Intersubjective Self Psychology

A Primer

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Section 1

The theory and practice of Intersubjective Self Psychology

Chapter 1

An introduction to Intersubjective Self Psychology

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In this chapter we present the fundamental concepts of *Intersubjective Self Psychology* (ISP) which combines the core concepts of Heinz Kohut's Self Psychology (Kohut, 1971, 1977, 1984) with the essential ideas of Robert Stolorow and George Atwood's Intersubjectivity Theory (Stolorow & Atwood, 1992; Stolorow, 1997). From these established theories we create a new, cohesive psychological, and therapeutic model that transcends both theories and that we call *Intersubjective Self Psychology* or *ISP*. We believe that ISP provides an orientation to psychotherapeutic practice that recognizes and promotes forward development in therapy (the leading edge) as well as addresses and works through the repetitive patterns (the trailing edge), all with a deep appreciation for the interdependent nature of the human experience.

Self psychology

What are the essential ideas of Self Psychology which undergird ISP?

At the heart of Self Psychology is the concept of selfhood. "The Self" is a theoretical abstraction that stands for the complex set of experiences and fantasies each of us has about our self, and who we know and feel our self to be. These experiences and fantasies become organized according to significant patterns of beliefs, feelings, memories, and values. These cognitive and affective notions of oneself constitute the experiential and motivational center of our sense of being and of being-with-others. Ideally, these varied experiences that constitute the self are organized into a cohesive whole, but are not fixed or rigid; rather they are emergent and fluid. The experiences of vitality, coherence, continuity, and personal initiative characterize the essential qualities of our experiential center, the sense of self. The sense of self is highly contingent upon and embedded within a matrix of relationships.

The foundational listening and exploring stance of the Self Psychological analyst is empathic immersion in the patient's experience. Empathy was famously defined by Heinz Kohut as "vicarious introspection" (Kohut, 2010). In other words, empathy is the often difficult and slow process of feeling and thinking oneself into another person's subjective experience, as fully as possible; hence understanding the person from within that person's frame of reference.

Kohut later expanded that understanding and came to see empathy as both a mode of exploration of the experience of another human being and a way of relating to another human being. As a means of exploration, the analyst seeks to understand the patient's experience from within the patient's experiential world as it unfolds in the shared psychological field of the analytic relationship. As a form of relating, the analyst's empathy communicates the value placed on the patient's lived experience as well as a fundamental acceptance of it as something that can be understood, even if not always condoned. The analyst's commitment to empathy as a mode of exploration, and as a means of relating to the patient, lays the groundwork for the whole of the analysis.

Kohut discovered that not only are the development of self and the sustained experience of healthy selfhood contingent on the felt responsiveness of caregivers in childhood and significant others throughout life, self development relies on experiencing the other as part of the self. The self also relies on the emotional availability of others to perform necessary developmental functions and tasks. Kohut identified three specific lines of development along which self development can successfully unfold. He labeled them mirroring, idealizing, and twinship experiences (Kohut, 1971, 1977, 1984).

In the mirror line of development, we look to others to feel truly known and accurately seen. In the archaic mirror experience, we feel admired, the object of the other's adoring gaze. In the more mature mirror experience, we feel recognized and valued for who we know ourselves to be. A successful mirror experience contributes to a cohesive, reliable, and realistic self-esteem, and a solid sense of self-worth.

In the idealizing line of development, we look for a merger with someone whom we experience as calming, strong, and wise; one who offers him or herself for our protection and guidance. A successful merger with an idealized other provides opportunities for soothing, which results in a reliable capacity for affect regulation.

Finally, in the twinship line of development, we look to find in the other an experience of alikeness, a feeling of sameness that is shared, which results in the consolidation of self experience. We seek to recognize ourselves in the other and yearn for the other to recognize themself in us. Twinship lays the groundwork for a sense of shared humanity, a feeling of being human among humans.

