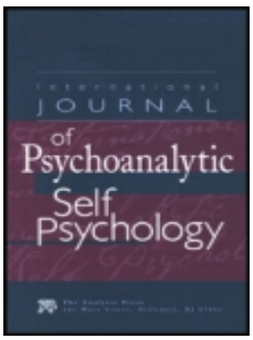

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The Ever-Emerging *New Us*: The Developing Therapeutic System

Lynn Preston, M.A., M.S., L.P., and Ellen Shumsky, L.C.S.W., L.P.

"The Ever-Emerging *New Us*" refers to an ever-changing, complexly layered vision of an evolving therapeutic partnership. We explore the developmental process of such an analytic system through the lens of complexity theory, and reflect on how this perspective illuminates our understanding of the therapeutic system and its processes of change and growth.

Keywords: complexity theory; improvisation; psychoanalytic complexity; relational development; self psychology; therapeutic systems; therapy relationship

Introduction

After 16 years of working together, Ellen asked Harry how he thought his therapy had helped him. He replied, "Because you didn't do therapy. We had a relationship. And I learned how to be in a relationship and now I can have other relationships."

The *New Us* refers to a complexly layered vision of an ever-evolving therapeutic partnership. Using a complexity theory perspective, we focus on the evolution of this system. The therapeutic partnership (the *Us*) consists of the living systems of the analyst and patient embedded in infinite, expanding, colliding, inter-affecting systems such as family, culture, supervisors, analytic zeitgeist, language, and on and on. Therapeutic relatedness has its own integrity, vicissitudes and trajectory even as it is, at the same time,

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ever newly forming, never established once and for all, and changing from moment to moment.

One could say that complexity theory is a meta perspective that continues to expand the field of the embedded existential individual, telescoping it in the direction of an infinite field of systems within systems. We are attending not only to intrapsychic, interpersonal, and intersubjective space, but to vast systemic spaces.

A complexity perspective offers a way of framing the unpredictable leaps and surprising turns that show up when we are least expecting them because of multiple, complex, indeterminate influences from systems within systems. From this point-of-view, therapeutic process is not only one person facilitating change for another, nor is it limited to the intersection of the organizing activity of two individuals. It is, rather, a dynamic process in which change in the system generates change in the individuals, and individual change results in change in the whole. As Coburn (2014) says, "The agent of change emerges as a product and property of the relational system itself" (p. 74).

Considering that it is not just the person that changes, but the system that changes, we want to investigate what systemic change looks and feels like. How do we recognize the minute and unpredictable development of new emergent forms of relatedness that carry the partnership forward?

The Perspective of the *Us*

It can be as difficult for us to notice the analytic partnership in which we are embedded as it is for a fish to perceive the water in which it swims. However, regardless of our noticing the therapeutic system, it is, from the start a living organism that is in the process of self-organization and complexification. Through the lens of the *New Us*, we see our job as therapists from a different perspective—not as developing the patient, but as developing the therapeutic partnership. It is a vantage point from which we can track the evolution of the "co-adaptive, mutually and reciprocally organizing" system of the analytic couple in which every dyad is irreducibly itself (Coburn, 2007). Its development is ordered but unpredictable; its challenges are specific; its creative unfolding is unique. Although the signposts of its journey may be written in the language of surprise and its trajectory may be unpredictable, its evolution can be tended and cultivated like a garden of wild flowers.

When we see our task as developing the therapeutic system, rather than the patient, the obstacles we face are not attributed to the patient's resistances, trauma, or deficits, nor are they viewed as features of the analyst's limitations. Instead the difficulties are seen as challenges of the system, and responsibility for them is distributed throughout the system.

This sensibility might find expression in the language of "we statements," for example, "We seem to have a lot of trouble ending our sessions on time," or "We were able to talk about money in a much more open way today. How did we get there?" or "We don't have a satisfying direction yet." The ability to collaboratively articulate our process is a step in the expansion of the system.

CLINICAL STORY

Harry called me (E.S.) for a consultation, having gotten my name from a list of therapists. We knew nothing about each other. Thirty years before he had been diagnosed as manic-depressive and had been on a complicated regimen of medications prescribed and monitored over the years by a succession of psychiatrists. He had endured half a dozen psychiatric hospitalizations, often-traumatic experiences, since early adulthood. He was absolutely determined to avoid another such hospitalization. Although he had for years worked as a salesman and street peddler, he had been unemployed for the past decade. And although he had known many women, he had never been in a sustained relationship.

