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THE PSYCHODYNAMIC TREATMENT OF RESISTANCE WITH A RELIGIOUS PATIENT FROM THE PERSPECTIVE OF INTERSUBJECTIVITY THEORY

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The analysis of resistances with religious patients from the perspective of intersubjectivity theory offers insights into the resolution of therapeutic impasses by focusing attention on intersubjective conjunctions and disjunctions (Stolorow, Brandchaft, & Atwood, 1987). Understanding resistance as an aspect of the intersubjective field between therapist and patient, which is co-determined by both participants, greatly assists in the treatment of difficult patients. Resistance analysis in the case of a patient using religious references as resistance is presented from an intersubjective perspective on psychodynamic treatment.

While religious practices can result in meaningful and authentic experiences (Leavy, 1988; Meissner, 1984; Rizzuto, 1979), therapists often find difficulty with the use of religious language in the treatment of religious patients (LaMothe, Arnold, & Crane, 1998). In an earlier article (Baker, 1998), I developed a psychological understanding of religious fundamentalism from an intersubjective perspective (Stolorow & Atwood, 1992) which I have found useful in the treatment of the more difficult religious patients. This article focuses on the technical aspects of the treatment of religious resistance from the perspective of intersubjectivity theory as contrasted to more classical psychoanalytic approaches.

In order to examine the specific use of religious references used as resistance, the nature of resistance in general must be discussed. It is posited here that Stolorow, Brandchaft, and Atwood's (1987) psychoanalytic intersubjectivity theory offers great insight into the treatment of resistance in insight oriented psychotherapy. I agree with Rabin's (1995) conclusion that treatment from an intersubjective approach involves a paradigm shift from previous forms of psychoanalytic therapies. Furthermore, it is hoped that the case example of the psychodynamic treatment of a religious patient presented at the conclusion of this article will serve as an apt illustration of the effective application of the intersubjective perspective to religious resistances.

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THE NATURE OF RESISTANCE IN PSYCHOANALYTIC PSYCHOTHERAPY

The classical view of resistance in psychoanalytic forms of treatment is that it is defensive activity on the part of the patient stemming from intrapsychic disturbances that lead the patient to distortions in the transference and to opposition against the therapist (Freud, 1926/1959). The term "classical" is used here in the sense that Aron (1996) did when he referred to therapists who conceptualize optimal treatment operating as a one-way influence. Resistance analysis from this perspective seeks to disabuse the patient of transference distortions, bringing him or her to a conscious understanding of the internal forces that were inhibiting an accurate perspective of the therapist. Stark (1994) described this as developing "the capacity to know and to accept reality, the hallmark of mental health" (p. 199).

The caricature of classical resistance analysis as the attempt to merely overcome patient resistances without analyzing the underlying anxiety and recognizing the self protective function of resistances has been criticized as a misrepresentation of modern

classical approaches (Busch, 1995; Sugarman & Wilson, 1995). Likewise, Sugarman (1992) has pointed out that many criticisms of classical analysis are based upon Freud's earlier conceptualizations, and they subsequently fail to recognize the advancements brought about by his structural model of the mind. However, modern classical analysts still point to the patient's "transference fantasy" as standing in the way of "accepting the analyst as *analyst* and as actually working with a morally neutral attitude" (Gray, 1991, p. 4). Sugarman (1992) claims "effective analysis of resistance requires activity, confrontation, and interpretation from a position of analytic neutrality" (p. 444) which is predicated on the theory that "most psychopathology can be understood in terms of intrapsychic conflict" (p. 434). The basic assumption of this classical perspective is that the therapist has a more accurate understanding of how the patient should perceive their relationship, and activity by the patient that is in opposition to the therapist's guidance in the course of treatment is termed resistance. This is a central point of contrast with intersubjectivity theory.