In all three lines of development – which correspond to relational experiences that facilitate the development of a cohesive sense of self – the other is experienced as part of the self and as providing essential functions in maintaining the self. For these reasons, Kohut called these relationships selfobject relationships (Kohut, 1971, 1977, 1984). Selfobject experiences are fundamental human needs akin to the needs for air and water. Like plants turning toward sunlight, humans strive to find relationships that provide the selfobject experiences that generate and sustain self development and that enable previously stalled development to resume. As such, they are ubiquitous and, given a responsive other, they will emerge spontaneously.

Because Kohut believed that the availability of emotionally responsive others – those who provide opportunities for selfobject experiences through the life span – is a basic human need, he located the source of most human suffering in the absence of reliable, emotionally attuned others and/or in the presence of emotionally misattuned others, which results in the failure to find sustained, attuned selfobject experiences with others. The absence of empathically attuned others results in the failure in the development of an adequately vital, coherent, and continuous sense of self. This lack of necessary responsiveness, in concert with the child's inherent vulnerabilities, sets the stage for psychological, emotional, and/or behavioral disorders. Selfobject failure in the formative years that is either protracted or traumatic results in rigidified structures of self and other, emotional scar tissue that manifests itself in specific character formations and personality disorders. Conversely, psychological and emotional healing is possible when the opportunity for a reliable selfobject experience is restored with an emotionally responsive and empathic other. This conceptualization of psychological development is the basis of all forms of self psychological treatment (Kohut, 1984).

Kohut recognized the unfolding of the selfobject tie with the analyst and called this the selfobject transference. Selfobject transferences are relational pathways established and facilitated in the analysis in the service of self development. The three lines of development that Kohut identified as pathways for self development take the form of specific transferences in the analytic setting. In the mirror transference, patients seek a sustained experience of affirmation and validation that generates a positively toned self-esteem and sense of agency. In the idealizing transference, patients seek an experience of merger with the felt strength and emotional reliability of the analyst, in the hope of being calmed and soothed. In the twinship transference, patients seek an experience of essential alikeness with the analyst and appreciation of the analyst's felt alikeness with them. This leads to a feeling of shared humanity and an affirmation of who the patient knows him or herself to be. As patients' selfobject needs emerge and are properly responded to by

the analyst, restoration, consolidation, and structuralization of the self experience occurs and the sense of self unfolds and solidifies.

Kohut understood that felt experiences of self and others – or selfobject fantasies[1] – constitute the bedrock of psychological life. These selfobject fantasies are established at the beginning of life and constitute the template for a sense of self as well as for all relationships. Over time, in interaction with caregivers and others, these fantasies are modified, and gradually transformed into increasingly mature, adaptive, and self-esteem-enhancing conceptions of self and other. Consistent with the selfobject themes described above, Kohut believed that the most important of these fantasies for the development of the self are the fantasies of the grandiose self, the idealized parent imago, and the twin in the twinship transference.

In its most archaic form, the grandiose self describes a self-experience in which perfection is attributed to the self and all imperfections are attributed to the other. Likewise, the most archaic form of the idealized parent imago is an image of the other as perfect and the self is only perfect when merged with the other. The most archaic form of twinship is a fantasy of a perfectly identical other.

All three of these selfobject fantasies undergo a similar developmental process. In interaction with empathic and attuned caregivers, these selfobject fantasies evolve and are transformed in age-appropriate stages to adapt to the increasingly complex reality at hand. These transformed fantasies then become the basis for mature self-esteem (mirroring), a reliably established capacity for self-soothing (idealization), and a solid sense of feeling human among other humans (twinship). In the absence of attuned caregivers, or in the face of traumatic ruptures in the tie with them, however, the child will retain early, archaic versions of these fantasies. In such cases, these fantasies will interfere with the development of a healthy and robust sense of self. To the extent that a person remains organized around archaic fantasies of self and other, he or she will struggle with feelings of fragility and vulnerability and will be prone to feelings of fragmentation and/or depletion. Defensive behaviors will be employed to maintain the incompletely developed sense of self and to ward off fragmentation due to anticipated failures of attunement or traumatic disappointment by needed others.