I had worked on a psychiatric inpatient unit upon completing my master's degree in social work, but I had never before worked with what felt like such a precarious, labile patient in my private practice. However, there was something about Harry—an earnestness and determination—that sparked my interest. We decided to work together. Thus began our unusual therapy partnership. What follows are some themes from our years of work together that helped to develop the *New Us.*

THE HONEYMOON

Basically, I let Harry lead and I followed. Week after week, in great detail, he told me the story of his life. He appeared to have no interest in anything like exploration. It seemed as if he just wanted a person to take him in, as a way of establishing connection. It is comfortable and easy for me to be a listener. Harry and I were close in age and culture of origin, and had both participated in the same counterculture events as young adults. It felt like a comfortable twinship was emerging as I joined him in his trip down memory lane. This honeymoon period created a platform of connectivity and trust that supported us through what was to come.

THE HONEYMOON IS OVER

It was not too long before a prolonged and vital struggle developed between us, as Harry began to escalate his demands on me for out of session contact. This was something he had done with his previous beloved therapist, which ultimately led to a crisis that resulted in an abrupt termination of that treatment.

Harry would call me repeatedly with long, sometimes desperate, sometimes rambling messages. I tried to set limits about where and when, and under what circumstances he could call me. I limited the amount of time for each message, and then the number of messages in a given amount of time. When, in a rage, he filled up my machine with angry or needy messages I let him know clearly that by doing so, he was endangering the rest of my practice and I would not tolerate it. The issue of vacation and weekend contacts then became critical. I did not want to do weekend phone calls except for emergencies. I told Harry that I needed to feel free on my time off. When he protested, I told him that I intended to be a strict enforcer of these limits because one way that Harry and I

had made sense of his previous termination of treatment was that his therapist had not been able to establish and enforce the limits she needed. I said that I did not want to participate in a repetition of a traumatic abandonment. I was trying to protect my own needs for self-care and, by extension, our relationship. Harry had lived through many, many experiences all his life, of pushing and disrespecting limits, of responding to them with uncontrollable, angry, attacking outbursts, with the result that many emotionally important people had cut off from him. In his increasing loneliness, he was suffering the wreckage from this dynamic. In his earnest desire not to experience further loss, he began to take on the struggle of accepting the limits I needed.

Giving and Receiving

In anticipation of the upcoming Chanukah holiday, Harry asked if I had a menorah. I told him I didn't but was considering getting one. At the next session he showed up with a menorah for me. Before I opened the gift, he told me that he realized that people have very different tastes and that if I didn't care for it I could exchange it for the menorah of my choice. I told him that I was very touched by his gift and his thoughtfulness. At one time I had shared with him, and he remembered, that I suffered from a "gifting disorder." My mother could only give me what she liked, not what I liked. For me, receiving gifts was fraught.

Harry subsequently asked if I loved the menorah he gave me and I told him, honestly, that I didn't love it because it was too modern for my taste, but I loved that he had given it to me. That weekend I received a flurry of enraged messages from him. He had gone to so much trouble to respond to my wish for a menorah and I didn't like it. He demanded that I give it back to him. I didn't respond. Later, I received a very different, amazingly sincere and vulnerable message: "My fear turns to anger and I destroy my relationships with my rage. You really should have a menorah that you love." I was deeply touched by his struggle and his candor and I, uncharacteristically, called him. "Are you angry?" he asked. "No, I feel your pain and I'm very moved. Giving and receiving are complicated for both of us. But we'll talk and straighten it all out." In the end, we agreed that I would keep the menorah that had now become the carrier of an emotionally moving struggle for self-transcendence for each of US. Harry subsequently referred to this incident as the first time he had ever expressed blind rage and ended up by receiving a caring response. It was a very important milestone.

The Great Depression

Years into our work together, Harry fell into a prolonged deep depression. (Only later, with hindsight, could we begin to untangle some of the contributing factors). For several years he hardly left his house. In our sessions, he mostly moaned about feeling exhausted and never wanting to leave his bed. He sometimes expressed the wish to die or to have the courage to throw himself off the roof. He asked me to help him die. I told him, "I will not help you die. I want to help you to live." He described recurrent violent nightmares.