From a self psychological perspective (Kohut, 1971), resistance is not seen as originating from intrapsychic activity, but as an aspect of the therapist-patient dyad. Resistance is not understood as the patient's opposition to the therapist, but it is "understood in terms of activities undertaken in the service of psychological survival" (Kohut, 1984, p. 115). For Kohut, the goal of resistance analysis is not to do away with resistances, but to recognize the primacy of the need to safeguard the sense of self. Kohut's objective in the analysis of resistance is not insight leading to renunciation, but a recognition of the need to preserve the self.

This shift from a one-person to a two-person psychology removes the need to uncover drive conflict as the motivational force behind resistance, replacing it with an emphasis upon arrested development of the patient's sense of self. From Kohut's perspective, it is empathic failures on the part of the therapist to be attuned to mirroring, idealizing, and twinship needs in the patient that result in resistances. Resistance analysis essentially becomes the analysis of the disruptions in the "selfobject" tie between the patient and therapist, for the restoration of this patient-therapist tie causes the patient's need for self-preservation in the form of resistance to abate. This stance by the therapist does not assume that patient distortions are at the heart of resistance, which then frees the therapist from the role of the arbiter of reality, a view that contrasts sharply with that of Stark (1994) mentioned above.

Stolorow et al.'s (1987) intersubjective conceptualization of the analysis of resistance agrees with self psychological theory in that when the therapist "interposes his own expectations upon the patient and the patient collides with these expectations, what the analyst calls resistance regularly occurs" (Brandchaft, 1985, p. 93). However, according to intersubjectivity theory, resistance not only is the result of an absence of mirroring, or an empathic failure on the part of the therapist, but it is also the evidence of the presence of mental activity on the part of both patient and therapist. The latter is termed by Trop (1994) as "organizing principles." Organizing principles are mental schemata that are primarily unconscious and serve to thematize and give structure to affective experiences, much like a blueprint provides the structure necessary to build a house. Just like a blueprint is not part of the physical house, organizing principles are not part of the content of human experience, but exist as a means of structuring experience in meaningful ways. When I refer to the "subjectivity" of either a patient or therapist, I am referring to the subjective experience of that person which is necessarily filtered through his or her organizing principles. A central aspect of the therapist's task in the analysis of resistance is the illumination and transformation of these unconscious organizing principles.

From an intersubjective perspective, resistance analysis is the analysis of endangerment (Stolorow et al., 1987). Rather than assuming the patient to have distortions in the transference from which he or she should be disabused, the therapist attempts to elucidate the patient's subjective experience of danger in the transference as a valid perspective. Unconscious organizing activity on the part of both the patient and therapist can result in the fear that past traumas in the patient's life will be repeated in the transference relationship. The intersubjective analysis of resistance focuses on making conscious the unconscious organizing principles of both patient and therapist within a new relational experience that is responsive to the patient's affective reaction to endangerment.

Intersubjectivity theory conceptualizes the transference field between patient and therapist as consisting of multiple oscillating dimensions of experience. The selfobject dimension of the transference

is in the foreground when the patient's developmental longings are being stimulated within a safe environment where he or she can experience a psychological connection to the therapist. This dimension of the patient's experience recedes into the background when the transference field becomes experienced as dangerous to the patient's sense of self or well-being and the repetitive dimension of the transference comes to the foreground. It is at this juncture that the patient's unconscious organizing principles signal the replication of past psychological trauma, and emergency procedures are implemented to protect the patient from impending injury. When the therapist is associated with the perceived danger, the patient must protect him or herself with strategies that the therapist typically perceives as resistance. Even though modern classical analysis recognizes that resistances are "the ego's response to anxiety" (Busch, 1995), and self psychology theory recognizes the patient's "dread to repeat" (Ornstein, 1974) past trauma, intersubjectivity theory applies the theoretical constructs of a multidimensional transference and unconscious organizing principles to the patient-therapist relationship in a manner that illuminates resistances in treatment as fundamentally co-created.

