intention, then, is not a simple one-person act but an emergent property of the interaction itself. Finally, the mental complexity and agency of each of the participants inevitably introduces unpredictable and improvisational elements into how any joint direction will be worked out. The essence of the therapeutic interaction can be seen to be this joint negotiation and co-creation of intent or direction.

SLOPPY PROCESSES, UNPREDICTABILITY, AND VARIABILITY

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We have noted that co-creativity is the upshot of an unpredictable, improvisational process and that fuzzy intentionalizing depends on variability and redundancy. We do not mean to imply that everything that happens in a session is unpredictable. Rather, we emphasize that the interplay of two subjectivities inevitably throws up unpredictable and surprising phenomena at the local level.

Let us look again at the clinical material in light of these multiple sources of new elements in the interaction. The patient has been talking about the second dream, in which the analyst seemed more like her. In this segment there are two extended silences, one for eighty-three seconds and one for sixty-eight. What is notable in relation to our focus here is that the outcome of each is unpredictable, variable. One cannot know how long each will last, who will end it, or what will happen afterward.

SECOND EXCERPT: HOW DO WE KNOW WHERE WE ARE GOING?

Patient: In the dream, it made me feel stronger.

Analyst: Yeah!

(He seconds her thought.)

Patient: It made me feel more . . . equal to you . . . [83-second pause]

Analyst: Is that something that's happened nowadays?

(Is there something about the idea of her being equal that gives both of them pause? Or is it the analyst's recognition that it is the patient's moment to take the initiative that sets the stage for the pause?)

Patient: Uhh . . . I think to some extent . . . my feeling is beginning to change about . . . about that. I wouldn't say that . . . I don't think it's a done deal [chuckles] . . . Umm . . . One of the things that I was thinking about on Saturday as I was thinking about calling you was that I, I was convinced in my own mind that I could call you and that I could tell you about that dream and it would be okay. So somehow that made me feel like I didn't have to do it.

(She is saying that she now recognizes that she had the agency and didn't have to prove it.)

Analyst: Um-huh.

(She shifts in a way that the analyst couldn't have predicted to focus on the thought of a Saturday call.)

Patient: You know I didn't have to prove anything so . . . so I didn't do it.

Analyst: Um-huh.

Patient: You know it was enough, it was enough to acknowledge to myself that I knew I could pick up the phone and tell you about it and that could be interesting, but I could also [brief chuckle] tell you about it today.

Analyst: Um-huh.

Patient: And I mean there's something in my viewing it that way, my viewing that it was okay to call you that makes me feel we're more equal . . .

Analyst: Um-huh.

Patient: . . . than unequal.

Analyst: Uh-huh . . . [68-second pause]

Patient: In the dream, um, the dream last night, I was feeling like, um . . . I don't know how to say it was exactly, the word *acceptance* keeps coming into my . . .

(She has broken the silence with the new idea of acceptance. While it relates to and expands on the idea of connection, it introduces a variation.)

Analyst: Um-huh.

Patient: . . . head. It was like I was feeling accepted . . . the way I am, and . . .

(She repeats the idea of acceptance, after the analyst's assenting um-huh, in a second initiative that underscores her interest in moving in this direction.)

When the patient introduces the idea of acceptance, a shift in the intersubjective field has occurred that could not have been predicted as an outcome of the silence. One can see that there is no consistent narrative structure at the local level, and no way to tell what would follow any of the relational moves. Even the most insightful analyst cannot know what the patient will say in the very next sentence. Even if the general topic is clear, the exact form it will take is unpredictable. Yet the exact form of what the analyst says will create the context and thus influence what happens next. This important feature of what actually happens in the therapeutic process is not revealed by a focus on dynamic unconscious meanings.

To take this unpredictability into account, one need only attempt to consider that what *did* happen is not what *had* to happen. Many things *could* have happened. At any point, guided by the meaning the moment had for either, either patient or analyst could have made a different relational move that would have changed the path of their interactional flow. The presence of co-creativity and fuzzy intentionalizing in the therapeutic interaction means that any particular relational move could have been different. There are many equally valid and effective pathways for the dyad, many of which might arrive at roughly the same destination. In biology and developmental psychology, this equivalence of diverse and idiosyncratic pathways is called the principle of equifinality.