Kohut also discovered that patients often fear the sense of vulnerability and potential retraumatization that may accompany the emergence of selfobject needs in treatment. Patients might be fearful that emotional intimacy and the reactivation of selfobject needs in relation to the analyst will lead to pain and a repetition of childhood experiences. Patients who have experienced significant selfobject failures or damaging misattunement by caregivers may protect themselves against retraumatization through psychological and behavioral strategies that deny, devalue, deflect, or otherwise neutralize the emotional connection with the analyst. Patients employ these

defensive strategies to protect a vulnerable self from what might be a hurtful relationship with the analyst.

If the analyst offers the patient experience-near and useful interpretations of his or her fears and the related self-protective efforts within a sustained, supportive, and empathic relationship, the patient may begin to feel safe enough to risk the reactivation of selfobject yearnings and needs with the analyst. In this way, the interpretations of defense are in the service of reinstating and developing the selfobject transference.

Intersubjectivity

What are the essential ideas of Intersubjectivity?

At the core of the theory of Intersubjectivity is the idea of the fundamental context dependency of all psychological life (Stolorow et al., 1987; Stolorow & Atwood, 1992). Stolorow and his colleagues argue that psychological phenomena in general cannot be understood apart from the *intersubjective context* by which they mean the *psychological field* that is generated by the intersection of the psychological world of one person with the psychological world of another as well as with the world at large. The clinical implications of Intersubjectivity Theory are that psychological health and psychological disorder originate in and are sustained by the intersubjective contexts in which they occur.

In other words, a person's self-experience is at all times determined by and dependent upon the specific intersubjective contexts in which it takes shape and by which it is sustained (or not). The experiences of connectedness, attunement, responsiveness to affect states and self states, and selfobject needs are fundamental to the development and consolidation of self-experience. These experiences are by definition intersubjective.[2]

A person's sense of self is constituted or disrupted in the context of attuned or misattuned responsiveness from significant others (selfobjects), as experienced by that person. As an example, for one patient the therapist's silence is experienced as a gift from the heavens, providing the space and freedom to free associate and unfold her world, and therefore consolidating her self experience, while for another patient that same silence is experienced as a traumatic repetition of the withholding angry father and therefore disassembling her self experience.

This context is referred to as the *intersubjective field* (Atwood & Stolorow, 1984) and is constituted in childhood by the intersection of the vulnerable and evolving subjectivity of the child with the (hopefully) more mature and developed subjectivity of the caregiver. Any two or more people engaged with each other constitute a specific intersubjective field within which each person's self-experience takes shape, contingent on the subjective frame of reference, the personal world, into which the experience is organized.

The concept of subjectivity includes the entirety of feelings, beliefs, fantasies, memories, and thoughts about oneself and others. This includes unconscious dimensions, which may have never required conscious awareness (Stolorow & Atwood, 1992) yet may nonetheless constitute basic reflective templates which Atwood and Stolorow (1984) call "central organizing principles"; a person's most fundamental beliefs. On the other hand, some unconscious aspects of subjectivity may have been banished from consciousness, and sequestered for safety's sake, because the affect and self states involved are experienced as threats to psychological health, the cohesion of self-experience, and/or the needed tie with an essential other. This dimension of subjectivity is traditionally called the *dynamic unconscious.* Intersubjectivity Theory contends that the dynamic unconscious consists of the defensive sequestration of any feeling or fantasy which poses a risk to the self, not simply because of the content of the affect or fantasy per se, but because of the threat it is felt to pose.

As we will demonstrate throughout this book, the notion of the intersubjective field, and its conscious and unconscious determinants found in the subjective worlds of interacting people, is fundamental to our understanding of the psychotherapeutic situation. Psychotherapy is an intersubjective field in which the psychological lives of patient and therapist meet and influence each other. And at the heart of the process is the way in which the unconscious dimensions of the patient's subjectivity are expressed and transformed in the course of the unfolding therapeutic interaction. Given this, we now turn back to Self Psychology, because it is the vicissitudes of self-experience and selfobject needs which emerge in the intersubjective psychotherapeutic field, manifest in the expression of the patient's fears and dreads, as well as his or her longings and hopes, creating the opportunity for therapeutic change.

