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CLINICAL PROCESS

THE TREATMENT RATIONALE OF SELF PSYCHOLOGY

Self psychological treatment aims to strengthen the patient's self-functioning and transform problematic aspects of the patient's self-experience. Treatment addresses the state of the patient's self both structurally and experientially. This encompasses the extent to which the patient's sense of self is whole, cohesive, vital, and authentic and feels continuous in space and time. On the behavioral level, it also includes the extent to which the patient is able to effectively pursue his or her goals and beliefs and form and maintain sustaining relationships. Symptoms, behavioral and relational difficulties, intrapsychic conflicts, and developmental deficits are all viewed as attributable to underlying impairments in self-development in need of a new developmental impetus from the treatment process (Donner 1991).

What is the overall strategy for treatment facilitating this new developmental impetus? The empathic connection that is developed between patient and therapist catalyzes the reactivation of the patient's thwarted selfobject needs. These needs are expressed in the selfobject dimension of the transference. Through the utilization of therapist responsiveness—characterized by empathic interpretations involving most crucially acceptance, understanding, and explanation (Ornstein and Ornstein 1996)—the patient's long-frustrated selfobject needs are made clear. Within the matrix of the therapeutic relationship, the patient's selfobject needs meet with a combination of "optimal frustration" (Kohut 1984) and "optimal responsiveness" (Bacal 1985). These responses foster a process of "transmuting internalizations" (Kohut 1984) that enables the patient (1) to rely more successfully on internal functions that previously could only be provided for externally and (2) to be able to use responsiveness from others more effectively to meet selfobject needs. As a result of the process of transmuting internalization, more flexible, cohesive, vital, and enduring self-regulating representations and processes are fashioned. This achievement enables the patient to live, in effect, in a more mature and varied selfobject milieu than previously, a selfobject milieu that more effectively sustains his sense of self (Kohut 1984). The patient's ability to pursue what is uniquely meaningful and important to him is strengthened by deeper self-acceptance, self-ownership, and empathy toward himself and others (Donner 1991).

How the Patient Is Viewed on Entering Treatment

Self psychological practitioners assume that a patient first entering treatment will display manifestations of, on one hand, an intense, mostly unconscious conflict between the desire to be understood and helped to experience developmentally needed experience and, on the other hand, the fearful anticipation of being painfully traumatized again. In accordance with this conflict, the patient is seen as organizing and constructing the analytic experience according to both the "old," painful past experience and a "new," hoped-for relational experience. In addition, the patient is viewed as attempting to connect with the analyst in those reliable ways established in past relationships (Fosshage 1990a). Therefore, it is useful for the analyst to await the manifestations of the patient's fears and then react appropriately to help make them discussable and help moderate them so that the therapeutic process can move forward (Wolf 1993).

How Self Psychology Views Empathy as Central to the Therapeutic Process

Self psychology views empathy as central to the therapeutic process for several reasons. First, it considers empathy, as a mode of clinical observation, to be our main way of understanding the experience of another. From the point of view of the therapist, it is our most useful tool for the gathering of data in the clinical situation. Empathy involves a shift in observing and listening to patients, mentally moving from the position of an outside observer to an attempt to understand and respond to our patients from the "inside" (Sorter 1999). By "inside," I mean from within the context of the patient's learned-about, imagined subjective world. The therapist tries to place herself imaginatively in the center of the patient's inner world in order to understand the patient's experience (Ornstein and Ornstein 1985). Therefore, empathic understanding is viewed as a prerequisite for informing all therapeutic interventions. It functions as a crucial guide to action for the therapist.

Second, from the point of view of the patient's experience, empathy (both as a mode of observation and as a mode of responsiveness) is viewed as fostering an effective clinical process. The patient's experience of being empathized with creates an atmosphere of safety and acceptance. Such an atmosphere promotes the patient's self-exploration.

Third, self psychologists view the patient's experience of being empathized with (empathy as a mode of responsiveness) as usually vital to his growth in treatment. Empathy, here the experience of being empathized with, allows the patient to feel understood in a way that helps him to feel connected to the therapist and to others. The experience of feeling recognized, accepted, and understood inevitably helps the patient to become more self-accepting. A patient's thoughts and feelings, often previously disavowed, that he considers most abnormal or shameful can, in the context of empathy, be brought into the realm of the thinkable and knowable. Carl Rogers, the famous client-centered psychologist, expressed this idea well: "[Empathy] brings even the most frightened client into the human race. If a person can be understood, he or she belongs" (1987: 181). Participation

in a therapeutic relationship characterized by sustained empathy can increase ownership of one's experience and expand the range of self-experience that falls within one's concept of humanness (Donner 1991). In turn, being more accepting of oneself usually results in becoming more accepting and understanding of others.

Last but not least, and most specific to the self psychological view of the clinical process, empathy is regarded as providing the most necessary condition for the development of the selfobject transference reactivation of a patient's thwarted selfobject needs. The reactivation of a patient's unique constellation of selfobject needs via the selfobject transference is considered to be the most powerful change agent in treatment. Once he feels understood, the patient is likely to invest the therapist with the ability to respond to his unmet developmental needs. In addition, once the selfobject transference is established, empathy is the glue that keeps it together and mends it when disrupted.

Empathy Is Not Considered the Only Useful Listening Position in Self Psychology

Self psychologists consider the empathic listening position to be essential to effective treatment and advocate that it be the therapist's main listening position. However, the empathic listening position is not regarded as the *only* useful listening stance for the therapist. While some self psychologists do advocate that the therapist always stay in the empathic listening position, I think the majority would not agree with this restriction. Most, I believe, would concur with Fosshage (1997), who recommends that the therapist oscillate between two different listening positions: the empathic or subject-centered listening mode, and the other-centered listening mode or position. In short, the therapist will normally shift between listening from the patient's vantage point to listening from the therapist's own perspective. In addition, critics of the self psychological emphasis on empathy, from other analytic orientations (see Bromberg 1989), have pointed out that to stay solely in the empathic listening stance results in the therapist forgoing his or her own relational experience of the patient.

HOW SELF PSYCHOLOGISTS UNDERSTAND AND WORK WITH RESISTANCE/DEFENSIVE FUNCTIONING

Heinz Kohut, perhaps more than any other object relations theorist after Sigmund Freud, revolutionized our understanding of resistance and defense. His revolutionary conception of resistance derives from his view of psychopathology as resulting from impediments to and deficiencies in self-development. As discussed, the task of treatment is to foster, in needed areas, the resumption of self-development. Self psychology conceives of resistance as the person's attempt to protect herself, not against forbidden drive wishes, but against the repetition of traumatic kinds of experience that have resulted in impediments to and deficiencies in self-experience. Resistance is seen as triggered by disintegration anxiety and, sometimes, by the need to preserve a fragmentation-prone self-structure. Defense and resistance are considered to play the vital, adaptive role of maintaining the integrity of the self.

Kohut believed that what we all fear most is a repetition of our most painful past experiences with our attachment figures. This is what we experience as most damaging to our sense of self. In object relations language, we fear being retraumatized by bad objects (Aron 1996). Anna Ornstein (1974, 1991) refers to this fear as "the dread to repeat." Therefore, self psychology views resistances as originally needed, adaptive self-functions. It regards resistances and defenses as being employed as bulwarks in order to safeguard psychic survival, to protect against any further weakening of the self by threatening, injurious, potentially traumatic experience (Shane 1985). Kohut asserted that defenses or resistances "safeguard the analysand's self for future growth" (1984: 142).

This view of defense and resistance, as originally adaptive and self-protective, positions the self psychological analyst very differently than the classical analyst toward the patient. The classical Freudian analyst regards resistance as opposition to the analytic work. Originally, Freud viewed resistance as the patient's opposition to recalling traumatic events. In time, Freud shifted to seeing resistance as meaning opposition to the revelation of repressed infantile fantasies and wishes. Therefore, the classical analyst tries to ally

with the observing part of the patient's ego in order to break through the patient's resistances by interpretation and reach the unconscious, drive-based wishes being kept out of awareness. This idea has been fundamental to the psychoanalytic model of treatment since Freud first began to trace associations back to the "pathogenic nucleus" of the neurosis (Breuer and Freud 1895; Summers 1994). The classical analyst views the patient's defenses as a resistance to the progress of treatment, since they are conceived of as interfering with the recognition of the patient's wishes. In this model, defending against the knowledge of drive-based wishes is theorized to be the source of psychopathology. The therapeutic task is viewed as expanding the patient's knowledge of these defended-against drive wishes and so increasing the dominance of the ego (over the id and superego) and thereby modifying or resolving unconscious conflict. Thus, the main interest in defense and resistance from this perspective is in what (drive-based wishes and fantasies) they defend against.