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THE REDUNDANCY OF SLOPPY PROCESSES

Despite this unpredictability in the precise path to be taken in the therapeutic interaction, analyst and patient convey meanings, develop implicit knowledge of how to be together, negotiate mutual directions, and feel connected with each other. With the conveying and inferring of intentions being such a fuzzy, unpredictable, and variable process, how does any individual come to know what meaning has been expressed? We felt the key to this puzzle lay in the recurrence and redundancy that characterize interactions. To state the case more strongly, an

enormous amount of time in treatment will necessarily be spent in repetitions, variations on a theme, restatings, so that intentions will be optimally inferred and collaborative directions can emerge.

We have noted that sloppiness, which is intrinsic to intentionalizing, is both variable and redundant. This iterative process characterizes the bit-by-bit exchange and negotiation of meaning. We see this again near the end of the first excerpt, where patient and analyst discuss which dream they are talking about. At this point the patient is talking about the “sick part” of her mind that she had felt pressured to discuss.

THIRD EXCERPT: WE NEED TO DO THIS IN MANY DIFFERENT WAYS

Patient: . . . feeling coerced to coming here on Friday, which I didn't feel, at least consciously. Because what I was feeling had more to do with [the therapy group's] asking me—it was like I had to be sicker than I felt. And I think that's frequently a part of what my mind-set is when I come here, that there is some sick part of my mind that I have to access . . .

Analyst: Uh-huh.

Patient: . . . in order to be talking about the right thing. You know, there's some pathological thing in my head that I have to be able to . . .

(She reiterates the sense of having to talk about the sick part of her mind.)

Analyst: Yeah, and that *is* something that you feel here sometimes.

(He emphatically agrees with her about the experience between them.)

Patient: Yeah.

(She says, yes, you're getting it.)

Analyst: So the dream is also about coming here, the pressure to get this sick part of your brain out in the open.

(By strengthening and clarifying in her own mind through the exchange what she had meant by pressure, the patient has helped the analyst *get* the idea that the pressure is about discussing the sick part of her, not about feeling coerced into the Friday appointment. His *getting it* has strengthened her sense that her initiative can enable her to make herself understood.)

Patient: The thing that is really confusing to me is that when I was in that group with [the therapist] the thing that was so impossible

for me was to feel convinced that my experience was somehow . . . comparable to the other people in the group.

(She's repeating the sense of feeling pressured about the "sick part of her mind," this time by saying she felt different from the other group members, who were more inclined to focus on their victimization and who seemed to feel more damaged by their abuse experiences.)

Analyst: Yeah.

Patient: And I just could not feel that . . . I first of all didn't understand why anybody would want me to think that. What good does it do me to think that?

Analyst: Huh.

Patient: I don't know. I get confused. You know, when I came to see you what I wanted you to tell me was that I was sicker than I thought I was and that it was okay for me to be here.

(Now she directs their attention to the way she and the analyst talked about the "sick part" of her in their first meetings: to be connected, one must be sick. Therefore, she had to exaggerate her "sickness," an earlier manifestation of the sense of pressure. She is indirectly referring to her sense that in those early meetings the analyst had also helped her retain focus on the positive parts of her self-experience.)

Analyst: Uh-huh.

Patient: And then, with that group and with [the group leader] it was like, oh yes, you're very sick. [chuckles] You've got this really horrible thing wrong with you. And I'm thinking it's not really that bad! It was like two very opposite experiences.

(Now she shifts the focus back to her experience in the group, in effect coming back to the topic of the first dream, feeling pressured.)

Analyst: Uh-huh.

Patient: [longish pause] And I think there is still some issue for me in my own perception of my self, about whether I want to be sick or not. I mean I can't, I haven't quite figured out how to make that scar fit in to my image of myself. [another long pause] And because of that, every time I come here I feel like I have to come with that wound, that gaping wound being the most visible thing. If I'm actually feeling in touch with the way my life is now [i.e., without that a sense of a gaping wound], then I don't know what to say to you, there's nothing to talk about. You know, you'll ask me why I'm here.

