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The Intersubjective Perspective: An Effective Treatment Model for Incarcerated Clients

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An Effective Treatment for Incarcerated Clients

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Forward

The clinical landscape has drastically changed since the inception of talk therapy. Even during my training years and internship, clinical programs and academia have undergone an incredible tectonic shift. While psychodynamic therapy still perseveres, I have been struck by newer clinicians' reticence to acknowledge dynamic and analytic treatments as modalities worth learning about. I have noticed a parallel process between clients and therapists, both in the lack of foundational knowledge of what dynamic work looks like, its mechanisms of action, and its implications for self-growth and discovery. When describing their history with dynamic and analytic treatments, many soon to be clinicians immediately free associate to Freud, libido, parent blaming, and other vague ideas about psychoanalysis. Meanwhile names such as Kernberg, Klein, Stolorow, Kohut and many others go unmentioned. During my internship year I was pleasantly surprised to find two facts to be true. First, many therapists had received limited training in dynamic therapies but were curious and interested in learning more once provided a general framework for relational, dynamic work. Second, and maybe more exciting, was the realization that many so called behavioral therapists were in fact inadvertently much more relational and dynamic then they realized. With this being the case, I approach this paper with two deeper more broad goals. The first is to begin to make a case for the utility of Intersubjective Systems Theory not just in jails and prisons, but in a wide range of unexpected, challenging and

underserved environments. Second, my other goal is to hopefully introduce clinicians unfamiliar with this model, to a potentially new way of thinking about, and collaborating with their clients.

Introduction

Out of all of Sigmund Freud's many ideas, his hypothesis that psychoanalytic therapy would be a treatment primarily accessed by the wealthy, has been especially salient for me during my clinical training years (Freud, Gay,1999). Despite the many ways in which psychotherapy has changed since the early days of the "talking cure", many patients I have worked with over the years have lamented the difficulty faced in finding the right provider, with the right training, for the right price. Others have no conceptual framework for what theoretically bound psychodynamic therapy looks like. Due to the intrusion of managed care in the therapeutic landscape, many clients are forced to seek help in therapy mills, in which poorly trained or overworked clinicians hold 80-person case-loads, and may only see some of the most in need clients for a single 45-minute session per month. These forms of treatment are in stark contrast to the early days of analytic work in which clients regularly met with their providers, sometimes multiple times a week. These early therapies, and many of the more contemporary relational therapies, prize the therapeutic relationship as the essential feature in allowing clients to develop new ways of relating to themselves and to others. The importance of the relational dynamic has been further emphasized in studies done by Johnathan Shedler, which pointed to the relationship as a foundational component of treatment (Shedler, 2011). Despite this finding, manualized treatments still exert supremacy on the Psychological landscape to the detriment of clients who may conflate advice giving with effective psychotherapy. In the modern era of psychotherapy, treatment continues to be paired down in terms of duration, and emphasis on the foundational

nature of the relationship which has shown to decrease the effectiveness of treatment (Tiemens, Kloos, Spijker, Ingenhoven, Kampman, Hendriks, 2019).

Alongside the shift in treatment approaches, has been a shift in the landscape of institutionalization of the mentally ill. Due to a process known as trans institutionalization, which will be discussed later in this paper, many of our most severely mentally ill find themselves incarcerated in jails and prisons (Primeau, Bowers, Harrison, XuXu, 2013). As opposed to the structured environment of an inpatient psychiatric hospital, jails present many unique and complex problems for the treatment of the many mentally ill inmates who find themselves warehoused, and without treatment. While jails such as Denver County Jail attempt to do their best to provide effective treatment, the volume of clients seeking help and the limited staffing often leads to the implementation of shorter term behavioral therapies, focused more on skill building then on insight and understanding. As a byproduct of the massive demand, these treatments are often only offered for a limited number of weeks. Short term treatment is further complicated by the fact that contextual environments such as jails and prisons may further concretize pre-existing organizing principles such as “I’m a criminal”, “I’m a bad person”, “I’m universally hated”, and other more insidious and pathological forms of self-experience. In essence, clients who may benefit the most from longer, more dynamic forms of therapy focused on collaboration, illumination and understanding, are some of the least likely to receive this specialized form of treatment. I believe that jails and prisons are a fertile ground for the implementation of a dynamic therapy focused on collaborative and empathic work. Clients in these environments may benefit the most from therapy focused on the illumination of how clients came to find themselves incarcerated, articulation of early childhood impact on the experience of

self and others, and the development of new, and potentially more hopeful ways of understanding oneself.