Intersubjectivity theory takes the emphasis off of the therapist's empathic failure as the source of resistance in treatment and places it on the subjective experience of the patient that is co-determined by both participants in the transference field. Both disjunctions, where there is an incompatibility between the two subjectivities of the patient and therapist, and conjunctions, where there is such an overlap of subjectivities that "blind spots" occur, are co-created by both patient and therapist (Stolorow & Atwood, 1992). Both are problematic because the organizing principles that constitute them are unconscious, making their presence known in the form of transference difficulties and their analysis difficult since their underlying roots are out of conscious awareness. It is not necessarily the therapist's empathic failure that produces resistance, but, more accurately, a selfobject failure that is co-determined by therapist and patient alike. Intersubjective resistance analysis is not only the provision or repair of a selfobject experience, but the making conscious and transformation of the collective unconscious organizing principles within the transference field that shape the patient's experience of the repetitive dimension of the transference.

One might say that under the classical view of resistance as distortion, the patient's view of reality was false and in need of correction. Under the self psychological view, it is the therapist's faulty view of the patient's experience that leads to the need for selfobject repair. Intersubjectivity theory suggests that the selfobject failure (or the anticipation of it) that leads to resistance is co-determined by both patient and therapist rather than the distortion of objective reality or a technical failure to achieve a state of ideal responsiveness. The authority of the therapist to analyze resistance is not based upon a superior view of reality or relationship, but on expertise in facilitating a process of illuminating and transforming the patient's subjective experience (Stolorow, 1991). The transference becomes less experienced as a source of danger as it becomes more experienced as a relational context for the development of new organizing principles, diminishing the anticipation that the patient is doomed to repeat psychological trauma of the past.

An intersubjective perspective on the analysis of resistance offers helpful insight into the treatment of resistance when it is encountered in psychoanalytic treatment, whether or not one chooses to make a distinction between psychoanalysis and other forms of psychodynamic therapy (Panel, 1987). This fact may be illustrated by the presentation of a case wherein a religiously committed patient in psychotherapy made use of religious references when the repetitive dimension of the transference was in the foreground of the treatment. However, it is necessary first to make a few comments about religious resistance.

The Analysis of Resistance in the Form of Religious References

LaMothe, Arnold, and Crane (1998) have noted the relative absence of empathic inquiry into the religious experiences of patients in psychoanalytic psychotherapy, and hypothesized that therapists' selective attunement to their patients has communicated a prohibition in this area. Sorenson (1994) demonstrated that the therapists in his empirical study worked with religious issues in their treatment of patients based upon how their religious issues were dealt with in their own personal therapy. This acknowledgment of the bi-directional nature of treatment with religious patients has been missing in the vast majority of previous articles on religious resistance (Kehoe & Getheil, 1984; Lovinger, 1979,

1984; Narramore, 1994; Peteet, 1981; Stern, 1985). The current article adds to previous studies with religious patients that acknowledge the mutually influential nature of treatment by applying an intersubjective perspective to the specific clinical technique of resistance analysis, which has not been the focus of other investigations (Fallot, 1985; Greenlee, 1986; Nino, 1990; Randall, 1988; Schlauch, 1993).

Lovinger (1984) has developed one of the most extensive approaches to the analysis of resistance among religious patients. He approaches the treatment of religious references in resistance by making a distinction between "genuine religious values and resistances of defenses given a religious appearance" (Lovinger, 1979). His aim is to equip therapists with the knowledge they need to spot counterfeit religion when it appears in the consultation room (Lovinger, 1984).

Spero (1996) supports this approach, acknowledging "it is crucial that the distinction be made since only disordered religiosity is the rightful target of psychotherapy" (p. 7). This process of insight leading to renunciation follows the classical view of the analysis of resistance by suggesting that resistances in the form of religious references are to be identified as distortions, and the therapist's more accurate view of reality is to be adhered to if treatment is to have a successful outcome (Kehoe & Getheil, 1984; Narramore, 1994; Peteet, 1981; Stern, 1985).