Intersubjective Self Psychology

What is Intersubjective Self Psychology?

Integrating Kohut's theory of the self with Stolorow's Intersubjectivity Theory compels us to eschew notions of isolated subjective experience in favor of the rich complexity of reciprocally influential, continuously interacting and mutually constituted subjective worlds. Together, both theories not only enhance our knowledge of the relational context of all psychological life but also provide a powerful therapeutic tool. The idea of self development as being co-determined by the intersubjective matrix within which it occurs is perfectly met by the conceptualization of the analytic situation as an intersubjective field, constituted by the intersection of the experiential worlds of patient and analyst. The result is that in the analytic situation we are not dealing with a patient's experience in isolation; rather

we are at all times dealing with the patient's experience as it is co-determined by the felt interaction with a particular analyst and as it evolves in response to it; similarly we are at all times dealing with the analyst's experience as it is co-determined by the felt interaction with the particular patient. The analytic situation is thus conceptualized as an intersubjective field of reciprocal mutual influence, constituted by the intersection of the experiential worlds of *both* patient and analyst.

By integrating Self Psychology with Intersubjectivity Theory, we are committed to uphold that all of what Kohut recognized to hold true for the development of the self, above all the selfobject transferences, with what Stolorow recognized to hold true for the therapeutic situation, above all the reciprocal nature of the intersubjective field, which means what holds true for the patient also holds true for the analyst. In other words, the analytic situation is constituted by the felt interaction of both the patient's and the analyst's sum total of their emotional worlds; the intersubjective field is bi-directional and co-determined by the specific intersection of the respective emotional worlds of patient and analyst, this includes the emergence and expression of selfobject needs for the analyst, as well as the patient.

Because both theories share the belief in empathy as the analyst's method of observation, we are committed to exploring the experience of the patient in the intersubjective field from the patient's perspective, from within the patient's experiential world. But based on the theory of Intersubjectivity we understand that empathy cannot be seen as disinterested or objective. The experience of the patient is co-determined continuously by the felt interaction between the patient's subjectivity and the analyst's, and vice-versa: the experience of the analyst is co-determined by the felt interaction with the subjectivity of the patient. Hence, from an ISP viewpoint, the analyst's empathy is more than just feeling oneself into the experience of the patient. Rather, it is a complex and rich immersion in the intertwined subjective experiences of analyst and patient, and the meanings these experiences assume for each of the parties involved, in turn, shaping how each responds to the other. It is this complex field of reciprocal mutual influence that constitutes the intersubjective matrix and becomes the object of analytic exploration.

Kohut's discoveries of the selfobject transferences are enduring and recognizable themes in all human relationships and thus we contend that in all treatments the intersubjective field is fundamentally constituted by the intersection of the selfobject transferences of patient and analyst. The sum total of all development-enhancing modes of relatedness – of these the selfobject transferences are foremost – are gathered under the heading of the *leading edge* (Tolpin, 2002).

On the other hand, self disorders are characterized by anxieties related to the potential emergence of selfobject transferences and accompanying

vulnerabilities associated with the fear of repetition of trauma and other selfobject failures. These fears, anxieties, and dreads give rise to the repetitive transference patterns of patient and analyst, the intersection of which will equally shape the intersubjective field. The sum total of all repetitive modes of relatedness comprise the repetitive transferences and derive from traumatic experiences and selfobject ruptures are gathered under the heading of the *trailing edge* (Tolpin, 2002).

The concepts of leading edge and trailing edge describe an important duality, central to the intersubjective field: hope vs. dread. The leading edge expresses one's hopes and other progressive elements. The trailing edge harbors one's dreads and those fears that serve to preserve the status quo. Taken together, the concepts of the leading and trailing edges capture the ways in which hope and dread serve to organize and motivate contrary aspects of the transference. ISP is the perfect medium for this duality to be expressed, on the one hand focused on the development of a shared psychological field within which the selfobject transferences, the leading edge of the patient's emotional world is permitted to unfold and flourish, and on the other hand, wherein the repetitive transferences, or trailing edge, is elaborated and worked through. The question as to why either the leading edge or trailing edge becomes the focus of work, depends on what themes are salient at any given point in time.