Although there is already a large body of theoretical literature on the utility of Intersubjective Systems Theory in working with more challenging clinical presentations, little has been written about the use of this approach in working with incarcerated clients. In this paper, I will be making the case for the utility and need for the Intersubjective Perspective in working within the forensic system. This paper will first focus on building a general framework for Intersubjective Systems Theory, and its theoretical understanding of clients' striving towards health, love and connection. Next, this paper will take time to focus on a brief history of trans institutionalization and its implications for treatment. This paper will also briefly cover the general framework for the clinical application of Intersubjective Systems Theory, as well as addressing the intersubjective understanding of aggression. Finally, I will use a previous case from my time at Denver County Jail to explore and highlight both the need for an intersubjective approach, as well as how the approach plays out in an actual therapeutic dyad. By the end of this paper I hope to have laid the framework for further thought and research into the need for a more dynamic and relational approach in the treatment of clients who have found themselves behind bars.

The Intersubjective Perspective

With its framework built on the philosophy of Phenomenology, Intersubjective Systems Theory places a heavy emphasis on the collaborative exploration and illumination of the internal subjective self-experience, the ways in which clients have learned to relate to others, and clients overall subjective experience of their place in the world (Buirski et. al, 2020). It is also important to note that the Intersubjective perspective does not discount the overlapping complexity of

nature and nurture. However, the relational approach, as well as the systemic approach, pay special attention to the ways in which nurture directly impacts developing children's, and ultimately adult clients' relation to their preset nature. As an example, a child may be born with characteristics of an Attention Deficit Hyperactivity Disorder diagnosis. In one scenario, this child may receive early and continuing messaging that they are energetic, creative, and dynamic. In another scenario, this child may receive early and continuing messaging that they are disruptive, lazy and annoying. Research supports the ways in which negative treatment of children with ADHD has been linked to the comorbidity between ADHD and Major Depressive Disorder (Simmons, Antshel, 2020)

In Sigmund Freud's initial conceptual framework of personality, early psychoanalysis imagined the Cartesian mind (Freud, 1920). The mind, and its internal workings, were seen as separate from the world, and functioning of its own machinations i.e. the mind in here, and the world out there are separate (Freud, Gay, 1999). The intersubjective model takes a post Cartesian approach to the experience of oneself in the world, and fundamentally believes that a person's experience and understanding of themselves is a co-created interaction between mind and world. This collaborative process is essential in understanding the Intersubjective theory of personality development, as well as the dynamic and collaborative interaction that co-occurs in the therapeutic dyad. This is especially important when attempting to understand and attune to the plight of the incarcerated individual. Society has an accidental tendency towards the Cartesian model of mind when thinking about inmates. The assumption frequently is that people who were incarcerated were born "bad" and "aggressive". This view places inmate behavior in a vacuum, and ignores the overlapping impacts of context and early relationships, that lead to personality development as a byproduct of interaction with the external world, not in spite of it.