In the self psychological model of treatment, the approach to defense/resistance is significantly different. The analyst does not ally with one part of the patient's personality against another part. In contrast, the self psychological analyst works at understanding and conveying his understanding and acceptance that the patient felt the need to adopt the ways of defending herself that she did. This involves understanding and expressing the understanding of the particular threat to the patient's self. The analyst's task is not to interpret defenses in order to challenge them, get rid of them, or bypass them. Rather, it is to use the analyst's understanding, empathy, and acceptance to create a sense of safety for the patient that will allow her to become aware of her defenses and eventually not feel the need to employ them as rigidly and pervasively.

According to the self psychological view of resistance, resistance should not be viewed solely in terms of isolated intrapsychic mechanisms located within the patient. Resistance based on the "dread to repeat" past traumas is to some extent evoked by the behavior of the analyst that the patient experiences as unattuned to his emerging needs and feelings. The patient's resistance is triggered because such experiences of selfobject failure threaten the patient with the prospect of the

impending recurrence of painful, traumatic childhood experiences (Stolorow, Brandchaft, and Atwood 1987).

Therefore, self psychology takes issue with an interpretive focus on mechanisms of defense and resistance. The belief is that doing so—as has been the practice in traditional psychoanalysis—leads to an adversarial stance between analysts and patients. Patients at these times are likely to experience defense interpretations as the analyst trying to rid them of their protective shields and/or the analyst holding them responsible for frustrating the analyst's therapeutic intention. These likely inferences by the patient add shame and guilt to whatever uncomfortable feelings are already present (Lichtenberg 1999).

This revised view of resistance, and correspondingly of the analyst's role, positions the self psychological analyst as more of an ally and less of an adversary than the analyst in the classical analytic model of treatment. As a result, this revised understanding of resistance and defense contributes, I believe, to a more cooperative, friendly treatment ambience in self psychological treatment than is typical of classical analysis.

Yvonne: Case Illustration of Defense and Resistance

Yvonne relied heavily on the use of avoidance to try to protect herself from anxiety, shame, and the possibility of rejection and disappointment in her relationships. When treatment began, her pervasive use of avoidance was striking. For example, she would often ignore and fail to return phone calls, even from close friends, if the call stirred up any uncomfortable feelings for her. With her avoidance also came the tendency to withdraw and feel isolated. Often, life felt like it was too much for her to deal with. However, isolating herself frequently resulted in Yvonne becoming lonely and depressed. Her pattern of avoiding contact with men only intensified her painful sense of being unattractive and inferior. In treatment, for the first few years, when material came up she found threatening, she would often avoid dealing with it directly, saying, "I don't want to talk about it." In response, I would usually take the tack of saying I respected her right not to talk about anything she did not want to but

I thought it would be useful to her to tell me her reasons for not wanting to. For the first couple of years, if intensely uncomfortable feelings were stimulated in her during one session, usually she would arrive quite late for the next one.

I came to recognize Yvonne's pervasive use of avoidance generally and, in particular, her use of avoidance regarding the uncomfortable subjects of relating to men and her sense of herself as a woman. In keeping with the self psychological approach to defense and resistance, I focused initially with Yvonne in trying to understand, and convey to her my understanding of, why she would resort to avoidance so frequently—both generally and with me.

Over time it became clear to both of us why Yvonne had come to rely so on avoidance to deal with uncomfortable feelings. In brief, both of her parents, she eventually recalled, usually dealt in the same way with both her and their own distress. Her mother had a reputation for withdrawing to her bedroom when feeling troubled. Her father would deny the situation, acting as if the uncomfortable subject matter or experience did not exist. Yvonne had a recurrent dream in which she had gotten out too deep in a pool and feared there would not be anyone to rescue her. We understood this dream to portray how she felt too often abandoned when she most needed help in dealing with her distress and saw that she understandably feared that the same plight awaited her with me. In various ways, I conveyed to her that I could understand how she came to believe without question that her uncomfortable feelings were too much for her to tolerate and overcome, and I also explained that she feared displaying her distress because she thought it would provoke others, myself included, to reject and/or withdraw from her (Yvonne also had numerous dreams in which I abandoned her during a session; usually I was envisioned walking out on her, slamming the door to my office).

The Danger of Viewing Disguised Selfobject Longings as Resistance

Kohut and other self psychologists have pointed out that selfobject longings may often look like resistances at first glance. Discriminating

between the two is of considerable clinical importance. Because self psychology considers the revival of selfobject needs in the analytic relationship to be the main engine of growth, it is crucial that the analyst recognize these needs when they appear. One illustration of this activation of selfobject needs looking like resistance is the well-known vignette about Miss F. repeatedly getting angry with Kohut, which led to his formulation of the selfobject concept (see chapter 1). Miss F.'s anger at and criticism of Kohut, he came to appreciate, were not a resistance to treatment but were more usefully viewed as a response to the frustration of her reactivated need for mirroring, echoing, and affirmation of her sense of archaic expansiveness (expansive-grandiosity). Miss F., rather than resisting, was trying to get her remobilized, thwarted childhood needs met by Kohut. For him to have continued to understand and interpret Miss F.'s anger as a resistance would have jeopardized this hopeful attempt to resume her psychological growth.

THE IMPORTANCE AND INEVITABILITY OF RUPTURE AND REPAIR

Self psychology's focus on and elaboration of rupture-and-repair cycles in treatment has been one of its unique contributions to understanding clinical process. Self psychologists, beginning with Kohut, have claimed that there is great therapeutic benefit to be gained by analyzing ruptures in the selfobject transference bond. First and foremost, because the selfobject dimension of the transference is viewed as the main catalyst and sustainer of psychological growth, it is essential to repair the selfobject tie when disrupted so that development may again proceed.

Disruptions in the selfobject tie, bond, or transference are considered inevitable because the analyst cannot be so perfectly attuned that "no shadow of misunderstanding falls on the selfobject experience sustaining the patient" (Wolf 1993: 680). Also, they are inevitable because a patient will tend to perceive and organize the therapeutic experience by employing problematic or painful organizing themes that entail the expectation of selfobject failure (Fosshage

1992). For example, Yvonne's problematic organizing principle—"No one will want to listen to me when I'm distressed"—influenced her to close quickly and unreflectively on any possible sign that I might not be receptive to hearing about her distressed state.

How do we know that the patient is experiencing a disruption in his selfobject bond with us? Usually the intensity of a patient's response to something in the interaction—even something that observationally seems trivial—serves as an indicator that the selfobject tie has been disrupted and the event has in fact been a very meaningful experience for the patient. The patient's response may be to fall silent, to become suddenly and dramatically withdrawn, to get directly angry, to become deflated, or to have an upsurge in symptomatology (Donner 1991).

The Therapeutic Benefits of Analyzing Ruptures and Disruptions

The rupture provides the opportunity to learn both about the patient's selfobject needs and about his painful organizing themes based on his fear of repeating painful or even traumatic experiences, for example, "No one understands me when I'm upset," "People don't listen to me," or "I'm not worthy of being loved." Thus, the experience of selfobject rupture permits a clearer view of the main organizing themes shaping the repetitive-negative transference.

Initially, Kohut theorized that the therapeutic benefit of analyzing ruptures results from optimal frustration leading to transmuting internalization. As discussed in chapter 5, this idea has been widely challenged in self psychology after Kohut. Later theorists have understood the therapeutic action of analyzing ruptures quite differently. More about this shortly.

Guidelines for Analyzing Ruptures and Disruptions

In analyzing a selfobject rupture, the therapist investigates and interprets the elements of the rupture from the vantage point of the patient's subjective frame of reference. These elements should

include the actions or qualities of the therapist that produced the disruption, its specific meanings to the patient, its impact on the selfobject bond and on the patient's self-experience, the early developmental trauma it revives or replicates for the patient, and, especially significant, both the patient's fears and expectations of how the therapist will react to the articulation of the painful feelings that follow in its wake (Stolorow, Brandchaft, and Atwood 1987).

The Rationale for Placing Special Emphasis on Ruptures in the Selfobject Bond

There is an extensive rationale for placing great emphasis on analyzing disruptions and ruptures in the selfobject bond. Robert Stolorow and his colleagues place special emphasis on the patient's expectations and fears of how the therapist will respond to her articulation of how she experienced the therapist as responsible for her distress. This is the case because, they assume, most patients have suffered repeated, complex experiences of selfobject failure with their parental figures.

