Intersubjectivity and the Shared Third Perspective in the Therapeutic Relationship

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Abstract

The relationship between two people and their own individual subjectivity, each with their own mental processes, requires mutual recognition of the existence, needs, and perspective of the other. The recognition of subjectivity in the therapeutic relationship is a co-created process that leads to a shared third perspective from which to reflect about the relationship and regulate the conflicts of the dyad. In integrative psychotherapy, the recognition of the client and the therapist as two different subjectivities co-creating the therapeutic relationship is expressed through inquiry, attunement, and involvement with the relationship's four components: acknowledgment, normalization, validation, and presence (Erskine, 1997, 2015; Erskine & Trautmann, 1996). The client may bring through transference with the therapist old relationships in which his or her subjective perspective was not sufficiently taken into account. The intersubjective therapeutic relationship is a co-created process in which the two participating subjectivities experience a "shared third perspective," from which both can reflect on their own relationship and feel a sense of "we." Recognizing that the client has a separate mind with their own needs and experiences is key to treating disorders of the self, fostering the evolution of the subject from his or her arrest at an experience of disconnected emerging self-states, such as psychosis, Autism spectrum disorder, Asperger's syndrome, etc., acquiring a coherent a nuclear self and, beyond, experiencing an intersubjective and verbal self (Stern, 1985).

Keywords

Intersubjectivity, integrative psychotherapy, autism spectrum disorder, Asperger's syndrome, mirroring, mirroring relating

In this article, I propose that an intersubjective relationship is a co-construction of the two participating "subjectivities" in the therapeutic relationship. The intersubjective relationship leads to the experience of a "shared third perspective" from which both subjectivities can reflect on their own relationship and feel a sense of "we." This is a new set of experiences of the dyad that allows both members to regulate emotional conflicts and impasses in the treatment. In the therapeutic relationship, this requires that the therapist be aware of several intersubjective relational levels that may be present in the relationship (Martínez, 2017a).

In order to enter into a truly intersubjective relational dimension, each person must be recognized for their differences. The symbolic dimension becomes a kind of bridge, so that the relationship develops beyond a level of projective relating (in which the other is used as a projection screen) or mirroring (in which the other is needed as a permanent source of emotional regulation or as a unifying mirror of the repressed, split, dissociated, or fragmented parts of the person). Adult intersubjective relationships are founded on the recognition of a different other, always unattainable, always somewhat unknown. It is our differences that allow us to get out of a narcissistic world, where we always risk looking for ourselves in others, and

where resonances and echoes cause the subject to disappear in a reflective, speculative infinity where there is only one solitary ego (Han, 2017).

Intersubjective relationships require accepting, tolerating, respecting, honoring, and validating differences and accepting the limits of sharing experiences. They interrupt the perspective of the one and introduce the perspective of the other. This begins something entirely new; an intersubjective paradigm that moves from using the other as a "magic mirror," reflecting the desired image or regulating unbearable emotions, to recognizing the other who waits beyond the mirror. This can be understood as the effort to build a "shared third perspective" and enter the world of mutual recognition of both subjectivities.

In psychosis, a regressive path may be undertaken by the individual, when their mirroring needs are frustrated and they subsequently enter into a self-created imaginary shell that tries to restore the lost relationship at the expense of reality testing. We can also find in clinical practice developmental states that are arrested before the appearance of the intersubjective relatedness, such as Asperger's syndrome and autism spectrum disorders, in which the relationship with another subjectivity is only partial.

Several Perspectives of a "Shared Third" in the Therapeutic Relationship

Psychoanalytic Perspectives

The development of a "third perspective" in intersubjective therapeutic relationships has been theorized in different ways by various schools of psychotherapy. For example, the "third" is conceived by Spezzano (1996) as an interactive process that creates an experience of mutual recognition and a mental space to think in the form of an internal conversation with the other. This space is conceived as an observation point external to the dyad: In the case of therapeutic relationships it could be the theory with which you work, the rules of technique, the profession, etc.