It is paramount to the Intersubjective Perspective that we understand humans as an especially relationally and contextually bound organisms. While this is true throughout the developmental life cycle, the impact of relationships and context is especially important during early childhood development (Doctors, 2007). As mentioned earlier, while children are born with certain preset biological dispositions, temperament, skin color, etc., personality and experience of self is not readily apparent and develops gradually over time (Beebe, Lachmann 1998). Babies are born ideally into a situation in which they are supported by primary care providers. Much in the same way that we look in the mirror to gain an awareness and understanding of our physical features, children look out into the world, and to their caregivers as early means of knowing themselves as reflected in the way they are responded to (Beebe, Lachman,1998). Much of the psychological literature supports that early child/parent interactions such as empathic mirroring, play an important role in facilitating self-experience. Moments in which a childs smile or sadness is reflected back by a parents' own facial or verbal recognition of affect, plays an important role in the development of personality (Winnicott, 1967). Similarly, concepts such as the "Winnicottian", or good enough parent, help to shape early understanding of the role and acceptability of affect (Winnicott, 1953). When parents work to set aside or effectively regulate their own affective states while making space for, and acting as a container for a childs affective states, children are more likely to follow a healthy developmental track. Affect plays an especially important role in all of human life in its ability to organize and inform personal experience and meaning making (Atwood, Stolorow, 2014).

While there are many ways for primary care providers to respond to children, and many scenarios which require responding, the Intersubjective Perspective focuses its gaze on two primary styles of responding. The first style is referred to as attuned responding. We can broadly

think of this response style as being geared towards empathy, compassion, unconditional love, and curiosity. As defined in the Merriam-Webster dictionary, attuned means "aware of and attentive to something" (Merriam-Webster, 2022). Attuned responding serves many purposes, all in the support of longer term mentally healthy functioning (Buirski et. al, 2020). As an example, a child may come home from school crying. An attuned parent might respond to this event by stating "You seem so upset! What happened?". The child in turn might respond with "another kid at school picked on me and called me a loser". Finally, the parent might respond with "It's upsetting to be called names and it really hurt your feelings. That was a mean thing that the other kid said". While this interaction may seem simple on the surface, the child has received an incredible amount of information about their sadness and their social interaction. In this short example, the child has learned that it is ok to be sad, that other people are able to recognize their sadness without being put off or burdened, and that sadness can be expressed and processed as opposed to "solved" as a healthy form of affect regulation. The child has also learned to recognize that sadness might be an appropriate response to cruel words from another, and finally that the child is not at fault or responsible for being insulted and is certainly not a "loser". Attuned responding in general helps to facilitate a healthy and compassionate self-experience (Buirski et. al, 2020), meaning that when others are attuned to us and our needs, it allows for the internalization of an ability to be attuned with ourselves. This is the goal for mentally healthy adults, in which we are able to relate to ourselves in a way that is, similar to the good-enough parent who is compassionate, empathic, supportive, and curious.

On the other end of the spectrum, we have missattuned responding. This way of responding comprises a wide spectrum of approaches to affect and experience. It is outside the scope of this paper to fully address the myriad forms of missatunement, especially in early

childhood. However, we can start to think of missatuned responses as generally being invalidating, pathologizing, judgmental, harsh or cruel, and not geared towards empathizing. Early missatunment can be as subtle and covert as a busy parent who rolls their eyes every time a child reports how tough their day has been, communicating that feelings are burdensome and better kept to oneself. Missatunement can also be as overt as physical, sexual and emotional abuse, which communicates worthlessness, unlovableness and helplessness. Missatunement does not facilitate a healthy self-experience and instead leads to adaptive ways of understanding oneself, others, and the world, in an attempt to maintain safety, stability, and connection, primarily to early caregivers (Buirski et. al, 2020). Early missatunement experiences lead to what is frequently referred to in clinical psychology as psychopathology, although the intersubjective perspective recognizes this as, clients' best attempts at striving towards health and connection (Buirski et. al, 2020).

Over time, a multifactorial combination of responding styles, life events, societal norms and many other factors exert influences on how clients come to experience and understand themselves (Atwood, Stolorow, 2014). Bronfenbrenner's ecological model highlights the many over lapping domains which inform our identity and behaviors (Bronfenbrenner, 1979). As the developmental process continues, children begin to develop organizing principles. Similar in some ways to the concepts of core beliefs or schemas, organizing principles are ideas that seem to be at the core of personality and self-experience, and exert and immense force on how clients view, understand, and relate to themselves and others. Organizing principles fashioned from early missatuned responding are especially malignant, and are often the reasons why clients find their way to therapy. An organizing principle such as "I am worthless" will inevitably impact mood, relationships, work and home life, pursuit and setting of goals, as well as other areas of

daily functioning. Much like an out of tune guitar will be especially notable in comparison to an accurately tuned band, clients coming into therapy may have noticed that they find themselves in a discordant relationship with many aspects of their life.