However, according to intersubjectivity theory, organizing principles that are unconscious are experienced as objective fact. Attempting to disabuse a patient of his or her "distortions" in the form of religious beliefs can easily result in a strengthening of the patient's need to resist the therapist, as conscious beliefs are experienced as objective *Truth* when they are rooted in unconscious organizing activity. It is only when the underlying organizing principles are made conscious that they are transformed into the experience of subjective beliefs; what was once held to be concretely absolute takes on the quality of personal faith.

From an intersubjective perspective, the use of religious references in resistances are resolved when the patient and therapist achieve alternative organizations for the subjective experience of endangerment in the transference. This new understanding is predicated on the illumination and transformation of unconscious organizing principles that shape the transference experience of both participants, which are the underlying cause of resistances. Much like Winnicott's (1971) suggestion that one should not question the objective reality of a transitional object, this approach to resistance analysis places its emphasis upon subjective meaning rather than objective evaluation of genuine versus distorted values.

How, then, are we to explain those instances of successful defense analysis utilizing the more classically oriented approach? Hopefully, the most prevalent answer to this question is that unconscious motivations for resistance are made conscious through the classical approach, resulting in genuine growth and a lessening of defensive activity. However, some of these cases might possibly be explained as examples of transference disjunctions and conjunctions by intersubjectivity theory (Stolorow & Atwood, 1992). For example, if the therapist's subjective experience of the patient's religious references are shaped by a set of organizing principles that are incongruous with those that shape the patient's experience, then a transference disjunction is likely to occur. Lovinger's (1984) advice to the therapist, that he or she seek additional information regarding religion, might produce shifts in the therapist's organization of the transference that could result in the ability to communicate a deeper understanding of the patient. Even if the patient's unconscious mental activity that serves as the roots of the resistance is never made conscious, the experience of the therapist making an effort to understand the most important area of his or her life may reduce the feeling of having the patient's religious expressions invalidated by the secular scrutiny of psychology. In this case the unconscious organizing activity that is the source of the disjunction remains unanalyzed, but the patient becomes less resistant, sensing the therapist's genuine attempts to understand.

A second explanation of the apparent successes of classical resistance analyses might apply in those cases that involve transference conjunctions. In these cases a therapist and patient have identical unconscious organizations of the transference, which results in areas of painful affect being avoided. An example of this would be when a therapist and patient with the same religious perspective are unable to explore the meanings of certain religious references that are serving to defend against painful aspects of the patient's psychological world because they are both under the belief that this area of religious faith represents factual truth, thus having no deeper psychological meaning in need of investigation. Religious references that are the consequence

of transference conjunctions may result in a "false self" (Winnicott, 1965) analysis at these points, with pockets of unconscious organizing activity remaining unanalyzed.

A third possible reason for the defensive disappearance of religious references used as resistance might be explained by Brandchaft's concept of pathological accommodation (Brandchaft, 1994). Certain religious patients may develop a transference experience that is shaped by feelings of defectiveness that inevitably arise whenever they are in the presence of authority figures. This unconscious organization of their relationship to the therapist leads them to acquiesce to the therapist's superior grasp of "genuine religious values" in a heartfelt attempt to maintain their attachment to the therapist that is desperately needed to combat the painful feelings of shame being stimulated, or the fear of isolation being threatened. The therapist's need to live up to a self ideal for proper therapeutic behavior that includes the eradication of "resistances or defenses given a 'religious' appearance" results in a loss of motivation to examine the patients' unconscious organizing principles that underlie their pathological compliance with the therapist.

I would like to turn now to a clinical application of the analysis of resistance in psychodynamic psychotherapy from an intersubjective perspective in the case of a religiously committed patient. The therapist in this case was an experienced pastoral counselor who was relatively inexperienced in his training as a psychodynamically oriented psychotherapist, and, as a result, he sought out my supervision in the treatment of this case.