They believe that these experiences of sequential selfobject failure usually occur in two phases. In the first phase, the child's selfobject need meets with frustration by the parental figure, producing a painful emotional reaction. In the second phase, the child feels a longing for an attuned response from the parental figure that would contain, modulate, and ameliorate her painful response to the selfobject failure. However, a parent who frequently rebuffs the child's selfobject needs typically is not able to provide attuned responsiveness to her painful, reactive emotional states. This is particularly unlikely when the child believes that the parental figure is responsible for producing her distressed state.

As a result of frequent repetitions of these disappointing, hurtful interactions, the child perceives that her distressed, reactive emotional states are unwelcome or even hurtful and damaging to her parental figure. The child often reacts to this perception by disavowing, walling off, these painful feelings so as to not endanger her needed bond with her parental figure.

Stolorow and his colleagues stress that when these painful affect states are disavowed under such circumstances, often they become a lifelong source of inner conflict and vulnerability to disorganizing, even traumatic states. In treatment, their reexposure to the therapist—because of the dread to repeat—tends to be strenuously resisted (Socarides and Stolorow 1984/85).

Stolorow (1993) theorizes that the therapeutic transference meaning of this investigative and interpretive activity regarding the rupture is that it establishes the therapist as the longed-for understanding parental figure. In particular, the therapist is experienced as a parental figure that can contain, understand, and thereby alleviate the patient's painful emotional reaction to an experience of selfobject failure. He can tolerate the patient's upset—and particularly the patient's upset with him—to help the patient make sense of her experience. In addition, as a result of this rupture–repair process, the selfobject bond is mended and strengthened. Saying this implies that the patient will feel freer to express selfobject yearnings as she feels more confident that her reactions to experiences of frustration and disappointment with the therapist will be met with containing, concern, and understanding. Concomitantly, Stolorow thinks, a developmental process is activated wherein the formerly disavowed painful reactive affect states, the legacy of the patient's history of selfobject failure, gradually become integrated and transformed. This process, in turn, allows the patient to learn that ruptures are manageable and so strengthens her capacity for affect tolerance, her overall regulatory capacity.

Other Elements Theorized to Be Involved in the Therapeutic Benefits of Analyzing Ruptures in the Selfobject Bond

There may be other elements inherent in the disruption–repair process further enhancing its therapeutic impact. By definition, an experience of disruption is a "heightened affective moment" (probably many moments). As discussed (see the section on Beebe and Lachmann's theories in chapter 5), this would contribute to its

therapeutic impact. Also embedded in this experience for the patient, at a time of heightened emotion, is the therapist acting at considerable variance from one (or more) of the patient's core, painful, organizing expectations. This experience helps solidify the selfobject transference bond.

Lachmann and Beebe (1993) have added an additional perspective to the beneficial impact of rupture-and-repair experiences. They suggest that the repair process be viewed as involving dyadic regulation. Patient and therapist influence one another to establish a new interaction pattern. The therapist and patient examine both the impact of the experience of selfobject failure and the efforts at restoration or repair. By means of this process of analyzing the disruptions of the selfobject bond, a representation of the expectation of mutuality is established for the patient. Therefore, according to Lachmann and Beebe, the specific way in which the bond is ruptured and interactively repaired transforms rigid, repetitive expectations and establishes new expectations and representational configurations.

Two Case Illustrations of Rupture and Repair

As mentioned, ruptures in the selfobject bond can vary greatly in the form they take. For purposes of illustration, I will briefly describe one dramatic rupture and one that was more quiet.

Ned. About a year into treatment, Ned and I had an animated exchange. At one point during it, our talking overlapped—in particular, I briefly began to speak as Ned continued to talk. Abruptly, he stood up, red in the face, and angrily said: "You're just like everybody else. You don't listen to me, either." He then turned on his heel and walked out of the office, turning a deaf ear on my request that he stay so we could discuss what had just taken place between us that had angered him so. When Ned returned (to my relief) for his next session, I was braced for a continuation of what had occurred but fortunately that proved unnecessary. To my surprise, Ned said something to the effect that he was sorry about last time, that he had "jumped the gun" and assumed for a moment that I—like many people in his family—had no interest in listening to how he really felt. By the time he got home, he had begun to reconsider his interpretation of my behavior and to feel sorry for having been so hasty with me. I let him know I could understand how my talking over him had felt like confirmation of his painful organizing expectation (principle), "No one wants to listen to me." We went on to further discuss the pervasiveness of this experience in his childhood in his large, chaotic family.

Evan. When I returned from a brief vacation several years into Evan's treatment, he complained that while I was away his "fog" had returned. He found that much of the time he felt somewhat disoriented, unsure of himself in an intensified way. It had felt very similar to how he remembered feeling when he began treatment. He linked his feeling to my absence and intensely missing his sessions. Investigation of what my absence meant to him revealed that sometimes he experienced it as confirming his fear that I am not really interested in him, his main repetitive-negative transference expectation. The therapeutic impact of this being examined appeared to reestablish the selfobject transference bond as well as his sense of me as an understanding, supportive figure. In the next session, Evan said that he noticed that by the time he reached his office after our session, his "fog had lifted."

THE SELF PSYCHOLOGICAL CONCEPTUALIZATION OF TRANSFERENCE

Transference, ever since Freud's original formulation, has been a pivotal concept in psychoanalysis. Freud conceived of transference as a "false connection," a distortion of reality in which the analyst in the present is erroneously experienced as being like an important figure in the patient's past (Breuer and Freud 1895). Transference has subsequently also been conceived of as a regression, displacement, and projection as well as distortion (Stolorow and Lachmann 1987).

Viewing transference as an unconscious organizing activity (Stolorow and Lachmann 1987; Fosshage 1990b) typifies how self psychologists conceive of transference. In this conception, transference is considered an expression of a universal psychological striving to organize

experience and construct meanings. It is understood as referring to the ways in which the patient's experience of the therapeutic relationship is organized by his own experiential themes, particularly configurations of self and object that unconsciously organize his subjective world. Therefore, Stolorow and Lachmann (1987) refer to transference as "organizing activity," because the patient is seen as assimilating the therapeutic relationship into the thematic structures of his personal subjective universe. Transference, from this perspective, is neither a displacement nor a regression from the past, but rather is an expression of the ongoing influence of organizing themes or principles that have emerged and been generalized from the patient's early formative experiences.

From this perspective, transference and resistance are inextricably linked. Much of the patient's resistance is seen as resistance based on transference. This resistance is based on the "dread to repeat" (A. Ornstein 1974, 1991) traumas and intense disappointments and frustrations with attachment figures. These are always, to one extent or another, evoked by the actions and characteristics of the therapist that the patient experiences as unattuned or inimical to his feelings and needs. Such painful experiences, experiences of selfobject failure, inevitably stimulate resistance because for the patient they herald the imminent reoccurrence of damaging childhood experience. Because this resistance based on the transference (in particular the repetitive-negative dimension of the transference) is in large part the result of the patient's organizing activity, it is considered an expression of the transference (Stolorow and Lachmann 1987). For example, with Evan, on a few occasions he fell silent in mid-sentence. When I inquired about it, we learned he felt hurt and angry with me because he thought I had looked at the clock. This perception signified to him that I was looking forward to the session being over because I was not interested in him—his principal repetitive-negative transference expectation, on the basis of which he tended to organize ambiguous experience of me.

The dominant self psychological concept of transference has moved to a two-person view. Transference is no longer understood as resulting from isolated intrapsychic operations residing within the

patient. Instead, it is seen as variably shaped by both patient and therapist within a two-person field model. In the words of Stolorow and Lachmann, "Transference and countertransference together form a system of reciprocal mutual influence" (1987: 42). They posit that the patient's experience of the therapeutic relationship is always shaped both by inputs from the therapist and by the meanings into which these are assimilated by the patient.

This two-person view of transference enables us to appreciate the extent to which the therapist contributes to the activation of the patient's problematic organization of experience. Depending on the particular patient and the particular situation and point in treatment, the therapist's relative contribution will determine whether the patient's problematic organizing principle will be illuminated or reinforced by the experience. For example, if the patient fearfully expects that the therapist will be judgmental of her when she is feeling distressed (as was the case with Yvonne), the extent to which the therapist's behavior corresponds to this expectation will determine whether the problematic organizing principle is reinforced or illuminated (Fosshage 1992). The therapist's contribution needs to be sufficiently minimal to permit the patient herself to bring the application of her problematic organizing principle—which results in her painful interpretation of the situation—into question (Fosshage 1990b).