(She's not sure, but it's becoming clearer that they are discussing the extent to which her "perception of herself" contains only the "sick"

part of her. From the beginning of this excerpt, the two of them have been looping around her feeling of pressure to focus on the “sick” part and have expanded the issue. She wonders, can they be connected with her not being sick? Within a few minutes, they have moved to talking more about the second dream and her feeling “stronger” and “more equal.”)

How in this brief exchange did they come to “agree to” what their shared intention was? It was not explicitly articulated. The key to this joint accomplishment lies in the recurrences in the patient’s and analyst’s statements. These recurrences are not redundant in the sense of being unnecessary or boring. The cycling of the pair’s recurrent turn-taking is crucial to how they co-create a shared relational intention. It is an exploratory process of slow, incremental steps toward co-creation of shared meaning and shared direction.

There are several reasons why this redundancy of relational moves is necessary. The objective behaviors making up the relational moves during each turn-taking step can only partly convey each partner’s emerging apprehension of the joint direction. The behaviors do not map the intention in a one-to-one fashion. The mapping is sloppy. We also see in this vignette how the same intention can be conveyed in a great variety of ways.

In addition to the inherent variability of the expressive and receptive processes, here we can see that intentions are most often not fully formed and are therefore often tentatively expressed. The recipient’s comprehension of the emerging intention is similarly partial and hesitant. Therefore, implicit questions are communicated between the partners in forms like “I want to talk about X, but do you? And can we talk about it, given the way we are together? And what shape will the intention take as we begin to jointly articulate it?” This expression of a relational intention is not simply a yes or no. Rather, it demands a series of responses from the other person as the two continue to negotiate and form the intention. In turn, each response is not simply a go-ahead yes or no, because it too demands a response (“Yes, I do, but do you, really?” or “I am not sure I get what you want” or “Is this the sort of thing you had in mind?”). The first person needs to respond again, and so on, recurrently. Out of the recurrence in their exchange, the shared intent emerges. This view of a sloppy, redundant, co-creative process gives us a way of modeling more specifically how relational intentions are created by dyadic systems. When the analyst “got” what the patient meant by

pressure, she also became clearer about it herself and moved on to say how with the analyst she felt differently from how she had felt with the group. The change in the analyst catalyzed a change in the patient. Her being able to facilitate the analyst's understanding heightened her own sense of communicative competence, an altered sense of self.

Redundancy overcomes the inherent variability of the expression and reception of a relational intent. It is a bit-by-bit process that not only clarifies each individual's sense of the emerging intention of the other person but also catalyzes the creation and consolidation of each partner's own intention. When recurrence is successful, a co-created shared intention or direction of interaction emerges. Although we view the individual as a source of primary activity, organization, and intentional direction, the emergent directions of the individual are continually selected, reassembled, recontextualized, and redirected by the relational context. Functionally speaking, then, the relational unit is the crucible in which "individual" intentions are forged as part of participating in a joint direction with another. Paradoxically, the only way to become oneself is through participating in shared intentional directions with others.

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SLOPPINESS, CO-CREATIVITY, AND THE PAST

Although we speak of intentions as co-created, we do not mean to imply that they are created *de novo*. *De novo* creation denies the past and the carrying forward of the past to relational possibilities available to each individual. The influence of the past on the present has been framed in several ways. For example, in earlier theory, the past was viewed through the lens of representations or meanings formed at the time of the events themselves. In one set of more contemporary views, the past is viewed as a narrative construction of the patient that is subject to change as a function of the therapy (Schafer 1992). In our view as well, the organization derived from the past, though influencing the present, is also being continually updated. Our conceptualization departs from the narrative approach in most other aspects, however. The narrative approach operates at the explicit level of conscious, reflective dialogue and views change as occurring through the dialogue in the therapeutic session. In contrast, we do not conceptualize the updating of the past as operating primarily through explicit narrative processes. Instead, in keeping with current models of brain function

(see, e.g., Freeman 1995; Edelman 1992), we view implicit relational knowing as being automatically or implicitly updated in small ways with each relational encounter, rather than as operating primarily through explicit narrative exchanges. Each time an aspect of older internalized models is accessed in the treatment, those past organizations are subtly reorganized by the present context of interaction between patient and therapist. In our view, the accumulation of many small changes in implicit relational knowing in this new context, these subtly shifting organizations, influences behavior outside the treatment situation. The recontextualization and reorganization process occurring at the local level is subtle and occurs in tiny shifts that would not be easily visible until they have accumulated in the treatment.