The Case of William

William is a 38-year-old, overweight Caucasian male who is articulate, affable, and enthusiastic in his presentation. He is married and has three children. Vocationally, he has held a variety of jobs, but primarily identifies himself as an ordained minister, even when he is between church appointments. William's presenting problems entailed ongoing struggles with addictive gambling, marital strife, and difficulty with finding appropriate employment.

William remembers his childhood as characterized by frequent verbal and emotional abuse by his father. He described his father as critical, rejecting, and emotionally distant. He recounted numerous events in which his inability to perform up to his father's standards led to William being referred to as "stupid," "a jerk," and "a good-for-nothing." William recalled as a central memory times when he worked in the garage with his father and failed to bring him the correct wrench for a particular task. His father would typically respond with, "This one, stupid" or "It's right here, dummy." William described his relationship with his mother as highly enmeshed, remarking that she was emotionally unstable. A nodal memory regarding his relationship with his mother involved William's bed wetting that continued through high school. He remembers waking up in the middle of the night after having wet his bed and going into his parents' bedroom to wake up his mother. She would routinely go into his room, change his sheets, and go back to bed without comment. William looks back on events such as these as too humiliating for his mother to even discuss with him, thus enabling William to continue in dysfunctional behavior that he could neither understand nor control.

Treatment began for William when his wife, Betty, insisted that they seek marital counseling. She came alone for the first few sessions, for William had flown to Oregon to pursue his "calling" as a pastor. Betty was very opposed to this move because William had spent the money that the church had given him for moving expenses to Oregon, and he had gambled away their mortgage payments so that they lost their home just prior to his departure for Oregon. A central theme in William's life arose early in his treatment: He emphasized the veracity of his "call from God" to the ministry whenever he began to doubt his effectiveness in life or to experience feelings of shame or inadequacy. This became the hallmark of William's use of religious references in the service of resistance.

In the marital therapy, William was relatively unresponsive to the criticisms he received from his wife, as well as her continual threats of divorce. He frequently deflected questions with brief responses of "no," "ummhuh," "I suppose," "maybe," and "perhaps." He rarely defended himself in the sessions, which took on the quality of trying to catch William in some deception. The marital treatment centered around attempts to get William to confess acts of wrongdoing and adopt a more honest and open relationship with his wife. The marital therapist found himself often agreeing with Betty's perspective on her husband, as William continued to take money from her bank account without her knowledge and engage in a number of deceitful behaviors that he always explained as having been for "good reason" once he was confronted.

William's attendance during the marital therapy was sporadic, and his resistance to engaging in this form of treatment caused his marital therapist to suggest that he enter individual psychotherapy on a weekly basis with Alan, who was both a therapist and a minister himself. Although he was more verbally expressive in this mode of treatment, William continued to maintain his emotional distance. He thematically complained about his wife's constant criticism, lack of trust in his call from God to explore a church position, and doubt about his capacities as a husband. Much of the content of his sessions revolved around his strong sense of needing to go to Colorado to explore a new church assignment. Alan initially attempted to help William see many of his religious references as defenses against painful anxiety, even though they were given a religious appearance. He interpreted William's emotional distance and references to God's calling to another church as an attempt to avoid his emotional pain, but these interventions were met with unresponsiveness or vague acceptance by William.

After a few months of treatment with William, Alan began to consult with me concerning the nature of William's use of religious references as resistance in their work together. I suggested that challenging the validity of William's call with attempts to interpret it as a form of defense given a religious appearance was likely to evoke in William very similar feelings to those he felt when he was in the presence of his demeaning and invalidating father. The very act of coming to therapy, for William, was like entering his father's garage. By the time Alan had begun his supervisory consultation with me, William had grown so uncomfortable with his wife's and his therapist's view of him that he had made plans to move to Texas to pursue a new "call" there, because "God told him" to do so. Alan had the impression that William was on the verge of terminating treatment and escaping into his "call" so that he could avoid the painful experiences that were being forced upon him here.