The Selfobject Dimension of the Transference

As stated, the selfobject dimension of the transference is accorded great importance in self psychology because it is viewed as the catalyst and vehicle for growth. The patient's selfobject experience with his therapist is conceived of as the developmental aspect of the transference. The patient is viewed as trying to reestablish with his therapist the ties that were traumatically and phase-inappropriately severed during the patient's formative years. The concept of selfobject transference implies selfobject need, "a transference of need" (Basch as quoted in Bacal, 1998) which, when met, constitutes selfobject experience. The patient is seen as coming to rely on these ties for the

restoration and maintenance of an expanded, strengthened sense of self. Stolorow and Lachmann (1987) theorize that even when it is in the background, the selfobject dimension is not absent. As long as it is undisturbed, they maintain, it continues silently to help sustain the patient, enabling him to face conflictual and frightening feelings.

Kohut used the term "selfobject transference." He would commonly refer to a patient as having developed a mirroring or an idealizing transference to his analyst. Stolorow and Lachmann have argued, for me persuasively, that it is a conceptual error to regard the term "selfobject transference" to refer to a type of transference characteristic of a particular type of patient. Instead, they proposed using the term "selfobject transference" to refer to a dimension of all transference. They theorize that this dimension of the transference may fluctuate to the degree to which it occupies a position of figure or ground in the patient's experience of the therapeutic interaction but, again, they emphasize that, if undisturbed, it is never absent.

They contend that it is the selfobject dimension of the transference that confers on interpretations their mutative power. In analyzing a patient's resistance, it is the therapist showing that she understands and empathizes with the patient's sense of subjective danger that has therapeutic results. In doing so, they remark the therapist is experienced to some extent as providing a calming, containing selfobject experience. This experience of the therapist in the selfobject dimension of the transference allows fearful and conflictual areas of the patient's subjective life to be revealed more freely.

Clinical Guidelines and Implications

Kohut discovered that in the early period of the mobilization of the selfobject transferences, interpretation is often harmful. It runs the risk of prematurely calling attention to the analyst's separateness and so disrupting or impeding the patient's participation in the developmentally necessary selfobject experience. In preference to interpretation, interventions are directed more toward articulating how the patient needs to experience the analyst's function in the transference. Kohut emphasized that it is important for the analyst to

openly and matter of factly accept the patient's need and to empathize with the patient's experience of the analyst falling short in these functions (Mitchell and Black 1995).

The Idealizing Selfobject Dimension of the Transference

The idealizing selfobject transference, Kohut (1971) theorized, is mobilized in order to fulfill the unmet developmental need to feel connected to and protected by a strong, wonderful figure. It is, he said, the therapeutic activation of the experience of the omnipotent other. In Kohut's words, the idealizing selfobject transference is the patient's attempt to save "a part of the lost experience of global narcissistic perfection by assigning it to an archaic, rudimentary (transitional) selfobject, the idealized parental imago" (37). This sense of feeling linked to an admired powerful other provides the patient with a sense of being calmed and soothed and/or safe or strong. Patients who will need to develop the idealizing dimension of the transference are those who have had their need to idealize a parental figure interfered with in childhood. Becoming immersed in an idealizing transference to the analyst allows these patients, Kohut believed, to reinstate the interrupted developmental process.

In the idealizing transference, the patient, Kohut averred, uses the analyst in two main ways: as a drive regulator or as an external figure to complete the idealization of the superego—the further establishment of the person's values and standards.

Previous psychoanalytic theory regarded idealization of the analyst exclusively as a pathological defense against the patient's hostile or sexual feelings toward the analyst. Therefore, this defense would be interpreted as a way of disguising underlying aggression. Idealization was not regarded as possibly being a growth-promoting experience. Clinically, a distinguishing feature of defensive idealization is that it usually is accompanied by the patient's self-depreciation. A second distinguishing feature is that when the idealizing of the therapist is developmental rather than defensive, the patient will usually react with disappointment and anger to being misunderstood when the idealization is interpreted as defensive. Also, in contrast to defensive

idealization, the idealizing transference is often silent. As it revives an earlier experience where the attachment figure's availability and perfection are taken for granted, it is not surprising that the idealizing transference tie tends to go on silently (Lee and Martin 1991). As previously discussed, the way it is often discovered is when it is disrupted.

With Yvonne, the idealizing dimension of the transference was most often in evidence when she was looking to me to assist her with affect—usually anxiety—regulation. Gradually, after considerable doubting, she was surprised and relieved that I was not dismissive and contemptuous of her, as she feared, when she was anxious. As Yvonne slowly became more confident that I would respond acceptingly to her sharing her uncomfortable feelings with me, she, not surprisingly, increasingly was able to feel calmed by doing so. And she came to do this with more frequency. A dream she had in the third year appeared to reflect the consolidation of a trusting, idealizing dimension of her connection with me. In the dream she had left her doll in my office overnight. We interpreted the dream to mean that she now felt more comfortable entrusting me with her more vulnerable feelings that she, in turn, equated with "the child within" her.

Tom: Case Illustration of Transference

Tom came to treatment to deal with his intense anxiety and panic attacks, hypocondriasis, and marital dissatisfaction. He had been to the hospital emergency room on a few occasions before initiating therapy when he had mistakenly interpreted his anxiety attack as a heart attack. Unhappy in his marriage for several years, he felt too dependent on his wife to leave her.

Tom came from a family run by his mother, with whom he felt quite close growing up. His father, a very limited, undeveloped man, Tom saw as extremely dependent on his wife. He thought his father would not be able to survive in the world without his mother. Once he became a teenager, he viewed his father, to his disappointment,

as being like another child in the family. With the paternal role effectively vacated, Tom sometimes played the part of his mother's confidante.

As treatment began to unfold, it became apparent that Tom saw his wife as very powerful. Repeating the pattern he witnessed with his parents, he relied on her heavily as an idealized source of security. However, this came with the large price for Tom of feeling both dominated and controlled by his wife. Thus, we can say that one facet of Tom's relationship with his wife included a pathological variant of idealization.

Initially, Tom's resistance centered on his fear that I would not be competent enough to help him. After understanding this resistance in the various ways it came up—particularly in light of his experience with his father—Tom formed a strong idealizing tie with me. This became apparent when seven or eight months into treatment Tom called in a panic and asked if I would see him as soon as possible. When we met later that day, Tom described his panic as well as what he thought had stimulated it. Somewhere in the middle of the session, he leaned back in his chair, breathed a deep sigh of relief, and announced he was feeling a lot better. I was amazed, because at this point in the hour I had said virtually nothing. Just my (idealized) presence was enough to calm him and restore his sense of safety and security. At that time, in my office I had a large poster of one of the clay figures of Chinese warriors from the caves of Xian. At times when he was strongly experiencing an idealizing tie, Tom's image of me was colored by the strength and power of this image.

The next several years of treatment were characterized by Tom's gradual but steady progress, becoming more comfortable with self-assertion and self-direction. Tom's tie with me appeared to facilitate his taking risks that previously he had been too fearful to attempt. He changed his work situation to enable himself to make much more money. His assertiveness with his wife led to more open and intensified marital conflict. After an unsuccessful attempt at working out their differences via marital therapy, he separated from his wife. An important theme for Tom became what he called "drawing the line."

He put it into practice first with his associates at work and his wife and later with me. "Drawing the line" encompassed both self-delineation and self-assertion. Doing this with his mother while growing up had provoked significant guilt and anxiety for him.

He had long been free of panic attacks and the severe degree of anxiety that he usually experienced when he had begun treatment. When treatment concluded, Tom was involved in a relationship with which he was very happy and which appeared to both of us to be free of the pathological idealization and dependence that characterized his relationship with his ex-wife.

THE MIRRORING SELFOBJECT DIMENSION OF THE TRANSFERENCE

The mirroring selfobject transference, Kohut (1971) theorized, is mobilized in order to ameliorate the pathological effects of an arrested maturation of the grandiose or expansive self by catalyzing the resumption of its growth. As discussed in chapter 2, Kohut theorized that the grandiose self does not become integrated into the main fabric of the personality if its development is sufficiently impeded. This happens, Kohut believed, either as a result of trauma or through the unempathic personalities of a child's parents that interfere with their capacity to mirror the child's pride and expansiveness. Either way, the grandiose self will remain in its archaic, primitive form, repressed or split off from the more reality-oriented part of the personality and uninfluenced by the outside world (Siegel 1996). Kohut conceived of the mirror transference as including all the conscious and unconscious manifestations of the "imperative need for confirmation" of the grandiose self experienced by all of us as children and reactivated by the regressive pull of the analytic situation (Wolf 1985).