A different way to think about the "third" in relationships is elaborated in postmodern psychoanalysis. Lacan argues that the third, and the beginning of triangular relationships, originates in the Oedipal stage. The third is seen by Lacan (1975/1991) as the father, who, by intervening between the child and the mother (a process Lacan calls "castration"), constitutes the symbolic third. This involves accepting the reality that the mother has her own desires and has chosen the father. This process allows access to the symbolic world, where a third party releases the subject who is imprisoned in the imaginary maternal orbit. When the subject does not access the symbolic world, he enters what Han (2017) calls the "hell of the sameness," where similarities are sought and differences are ignored or avoided. This perspective of a shared third party prevents relations from collapsing (Lacan, 1975/1991) in the form of fusion or unity, in which differences are eliminated, or in the form of opposition, in which differences are polarized in a power struggle.

Other authors, such as Benjamin (2004), are far removed from this perspective. This author sees the "third" as a quality of experience that entails the co-creation of an internal mental space. She states that the third originates early in the mother-child dyad. Unlike what Lacan proposes (1975/1991), recognition of the other would not be originally given by spoken language. Rather, it would begin with the early, nonverbal experience of sharing a pattern, a dance with another person. Thus, the shared third, as an intersubjective process, is constituted in the early pre-symbolic experiences of accommodation and mutuality and in the intention to

recognize and be recognized by the other. For Benjamin the third is more than a space from which to observe; it is a principle, a function, or a relationship.

In Benjamin's (2004) conceptualization, the mother must create the third by being empathetic; able to maintain both her own subjectivity, desires, and awareness and the needs of the child; and aware that the child's distress will end. The symbolic space of the third is created when the tension between "my needs" and "your needs" is sustained while, at the same time, I stay attuned to you. This third space prevents the Oedipal third, proposed by Lacan (1975/1991), from becoming a persecutory invader rather than a representative of symbolic functioning or an identification figure that both mother and child love and share.

According to Benjamin (2004), the therapist can relieve or regulate the patient only if interventions are made from the position of a shared third party. If the therapist tries to help from a symbiotic position, he or she becomes "the one who knows," "the one who heals," the one who "is in charge." This has the risk that the patient feels that he or she "has no impact" on the therapist or that he or she is "in debt." The patient may inhibit his or her differences in order to feel that he or she "gives something," or they may react to the power of the therapist with "envious defiance" (Benjamin, 2004).

From a modern psychoanalytic perspective, Fonagy et al. (2002) have shown how the mother can show her empathy for the child's discomfort or negative emotions and, at the same time, through a kind of exaggerated mirroring, make it clear to the baby that the stress that the baby has is not the mother's. The contrast between the maternal gesture and her internal level of tension is perceived by the baby. The child is relieved by the fact that the mother is not also stressed, but reflects and understands her feeling. This incipient differentiation between the maternal gesture and the feeling initiates the "symbolic third." It is the point where the mother's self-regulation and mutual regulation meet. The mother distinguishes her distress from that of the child and understands this as a necessity rather than an urgency in her mind. This allows differentiation with empathy rather than projective confusion.

Relational Transactional Analysis

From the perspective of relational transactional analysis, Helena Hargaden and Brian Fenton (2005) also move away from Lacan (1975/1991) and propose that the third is already observable in the first six months of life. They argue that in this early period we can find a form of "tertiary intersubjectivity," one created jointly by the mother and the baby, in which the latter accesses the emotional experience of the adult and the adult feels and contains the emotional states of the baby (Hargaden & Fenton, 2005).

All human emotions can impact the other and transform the feelings of the other through primary intersubjective experiences, and this opens the emergence of a co-created space between mother and baby. For example, face-to-face parent-child play research shows that a rhythm is co-created. The rhythm is not constructed through a reaction-action model in which one participant is active and the other passive, or one leads and the other follows. Further, the co-creative process is not simply imitation, but is shaped by the innate call to align and synchronize with another human being. When a caregiver recognizes the baby's processes and surrenders to his or her rhythms of feeding, sleeping, and playing, an organized system begins to form with a new, co-created rhythm. As the caregiver and the baby settle in, they mutually accommodate each other in a symmetrical response. Thus, we learn to accommodate the accommodation itself, to recognize it, identify with it, and then use it.