Surprisingly, he also spoke of getting in touch with loving feelings for his up-until-then hated mother.

As Harry lay in his filthy bed surrounded by mountains of accumulating garbage, he did not want to focus on his painful empty life. Instead, he preferred to hear about my life. Although talking about the daily events of my life—going to a movie, meeting a friend for dinner, describing the charming behavior of my cats—seemed like fiddling while Rome was burning, I was learning that by responding to this need I was going in the direction of life energy.

At the same time, I was exceedingly troubled by Harry's prolonged depression. I often felt frighteningly helpless and sometimes hopeless. I felt pained, deadened, sad, and sometimes angry at Harry's passivity and refusal to fight. I was sometimes very scared about his potential suicidality and one way I dealt with this was by keeping in touch with his medical doctor (MD). I felt impotent and desperate to make sense out of what was happening. I welcomed the respite of sharing about my life in a way that seemed to enliven the system. And then, from out of the blue, "unbidden" (to use Donnel Stern's term), I began to experience, from deep inside myself, a conviction that he was in a prolonged "dark night of the soul"—in a chrysalis preparing to be reborn. I shared this hope/belief with him and he found it comforting too.

Some years into this depression, Harry fell into a helpless panic, as he was required by his co-op board to let people into his apartment for repairs. He was convinced that when they saw the filth and garbage he would be evicted. He was consumed with obsessive worry, but felt paralyzed to do anything about it. I felt worried too. Was this a tipping point that would destabilize the containing familiarity of his home life? Then, miraculously, just before the mandated inspection, an old college friend with whom he had maintained (through many ups and downs) a close, almost family like relationship, showed up uninvited at his door and with love and determination, performed the Herculean task of cleaning up and removing dozens and dozens and dozens of bags of trash. This heroic rescue, overnight, restored Harry's will to live. He experienced that he had been saved by the love of a brother-like friend who, over the years, had survived all of his destructive attacks and dismissals. He felt deeply cared about and it was like a resurrection. He had his apartment cleaned and began to reconstitute a life. He started reorganizing and refurbishing his home, making lunch and dinner dates with friends and neighbors, partying with a group of artists from his counterculture years, going to the movies. It felt to me that he was putting into practice my life that he had lived vicariously during his depression. I found it charming—he was being like the proverbial chip off the old block.

He was showing up for sessions again and there was a close and celebratory feeling between us. We spontaneously slipped into a session-ending ritual in which first he, and then I would say, "I love you sooooo much," competing to see who could draw out the *sooooo* the longest. We called ourselves "two peas in a pod" because of overlaps and similarities between us. We once again played, joked, argued, and teased. I felt relieved beyond words that we had weathered this long, life-threatening storm and arrived home safely.

And then, miracle of miracles, a woman (L) he had had a brief relationship with some 30 years before, called him from her home in Europe. She recalled him as the "handsomest" man she had ever known and they began a telephone friendship. (Harry had many of his relationships by telephone). As the relationship developed she planned a several week vacation to be with Harry in New York City. He was extremely anxious about it and during this time I functioned as support and coach. When she came to stay with him they became lovers. He was very smitten, ardent, and romantic. Now for the first time in his life, he had to deal with the vulnerability of close physical/emotional intimacy and the struggle of finding limits and establishing boundaries with someone who really wanted him. He swung between being ardently enamored, or turned off and isolative. This intimacy was a huge developmental challenge and a profound learning experience for him.

When L left to return home, he started finding fault with her in his mind. I tried to help Harry stay open to a complex, nuanced relationship with her. I worked with him to help him not jump to conclusions or closure, but to weather conflicts and differences and give the relationship a chance to develop in whatever way it needed to. He has, not without difficulty, hung in, through all the ups and downs. Over time the relationship has grown into a deeply loving intimacy.

The Most Recent Challenge

The most recent relational challenge emerged between us, after Harry had a fall, injuring his back, with the result that walking became very painful. He was feeling so disabled that he was admitted to an inpatient rehab facility. He wanted me to visit him there, as a previous therapist had visited him when he was hospitalized many years ago. I told him I couldn't. He was not happy and tried to guilt and persuade me, but I held my ground. One night he left a phone message. He had just been told he was soon to be discharged and was realizing that he had had very few visitors during his hospitalization. At first he was weeping as he expressed how alone he felt, but then he launched into an accusatory rage about how I had failed him by not visiting. I was struck by the depth of his pain and rage. Our next scheduled contact was two days away. I thought perhaps I should call him before then, but something in me resisted. I was aware of feeling angry with him both for his demands on me and for his uncontained expression of rage. But I was also feeling guilty about not being there for him because I sensed that facing discharge and having to care for himself alone at home was terrifying for him. In the end, I decided to not call and trust him to use other resources to handle his feelings.