Kohut maintained that the therapist's empathic responses to manifestations of the patient's grandiose-expansive self—combined with necessary attention to the patient's defenses and shame—results in the mobilization of the grandiose-expansive self in the mirror transference. For the mirror transference to emerge and be sustained,

the therapist must understand and respond in an accepting manner to the patient's experiences and needs of her, appreciating their significance in the context of the patient's developmental history. Kohut stressed the therapist's acceptance of the phase-appropriateness of the patient's grandiose-expansive needs and wishes in order to counteract the usual tendency of the personality to wall itself off from the grandiose self by means of defenses such as disavowal, isolation, and repression. The patient fears that his remobilized grandiose-expansive fantasies and wishes will meet with the same traumatic lack of approval, echo, or reflection they encountered in childhood. At these times, when the mirroring dimension of the transference is in the forefront, treatment may become largely focused on the patient's desire for confirmation and affirmation of his grandiose-expansive self.

In the mirroring dimension of the transference, Kindler (1996) points out that the patient's experience of his therapist becomes symbolically elaborated as a relationship between himself and an admiring or affirming other, for example, "My therapist loves me, admires me, finds me very desirable," and so forth. This characterization may or may not be agreed upon by the therapist or be perceived by an outside observer. The mirroring experience has been evoked by the patient's preexisting needs and expectancies, together with the "triggers for selfobject experience" provided in the therapeutic relationship (Kindler 1996: 10). Kohut (1971) believed that the mirror transference creates for the patient a position of security that enables him to persevere with the difficult task of exposing the grandiose self to a confrontation with a more realistic conception of the self.

Kohut was at pains to emphasize that the analyst's facilitation of the emergence of the transference's mirroring dimension does not mean that the analyst is attempting to provide the admiration and affirmation that were found lacking in the patient's childhood experience. The analyst's task is to foster the emergence and maturation of the grandiose-expansive self but not to gratify it. The patient feels mirrored by the analyst's empathic understanding of his desire for recognition and affirmation. The analyst does not actively "mirror." It is not a separate analytic activity, as sometimes has been implied.

Miss F.: Case Illustration of the Mirroring Selfobject Dimension

Kohut's case of Miss F. (see chapter 1) provides a good illustration of the mirroring dimension of the transference. Miss F. would become intensely angry with Kohut, accusing him of wrecking her analysis, whenever his comments and interpretations went one step beyond what Miss F. had said in that current session. What Miss F. could not tolerate, Ernest Wolf observed, was Kohut's position in their dyad as the center of initiative. Her angry, demanding behavior toward Kohut implies her wish that Kohut totally submit to her own thinking, relinquish his initiative, and devote himself exclusively to accepting and affirming whatever aspect of herself she chose to present to him. In this respect, she expected Kohut to act as an extension of herself. As Wolf put it, "Such a claim is reminiscent of an absolute but insecure monarch's attitude toward his subjects. . . . One might say that the mirror transference is the reenactment of the archaic claims of His Majesty the Baby in the here-and-now of the analytic situation. In self psychological terms, these demands are recognized as the imperative need of any child for confirmation" (1985: 272).

HOW SELF PSYCHOLOGY VIEWS THE INTERPRETIVE PROCESS

Kohut (1977) believed psychoanalysis has dual methods that move treatment forward, namely, the tactful, interactive use of understanding and explaining. Kohut was rigorous in his standards for understanding and explicit about the inadvisability of premature explanation. Understanding comes from careful listening, of a sort that requires much from the analyst. She must introspect about her own experience of the patient's presence and use empathy in her efforts to understand the totality of the patient's subjective world. Introspection (and empathy, its vicarious counterpart) Kohut saw as focused on the multiple meanings, diverse motives, and complex relationships of the patient's experience. Explanation, on the other hand,

proceeds by inference or reasoning from specific events to derived general principles. This leads to the formation of tentative hypotheses and theory building, as the analyst searches for causal connections both in the story of her patient's life and in his current experience. Kohut's succinct summary was that "psychoanalysis explains what it has first understood" (Ornstein and Ornstein 1985: 45).

Anna and Paul Ornstein (1985), Kohut's colleagues who built on his work to elaborate a self psychological view of the interpretive process, emphasize that ultimately what is most important for the analytic process is not what the analyst says or thinks he says but how the patient experiences what the analyst says. In other words, it is crucial that the analyst be aware of his own impact on the patient's experience.

In addition, the Ornsteins stress that a crucial characteristic of the entire interpretive process is that everything that transpires is viewed as occurring in the self–selfobject matrix. What transpires in treatment can be understood only in the context of the empathic vantage point within this matrix. Only the patient whom we are trying to understand can tell us whether we have understood him. They caution that we need to make the patient's experience of us and our interventions the single indicator of our impact and not confuse his response with what our intentions were.

Feeling understood is accorded great importance in the interpretive process. This, the Ornsteins argue, is vital to having the analyst's interpretation be emotionally affecting and meaningful. They consider understanding as both an ongoing process and a cumulative achievement of the analytic dialogue. It comes about through a sustained focus on the patient's self-experience. Indeed, the Ornsteins believe a vital ingredient in the understanding process is that the analyst stay with the patient's experience and demonstrate that she is doing so in order to maintain a sense of contact, of reliably being with the patient. Thus, it is clear that the Ornsteins view the understanding process as a multifaceted interpersonal process, not simply a cognitive operation.

The feeling of being understood contributes to the establishment and maintenance of the patient's selfobject experience with the analyst.

As a result, the Ornsteins maintain, the frequent feeling of being understood continuously reinforces the stability and cohesiveness of the patient's sense of self.

The Ornsteins emphasize the effect of the interpretive process on yearnings deriving from long-frustrated selfobject needs. They assert that it is only the empathic acceptance, understanding, and explanation of childhood longings that will allow their gradual transformation and ultimate integration into the adult psyche. Crucial to this effort is the analyst's understanding acceptance of the patient as he is. Especially important is the mutual delineation of the patient's motives and self-protective operations in safeguarding personal integrity, for example, Yvonne's pervasive use of avoidance.

This part of the interpretive process, they point out, involves describing unconscious, split-off, and repressed aspects of self-experience, particularly with regard to selfobject longings. Kohut would often focus on what the patient found missing in the relationship with the analyst: "You do have to show the patient over and over again how he defensively retreats because he expects that he will not get what he wants and that he doesn't dare to let himself know what he wants" (1996: 373). Thus, evidence of progress and deepening of the analytic process comes from the patient showing greater access to feelings and memories, so that previously defended-against wishes and longings are more directly and frequently expressed. In this way, these sequestered desires can become part of the total, more unified, and richer self-experience. The Ornsteins stress that what is critical is that the patient, rather than the analyst, be the one to bring these long-defended-against feelings into awareness and into the analytic process. This indicates the patient now feels it is safe to do so, as opposed to the analyst deciding for him.

Another important self psychological emphasis in interpreting is that an interpretive focus on the structure of experience at times may need to precede the exploration of content. When a patient is gripped by disintegration anxiety, he is not concerned with what has precipitated that inner crisis as much as he is in getting relief from it as quickly as possible—just as in the analogy that occupants of a house on fire will have more pressing concerns than what caused the

fire (Mollon 2001: 2). Kohut (1972) made the observation that in certain psychological conditions there has been an uncomfortable, felt alteration in the patient's sense of self. He advised the therapist to interpret this sense of self-alteration before the content of the patient's experience.

The Concept of the Leading and Trailing Edges of an Interpretation

In the framing and expressing of interpretations, Kohut advocated that the analyst usually combine what he called the *leading edge* and *trailing edge* of an interpretation (see Miller 1985). By the "leading edge," Kohut meant interpretations that capture the patient's strivings, the quality of self-experience that the patient is trying to attain or maintain, the evolving or developing aspects of the transference, and progress in the patient's life. Kohut's "leading-edge" emphasis reflects his underlying, optimistic belief that all human beings struggle inherently toward health (see chapter 12). By the "trailing edge," Kohut meant the dynamic and historical basis underlying the patient's motivations and defenses—in other words, why the patient came to have the particular desires and ways of self-protection and coping he displays.