Therapy Through the Intersubjective Lens

When people eventually find their way to psychotherapy, their presenting problems are often this felt sense of discordant interaction, usually presenting as depression or anxiety, as well as what might be defined as a pre-reflective yearning. As previously mentioned, the development of a healthy, compassionate and unconditionally loving self-experience is the key ingredient to a healthy inner and outer life, and its absence leads to problems in functioning. It is the striving towards health and a yearning for attuned responding that brings people into our waiting room; a hope for a new experience, paired with the simultaneous fear of the repetition of a harmful yet familiar experience (Buirski et.al, 2020). While Intersubjective Systems Theory does not see the therapeutic process as one of "reparenting", it is an environment in which the psychotherapist can provide a new and potentially corrective attuned experience through collaboration with patients in an effort to illuminate a patient's developmental narrative in the context of present day deficits in functioning (Orange, Atwood, Stolorow, 1997). There is no "curing" or "fixing" from the Intersubjective lens, in the same way that you do not "cure" or "fix" appropriate sadness. Instead, the relational psychotherapist highly prizes the subjective experience of the client. While there is an infinite amount of interactions that are birthed out of each unique dyadic alliance, there are three primary skills implemented in an intersubjective endeavor. Attunement to affect is the first tool that the intersubjective therapist utilizes to illuminate subjective experience. By labeling the clients subjective emotional experience, the therapist provides a unique experience where clients can feel understand, better understand themselves and develop a

broader emotional vocabulary. A byproduct of therapeutic attunement is the increased familiarity with the sensation of appropriately being attuned to, thus engendering a retroactive understanding of early missatunement and the potential for the development of new organizing principles (Buirski et. al, 2020). When a patient makes a statement like "when I used to try to tell my dad I was sad, he'd always tell me to suck it up. I just kind of stopped letting him know how I was doing", the intersubjective therapist might respond with "It hurts to have your feelings dismissed. It makes sense that it would feel scary to open up to others". This statement provides a new and corrective emotional experience by attuning to feelings of hurt, invalidation and even fear, instead of dismissing those feelings as they had been in early childhood. This client may have never been able to put into words the ways in which their father's response impacted their ability to connect with or share with others. Conversations such as this one, and attunements in general play a major role in the collaborative process of building a conceptualization with the client.

A second major role of the therapist is to use subjective experience in the present to find our way back to past misattuned experiences, as well as being curious about affect words utilized by the client. In the early parts of the conversation with the previous client, the therapist might have taken notice when the client stated. "I kind of get scared when I think about telling my partner how I feel", to which the therapist might respond with "tell me about feeling scared". The client may respond with "I'm just scared they'll get annoyed with me or it'll stress them out". Finally, the therapist might respond by asking, "I'm wondering if there have been other people in your early life who made you feel like you were burdening or bothering them with your feelings? How did your parents respond when you would tell them you were upset or anxious or scared?". Through this technique, the therapist uses jumping back to the past as a way to better understand

the contextual and relation circumstances that make up the clients' assumptions about sharing their feelings with others. In essence, attunement is used to better understand how the client came to be the way that they are, and better understanding leads to more effective attunement, allowing the therapist to provide a continuous and ever expanding corrective experience. Jumping back to the past also allows clients to recontextualize, and better understand the ways in which they have learned to relate to others, and to protect themselves from real and perceived threats to love and safety.

Finally, through the use of attunement and exploration, the therapist is able to articulate to the client, the collaboratively built narrative of how the clients sense of self is organized. It is important to note that yet again we see an important distinction between early Freudian analysis and the more contemporary relational perspective. Interpretation presents communication from therapist to client as objective truth. On the other hand, the concept of articulation places more emphasis on communicating a shared and co-created narrative of how the client came to be the way that they are, that is birthed from the intersubjective field created by the overlap of the therapists' and clients' unique subjective worlds. While the distinction between "interpretation" and "articulation" may seem purely semantic, it highlights the style of thinking about the therapeutic situation that is the foundation of the intersubjective model. Specifically, the use of the word articulation highlights that the intersubjectively oriented therapist recognizes the uniqueness of each new therapeutic dyad, as well as the fallibility of the therapist due to their own unique subjective experience with their own set of potentially limiting organizing principles; a concept frequently referred to as countertraference.