When we next spoke at our appointed time, I experienced a very different Harry. He was calm, not contrite, but emotionally connected to himself. He said, referring to his previous message, "I wasn't so much angry with you as I was very disappointed. But I realized you're not coming to see me doesn't mean you don't love me. It means you have a life. I know you love me and I'm sorry for the way I talked to you." I thanked him for his lovely apology and affirmed that I did love him.

In retrospect this was not only about Harry's growth, but also about both of us trusting the solidity of the relationship. My sense that it would be better not to call, was

perhaps my tuning into the developmental leading edge of Us—his expanded relational capacities and ability to reach out to other people, and my greater ease with handling my anxiety and guilt in times of collision.

DISCUSSION OF THE CLINICAL NARRATIVE

There are many different perspectives that might help us to make sense of this clinical story. We are choosing to highlight the evolution of the system through which the individuals changed, rather than emphasizing the changes in the individuals that resulted in systemic change. To this end we are tracking the development of this partnership—this particular *Us.*

One of the things that strikes us about this clinical narrative is that were it not for a complexity perspective, it might never have taken place. Embeddedness in a complexity milieu—with its emphasis on unpredictability, uncertainty, and contextualism—permissioned Ellen to commit to a relationship where radical emergent *being with* rather than making sense together had to be the fulcrum of the healing force. Originally uncertain about the challenge of a "non-analytic" framework in private practice, she was able to relax into a wildly unpredictable Ellen/Harry interbeing process that held the hope and potential for healing. (What we are referring to as a *complexity milieu* is a sensibility constituted by a set of *attitudes* [Coburn, 2014] or emotionally saturated perspectives that determine our clinical posture and disposition. We will expand on the nature of these attitudes later in our discussion.)

This complexity sensibility enabled Ellen, a self-described "somewhat bounded" therapist, to enter into an uncharacteristically informal, playful, and intimate mode of living together with her patient, which was a refreshing improvisational stretch for her. She had to tolerate long periods of uncertainty, clinging to the immediacy of each interaction without being able to make linear sense of it—from negotiating acceptable boundaries (the ground rules) to playing the made-up game of "I love you soooo . . . much." Every step was a new emergent engagement for Ellen and Harry.

Let's look briefly at some of the challenges that this partnership faced and how they were able to negotiate the non-linear process of an *ever-emergent us.* This dyad was made up of a bounded analyst and a patient whose life was characterized by defying all limits and constraints. Negotiating a frame was tumultuous, delicate, ongoing, and foundational. In the language of complexity theory, the partners were struggling to become a complex open system—a system that has enough fluidity to allow for changes and enough order to allow for continuance of changes. Hovering around the tipping point of order and chaos, these partners struggled to find and refind a balance between constriction and mayhem. They worked to feel safe enough to tangle with each other as well as to share intimate, loving, playful give-and-take.

Through years of a Great Depression this couple had to stay alive with only the analyst's occasional glimmers of hope to sustain and hold them. During this time it was incumbent upon the analyst to provide the lion's share of vitality and stimulation for the system by sharing her daily life stories. This is an instance of how, in stuck periods,

rather than trying to get the patient to change, the analyst can herself bring the missing ingredient into the partnership. (We'll elaborate on this further, later in our discussion.)

There were myriad levels of perturbation in this clinical narrative that moved the system forward. The menorah struggle stretched the dyad in their empathic grasp of each other and of their system, and also expanded the giving/receiving capacities of their partnership. The analyst's receptivity to Harry's angry feelings was another perturbation that introduced a powerful needed dynamic into the relationship. The out-of-the blue emergence of the friend/savior who cleaned up Harry's apartment was a dramatic turn of events that helped turn winter into spring. This was followed by the amazing, Hollywood-like reappearance of the woman friend from 30 years ago that launched a foray into physical/emotional intimacy. The final perturbation was Harry's injury, his ensuing disability, the conflict with Ellen about her unavailability, and the big developmental step for the dyad—as Harry raged and Ellen held her ground—trusting the capacities of each of them to self-regulate.