Integrative Psychotherapy

From an integrative psychotherapy perspective, we may conceive the "shared third" as an intersubjective co-constructive process resulting from the use of relational methods, whereby both members of the therapeutic dyad experience a shared perspective of the other's thoughts, feelings, and inner efforts to self-regulate through unconscious scripts. This contributes to the co-creation of an internal mental space in both members, which mediates between "me" and "you." This is a co-created space where each may reflect on the relationship, and recognize and accept mutual influence of the other. In this space we co-create a sense of "we" or "togetherness," free ourselves from trying to control or exercise coercion, and follow some process that mediates between the self and the other (Ghent, 1990). At this point both members are aware of and experience each other's perspective and how aspects of the other's subjectivity influences what occurs in the therapeutic process. This is the experience of becoming aware that both members of the dyad are co-creating what happens in the therapeutic relationship.

We cannot conceive of this shared third perspective as the Parent ego state of the ego, or the theory with which we work, with its rules and ideals to which the therapist adheres. The "shared third perspective" is both an intersubjective process and an intersubjective experience, and as such helps to understand and analyze the factors of the client-therapist dyad that make the therapeutic relationship a co-construction—a unique and unrepeatable process.

It requires the therapist to consider his or her own script beliefs, countertransference, and understanding of how this may mobilize the client's own transference. The therapeutic relationship that takes place is built together, and the characteristics it adopts depend closely on the two people involved in the process. It is an essential process to address impasses in the therapeutic relationship, to treat personality disorders and psychotic states, and to address developmental arrests at a level of primary intersubjectivity.

In contrast to an "objective" analysis of the client, the intersubjective approach needed to build a "shared third" in the therapeutic relationship acknowledges how difficult it is for a therapist to be "neutral" and "objective" due to his or her own history (Atwood & Stolorow, 1984; De Young, 2003; Stolorow & Atwood, 1979, 2004). Therapists need to be aware that sometimes it is difficult to separate the observer from the observed, and they should accept that the role of the observer modifies the observed field. We maintain an intersubjective relationship when we are aware of our role as an observer participating in each other's process. The therapist is, at best, a participant observer in the therapeutic process. If we were not aware of this, we would tend to treat the client as an isolated mind, about which value judgments are made (Atwood & Stolorow, 1984; De Young, 2003; Stolorow & Atwood, 1979, 2004).

Since the development of the self is only possible in the context of a relationship (Erskine, 1991), it is in the therapeutic relationship that the subject will develop the self and find the vocabulary needed to name and symbolize frustrated needs. This requires experiencing a new and shared perspective with the therapist. The set of relational methods in integrative psychotherapy foster the development of a "shared third," that is, a process and experience of shared perspective of the other's needs, affects, and mental states in the therapeutic relationship.

Intersubjectivity, Sharing of Experience, and Impasse Resolution

Intersubjectivity allows us to understand the developmental trait that allows us to recognize the existence of another subjectivity (Benjamin, 2004). The intersubjective therapeutic relationship needs the recognition and acceptance of the mutual influence of the two members of the dyad.

The resolution of impasses in the therapeutic relationship requires that both members of the dyad can exchange their experience of the situation in a dialogue about each person's perception of the problem. This is an intersubjective process. It is necessary to reflect on what is happening in the relationship and to accept and respect the experience of the other. This process leads to a co-created experience that can be visualized as the establishment of a "third position" between both. From this third position, the members can understand the experience and transform it in a way that allows the relationship to continue without erecting defenses. The "shared third" party mediates between you and me and facilitates the recognition of the other's subjectivity. Berne (1958, 1961) stressed the importance of mutual recognition in relationships by categorizing it as a basic need, as its absence generates personal suffering and dysfunction in the interpersonal relationship. Recognition is defined by Berne (1961) as the awareness and acceptance of various dimensions of the other: the existence of the other, his or her inner experiences (thoughts, feelings, sensations, etc.), the results of his or her actions, his or her principles and values, his or her personality, his or her life plan, and the personal meaning he or she has for us. In integrative psychotherapy, the recognition of the other subjectivity in the therapeutic relationship is expressed through inquiry, attunement, and involvement with the relationship's four components: acknowledgment, normalization, validation, and presence (Erskine, 1997, 2015; Erskine & Trautmann, 1996). Relational methods in integrative psychotherapy are a guide to intersubjective treatment (Martínez, 2016). That allows the person who has entered into the therapeutic relationship to be aware of his own mind through the eyes of the therapist.