Lachmann (2000) points out that a leading-edge interpretation can stand alone in treatment. However, a trailing-edge interpretation, without inclusion of the leading edge, can be experienced as confrontational and hurtful to the patient, as an iatrogenic injury. Lachmann observes that, when effective, a trailing-edge interpretation can provide the patient with a feeling of being understood, can be felt as enlightening and relieving, and can construct a broader, more meaningful historical context for an experience or way of behaving.

Yvonne: Case Illustration of Interpretation

I made interpretations to Yvonne early in treatment about her pervasive use of avoidance, in which I used both the leading and trailing edges of interpretations. A typical interpretation of this type was: "We know you feel much better when you don't let your anxiety stop

you anymore from doing what you want, as when you went to Paul's party. And you did this in the face of your parents' message that you came to believe that your anxiety is too much to deal with."

What Stolorow Added to Self Psychology's View of the Interpretive Process

Stolorow and his collaborators (Atwood and Stolorow 1984; Stolorow, Brandchaft, and Atwood 1987) have conceived of psychoanalytic understanding as an intersubjective process involving a dialogue between two personal universes. The process of formulating a psychoanalytic interpretation, Stolorow states, involves making empathic inferences about the principles organizing the very different subjective world of the patient's experience. These empathic inferences, tested for accuracy in the analytic exchange, alternate and interact with the analyst's reflection on her own subjective reality in the ongoing investigation (Stolorow 1994).

Stolorow argues that his conception of the interpretive process renders obsolete the long-standing debate within psychoanalysis over the role of cognitive insight versus affective attachment in the process of therapeutic change.

He maintains that once the psychoanalytic situation is viewed as an intersubjective system of mutual and reciprocal influence, the dichotomy between insight through interpretation and affective bonding with the analyst disappears (Stolorow, Brandchaft, and Atwood 1987). For example, the therapeutic impact of the analyst's accurate transference interpretations, he contends, resides not only in the insight it imparts but also in their demonstration of the analyst's attunement to the patient's emotional states and developmental longings (Stolorow 1994). "Every transference interpretation that successfully illuminates for the patient his unconscious past simultaneously crystallizes an illusive present—the novelty of the analyst as an understanding presence" (Atwood and Stolorow 1984: 60). Stolorow (1994), in agreement with the Ornsteins, contends that if an interpretation is to have a therapeutic effect, it must enable the patient to have a new experience of feeling deeply understood.

An additional contributor to the therapeutic effect of an interpretation, Stolorow argues, is the specific transference meaning for a particular patient at a particular point in treatment of the experience of being understood. The patient's needs and longings mobilized in the transference at a specific time will influence the meaning that feeling understood has. To illustrate, Stolorow (1994) describes some characteristic attributions of meaning when different selfobject dimensions of the transference are in the foreground. For example, if the patient is longing for the analyst to be the strong, calming protective parent she had only too briefly as a child and adolescent, the analyst's understanding is likely to serve as restoring a lost ideal. This idealizing transference experience enhances stabilization by providing a model of strength and security. For a patient experiencing the mirroring selfobject dimension of the transference, Stolorow points out, the sense of being understood may evoke a feeling of being deeply treasured by the analyst. In the case of experiencing the twinship selfobject transference dimension, feeling understood is likely to be processed by the patient as evidence that she has found a longed-for soul mate whose likeness promises to alleviate a long-standing painful sense of differentness.

THE CONCEPT OF OPTIMAL RESPONSIVENESS

In keeping with his criticism of Kohut's concept of optimal frustration (see chapter 5), Howard Bacal (1985) formulated the concept of optimal responsiveness as a guiding principle for the therapist's conduct of treatment. Bacal defines optimal responsiveness as "the responsivity of the therapist that is therapeutically most relevant at any particular moment in the context of a particular patient and his illness" (202). Optimal responsiveness involves the therapist's responsivity, which facilitates certain kinds of therapeutic relatedness, and this relatedness occurs within an interactive, reciprocal system (Bacal 1998).

Bacal distinguishes between optimal responsiveness and empathy. *Empathy* is the process by which the therapist comes to understand the patient by tuning in on his inner world. *Optimal responsiveness*,

in distinction, refers to the therapist's communicating her understanding to her patient.

Bacal's fundamental assumption is that there is a basic tendency toward development and growth in every person that requires the optimal responsiveness of the selfobject-providing other in order to be realized. The therapist's response needs to be commensurate with the patient's level of self–selfobject organization.

This response is usually but not necessarily communicated through verbal comments and interpretations. For example, Kohut (1980) recounted an instance when he allowed an extremely vulnerable woman patient to hold his hand during a particularly difficult time.

Bacal points out that it is difficult to generalize about optimal responsiveness because of the specificity of individual psychological need and the complexity of the particular therapy dyad that attends it. The generalizations that can be made are that optimal responsiveness involves (1) the patient's experience of significant disconfirmation of the expectation that the therapist will act in ways that repeat the problematic or traumatic experiences that contributed to the patient's pathology, and (2) the patient's experience of the analyst as responding in ways that facilitate the growth, strengthening, and vitality of his sense of self (Bacal 1998).

The concept of optimal responsiveness moves self psychology more in the direction of emphasizing the patient's relational experience with his therapist—and particularly on his selfobject experience—and diminishes Kohut's emphasis on interpretation in the treatment process. There is considerable variation among self psychologically oriented practitioners with regard to position on this question of one's relative emphasis on insight versus relational experience in the conduct of treatment.

COUNTERTRANSFERENCE

How Kohut Conceptualized Countertransference

In recent psychoanalytic writing, there has been a noticeable shift away from viewing countertransference primarily as an undesirable

interference coming from the psychoanalyst or, worse still, as the analyst's unique pathological reaction to the patient. Instead, attention has been called to the use of countertransference as a diagnostic and therapeutic tool in the conduct of psychoanalytic treatment (Wolf 1979). This reconsideration of countertransference can be viewed as part of the overall paradigm shift from a positivistic science, with its central tenet of the analyst as an objective observer, to a relativistic science. In this later model, "reality" is viewed as shaped by (relative to) the analyst-observer (Fosshage 1995a).

Although Kohut helped foster this paradigm shift in psychoanalysis, he did not place his view of countertransference within it. Rather, he subscribed to a traditional view of countertransference as solely the analyst's problematic reaction to the patient's transference. More specifically, within the framework of self psychology, Kohut viewed countertransference as those vestiges of the analyst's own narcissistic disturbances that interfere with the development and analysis of the patient's selfobject transferences (Orange 1993).

How Kohut Conceptualized Specific Countertransferences

Corresponding to the three types of selfobject transferences that unfold during treatment—the mirroring, idealizing, and twinship transferences—Kohut (1984) pointed out that three types of countertransference reactions are predictably evoked. In more archaic versions of the mirroring transference, the therapist is subjected to the difficult experience of receiving little personal recognition and acknowledgment by the patient for his separate, individual personhood, since the patient often views the therapist as coextensive with her self-experience. The experience of not being responded to as a separate, individualized person evokes in the therapist certain characteristic countertransferences, which depend in part on his particular narcissistic vulnerabilities.

Kohut (1971) observed that in the case of the mirroring transference, the most frequent countertransference reaction is for the therapist to become bored, inattentive, or sleepy. In the case of the twinship or alter ego transference, in which the patient wants to have an

experience of likeness or kinship with the therapist, the most common countertransference reactions have to do with assertions of the analyst's separate identity. For example, the therapist may become aware of asserting his separate identity by talking about how his opinions differ from the patient's. In the case of the idealizing transference, in which the patient experiences the therapist as a source of admired security-providing strength, a frequent countertransference reaction is for the therapist to distance himself from the uncomfortable narcissistic resonances within himself by making some deflating reality-oriented or self-deprecatory comment.

Also important are the patient's defenses against the idealizing dimension of the transference and the therapist's corresponding countertransference reaction stimulated by these defenses. For instance, an early sign of a nascent idealizing transference often is observed in the appearance of an overtly critical attitude toward the therapist, indicating defenses against the developing idealizing transference. The therapist's feelings of being hurt or slighted, if not recognized and processed, may interfere with allowing the transference to develop. However, if the therapist recognizes the situation and realizes it does not indicate a failing on his part that needs to be overcome, these unpleasant experiences can be nurtured as a possible indicator of an emerging idealizing transference (Wolf 1979).