The intersubjective nature of the resistance in the transference in this case began to unfold as we uncovered Alan's, as well as William's, unconscious organizing principles at work. Alan saw himself as sincerely trying to help a recalcitrant pathological gambler come to the conscious awareness that he was using religious references as a defense to cover up his unresolved anxiety and shame. This behavior, however, was being experienced by William through the grid of his own unconscious organizing principles. For him, Alan's attempts at correcting his religious distortions were experienced by William as piercing criticisms that revived lifelong feelings of humiliation. As Alan became more intent upon freeing William from his pathological religiosity, William became even more in need of the belief that his call from God was true, as this became the only experience in his life that could adequately defend against his shame. As a minister himself, Alan unconsciously needed to be confrontive to purge religion of its pathological impurities, and William unconsciously experienced him as his shaming father. This resulted in an intersubjective disjunction in the transference that was experienced as a power struggle by Alan that made William difficult to follow, resistant to interpretations, and increasingly dependent upon his belief that God was calling him to a greater good, even if no one else could see it.

After his supervisory consultation, Alan shifted his interpretive stance to one of investigating the meanings and the function of William's religious references. Instead of trying to persuade William to stop his use of religious references as a form of resistance, the goal now was to help William understand why he was doing what he was doing in his relationship with Alan, and that given his unique history, this is exactly what he believed he must do. This interpretation of resistance was designed to remove Alan from the position of a critical father and realign him as an ally who had the potential of facilitating an understanding of the unconscious principles that shaped William's transference experience.

In a following session, William started by reporting that he was ashamed to say that he had not done what he had intended to do that week, which was to write a hypothetical letter to his father expressing his feelings of anger towards him. When Alan asked him how he felt about this, William associated briefly to a painful conversation with his father and then began talking about his call of God to Texas. In response to this discussion, Alan for the first time suggested, "It's really difficult for you *not* to take this job," at which point William immediately sighed with relief and said, "Yeah, well that's one way to put it. Yes." The transference then deepened as William reflected on how shameful it felt to not live up to his wife's expectations of him, and how humiliating it felt to not be able to keep his children in private schools due to the financial problems that he had created. Once Alan understood the self-preserving function that William's resistances played in his life, William could begin to experience Alan as something other than the critical parental fig-

ure from which he needed to protect himself, and resistances in the transference became less necessary.

In the next few sessions, William oscillated from intellectualizations to the expressions of deeper emotions as he felt both frightened and comforted by his experience in therapy. He began to risk telling Alan about deceitful behaviors that he was keeping secret from Betty, and he began to come forward with genuine expressions of affect that he had previously kept walled off from Alan. Most notably, William decided not to go to Texas; working on himself in therapy had become a priority.

In one session Alan suggested that he might sound like William's father at times and was wondering how that might feel to him. William responded rather glibly with, "Just pain. You know, feelings of uncomfortableness." Alan pursued this with the thought that William may have experienced him as siding with Betty and "ganging up" on him with criticisms, but William said, "No matter how careful a doctor can be, still once in awhile the patient is going to feel pain . . . In here there is no Novocaine." When Alan invited William to tell him when it hurt in their therapy, William responded, "That would be difficult. I was brought up to be respectful." Alan replied, "I want you to know it's okay to tell me when it hurts."

Although this exchange indicated progress in the deepening of the selfobject dimension of the transference (William appeared more willing to make an acknowledgement of the father-transference between them), his expressions of affect were still somewhat intellectualized. This pointed to an intersubjective conjunction in the treatment. For William, to discuss the pain in his relationship with Alan was disrespectful because he unconsciously organized his pain as something that disrupted relationships and made them intolerable for the other person (as with his father) or humiliating for himself (as with his mother). For Alan, the goal was to help William so that his motivation in getting him to verbalize hurtful moments in the treatment was to repair whatever had caused the damage and resolve the underlying pain. This conjunction that pain was the signal of something bad in their relationship caused the therapy to take on a "false self" quality (Winnicott, 1965). William would agree with Alan's interpretations about his father, but reassure Alan that the pain he was experiencing was the tolerable byproduct of a necessary psychological surgery being performed by a highly skilled doctor who only had his best interests in mind. Just as Alan felt the need to reassure William that their relationship was "okay," so too William felt the need to reciprocate in kind.