Relationships may decline in quality when this advanced intersubjective perspective is not present enough, as in during client or therapist transference, when the other is experienced as a projection screen, when the other is a permanent source of emotional regulation, or when the other becomes a mirror that unifies the repressed, split, dissociated, or fragmented parts of the person. At that point, the other is lost behind a projection screen. The relationship may then regress to a point where the other's existence and his or her physical, emotional, relational, and developmental needs are discounted or distorted. One person becomes a subject and the other an object. There is no recognition of the other's subjectivity, of his or her feelings, needs, and actions (Benjamin, 2004). The intersubjective perspective is distorted at several levels.

Clients may transfer to the therapist aspects of their archaic relationships in which they experienced deficiencies in the recognition of their own subjectivity. When consideration for the subjectivity of the other is lost, symbiotic relationships of a complementary or competitive type may be established (Schiff et al., 1975). In these relationships differences are denied. Dependency becomes obligatory, one attracts the other into the orbit of submission or reactivity, and the impasse escalates. In the case of complementary symbioses, one person assigns to the other the ability to define reality. In either case, symbiosis is the sign of the absence of recognition of separation from the other, the denial of that space that allows desire and acceptance of loss.

This can be brought into the therapeutic relationship in a transferential way. A parental figure who failed to respond to developmental needs may be projected onto the therapist. We

can clearly appreciate the role that the projected other plays in the relationship in the course of grieving work (Martínez and Fernández, 2013). In therapeutic relationships the transferential repetition of symbiotic relationships are similar to the so-called complementary relations described by Benjamin (2004) and to what Racker (1953, 1957) describes as complementary—not concordant—countertransference.

In other cases, some clients who have experienced deficiencies in the recognition of their own subjectivity by parental figures may develop split relationships (Haykin, 1980). In these relationships, differences are polarized, maximizing the impact that comes from the predominance of projections and/or redefinitions in the relationship. In this situation the conflict cannot be observed, contained, or mediated. Vengeful reactions may arise during the conflict, based on the use of splitting of ego states, believing that one is absolutely right and the other is totally wrong. We can see it in the transference and countertransference responses found in the treatment of personality disorders that may reflect split relationships (Martínez & Fernández, 1991; Martínez, 2013).

In both cases, when an intersubjective perspective disappears, each person may feel that the other "does something to him" ("the therapist cures me" or "this is the client's resistance") instead of feeling that both agents help build a co-created reality (Benjamin, 2004). In such a situation, there seem to be only two choices (Ogden, 1994): submission or rebellion to the other's demands. Each person feels unable to gain recognition from the other. This causes the implementation of psychological games (Berne, 1964) to obtain from the other what he is not supposed to give. In the competitive symbioses described by Schiff et al. (1975), the two perspectives are irreconcilable: "either I'm crazy or you're crazy." It's what Robert and Mary Goulding (1972, 1978, 1979) called the third-degree impasse: it's "either you or me."

The resolution of impasses requires that the client and therapist be able to discuss their own subjective perception of the impasse and that the experience of the other can be accepted and respected. People who are truly willing to acknowledge each other's experience can, in the course of this learning process, transform their views and thus become more aware of their script beliefs.

Inside the Mirror: The Shared Third Perspective in Psychosis and Autism Spectrum Disorders

The recognition of the other's mind is a developmental acquisition, a long learning process that begins at birth, due to the pressure of innate programming to relate to another, and that lasts until the age of six. There is a large difference between the primary forms of intersubjectivity observed at birth (Meltzoff & Moore, 1977, 1994, 1997, 1998), the discovery of a mind that has similar experiences at seven to nine months (Stern, 1985), and the development of a reflective awareness of self and other. In the sixth year of life, the child acquires the ability to think what another person thinks of the thoughts and intentions of a third person (Fonagy et al., 2002).

Mirroring Relating

Is it possible to create a "shared third" in a relationship with people who are developmentally arrested in a period of primary intersubjectivity? Yes. In these therapeutic relationships, we can experience a special form of symbiosis that I call here "mirroring relating,"

which carries a special quality of relationship that differentiates it from other symbioses (Martínez, 2017a).