There is no definitive narrative that explains what happened here. As Coburn (2014) puts it, "therapeutic action and change are as much of *ambiguous ownership* as are one's past, present and future emotional life" (p. 94). While it is tempting to attribute the dramatic emergence from the depression to the heroic rescue, we are reminded of Sucharov's words (2013), "We all stand at any given moment, at the center of a complex totality of experience that is informed by multiple and interweaving contextual relational systems" (p. 381). The dormant seeds that bloomed had been planted gradually through all the years of Harry's life, including all his relationships, his many therapies, this therapy and all the infinite systems in which he has been, and is continually embedded.[1]

Clinical Implications—*Us* Thinking

Psychoanalytic complexity is an ever-expanding frame that challenges us to transcend our natural inclinations to reify individuality and "thingify" the self. We hardly notice the imprisoning "entity" assumptions that we, like homing pigeons, return to again and again. For many of us, it is a stretch to emotionally grasp the absolute embeddedness of our unique individual selves.

Us thinking, for example, thinking clinically about the therapeutic dyad as a unique cohesive organismic system, is even more difficult for most of us in the heat of clinical impasses and "now moments" (Stern, 2004). We easily get caught in the simplifications of searching for who is doing what to whom, which may result in a flattening out of myriad dimensions of inter-affecting worlds of experience.

In the inevitable vulnerabilities of clinical work that may threaten our sense of identity, we can find ourselves enmeshed, helplessly caught like a bug in the web of the field. We flail about with no foothold, no self-orientation, struggling for survival.

[1]Aron and Atlas (2015), using a relational psychoanalytic lexicon, might speak of these dyadic developmental steps as generative enactments, "part of a developmental process within the dyad that relies on implicit and emergent processes . . . as the threshold for the introduction of emergent ways of being, of a coming toward new relational possibilities" (p. 316).

When we can find the space to reflect on the situation, *Us thinking* can come to our aid. A complex systems perspective can generate such questions as "What is the pattern of our web?" "What are we fighting for, warding off, fleeing from?" "How did we get here?" "What does our system need?" Thinking in terms of a systemic journey sheds new light on therapeutic process, giving us an alternative to pathologizing or blaming either the patient or ourselves. Issues of responsibility take on more nuanced dimensions, leaving behind a reductionistic investigation of who is the culprit not doing her job adequately—the analyst or the patient.[2]

An Expanded View of Empathy

With a complexity sensibility, we understand empathy as more than entering the patient's world and allowing the patient to enter ours. It is also the formation of a joint experiential world, larger than the sum of its parts. *We* both enter from our own individual situatedness and each of us has an inchoate, idiosyncratic feel of the larger whole. We might think of this as a felt sense of the field. This is sometimes talked about as a *feeling in the room*, for example, an ambiance of heavy pressured silence, a shy tentative precariousness, or a bodily sense of impending explosiveness.

Even when we are consciously aware, only of our own particular experience, we are immersed in the dynamic interplay of the field. We are, after all, not only in the field, but the field is also in us and we are an emergent expression of it. We each have some implicit sense of the vast intricacy of the system in which we are embedded—its strivings, its obstacles, its tipping points and even its as-yet-unimagined possible new directions. Coburn (2014) points to this when he says that the analytic dyad is able "to sense and feel when their system is in flux and ready to change" (p. 75).

An example of this is when Ellen came to recognize an inchoate sense that tendrils of new growth were germinating under the deep snow through the Great Depression. This felt sense held the *Us*, giving encouragement to the dyad through their crisis.

An expanded view of empathic attunement—the assumption that the analyst's empathic reach can include the experience of the dyad as well as of the individuals—is not only theoretically intriguing, but can be profoundly clinically useful. We can develop the therapeutic activity of aligning ourselves with our glimmerings of the developmental tendencies of the system by *asking into* our felt sense of the field—silently to ourselves and out loud to our patient; examples include "It feels to me like we are stepping around something. Does it feel that way to you?" "It seemed like we became lighter just then, does that seem right?"[3] We are highlighting the systemic space that includes recognition of our embeddedness in multiple larger systems.