The net effect of this conjunction of unconscious organizing principles between Alan and William was to render Alan's attempts to uncover deeper painful affect less effective. For example, when Alan suggested that it might be hard to deal with his feelings about his inability to financially provide his children with an adequate Christmas this year, William responded with "Yes, but things are only going to get better from here on." Or, when Alan interpreted that William might feel scrutinized by the fact that he was also a pastor as well as a counselor, William said, "Oh, that doesn't bother me. You know what I'm talking about all the better." This pattern of response only began to change when Alan became aware of the conjunction between his and William's unconscious organizing principles regarding the meanings of the expression of painful feelings in treatment.

Alan ceased reassuring William that bringing up painful subjects was safe to do in therapy, and he began lifting into conscious awareness the unconscious organizing principles that caused William to feel unsafe instead. He discontinued his attempts to get William to stop employing religious references defensively, and he began trying to come to a fuller understanding of why he needed to do exactly that. Alan's perspective on William's use of religious references as resistance in the transference shifted to viewing this activity as a relational event. The strength of their grip on William lessened only when the intersubjective conjunctions and disjunctions in the transference began to be analyzed, and Alan began to understand how desperately William was fighting for his psychological life.

When Alan surrendered his view of William's religious references as distortions and accepted them as meaningful attempts to organize his world as a safer place, they both came to a deeper understanding of why their relationship felt threatening when it was supposed to be helpful, and their dialog took on a more genuine quality. William began opening up to more vulnerable feelings in the presence of an authoritative man as Alan communicated his understanding of how difficult this must be for him given that asking for help had led to humiliation in the past. Alan and William began to talk about the nature of William's call from God in a more candid manner. Because Alan was not questioning its validity, but was now using his ability as a minister himself to understand William's perspective as a valid one,

they both felt more open to look at the multiple functions it might play in William's life.

Conclusion

One might conclude from this article that the intersubjective approach to the analysis of resistance in the religious patient is done in the same manner that might be done with any patient. This notion is both true and false. Yes, the principles that guide resistance analysis from an intersubjective perspective focus upon the patient's subjective experience of danger rather than upon the therapist's arbitration of genuine versus distorted references. This would be the case no matter what the content was of the patient's resistance, religious or otherwise. However, the specific meanings that religious references have for a particular patient must be understood within the unique context of the patient-therapist dyad in which they occur. Because of this fact, my approach to resistance analysis with a religious patient differs from my resistance analysis with a nonreligious patient.

Although Alan's lack of experience with psychodynamic approaches to treatment contributed to the difficulty in the resistance analysis in this case, his ability to understand the meanings embedded in William's use of religious references facilitated the process of bringing into conscious awareness the roots of William's subjective sense of danger. Theoretically, even though every patient's form of resistance is potentially analyzable, it is not analyzable by every therapist. Each treatment is enhanced, as well as limited, by the subjectivities of both the patient and therapist, making transference resistances co-determined in their creation as well as in their analysis.

It has been suggested that the use of the term resistance may not apply to self psychological forms of treatment (Malin, 1993), and perhaps it is a concept that is in need of theoretical overhaul. In William's case, the attempt to remove his religious references from the service of resistance in the transference appeared only to strengthen their use. Once they were understood as necessary and preserving of his psychological life, he became less in need of them as defenses.

Since resistance implies one person opposing the activity of another, perhaps the use of the terms conjunction and disjunction better describes the experience of two people both participating in a relationship that at times encounters struggles. From this perspective, growth is not being thwarted by resistance, but actually something that is being strived for, based upon the perspective of the patient.

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