The creative process we delineate at the level of primary moment-by-moment interaction does not vitiate the influence of the past on the present interaction; instead the past configures the present moment through the constraints contained in the implicit relational knowings that both partners bring to the encounter (i.e., transference and counter-transference). As noted earlier, these knowings include expectancies derived from the individual pasts of the two participants and expectancies derived from their joint history of encounters with each other. Thus, the co-created parsing of a highly variable flow of behaviors into mutually shared relational intentions is contextualized, and in part made possible, by the dyad's already created implicit relational knowings, knowings that in turn draw on each participant's past outside the dyad.

This implicit relational knowing includes implicit knowing of how analyst and patient have been together in the past and their implicit and explicit goals, both short- and long-term. The following illustrates how their history together can be seen in the material.

Analyst: Is that something that's happened nowadays?

Patient: Uhh . . . I think to some extent . . . my feeling is beginning to change about . . . about that. I wouldn't say that. . . . I don't think it's a done deal. [chuckles] . . . Umm . . . one of the things that I was thinking about on Saturday as I was thinking about calling you was that I, I was convinced in my own mind that I could call you and that I could tell you about that dream [about the disturbing group session] and it would be okay. So somehow that made me feel like I didn't have to do it.

(Despite reassurances, calling between sessions was something she felt she shouldn't do, and had done on only one occasion.)

Analyst: Um-huh . . .

Patient: You know I didn't have to prove anything so . . . so I didn't do it.

Analyst: Um-huh.

Patient: You know it was enough, it was enough to acknowledge to myself that I knew I could pick up the phone and tell you about it and that could be interesting, but I could also [brief chuckle] tell you about it today.

Aside from the fact that the telephoning between sessions had a mutual meaning for this patient and analyst, the patient's chuckle also communicated shared knowledge—for example, of the way they both frequently used humor, often of this mildly self-deprecating kind, to ease tension. When she chuckled, they both knew implicitly that he would understand that she was trying to ease tension. This shared awareness affects the analytic interventions—whether to interpret the turning away from negative affect, or whether to appreciate the patient's self-regulatory activity as having the goal of continuing to explore challenging issues in the hour. Another instance of this kind of shared implicit knowing is the way the analyst's um-huhs were understood by both of them as meaning "Yeah, go on."

However, even though we view each individual as having a past and as bringing a set of potential ways of relating into the new encounter, we see the dyadic situation as dominating the past events. In our view the way the past of the two participants influences their interactions is the way transference and countertransference expressions present themselves in this model. It is the present interaction of the participants that recontextualizes the transference manifestations of the past. The current dyadic direction will continually select from the past of each person those elements that will be used to fashion a joint direction in the dyad. And those elements will be rapidly recombined into new, jointly created elements of process between the two parties. The creative elements of the therapy will often overshadow the static elements that depend on the past, to the extent that the two parties begin to construct a joint direction. We believe that the center of gravity lies in the interaction between two parties, not in the individual past of either person. In agreement with current views of memory, we believe the present moment contextualizes what will be remembered but also transforms that memory as it is recontextualized in light of the present interaction (Freeman 1995; Edelman 1992).

CO-CREATIVITY AND THE NEED FOR A RECOGNITION PROCESS

Some obvious questions arise about so sloppy and variable a dyadic system. How does it arrive at adequate resolution to move on? What is the punctuation of the relational exchange? How do patient and therapist sense when they have successfully joined in an intentional direction? How is it that some relational initiatives between patient and analyst are selected to be repeated, followed up on, and elaborated and others are not? Here Sander's work on recognition process (1980, 1997; see also Weiss 1947; Lyons-Ruth 2000) served as our guide. He has repeatedly examined the problem of accounting for directionality in human growth and development and sees both biological and psychological organization as directed toward increased coherence of adaptive organization.