[2]We, the authors, began thinking in this direction in 2004 (Preston and Shumsky, 2004). At that time, we wrote, "A systems view of the idea of responsibility shifts discourse from a focus on 'Whose fault is it?' to 'How did we get here?' or 'What is the meaning of this?' It assumes a web of connection in which the question 'Who tore the web?' is impossible to answer. It is like asking the question, 'What is the sound of one hand clapping?'"

[3]Ipp (2015) makes the distinction between empathic immersion and what she calls "complex empathy" that "incorporates feeling and knowing the multiple, more deeply held and often paradoxical aspects of our patients and indeed of ourselves as these have played out in intersubjective space."

ATTITUDES AND A COMPLEXITY SENSIBILITY

According to Coburn (2014), "Much of the clinical exchange involves playing with both the analyst's and patient's respective set of attitudes" (p. 94). He states that the therapist's attitudes, "often implicit and pre-reflective, exert powerful influences on the analyst, the patient, the treatment dyad and the trajectory of the analytics relationship" (p. 26).

Although the Oxford dictionary simply defines attitude as "a settled way of thinking and feeling about something," the clinical use of this concept overflows its definition, settling "somewhere between a belief, a stance, a mood, a pose" (definition of attitude according to www.vocabulary.com). Coburn (2014), citing Piers, defines attitude as "a particular perspective or vantage point in relation to the flow of subjective experience, leaving it poised in a state of biased readiness to perceive, organize, interpret, respond to and remember experience in a distinctive and recognizable manner" (p. 251).

Orange (2009) speaks of attitude as "a complex amalgam of outlook, emotional perspective, and disposition taken up . . . an attitude shares both the where-I-find-myself-ness . . . and also constitutes a kind of personal choice" (p. 240). It is, perhaps, the very slippery nature of the concept of attitude—its refusal to be easily packaged, along with its location between given and made, implicit and explicit—that lends itself so well to the exploration of a complexity sensibility.

Coburn has given attitudes the leading role in his 2014 book on psychoanalytic complexity. Some of the attitudes that are constitutive of a complexity sensibility include:

- A respect for, and humility in, the face of the vast, interconnected, almost infinitely complex experiential worlds within which the individual and the dyad are embedded;
- A deep commitment to the ongoing pursuit of our understanding of this vast intricacy;
- An open receptiveness for radical surprise;
- Valuing the feeling of complexity in the phenomenological sense; and
- A commitment to complexity rather than collapsing into binary simplifications.[4]

We are emphasizing attitudes that foster attention to the system of the therapeutic dyad and, giving particular attention to the attitudinal milieu that informs, inspires and delimits the dyad's movements. The implicit and explicit attitudes of therapist and patient are the shaping forces of the dyadic culture. Our attitudes form the ambiance within which the system operates. A dyadic perspective necessitates a relentless examination of the attitudes that are the music behind the words, because the system is dancing

[4]For a compelling elaboration of this, see Leighton (2004), Brothers (2008), Maduro (2013), and Sucharov (2013).

to the beat of its intersubjectively determined attitudinal music. Ellen and Harry's growing commitment to accepting the tension between Ellen's boundedness and Harry's boundlessness is an example of this.

Attitudes that flow from a focus on the centrality of the developing therapeutic dyad include:

- A spirit of collaboration in which the primary therapeutic goal is the quality of here and now relating—keeping the ball in the air;
- A respect, trust and concern for the relational home of the therapeutic system within which the members live;
- A delight in the improvisational movements that arise spontaneously from the interaction and move the conversation forward;
- A relentless commitment to examining assumptions and a willingness to hold even the most cherished ones lightly in the service of genuine conversation; and
- Appreciation of the particularity of the therapeutic couple—heralding its strengths, holding its struggles with tenderness, enjoying its small steps of growth.

Cultivating Relational Freedom

From the perspective that we are suggesting, relational freedom is an attribute of the relational field that is shaping the experience of the participants. As Stern (2015) puts it, "the freedom to allow the greatest range of unbidden experience rests on the degree of flexibility and freedom of the field" (p. 113). How can we increase the range of possibilities of the field? The Ellen/Harry story suggests that relational freedom can be expanded by tending to how we are *being together* in each moment, nurturing trust and intimacy through surrender to the vicissitudes and beckonings of the relational moment—balancing the needs of the individuals and the systemic us.