In relation to working with incarcerated clients, the intersubjective model is especially well suited due to emphasis on early experience in the shaping of identity. Many clients in the

jail and prison system grow up in contextually harsh environments in which factors such as poverty, parenting, education, available opportunity and discrimination are all present (Altman, 2010). Adults from such environments may especially benefit from a therapeutic approach that focuses on collaboration and attunement. Incarcerated patients may benefit from better understanding themselves as complex selves, shaped by their unavoidable circumstances, as opposed to being organized around being "bad people" or "criminals".

Aggression and Intersubjectivity

It is important to briefly touch on how the intersubjective perspective approaches the concept of aggression in patients, as patients in the criminal justice system often have a history of violence, and a tendency towards the expression of aggression. The early Freudian model of analysis is oriented around the Cartesian mind and its internal drives (Freud et. al, 1999). Freud in his medical model of the mind, hypothesized that the unconscious mind was split into three distinct section, id, ego, and superego (Freud, 1920). The superego was the stern rule bearing sector of the mind, and the ego took on the role of marriage counselor in encouraging collaboration between the superego and the id (Freud, 1920). Finally, the id was a sector of the internal unconscious made up of pure drive and sexual and aggressive impulse (Freud, Gay, 1999). Freud conceptualized aggression as an internal process that is innate to human psychology (Freud, 1915).

By comparison, two-person relational models view aggression and all feelings as a co-occurring process between person and context (Lachmann, 2000). In the case of my patient we will see how early missatunement, and its impact on the development of self-experience, overlap with situational aggression. In thinking about many incarcerated patients, the phrase "A culture of Violence" needs to be taken literally. The intersubjective perspective places a heavy emphasis

on the impact of culture in shaping organizing principles and normative behavior in individuals. Patients who grow up in crime families and gang culture, learn young that violence is not only a means to an end, but is deeply interwoven with personal safety, respect and success (Spapens, Moors, 2019). It is helpful to empathize with the gang perspective that members of criminal organizations may organize themselves around the idea that they are soldiers. Acts of aggression towards other gangs can then be seen as a response to context, as opposed to aggression occurring in the vacuum of the unconscious. It is also helpful to see acts of aggression towards civilians as a way of maintaining connection to loved ones and perceived family. As mentioned earlier, patients seek out therapy in search of a longed for attuned responding and connection. Children with absent, drug abusing parents may hypothetically seek out gang culture for similar reasons.

Trans institutionalization

No conversation about the treatment of incarcerated psychology patients is complete without first understanding where the need for increased psychotherapy for this population arises from. In the early days of psychotherapy, patients struggling with severe and persistent mental illness were almost entirely treated and warehoused at large asylums. Understanding of psychology was limited and the mentally ill were often viewed as lepers, needing to be kept away from the general public. Frequently, asylums were overcrowded with hundreds of psychiatric patients. Eventually a major shift occurred in the treatment of the mentally ill referred to as de-institutionalization. The shutting down of large asylums was a push towards seeing patients as whole people, spurred on by the Kennedy family (SAMHSA, 2022). After the unsuccessful and destructive lobotomy of her younger sister Rosemary Kennedy, Eunice Kennedy began pushing for the improved treatment of the mentally ill and as a result, blazed a

path for the closing of massive asylums (SAMHSA, 2022). However, de-institutionalization came with an unfortunate and heavy price.