How Self Psychology Views the Analyst's Selfobject Needs as Influencing the Countertransference

Wolf (1979) took the logical step of considering that the therapist, just like the patient, brings her selfobject needs into the treatment situation. He pointed out that the therapist's countertransference is indispensable to the therapist's empathy for the patient's experience. In addition, Wolf suggested using the term *selfobject countertransferences* to denote the counterpart in the therapist of the selfobject transferences of the patient, regardless of whether they are evoked by the patient.

Bacal and Thomson (1996), working within a more carefully developed relational framework than was available to Kohut, have built

on Wolf's thinking in elucidating their view of countertransference. They elaborated on Wolf's idea that the selfobject needs of patient and therapist are bidirectional. In other words, both therapist and patient are variously sustained by the experience of each other's responsiveness. Therefore, the therapist—just like the patient—may experience disruption in the selfobject dimension of the relationship when these vital needs are frustrated. Bacal and Thomson argue that the therapist ordinarily has a variety of expectations of the patient, some conscious and some unconscious, many of which embody selfobject needs usually responded to by the patient in the course of therapy. Some of these needs, they point out, are ubiquitous and some are specific to particular certain patient–therapist pairs. In part, they are embedded in the rituals and procedures of the therapy situation, with which patients customarily comply, for example, arriving and leaving on time, paying a fee, listening intently to the therapist's comments and interpretations, and so forth. They point out that the therapist usually takes these therapeutic procedures and rituals for granted and is unaware that they embody selfobject functions for her. Perhaps the most common selfobject need for the therapist is mirroring or affirming of her therapeutic functions and usefulness, her capacity to understand, and her caring, humanistic motivation.

When both the patient and therapist's selfobject needs are being met, the authors observe, the ensuing system of mutual regulation of selfobject needs produces a kind of harmony in the treatment ambience. At these times, the therapist is likely to experience self-syntonic emotions such as liking, friendliness, concern, compassion, mild idealization, and sympathy for the patient.

However, when the therapist's selfobject needs are not met, she may experience the painful sensations of disrupted self-states that can undermine her therapeutic function. These disruptions include disinterest, distancing, prolonged boredom, sleepiness, eroticism, hatred, and contempt (Bacal and Thomson 1996). This selfobject disruption in the therapist will affect, and usually diminish, her capacity to attune and to respond optimally to the patient. Not surprisingly, given the mutual regulation perspective on the therapeutic relationship, it is usually when a patient becomes seriously disrupted that the

therapist's selfobject needs become significantly frustrated. Most commonly, the therapist will experience a loss of a sense of efficacy. Concomitantly, she is likely to experience uncomfortable feelings such as inadequacy, anger, disappointment in herself, and shame. Remember my experience with Evan (see chapter 4).

Bacal and Thomson believe the therapist's shame over her selfobject needs in relation to the patient is a major factor leading to constricting and disruptive countertransference reactions. Conversely, they advocate the therapist having an accepting attitude toward the selfobject needs stirred up by and felt in relation to the patient. They believe the therapist's functioning is enhanced as a result of her diminished requirement to protect herself against the recognition and awareness of these needs. Conversely, if we as therapists feel compelled to protect ourselves from shame-based awareness of our needs in relation to our patients, we will be unlikely to be able to resonate empathically and respond optimally to their disavowed selfobject needs.

Bacal and Thomson assert that the situation for the therapist is the same in this respect as for the patient. If the therapist cannot recognize and accept the psychological legitimacy of her selfobject needs in relation to the patient, then her needs will intensify and she will become more apt to act them out. Moreover, she will be more likely to act them out in relation to the patient.

How Fosshage's Concept of Listening Positions Has Added to the Self Psychological View of Countertransference

Fosshage (1995b) has made a major contribution to the reformulation of countertransference from within the framework of self psychological theory. His work on listening positions (earlier in this chapter) and its implications for countertransference developed the theoretical rationale for the self psychological therapist to make clinical use of his relational experience with the patient.

Fosshage states that patient and therapist variably codetermine the countertransference, that is, the analyst's experience of the patient. He notes that, as with the transference, the contribution of each party to the countertransference from moment to moment can range from minimal to considerable.

Rather than employ the term *countertransference*, Fosshage prefers to refer to the "analyst's experience of the patient." He believes this term has two advantages over "countertransference." First, it more fully reflects the complexity of the analyst's involvement in the analytic process. Second, he asserts, it correctly underscores the analyst's experience as a central guide for inquiry and interventions.

He observes that self psychology's emphasis on the therapist's use of empathy in order to enter into the patient's experiential world appears, at first glance, to minimize the importance of the therapist's experience. He argues that this is not actually the case. Fosshage points out that empathic inquiry requires the therapist's affective resonance and vicarious introspection, a reflective process that focuses on the patient but is inevitably filtered through the therapist's experience. Therefore, he concludes, in a self psychologically informed analysis—as in all analyses—the analyst's experience is paramount.

Fosshage asserts that the analyst's experience can be thought of in terms of two different "listening positions" he can assume: the subject-centered and the other-centered listening perspectives. The subject-centered listening position refers to listening from within the patient's vantage point in order for the therapist to resonate experientially with the patient's affect and experience. This is what self psychology refers to as "empathically oriented listening." This listening position facilitates the therapist's identification with the patient.

The other-oriented listening position refers to listening to the patient from the vantage point of someone in a relationship with the patient. Fosshage points out that this position is usually the listening vantage point of object relations and interpersonal approaches. He observes that countertransference discussions traditionally have entailed listening from the other-centered perspective—for example, the patient is seductive, manipulative, controlling, and so forth.

Fosshage asserts that relating usually involves a natural oscillation between these two listening perspectives as one listens to another person. He proposes that in the therapeutic encounter, we as

therapists can be most helpful to our patients if we shift between these two listening modes as we listen, because important experience is obtained through each listening stance. While the subject-centered perspective tends to decrease our reactions as the other person in relationship to the patient, the other-centered perspective accentuates these reactions. For example, if a patient complains about some aspect of our treatment of them, the subject-centered perspective facilitates our "decentering" (Piaget 1974; Atwood and Stolorow 1984) from our personal reactions (e.g., hurt feelings, irritation, etc.) as the other and shifting our focus to appreciating the patient's experience with us.

Fosshage notes that stressful interactions with our patients tend automatically to trigger in us the other-centered listening perspective that often conveys valuable experience and knowledge of our patients and their relationships (as well about ourselves). At these times, he argues the analyst's ability to initially shift into the subject-centered perspective can facilitate creating an observational platform (Lichtenberg, Lachmann, and Fosshage 1992) for both patient and analyst. Familiarity with and focus on our shifting listening perspectives can enable us, Fosshage says, to make more effective use of our countertransference, our experience of our patients.

Yvonne: Case Illustration of Listening Positions

During therapy with Yvonne, in response to her frequent withdrawals from me, I initially would feel surprised, puzzled, and sometimes hurt and rejected. Her withdrawals would take the form (from my other-centered perspective) of sudden and extended silences, pronounced lateness, and, on a few occasions, not showing up for sessions. However, for the first several years of treatment I chose not to share these personal reactions with her but to focus solely on her experience at these times (Fosshage's subject-centered perspective). My belief at the time was that to share my experience with her would result in her feeling criticized by me, unnecessarily confirm her repetitive transference to me as a critical father figure, and cause her to react even more self-protectively and adversely.

However, at a later point in treatment when the selfobject dimension of the transference had solidified (her experiencing me as an affirming man who was interested in and could tolerate and contain how she felt), I began to share my reactions with Yvonne to her withdrawing behavior (which had already diminished some). We discussed her withdrawing behavior in the context of her interactions with men as she began to date after several years of treatment. Drawing upon my own reactions, I pointed out repeatedly when she described her interactions with men, in which she employed her customary withdrawing reactions and impassive manner, that many men would feel puzzled, hurt, and rejected as I often felt with her. This shift in focus, bringing in more of my experience, seemed to help her appreciate her impact on others. In fact, at first she seemed surprised and pleased to hear that she had as much impact on me as she did.

THE CONCEPT OF SELF-STATE DREAMS

Kohut (1977) added a useful conceptualization to our understanding of dreams with his concept of the "self-state dream." In a self-state dream, in contrast to our more usual dreams, imagery is relatively undisguised in portraying the dreamer's sense of self. In these dreams, the manifest content, with little further associative information, reveals the essential meaning of the dream (P. Tolpin 1983). Kohut associated self-state dreams to Freud's (1920) explication of dreams in traumatic neuroses in which a traumatic event is realistically portrayed. In self-state dreams, we see a portrait of how the patient is "reacting with anxiety to a disturbing change in the condition of the self" (Kohut 1977: 109). Self-state dreams, Kohut thought, "attempt to deal with the psychological danger by covering nameless processes with nameable visual imagery" (109).