By *recognition process* we mean the sensing by both parties that a specific fitting together has occurred in their responses to one another in the service of moving toward shared goals. Sander has pointed out that the essential characteristic of these moments is that there is a specific recognition of the other's subjective reality, or intentional direction, at several levels simultaneously. Each partner grasps and ratifies a similar version of "what is happening now, between us," by providing a specifically fitted response to the other's initiative (Stern et al. 1998).

Sander's view of recognition process at the level of self-awareness can be extended to encompass this kind of specific fittedness at an implicit, unarticulated level, with no implication of awareness or consciousness. For example, in Sander's classic frame-by-frame film analysis of a father and an infant, the infant falls asleep in the father's arms at the moment of a specific fittedness between the father's actions and the self-organized sleep processes of the infant. The implicit recognition that comes with specific fittedness serves the same function for patient and analyst. When fittedness of intention is achieved, a coherent shared state of intersubjectivity emerges, together with a sense of shared direction. Recognition process is the joint apprehension of this dyadic state.

This recognition of the fittedness of one person's initiative is most often conveyed by a responsive move on the part of the other, a move that when successful builds on the previous move in a way that deepens the dialogue in the service of the collaborative goals. Both

partners sense the fittedness of their actions to the relational potential of the other and hence to the potential achievement of more complex and more collaborative ways of being together. Recognition process is in this sense the directional element of developmental and clinical process; it is how we feel our way along in unscripted relational encounters.

Sufficient fittedness is most easily defined in terms of what happens next. Has it permitted a change in direction, a shift in felt coherence, a vitalization? This functional definition raises the problem of intrinsic and extrinsic criteria for knowing when fittedness is achieved. The actual criteria of sufficient fittedness are so fluctuant, so relative to such happenings in the past, that it is a constantly moving set point.

Two illustrations of how fittedness and recognition are ratified are seen in the transcript. The first comes toward the end of the first session of the week, after the patient speaks of the uneasiness she feels with the feeling of acceptance.

Patient: It was like I was feeling accepted . . . the way I am and . . . there's something about the feelings that go along with that, that make me afraid, and I start to feel afraid of being hurt, when I notice that I'm letting my guard down, or something—and, you know, one of the things that is disturbing to me is that I'll wake up with that feeling of being accepted and then as soon as I'm conscious of the fact that it's a dream I start to feel afraid of the feeling. It's like I don't really want to feel that with you.

Analyst: Huh! . . . Somethin's scary.

Patient: Yeah.

Analyst: Yeah.

When the two echo each other with “Yeah” and “Yeah,” we see the shared acknowledgment of their shared state.

Another example of the recognition process can be seen at the beginning of the second session of the week, after the excerpted session. It began very differently, with the patient wanting to sit rather than lie on the couch. For the first time, she began talking while sitting up on the couch and looking at the analyst.

Patient: Today I somehow don't want to lie down right away.

Analyst: Well, that's a change!! Can you say what's happening?

Patient: I'm not exactly sure, but somehow I feel like I'm more aware of what I want for myself. It's like I have my own agenda.

Shortly after that, she lay down and continued to talk about this feeling of being in a new state with her analyst.

Patient: Today it feels a lot more connected here . . . because it feels like I'm opening up something to you . . . in a voluntary way. It's like, you know, I'm in control of what we're talking about, in a way that I don't usually feel. It's like I have an agenda today.

Analyst: [wryly] It's hard to have agendas other days?

Patient: Yeah!

The two then burst into laughter, enacting a sense of shared fittedness of initiatives. This shared recognition of fittedness is the period, or sometimes the exclamation point, that marks the creation of a new joint intention that contextualizes the interaction. When this recognition occurs, a new phase of exploration can begin. In fact, it did later in the session when for the first time the two began to realistically discuss termination.