Closing the large asylums did not decrease the amount of people struggling with severe and persistent mental illness. Instead, this over correction has made it far more challenging for those in need to find beds in long term psychiatric facilities (Primeau et al, 2013). Due to this lack of supply, a process known as trans institutionalization has occurred in our country. As a result of this lack of access, more and more severely mentally ill patients find themselves in another kind of inpatient setting; the jail and prison system (Primeau et al, 2013). Instead of avoiding the warehousing of psychiatric patients, the process of de-institutionalization simply led to patients being more likely to get picked up by the police and to fall through the cracks of the criminal justice system. Due to this process, there is a greater need to understand and implement new, more advanced forms of psychotherapy in criminal justice settings.

The Case of Patient X

Patient X was referred to me during my time at the Denver County Jail. Important to note is that patients are generally self-referred by a process in which an inmate may request to work with the psychology department. Also, important to note is the fact that inmates are traditionally provided six to eight weeks of individual therapy which can be extended at the preference of the therapist and the supervisor. The duration of this therapy was seven weeks. At the time of our meeting, Patient X was a 38-year-old cisgender heterosexual Latinx male. He initially presented to treatment for management of depression and, in his own words “to talk about how I ended up here”. In our initial consultation session, Patient X reported feeling lost and concerned about the future. He reported that he might be going to prison for a long time and expressed feeling

ashamed of the fact that his actions may have led to his 5-year-old daughter growing up without him in her life.

Two important counter concepts ran through the entirety of our 7 sessions together. The first was that in our initial session, Patient X reported that he was a high-ranking cartel member. He also reported that he was a "shot caller" in the jail for the Latinx gang population, meaning that other inmates often deferred to him for the solving of problems, marching orders and leadership. Acts of violence committed in the jail often involved his approval or involvement. The second was that if you did not know any of these things about Patient X, you would most likely find him to be thoughtful, humble, conflicted and likeable. Initially, I wondered frequently about the dichotomy of these two ideas in the way that I understood patient X and whether these were signs of a narcissistic personality disorder or an antisocial personality disorder. However, it is important to keep in mind that diagnostic category may in fact obfuscate the truth of subjective experience, as opposed to illuminating it.

Patient X was born in a small town in Colorado, and directly into a family with connections to the cartel. Patient X did not remember much about his mother. He did recall that his mother had what he reflected on in our treatment as a drug problem. During one session. He discussed an early memory, around the age of 9 in which he recalls his mother belligerent and screaming in their house as he went up to his room and closed his door. He recalls that she left the family shortly after and that he had not seen his mother since. In discussing this moment during our session, Patient X stated "I think I was scared back then but it kind of makes me angry to talk about now". I asked him about his anger to which he explained "Moms aren't supposed to act that way. I think it was the first time I saw how crazy and out of control women

could be". In this moment, we reflected on an already developing organizing principle that to be emotional was to be out of control and weak.

Upon the absence of his mother, Patient X's father would loom even larger in his life. In one of our earliest sessions he described his father as "Not being much bigger then I am now but he seemed like a giant". Patient Xs father further concretized the concept that showing emotion was not only weak, but was also "not something that men do". Patient X was beginning to learn that men were meant to be strong, logical, ruthless and the head of the family.

The year after his mom left, at the age of 10 years old, Patient X went on his first drug run with his father, bringing cocaine from one side of the country to the other. "I grew up pretty fast after that. My dad just started taking me with him. I didn't really have a choice and it was when I spent the most time with him". Family and crime became closely connected at a young age. Patient X quickly learned that the way to maintain his connection with the only caregiver still in his life was to "grow up fast" and follow in his father's footsteps. In later sessions, my attunements were about the dichotomy between Patient Xs love, and fear for his father. In some of our final sessions Patient X would acknowledge that he had been worried that if he had stopped going on these drug runs with his father, his father might have stopped loving him and left, much like his mother had. During these early years, patient X experienced, what we would come to see in our work, as a long list of traumatic and violent situations. Patient X recalled witnessing his father, and those close to his father brutally physically assaulting other people. In one session, Patient X recalled that at the age of 12, he watched his father remove the hand of a women with a machete to get the many bracelets she had around her wrist. Patient X recalls having a "complicated" relationship with his father as he grew old. He frequently spoke about how his father would encourage him to engage in criminal activity and recalls the "proud look"