Central to many self-state dreams is the terror of disintegration. Many of these dreams forecast a sense of threatened or impending devastation. The patient dreads the loss of his cohesive self—"the fragmentation of and estrangement from his body and mind in space, the breakup of the sense of his continuity in time" (Kohut 1977: 105).

Typically, these dreams deal with things falling apart or about to fall apart. Dreams of this type, Kohut recounted, were of "the frightening infestation of . . . spreading vermin" in one's home or the "ominous discovery of algae in the swimming pool" (105). In other types of self-state dreams, self-states may be portrayed as "an empty landscape, burned out forests, decaying neighborhoods . . . an airplane out of control that flies higher and higher" (Kohut 1980: 508). These dreams depict a sense of devastation and depletion of the self. More generally, such dreams may herald distressed self-states such as despair, fragmentation, hypomania, aimlessness, and depression (Lachmann 2001).

How Theorists after Kohut Have Elaborated the Concept of the Self-State Dream

Paul Tolpin (1989) suggested broadening Kohut's conceptualization. He proposed that self-state dreams be thought of as existing along a continuum. This continuum encompasses degrees of self-disruption ranging from mild distress to calamitous disintegration. Common to all, however, is the main focus of the dream as the depiction of the state of the self, of its mood and experienced organization.

While inspired by Kohut's concept of self-state dreams, Atwood and Stolorow (1984) differ from Kohut somewhat in their understanding. In doing so, they build on their central thesis that dreams are guardians of psychological structure and that they carry out this vital function by employing concrete symbolization. Atwood and Stolorow take issue with Kohut's assertion that the principal purpose of the perceptual imagery of self-state dreams is to name formerly nameless psychological processes. Instead, they contend:

> By vividly reifying the experience of self-endangerment, the dream symbols bring the state of the self into focal awareness with a feeling of conviction and reality that can only accompany sensory perceptions. The dream images . . . both encapsulate the danger to the self and reflect a concretizing effort at self-restoration. (Atwood and Stolorow 1984: 104–5)

Atwood and Stolorow have extended Kohut's formulation by theorizing that in self-state dreams, imagery not only maintains the organization of the self against the threat of self-dissolution but also helps consolidate new, emerging configurations or themes that are in the process of coming into being. Thus, the authors theorize that such dreaming serves two vital functions: (1) maintenance of the organization of a person's subjective world in which already-existing structures are starting to break down, and (2) consolidation of unformed or weak organizing themes that are in the process of coming into being.

Fosshage (1983) expanded this model further to encompass, in addition to a self-maintenance function, a developmental function of dreaming. From this perspective, dreaming not only maintains psychic structures but also contributes to the development of new organizations of experience (Fiss 1988).

Paul Ornstein (1987) cited the following dream as a prototypical example of a self-state dream. One of Ornstein's patients dreamed that he was "inside a rickety house or structure—of corrugated iron. There was a ladder in the middle—wobbly; it looked like it would soon collapse, too, just like the house or structure." The patient commented about his dream: "That is where I live emotionally, in a rickety house that is about to collapse. The house is me . . . the way I feel . . . not just now, always. . . . There is no stability in my life and I am threatened by collapse all the time. I live in fear of that" (92).

HOW THE PARADIGM SHIFT FROM A POSITIVIST TO A CONSTRUCTIVIST MODEL HAS AFFECTED SELF PSYCHOLOGY'S CLINICAL PRACTICE

Self psychology has contributed to and been influenced by the paradigm shift in psychoanalysis from a positivist to a constructivist/hermeneutic model. This shift has contributed to shaping self psychology's view of the role of the therapist and of the therapeutic process. The therapist is no longer viewed as the somewhat distant, objective observer of the distorting patient. Also, the therapist is no

longer viewed as an authority figure acting as the arbiter of reality for the patient, as had been customary in the Freudian, Kleinian, and, sometimes, interpersonal traditions. In addition, Kohut (1984) emphasized that the observer and the observed are not separable but are always influencing one another. Instead, the therapist/analyst has become more of an involved, interacting, experiencing participant (with clinical expertise). It is not only what the therapist knows but also what the therapist experiences and gives meaning to that becomes crucial in promoting change. The therapist's role, according to self psychology, encompasses both collaborating with and guiding the patient in a joint exploration to understand the patient's experience and conduct, as well as, in doing so, to help create the relational experience that will facilitate the patient's growth.

HOW THE PARADIGM SHIFT FROM A DRIVE REDUCTION TO A RELATIONAL MODEL HAS BEEN REFLECTED IN SELF PSYCHOLOGY'S CLINICAL PRACTICE

The Comparison with Classical Analysis

Self psychology has played a large part in bringing about the paradigm shift in psychoanalysis from a drive reduction to a relational model. In the drive reduction model, people are seen as impelled to seek gratification of their biological instincts for sex and aggression via relationships. Relations with others are viewed as the means to secure the pleasure of drive discharge. Attempts to obtain drive discharge are frequently frustrated by environment and culture. Individual success and happiness depends primarily on how well one manages to negotiate these obstacles and realize drive satisfaction.

Freud and his followers had conceived of the clinical practice of psychoanalysis as a method of reducing the conflicts caused by disguised drive expression coming into conflict with superego requirements, as well as by the realities of one's environment. The primary means to do this is via insight usually provided by the analyst's interpretations of the analysand's unconscious processes, for example, dreams, slips of the tongue, sequences of associations, transference patterns, and so on. Therefore, the clinical method of psychoanalysis centers around the analysand free associating—saying whatever come to mind—in order to provide the analyst, who is viewed as an outside observer of this process with a ringside seat, with the best possible access to the analysand's unconscious thoughts and processes. The analyst matches the patient's free-associating with evenly hovering attention so as to be able to detect the patient's unconscious conflicts and be able to formulate accurate interpretations about them. In keeping with this model, the analyst is positioned—both literally (sitting behind the patient) and figuratively—at some remove from the analysand/patient. The analyst is to be both a somewhat removed and ungratifying figure (for the analyst to gratify the patient is seen as obscuring and interfering with the unfolding of analysand's unconscious, drive-based associations).

In order to assist the analyst with maintaining the most useful stance vis-à-vis the analysand, Freud recommended certain technical guidelines for the analyst's behavior. They are neutrality, abstinence, and evenly hovering attention.

The Main Guidelines for Clinical Practice According to Self Psychology

In contrast with the classical analysis methods described above, self psychology promotes the following key principles:

1. The primacy of the empathic listening position.
2. The close tracking of the patient's self state. Symptomatic alterations in the patient's sense of self must be recognized and understood.
3. The close tracking of the patient's experience of the analyst. This involves both the close tracking of the state of the selfobject bond and the meanings to the patient of analytic behavior or activity.
4. Attention to disruption and repair experiences. When ruptures (in the selfobject bond) occur between patient and analyst, such ruptures are analyzed.

5. Understanding resistance as self-protection and as related to the experience of the negative-repetitive dimension of the transference.
6. Attention to the leading edge of the patient's experience. This includes the patient's needs, strivings, expectations, and motivations for self-development and fulfillment.
7. Attention to the need for self-liberation from pathological enmeshment. (Sorter 1995)

8

INTELLECTUAL AND SOCIOCULTURAL INFLUENCES ON KOHUT

Heinz Kohut grew up in Vienna just after the turn of the twentieth century. He was born in 1913 at the start of World War I, the most widespread, devastating war in human history. Fittingly, he was born the same year Freud published his famous paper, "On Narcissism." Early twentieth-century Vienna was the intellectual center of Europe. It was then a place of intense intellectual ferment and creativity. Great intellectual innovation took place in many fields—in music, philosophy, economics, architecture, and, of course, psychoanalysis. In all of these fields, innovators broke their ties to the historical outlook that was central to the nineteenth-century liberal culture in which they had been reared (Schorske 1981[according to Library of Congress catalog]).

HOW KOHUT WAS INFLUENCED BY THE GLORIFICATION OF PERSONAL SUBJECTIVITY

One of the intellectual currents of the time was the emphasis on—and sometimes glorification of—personal subjectivity. Carl Schorske, the intellectual historian of Vienna, says this was a time in which the