THE SLOPPY PROCESS OF THE LOCAL LEVEL AND OTHER VIEWS OF PSYCHOANALYTIC PROCESS

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Of course, the clinical material presented can be considered from many perspectives. Our goal in viewing the material here was to examine the local level of interaction, where the process of negotiating a shared intention comes into focus. Other theories, where the focus is on the narrative level, might find in it the unfolding of an existing narrative, or unconscious fantasy about ambition, or conflicts about aggression, or the exchange contributing to the emergence of a sense of self. They might focus on the transference meaning of these developing themes in the therapeutic relationship. They might understand the intensification of affect in the analytic process in terms of an underlying fear of aggression that free association has revealed. Then they might identify insight as the mechanism through which the conflict is resolved and fear is diminished. In addition, the analyst who has integrated these many alternative readings of possible intentional directions for the patient-analyst interaction may have more possibilities for helping the patient. However, we feel that the analyst's openness to the sloppiness of the therapeutic process and the need to join directions with the patient through a process of dialogue and negotiation is necessary to the successful emergence of a shared direction and therefore to a successful analysis. The local level of the patient-analyst dialogue is the crucial matrix for this process of creation and recognition.

We could also consider alternative paths from the point of view of the analyst's activity. The analyst might have chosen to give priority to free association and so not have interrupted the free-associative process with his comment early on about the patient's thoughts of telephoning him. Similarly, he might have analyzed the patient's defensive departure from free association in the two quite long pauses, perhaps by inquiring about what happened at the point she fell silent. Alternatively, he might have chosen to return to the dream to analyze transference issues such as conflicts about dependent longings, sexuality, and aggression. Or he might have chosen to elaborate her fantasy of being "very sick" as an avenue into intense affect in relation to a self-representation as sexual and as aggressive, bad, and damaged. Finally, but not exclusively, he might have worked in displacement to explore transference reactions, as through a focus on the therapy group and its leader. All of these approaches may inform the analyst's work. Whatever approach is taken, however, it is inescapable that every analyst is simultaneously interacting with the patient at the micro level. And any approach will have implications at this level. It cannot be ignored in any view of treatment, whatever the orientation. It has changed our clinical sensibilities.

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SUMMARY AND CONCLUSION

We have explored the sloppiness that is an inherent property of the two-person intersubjective dialogue at the local level. We find it to be an enormously interesting and productive aspect of a dynamical systems model of psychoanalytic treatment. It is also an essential element of the co-creative process that leads to greater intersubjective coherence. We view sloppiness not as errors or mishaps in the dialogue, but rather as a generator of potentially creative elements that may alter the direction of the dyad's evolution in unexpected, even previously unimaginable, ways.

Where do the novel elements come from in the analytic process that make it such a surprisingly specific journey? One could say that sloppiness is to a two-person psychology what free association is to a one-person psychology. They each add the unexpected specific details. They create the surprise discoveries that push the dyad to its uniqueness. However, there is also an important difference. Free associations are assumed to lead to and from pre-existing networks of meanings.

Sloppiness, by contrast, is not part of any established organization, even though it, too, is influenced by the past.

Sloppiness, like free association or other unanticipated “pop-up” events, can be used creatively only when framed within a well-established therapeutic system or within a well-functioning dyad. Without the direction and constraints of those dyadic systems, the improvisational elements can veer toward chaos.

We have demonstrated with audiotaped transcripts of two analytic sessions several examples of sloppiness and its associated features, and have suggested how these features may advance the co-creative process of psychotherapy. This view contributes to the emergence of a relational theory of psychoanalysis based on a dynamical systems model and provides descriptions of how such sloppy dyadic processes work to create psychoanalytic change.

APPENDIX: SESSION TRANSCRIPTS

Day 1: Monday

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Patient: So there are two completely different . . . the dream that I had last night left me feeling really connected to you, and you know it made me feel—I don’t know, I guess closer to you, that you would tell me that you were not perfect.

Analyst: Uh-huh.

Patient: Um.

Analyst: You actually thought about calling me on Saturday about this other dream.

Patient: Yeah!

Analyst: Which would have been, uh, and the reason you were thinking of that, that kind of very real connection, was what?

Patient: What are you referring to, the calling?

Analyst: Yeah, the calling.

Patient: Well, because I had seen you on Friday and felt there was like a thread of consciousness that had flowed into that dream.

Analyst: Yeah.

Patient: It seemed kind of confusing to me that—I don’t know how to say this exactly. It’s like a throwback or something. To be dreaming about [the group therapist] and feeling that kind of pressure . . .

Analyst: Yeah.

Patient: . . . is what I don’t quite get—I mean, I think . . .