on his father's face. He also recalls moments in which his father would beat or insult him for expressing fear or sadness. These moments of affect missatunment further concretized the importance of being "emotionally tough" and that expressing emotion was not only frowned upon, but was also potentially dangerous. In moments when I attuned to his feelings, or expressed that he had been through many traumatic experiences, Patient X initially reflected "I guess I must have been. I don't know. It's just the way things were so I didn't really know anything else". In comments like this we can see evidence of Patient X developing organizing principles about his role in the world, as well as his shifting baseline around danger and violence. In one session, I attuned to the fact that Patient X was "robbed of a normal childhood" and articulated that his fear of going to prison may have been partially due to the shame he felt of potentially robbing his daughter of a normal childhood. This was the first-time Patient X became tearful during our sessions.

Patient X found himself in and out of the prison system throughout most of his life and leading up to our meeting. He often described how exhausting this had gotten, and frequently reflected on the dynamics that came with incarceration. "If the guards are going to act like guards then the inmates are going to act like inmates" he stated as a matter of fact in one session. Although predominately a pre-reflective understanding that became illuminated more fully during our treatment, Patient X had some insight about how the prison system impacted his sense of self. In another session, Patient X bluntly stated "I can cry in here with you but if I go and do that out in the yard I'm putting myself in real danger". All of the messages passed down by his father, a man who also spent time in the prison system were being further concretized.

Spurred on by his father's praise for his criminal activity, Patient X became more involved in the cartel and received similar praise from other members of the cartel community.

Patient X learned quickly that violence and power were a means of getting respect, protection, money and success. However, by the time he found his way to me, he was also beginning to feel that he was losing more then he gained from these acts. With the potential for a longer sentence and the disconnection from his daughter, Patient X was beginning to feel new and confusing feelings such as regret, shame, and fear. Much emphasis was placed on attunement to the fear associated with opening up and acknowledgment of the fact that, despite not wanting to be sad, Patient X had been terribly sad many times throughout his life. As treatment progressed, Patient X was able to empathize with a part of himself that had been cut off and ignored throughout most of his life. He was able to acknowledge that he felt betrayed by his father who he experienced as having led him astray. In later sessions, early signs of the development of new organizing principles began to appear. In one session Patient X commented on a previous articulation made by me and stated "you mentioned that you've cried before and still think of yourself as a man. I've been thinking a lot about that. I didn't even realize that was an option. I didn't really have many options". Initially organized around the ideas that he was born to be a criminal, Patient X slowly began to recognize that he had in fact been a lonely child whose only way of maintaining family ties, was to enter the family "business". Close to the end of our treatment, Patient X responded much more strongly to the attunement of having been robbed of his early childhood.

There were also many signs that pointed to our relationship as being a novel and potentially corrective experience. Patient Xs ability to cry with a male therapist was a good marker that his ideas around masculinity, and the need for aggression to manage complex emotions were shifting. In the follow up session to Patient X's first time crying in session, we reflected back on that moment. I was able to attune both to the shame of crying, as well as the relief Patient X appeared to feel after this moment. In our second to last session Patient X

reported that he had made significant changes to his role in the jail. As a high-ranking cartel member, Patient X reported that he had begun to be a source of support for other men in his pod. He described how after one of our sessions, he had returned to his cell and wondered if any of the other men had felt like he did. In our final therapy session together, Patient X presented as having developed the beginnings of a healthier self-experience. He showed an increased capacity to recognize and express affect and reported that he felt he could trust me and the therapy as a safe space where he could "just say what needs to be said".

Treatment Outcome

While treatment was shorter than most dynamic therapies, Patient X was able to reflect on seeds that were planted during the course of his treatment. Patient X was able to better understand the factors, outside of his control, that had led to the concretization of his criminal identity, and eventually led him to incarceration. He was also able to start to develop new and healthier ways of experiencing and understanding himself which included his role as a father, as well as his role as an unwilling participant in his father's life of crime. During treatment Patient X began the process of broadening his emotional vocabulary. By the end of our work together, Patient X was much more capable of acknowledging moments in his life that had been traumatic, painful, and upsetting. Similarly, Patient Xs ability to cry in session, especially with another man was a sign of the development of a healthier understanding of masculinity. These tearful moments were also beneficial in allowing Patient X to come into contact with split off feelings of sadness, as well as empathy for his predicament. Finally, Patient Xs' frequent acknowledgment that he had "never really talked about this stuff with anyone" points to the novelty of the relationship he had with me.