As Maduro expresses these ideas: "We can cultivate a clinical eye for the fieldness-of-emotional-experience . . . and, in so doing, cultivate a therapeutic field of recognition and understanding (a kind of field selfobject) wherein such experiences (embedded-selfhood) may express themselves more readily" (Peter Maduro, personal communication, November 20, 2014). The term, "field selfobject," catches the emphasis on building a sustaining and enriching dyadic culture that can nest fledgling agentic possibilities.

The culture of anticipating and nurturing dyadic forward movement, what Aron and Atlas (2015), borrowing from Bollas, call "a destiny drive" (p. 314), is built on a trust in the experience of organismic forward movement.

A systems sensibility highlights the web of connectedness, adding dimensionality to the embedded individuals.

Working to Change a Stuck Dynamic

We cannot change the other, but we can change the dynamic. One of the primary advantages of taking a systems perspective is that it helps clinicians to pull back from doomed efforts focused on "*getting* the *patient*" to change. It suggests that just as a butterfly

flapping its wings may result in a storm across the sea, a shift in the therapist's participation in a stuck dynamic can be the perturbation that may result in a new beginning. Bromberg (2013) elaborates on this idea. "When one person—patient or analyst—begins to emerge from the rigidity of whatever self-state is protecting him from 'otherness,' his partner becomes more able to do the same, and each begins to feel the presence of the other as less alien, less 'not-me'" (p. 5). For example, instead of Ellen trying to get Harry to wake up and take on life, she brought vitality to the system with her own daily life stories and her willingness to tolerate intense discomfort during the Great Depression.

Psychoanalytic Improvisation

"Living in the realm of the improvisational rather than the realm of the scripted" (Ringstrom, 2006, p. 85) can usher us into what we might call "U*s consciousness.*" When we allow ourselves to let go, into the dimension of collaborative play, we experience our therapeutic interaction itself as the focus—an art form of mutual creative expression. As Ringstrom (2007) says: in an improvisational mode, "It is implicit that we explore, through words or actions who we are, what we're doing, where and when we are doing it and why. In short the domain of exploration quickly becomes the field of enactment" (p. 78).

Improvisational, skilled, attuned spontaneity does not center around the clever analyst, quick on the draw, who can artfully turn the session around with just the right remark. Rather, an improvisational spirit is one of invitation into an un-thought-out intuitive construction, eliciting imagination and collaborative freedom. Successful improvisation hinges on the coordination of the participants, emerging out of a shift into *us-thinking*, fueled by values, such as:

- Catching the ball and throwing it in such a way that the patient can creatively respond;
- Being a good team player. The goal is not to get the patient to do or be anything, but to enable an interaction to take flight; and
- The ability to let go of one's scripted, automatic response and take an unexpected turn.

Conclusion

A complexity sensibility perspective, that we call the *New Us*, helps us to inhabit the idea that it is not the individual, but the system that changes. Through this lens we can envision the therapeutic project as that of expanding the experiential world of the analytic dyad and thus the individuals within it.

How we participate in the therapeutic conversation proceeds from what we look for, what we notice, and what we welcome. Through the window of the *New Us* we can envision the organic living system of the relationship struggling for fittedness, safety, and aliveness and come to recognize its little steps of growth. The partnership has a life of its own and by noticing its incremental developments we invite attention to how we are

being together. We are involved in a mutual, meaning-making venture of cultivating an atmosphere of openness and resilience in which conflict and loss can be tolerated, trust can be expanded and risks can be taken. We may choose to silently track these changes or to point to the small steps of development that we notice in the dyadic process of building a more and more livable and life-generating home.

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TRANSLATIONS OF ABSTRACT

« *Le Nouveau Nous Toujours Émergent* » renvoie à une vision complexe et toujours changeante d'un partenariat thérapeutique en évolution. Nous explorons le processus développemental d'un tel système analytique à l'enseigne de la théorie de la complexité et réévaluons notre conception du système thérapeutique et de ses processus de changement à la lumière de cette perspective.

"Il *Nuovo Noi* permanentemente emergente" si riferisce ad una visione stratificata in modo complesso e in continuo cambiamento di una associazione terapeutica in evoluzione. Esploriamo il processo evolutivo di un simile sistema analitico con le lenti della teoria della complessità e riflettiamo sui modi in cui questa prospettiva illumina la nostra comprensione del sistema terapeutico e dei processi di cambiamento e di crescita.