Analyst: The pressure is there, isn't it? Here we come into the issue of coercion, being made to do something. And in this dream you really are being pressured to say something more. And I guess I wonder how did it, uh, connect to the fact that we had that extra session on Friday.

Patient: What it seems like to me is that—the dream was more connected to the idea of me feeling I have to measure up, come up with the right stuff . . .

Analyst: Uh-huh.

Patient: . . . than the feeling of [being] coerced into coming here. Somehow there's a difference somehow in there from sort of making a link with . . .

Analyst: Yeah, uh-huh.

Patient: . . . feeling coerced to coming here on Friday, which I didn't feel, at least consciously. Because what I was feeling had more to do with [the therapy group's] asking me—it was like I had to be sicker than I felt. And I think that's frequently a part of what my mind-set is when I come here, that there's some sick part of my mind that I have to access . . .

Analyst: Uh-huh.

Patient: . . . in order to be talking about the right thing. You know, there's some pathological thing in my head that I have to be able to . . .

Analyst: Yeah, and that *is* something that you feel here sometimes.

Patient: Yeah.

Analyst: So the dream is also about coming here, the pressure to get this sick part of your brain out in the open.

Patient: The thing that is really confusing to me is that when I was in that group with [the therapist] the thing that was so impossible for me was to feel convinced that my experience was somehow . . . comparable to the other people in the group.

Analyst: Yeah.

Patient: And I just could not feel that, I first of all didn't understand why anybody would want me to think that. What good does it do me to think that?

Analyst: Huh.

Patient: I don't know. I get confused. You know, when I came to see you what I wanted you to tell me [was] that I was sicker than I thought I was and that it was okay for me to be here.

Analyst: Uh-huh.

Patient: And then, with that group and with [the group leader] it

was like, oh yes, you're very sick. [chuckles] You've got this really horrible thing wrong with you. And I'm thinking it's not really that bad! It was like two very opposite experiences.

Analyst: Uh-huh.

Patient: [longish pause] And I think there is still some issue for me in my own perception of my self, about whether I want to be sick or not. I mean I can't, I haven't quite figured out how to make that scar fit into my image of myself. [another long pause] And because of that, every time I come here I feel like I have to come with that wound, that gaping wound being the most visible thing. If I'm actually feeling in touch with the way my life is now, then I don't know what to say to you, there's nothing to talk about. You know, you'll ask me why I'm here.

Analyst: Huh. If you don't come with the gaping wound?

Patient: Uh-huh. Yeah, if I don't present myself in the proper damaged state, then I'm not going to get—taken seriously, or something. It's like I'm not in my proper role . . .

Analyst: And that is in the dream Friday night, that you feel that I'm sort of trying to get you to be in this proper role of a damaged person. And it is like in the second dream too, that and the issue is how damaged are you. On the one hand you're pressured into being more damaged and on the other you're being told you're not so bad, sounds like.

Patient: Yeah, I mean the issue.

Analyst: That's the issue, you're not sure how bad.

Patient: Well, my feeling in the dream last night was that the reason I was allowed to see your children and your wife was that I was okay.

Analyst: Uh-huh.

Patient: That somehow that was okay, that you were trying to convince me that—I guess that I was like everybody else [i.e., normal].

[Several lines of transcript are deleted.]

Patient: One of the books that I picked up while I was out at the Bookfair was—I mean I went out there for one specific thing and I found it immediately and so then I made the mistake of starting to roam around. And I found this book completely by accident, called, um, *How to Go to Pieces Without Falling Apart*.

Analyst: Hum.

Patient: Hum. It's written by a psychiatrist in New York who is also a Buddhist. And I just was flipping through it while I was waiting for you. He was quoting Freud's disciple, Sandor Ferencz, or whatever his name is.

Analyst: Uh-huh.

Patient: And Ferenz said it's not the free assoc itself that is the cure. It is that if you *can* free associate, you're cured. [chuckles]

Analyst: Uh-huh.

Patient: And I thought, you know, that really struck me as relevant to what you and I have been talking about.

Analyst: Yeah, uh-huh, how specifically about you and me?

Patient: Well, that you know my problem seems to be that I'm still way too much in control of what I'm aware of thinking.