The "other" of the relationship in mirroring relating is needed as a unifying mirror and/or a stimulus-regulating other that responds to the relational need for security. The other provides the experience of attachment security, arousal, interest, attention, transformation of somatic states, transformation of emotional states, activation, etc., that the person may not achieve on his or her own. We may find this kind of relationship in autism spectrum disorders, psychosis, trauma work, people arrested at a stage of pre-symbolic primary intersubjectivity (Meltzoff & Moore, 1994), and in the transference of some borderline and narcissistic patients. We also can find mirroring relating in non-symbolic, non-linguistic relating, whereby the therapist attunes to cues about the client's body experience which seems to be outside of the relationship (Martínez, 2017a).

Mirroring relating goes beyond the concept of mirroring transference, described by Kohut (1971) in the treatment of narcissistic personality disorders. In these cases, the therapist conveys a sense of value and respect for the real qualities of the patient to compensate for the lack of an experience where the caregiver recognizes the child's capabilities and talents and affirms the child's feelings of strength.

I extend this concept to include the therapist's developmental, affective, and rhythmic attunement to the client's sensorimotor and proprioceptive experiences, his or her body experience, the developmental attunement and accommodation to states of the emergent self, and experiences of primary pre-symbolic intersubjectivity (Meltzoff & Moore, 1999) prior to the development of a nuclear self (Stern, 1985). This kind of mirroring relating underlies the genetic pre-programming of our mirror neurons.

We can notice the loss of intersubjective relatedness that takes place in psychotic regressions, when the client builds a parallel delusional world trying to restore the loss of former mirroring relating. We can also find mirroring relating in some clients arrested before the development of the intersubjective self, for example, Asperger's syndrome or autism spectrum disorders. Most of these children and adolescents lack an appropriate development of their experience of a subjective self and are arrested in the experience of primary intersubjectivity (Martínez, 2017a). They benefit from an attuned response to the needs of preverbal levels of experience. The therapist has to attune to the needs and affective states of the patient and open up to forms of connection typical of the levels of primary intersubjectivity (Martínez, 2017a, 2017b, 2017c, 2021).

Mirroring Relating in Psychoses and the "Shared Third"

In the tale of Snow White by the Brothers Grimm (2015), the magic mirror always told the truth, and that for a while coincided with what the Queen wanted to hear. When the magic mirror thwarted the stepmother's mirroring desires, she killed Snow White and "ate her heart."

Some psychotic clients could take a regressive path when a mirroring relationship is frustrated. When the denial of reality is no longer possible, the person may initiate a psychotic regression where the elements of the lost relationship appear as unconnected islands, in the manner of the fragments of a broken glass that can no longer reflect a unified image of the subject. These fragments call for the creation of delusional fantasies that try desperately to restore a sense of self, at the price of replacing reality and the lost relationship in an equally mirroring way. One mirror replaces the other lost one (Martínez, 2021).

A 12-year-old patient, whose mother had just committed suicide, started a session by telling me, "And how do I know if you and me only are someone's dream." "How do I know if this is reality?" He had initially been brought to consultation a few months ago by his parents

because he claimed to hear voices, which had appeared shortly after their divorce. After the divorce of his parents, he did not express any emotion. The mother subsequently committed suicide.

In that session, it seemed to me that he was trying to deny the traumatic experience of his mother's suicide through the fantasy that life is a dream and not reality. It seemed to me that he was making efforts to re-establish a mirroring relationship and gain validation of his reassuring fantasies. In psychoses the therapist should be open to resonance with the client's fantasies to understand their function and to elaborate the preverbal states that may be evoked during the therapeutic process.

We explored the experience of what it was like for him to live in his dream and the emotional implications of this fantasy. Together, we appreciated the way in which this invented reality had the function of calming the anguish of abandonment experienced after his mother's suicide. In those days he also had auditory hallucinations: "I hear my mother speak with her same tone while talking to another person I don't know." The voices he heard seemed to have the same purpose of denying suicide and restoring a mirror relationship with his mother. We explored the sentences he heard and what they meant for him.

The efforts to receive a mirroring validation extended to other areas and obtained, at most, limited satisfaction: "If I break something, a paper or a toy, I get very sad because sometimes I think they feel," or "If I step on the cat's tail, I approach him to ask for forgiveness as if he were listening to me." I asked him if he also sometimes felt that he was distressing for people. He replied, "Yes, I have the feeling of having harmed my parents... of having influenced them in something but I don't know what." Later, this patient connected with a feeling of guilt in relation to his mother's suicide that we elaborated upon in the following sessions.