The intersubjective field that Patient X found himself involved in with me, may have been unlike any other he had ever had in his life. As should be standard in all therapeutic alliances, my unconditional positive regard for Patient X was paramount. In his early development, Patient X had learned that the strong, violent and happy child gets loved, while the sad child gets beaten. In our therapy, Patient X found that I was equally curious and empathic regardless of how he was feeling. Unlike his father, I did not physically or verbally beat or invalidate Patient X when he began to explore feelings of sadness, fear and loss. Even more important were moments of intersubjective conjunction in which my own self-disclosure of my relationship to masculinity and sadness, helped to articulate a healthier way for Patient X to experience and understand his own latent sadness. It is possible that my identity as a man who had achieved success without engaging in crime, who was in touch with his feelings yet still able to work in the harsh environment of the criminal justice system, was an important factor in our work together. These factors may explain the rapid development of new organizing principles as I strived to make therapy a place where men were safe to approach discussions about feelings and were strong for allowing themselves to experience them.

There is a high likelihood that new organizations may have faded into the background since working with this client. While new organizing principles can be developed and concretized with long term treatment, old patterns of organization tend to resurface in times of stress, and especially when clients find themselves in old yet familiar contextual environments and circumstances (Buirski et. al, 2020). Upon the conclusion of our work together, and even at the end of my time at Denver County Jail, Patient X was still awaiting trial and may have received a prison sentence. Patient X was able to acknowledge that his capacity to connect with his feelings was impart due to the safety of our therapeutic alliance. He also recognized the

adaptive nature of shunting off feelings such as sadness, fear and anxiety, as well as the potentially dangerous implications of showing this "weakness" to others while incarcerated.

Discussion

From the lens of the Intersubjective perspective we can see that Patient X, along with many forensic cases, are fertile ground for a more relational approach to therapy. Patient X's experience of himself, others and society was drastically shaped by early missatuned experiences. In the case of Patient X, missatunement to his authentic nature, as well as to his feelings, wants and needs, developed organizing principles that eventually led this patient to the jail and prison system. We might also take note of the ways in which jails and prisons further concretize inmates around organizations of being violent, unlovable, and beyond help or reform. It is especially important then for clinicians working with patients in the criminal justice system to work as a counterbalance to a system that tends to swallow patients whole. We come to better understand Patient X through the understanding of traumatic experiences early on in his development, and the impact that they had on his ideas about violence and masculinity.

As mentioned, it is likely that, due to the context of jail, Patient X may have found safety in reverting back to older organizing principles. However, the course of therapy highlights two important points about the benefits of the Intersubjective perspective. First, my work with Patient X highlights the importance of providing jails and prisons with more clinical staff capable of providing longer term therapy to incarcerated clients. Clinicians in the correctional world are constantly fighting to counterbalance long histories of relational missatunment, as wells as systemic and contextual impacts on the concretization of pre-existing organizing principles. Seven sessions are not nearly enough to fully illuminate a whole subjective universe. Secondly, my seven weeks of work with Patient X highlights the strength of the Intersubjective perspective

in this setting. Although a tree may not have been grown, seeds were certainly planted. In only seven sessions, Patient X was able to vastly increase insight around his development, the ways he had been missatuned to, and his capacity for new ways of being in the world. In our final moments of work together, Patient X simply stated “If I had been given a choice, I might have said no. I might have chosen differently”. Many patients in the criminal justice system world may also come to this subtle yet profound insight as well. However, this will only occur if the clinical community helps to provide patients in this setting the opportunity to rewrite their narratives and reach for a new experience unlike any they have had before.

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