Analyst: Uh-huh.

[Several lines of transcript are deleted. Somewhat later in the session the issues about the first dream come back into discussion.]

Patient: [Talking with the group therapist] makes me feel too vulnerable, and it makes me feel something I don't feel I can afford to feel. Y'know, I would rather . . . I would rather focus on—I don't know, the part of me that feels strong—than to be in touch with the part of me that felt like I was going to be stabbed to death [a reference to some of the sex play that occurred in her familial sexual abuse]. It just makes me think I could never, I couldn't have tolerated doing therapy with her or something like her because that really would make me fall apart, and it feels like I would be disintegrating in such a way I could never reconstruct myself. I would be too, like I'd have no confidence in myself at all, as opposed to the way my relationship with you has always been. You and I both know that there is a part of me that is strong. . . . I don't know where any of this is going, but . . .

Analyst: Well, where, I, I mean I guess I was thinking, do you feel that in the second dream this, are you, how strong are you vis-à-vis me? I . . . you told me how strong I am raising these children and yet . . . I tell you that, you know.

Patient: In the dream, it made me feel stronger . . .

Analyst: Yeah!

Patient: It made me feel more . . . equal to . . . [83-second pause]

Analyst: Is that something that's happened nowadays?

Patient: Uhh . . . I think to some extent . . . my feeling is beginning to change about . . . about that. I wouldn't say that. . . . I don't think it's a done deal [chuckles] . . . One of the things that I was thinking about on Saturday as I was thinking about calling you was that I, I was convinced in my own mind that I could call you and that I could tell you about that dream and it would be okay. So somehow that made me feel like I didn't have to do it.

Analyst: Um-huh . . .

Patient: You know I didn't have to prove anything so . . . so I didn't do it.

Analyst: Um-huh.

Patient: You know it was enough, it was enough to acknowledge to myself that I knew I could pick up the phone and tell you about it and that could be interesting, but I could also [brief chuckle] tell you about it today.

Analyst: Um-huh.

Patient: And I mean there's something in my viewing it that way, my viewing that it was okay to call you that makes me feel we're more equal . . .

Analyst: Um-huh.

Patient: . . . than unequal.

Analyst: Uh-huh . . . [68-second pause]

Patient: In the dream, um, the dream last night, I was feeling like, um . . . I don't know how to say it was exactly, the word *acceptance*, keeps coming into my . . .

Analyst: Um-huh.

Patient: . . . head. It was like I was feeling accepted . . . the way I am and . . . there's something about the feelings that go along with that, that make me afraid, and I start to feel afraid of being hurt, when I notice that I'm letting my guard down, or something—and, you know, one of the things that is disturbing to me is that I'll wake up with that feeling of being accepted and then as soon as I'm conscious of the fact that it's a dream I start to feel afraid of the feeling. It's like I don't really want to feel that with you.

Analyst: Huh! . . . Somethin's scary.

Patient: Yeah.

Analyst: Yeah.

Patient: And I don't know whether it's because I know I have to tell you about the dream [chuckles] and I'm, you know, afraid of your reaction when I tell you that, or if I'm afraid of the reality of trying to have the relationship feel that way, or maybe that's the same thing. I don't know.

[The session ended with patient and analyst exploring more of what was scary to the patient about feeling "accepted."]

Day 2: Tuesday

[The following day began extraordinarily differently, in that the patient wanted to sit rather than lie on the couch. On this day, and for the first time, she began talking while sitting up on the couch and looking at the analyst.]

Patient: Today I somehow don't want to lie down right away.

Analyst: Well, that's a change!! Can you say what's happening?

Patient: I'm not exactly sure, but somehow I feel like I'm more aware of what I want for myself. It's like I have my own agenda.

[Shortly after that she lay down and continued to talk about this feeling of being in a new state with her analyst.]

Patient: Today it feels a lot more connected here . . . because it feels like I'm opening up something to you . . . in a voluntary way. It's like, you know, I'm in control of what we're talking about, in a way that I don't usually feel. It's like I have an agenda today.

Analyst: [wryly] It's hard to have agendas other days?

Patient: Yeah!

[The two then burst into loud mutual laughter.]

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