It seemed to me that we were working at a level of secondary intersubjectivity that required a developmental attunement, maintaining joint attention and intentionality in relation to the traumatic event, and affective attunement to the unbearable affects stimulated by his mother's suicide.

The phenomenon of interintentionality, by which desires can be shared in the relationship ("I miss my mother," "I want to understand your current experience"), and the phenomenon of interattentionality, by which we can share a common focus of attention ("Look at that fantasy"), helped to start a shared process. We also shared affects, feelings of deep sadness ("This makes me sad"), and fear ("I feel abandoned"). All of this implied a shared desire to know and be known through various methods: gestures, postures, movements, facial expression, etc. A system of shared meanings without words was created to convey involvement with the experience of solitude by holding the emerging self-state of catastrophic abandonment. Thus, secondary intersubjectivity could be accessed from the place of a shared third party, a common new perspective. At the same time, the limits of sharing were acknowledged.

So, developmental and rhythmic attunement were important elements alongside attunement to cognition, affect, and relational needs. Developmental attunement guided the work at the beginning. Stern (1985) describes how, at 7 to 9 months, there is a quantum leap in a baby's experience. He or she begins sense the other's mind. With the appearance of the intersubjective self (Stern, 1985), the interaction expands to a third party, object, or person, which mediates the interaction between the baby and the mother and includes joint attention and joint action.

Stern's discovery occurred in a cultural context in which research on the theory of mind had been taking place in different areas of science. In the field of ethology, Premack (1978) had described chimpanzees that have a theory of mind. In 1983, Wimmer and Perner created a test

to verify the individual development of the theory of mind. They called it the false belief test because the focus was on the child's ability to infer false beliefs about the character's situation. Then, in 1985, Baron-Cohen et al. developed the Anna and Sally test to test the development of the theory of mind in children with healthy development, in children with intellectual disabilities, and in autistic children (Baron-Cohen et al., 1985).

Primary Intersubjectivity in Autism Spectrum Disorders

In other clinical conditions, we find a relational experience prior to the development of a secondary intersubjectivity, as in Asperger's syndrome or autism spectrum disorders. In these cases, the handling of language is very literal, presenting great difficulties in making use of linguistic metaphors.

This literal use of language, in which words are treated as things, features in the book *Through the Looking-Glass*, written in 1871 by Lewis Carroll. The author describes Alice going through the mirror in her room and entering a world where she finds that flowers treat her as if she were another flower, where time runs from front to back, and where the birthday cake is distributed first and cut later.

In this world Alice is informed that she is nothing but a product of another's mind, and that if she woke up, she would vanish. In the same way as in "Alice in Wonderland," there are transformations of the characters in the story; for example, the objects in the store are transformed: the chair into a tree, an egg into Humpty Dumpty, etc. Things and natural phenomena take on a life of their own: "It can rain if it wants to rain" (Carroll 1871/1986).

The constant throughout the story are the linguistic games, in which vocabulary loses its metaphorical, symbolic dimension and gives rise to misunderstandings. From a relational point of view, Alice is subjected to continuous experiences of lack of attunement due to the literalness of the language used by the characters with whom she interacts.

The lack of attunement is almost permanent. At a high point in the story, a character doubts even his existence: "You are not real." Alice replies, "If it wasn't real I wouldn't be able to cry," and she receives in return, "You're not going to take these tears for real!" In the "nameless forest," Alice forgets her own name. Communication is impossible. One character declares, "When I use a word it means whatever I want." Someone explains to her how to create words with multiple meanings—the "briefcase words." Experiences of estrangement and depersonalization are frequent in the book, as in *Alice in Wonderland*. Only rarely does Alice manage to establish a syntonic communication. The aspects of mirroring absorption are well symbolized by the duel between the twins that comes to represent the efforts of differentiation in the context of a purely speculative relationship (Carroll 1871/1986).

Valeria Bizzari (2018) hypothesizes that the core limitation of people suffering from Asperger's syndrome lies in deficits in intercorporeality and interaffectivity, which have been stopped in a pre-reflective stage, a stage prior to cognitive development, in which attunement and affective and bodily resonance constitute the main means to establish the connection with the other. This is a theory that is postulated as an alternative to the most popular explanation for this condition, which suggests that it is a brain dysfunction or a deficit in mentalization. Also, Greenspan (1997), like Bizzari, argues that emotional interactions emerge before the sensorimotor schemes postulated by Piaget (1977). This would mean that the person remains fixed in a precognitive developmental moment and cannot not use affective language in the context of spoken language. That is, the ability to accompany words with facial expressions, body gestures, modulation of sounds, etc. The language of these people is literal, monotonous,

devoid of prosody, robotized, and artificial. They try to reproduce the feelings of others, but they cannot put themselves in the place of others.

Valeria Bizzari (2018) vindicates the work of Georg Frankl (1943), a Jewish psychiatrist who worked with Hans Asperger in Vienna and with Leo Kanner in Maryland during World War II. After analyzing autistic language, Frankl concluded that the autistic person does not communicate his or her thoughts or feelings to others. The word "communication" implies, for Frankl, much more than the articulation of words. It also includes what he came to call "affective language," a set of facial expressions, body gestures, modulation of sounds, etc. We can see this theory at work in the following case, which describes an autistic child who does not speak and who establishes contact by means of primary intersubjectivity.

Mirroring Intersubjective Relating and the "Shared Third Perspective" in Autism Spectrum Disorders

Mirroring relating can help create, with integrative relational methods, a "shared third" in relationships with people who are developmentally arrested in a period of primary intersubjectivity. Primary intersubjective experiences open the emergence of a co-created space between therapist and client: shared rhythms, patterns of activity, or explorations of the otherness from a sensorimotor perspective. The "shared third" is co-created through mutual attunement and accommodation. When another recognizes the preverbal needs and adapts therapeutic activities to the need of experiencing symmetrical and mirroring responses, the client may recognize it and then identify and use it. Beebe and Lachman (2002) have described how, while executing the actions of the other, we replicate his or her intentions within ourselves. The "shared third" is based on the intention to align and accommodate, in affective resonance and attunement proper to primary intersubjectivity, and underlies the genetic preprogramming of our mirror neurons.

We can appreciate the importance of mirroring relating in the following vignette (Martínez, 2017b).

Paul came to my office with his parents, who were looking for treatment for attention, communication, and reciprocal interaction problems, previously diagnosed as autism when he was four years old. Paul is now nine years old and speaks in an affected and robotic way. He seems to be an adult. I observe the way he unconsciously imitates my gestures, for example, the way I am leaning my finger against my temple while I am listening to him. He is fascinated with dinosaurs. After watching films, he imitates their sounds, studies their movements, and makes these sounds and movements during the therapy session. He puts his tongue out as a lizard and growls as a dinosaur. Paul says, "I keep them in my brain and they help me do my exams. Sometimes I chase them out because I don't need them."

During the therapy session, he reaches out his hands to me and then "lends me" the soul of an ankylosaur. Then I give it back with my hands. He picks it up and sucks it out as if it was a material substance. He seems to be possessed by the dinosaur while he is growling and moving like an animal in my office. Then he tells me that the dinosaur has fallen asleep inside his body. Paul is not interested in inventing stories about dinosaurs and playing with other children. He is instead fascinated with them and imitates them. He likes "becoming them." I feel that as he is identifying with them, as he "absorbs" their qualities, his experience becomes regulated by the "souls of the animals." It seems to me that this helps him experience a feeling of agency and power that reinforces his nuclear self (Stern, 1985). He observes the coherence of their movements, their heaviness and strength. Watching his imitations, I am able to build a

proprioceptive representation of his experience and his need to build a feeling of coherence, agency, and continuity. He teaches me his need for imitating, and I experience the proprioceptive other that he is for me. We relate through a primary intersubjective mirroring experience.

From Attachment to Intersubjectivity

A different boy, 11 years old, is diagnosed with autism. At the present time of treatment, he seems to be exploring how to satisfy a relational need for security with humans. In response to treatment, he has improved his discrimination between animate and inanimate objects. He was interested only in objects before: he had a toy cow with whom he seemed to establish a symbiotic attachment relationship. He used the toy cow to feel reassured, and he carried it everywhere.

After having developed some affective links with objects, he started to take an interest in people. At this point in the treatment, the boy had succeeded in establishing, with his father, mirroring attachment relationships of a fusional and undifferentiated type. He was absorbed in the relationship with his father and excluded other people. However, any interruption, such as the father driving or doing something else, might cause irritation and aggression. For a year he had a persistent constipation that could correspond to the fact that he had achieved greater discrimination of his body and relations with the outside. He was afraid the hairdresser would cut his hair, as if he were losing a part of himself. A few months ago, he also started answering to his name. He didn't do it before—a year ago he seemed deaf.

During play therapy sessions, he usually selected some toy animals from the game box and put them in line. He did not play symbolically; rather, he entertained himself by "measuring" the perimeter of the animals with his hand. I wondered if he was elaborating the representation of a signifier "continent." He stuck to shapes and textures, looked at objects, and manipulated them but did not give them a representative value. He didn't build a story during gameplay or create any kind of relationship between the animals in the game box. He only looked at them, placed them, and ordered them. He was fascinated with shapes. He already maintained episodic eye contact. At times he whispered soliloquies while playing. The father reported he also did it at home and had even started singing.

One day I talked to his father outside the play therapy room before starting the session. The boy goes in before I do. Suddenly I hear screams and rush into the room. I find the boy agitated and anxious because he had put toy animals inside a slot in a table and couldn't get them out. It seemed to mean that objects were out of reach for him, and he was agitated about it. He screamed, "They're trapped... it has swallowed them up!" He calmed down when I helped him take them out. I said, "Your toys are now safe, they haven't gotten caught in the hole in the table." He looked at me, and then he took his father's hand to calm himself down. It seemed to me that he needed, at that moment in his development, an external regulation of the intense emotions that overwhelmed him in the moments when he felt trapped in the mirroring relationship or frustrated. This resulted in aggressive behavior that was common in their home. Later in the commented session, for the first time since I've known him, he acknowledged my existence by answering my questions. There was also a moment of emotional contact with me at the end of the session. It seemed to me that at this moment, the boy experienced my presence in a meaningful way, which could open the door to a future mutual recognition of our subjectivities. In this session, it seemed to me that he was responding to my attempts to attune

to his need for regulation during the mirroring relating. For the first time, I experienced a sense of sharing an experience with him.

Other autistic children have greater language proficiency but, like this child, have not yet learned to share experiences, identify with caregivers' attitudes, and exchange roles with them (Hobson, 2004). They can only imitate the way they see others speaking or expressing themselves, but they cannot identify with them "from within." That is why they repeat as an echo what they hear and use the pronoun "I" to refer to others and "you" to refer to themselves.

Conclusion

Relationships involve the meeting of two subjectivities. Everything that happens in a relationship is explained by the interaction between both subjects, their history, their life scripts, their expectations, and their ways of managing their emotions. Transference may bring to the therapeutic relationship the repetition of archaic relationships in which the client didn't experience enough recognition of his or her own subjectivity. There was a failure or absence of acknowledgment of appropriate developmental levels, validation, and attunement to his or her needs, mind, or emotions. Transferential projections may hinder intersubjectivity in the therapeutic relationship and give rise to impasses or acting out. Unconscious efforts may be made to repeat in the transference complementary or competitive symbioses, where differences are denied, or split relationships where differences are polarized.

The resolution of impasses in the therapeutic relationship requires that both members of the dyad can exchange their experience of the impasse situation, that they can dialogue about the perception of what each considers the problem. For this it is necessary to reflect on what is happening in the relationship and to accept and respect the experience of the other. Dialogue may transform each other's views and thus participants become more aware of their script beliefs. This process leads to the constitution of a co-created experience that can be visualized as the establishment of a "shared third" position between both members, from which to understand the experience and transform it in a way that allows the relationship to continue without erecting defenses. The "shared third" experience mediates between you and me and a sense of "we" may be created.

It is also possible to create a "shared third" in relationships with people who are developmentally arrested in a period of primary intersubjectivity through that I call here "mirroring relating." The client arrested at this stage of development requires the therapist to work as a unifying mirror and/or stimulus-regulating other that responds to the relational need for security. The therapist provides the experience of attachment security, arousal, interest, stimulation, activation, attention, transformation of somatic and emotional states, etc., that the person may not achieve on his own. The therapist may so foster the co-creation of shared interactive patterns through his or her developmental, affective, and rhythmic attunement to the client's sensorimotor and proprioceptive experiences. This kind of mirroring relating underlies the genetic preprogramming of our mirror neurons.

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