Both patient and analyst experience the duality of hope and dread (Mitchell, 1993; Bacal & Thomson, 1996). Hence, each brings to the analytic situation their leading and trailing edges. The following is an example: The empathy and attunement of the analyst, while reflecting her leading edge, may stir up longings and needs in the patient, his nascent leading edge. This paradoxically may intensify the patient's trailing edge protections against rejection and abandonment, resulting in avoidance and "resistance." The patient's transference manifestations then activate the analyst's fear of rejection and failure, leading to her emotional withdrawal or dissociation: the analyst's trailing edge. The patient senses this and feels confirmed in his expectation of abandonment, thus warranting a redoubling of defenses and self-protective measures. The analyst becomes aware of how the patient's attitude evokes an old experience of rejection by her depressed mother. She also senses the patient's need to protect himself from his abusive parent. In this way, there is a congruence of trailing edges. The analyst's understanding helps her feel more empathic with the patient's need for self-defense and signals that the analyst's leading edge has moved to the forefront. The analyst puts into words what she thinks the patient may be feeling and the reasonableness of his seeking to protect himself. The patient begins to feel understood and safe, and his leading edge is activated as he feels more connected, as his fears are acknowledged, and he does not feel ashamed. Tentatively, the leading edge of both analyst and patient slip into congruence and tendrils of hope are extended, strengthening the sense of attunement.

The objective of ISP is the unfolding and development of the leading edge of the patient in the intersubjective field of the analytic situation, for it is at the leading edge of the transference that the patient's hope for self-object experience is strongest and the associated motivations for renewed development most imminent. The unfolding of the creative capacities of the patient's leading edge is further facilitated by the engagement with the analyst's leading edge. So, for example, if when the patient seeks and finds a selfobject transference experience of mirrored expansiveness, at the same time the analyst experiences the patient's well-being and feels mirrored him or herself, a co-determined selfobject transference within the intersubjective field facilitates the patient's healthy sense of self. The same holds true for the idealizing transference and the twinship transference. Each of them may be the central leading-edge theme for both patient and analyst. The synchronicity of the patient's leading edge and the analyst's leading edge constitutes the dynamic basis for growth and creative change.

That being said, ISP recognizes that hope and dread are linked in a dialectical relationship. Hope is already contained in dread and dread is contained within hope. In the language of leading and trailing edges, the leading edge invariably revives the trailing edge themes, just as imbedded in the trailing edge is the kernel of the leading edge. In other words, in the experience of many patients, hope has too often resulted in failure and injury. Inevitably, the analyst's offering of an opportunity for a longed-for selfobject tie will activate old fears. At the same time, the activation of the trailing edge intensifies the desire for repair and restoration associated with the meeting of selfobject needs. This dialectic, which is also active for the analyst, opens up infinite configurations that might emerge in the analytic relationship. The analyst seeks to feel her way into and through this complex, ever-changing, and volatile psychological and emotional dialectic. It is the tension inherent in this dialectic between leading and trailing edges (the hopes tied to and restricted by the dreads that keep us safe) that creates distress and is thus the primary motivator for the patient. Yet it is this same tension that provides the opportunity for the analyst to support the leading-edge hopes and thus tip the balance of the transference toward change.

The patient's dreads are particularly strong and unyielding when the core organizing fantasies remain undeveloped and therefore maladaptive. Untransformed grandiosity mobilizes dependency needs, which may be accompanied by threatening memories and emotional trauma. As a result, the mobilization of self-protective, defensive strategies accompanies the dread of repetition. Because the trailing edge emerges in these symptomatic and resistive dynamics, the analyst inevitably becomes personally embroiled, not least because of the analyst's own trailing edge. Working with and through the complex trailing edge toward therapeutic change becomes possible because of the unique characteristics of the analytic relationship. The analytic dialogue, which is tilted toward the subjective world of the patient

through the tool of empathy, is facilitated by the analyst's ability to decenter from his or her own trailing edges. The analyst's ability to interpret the patient's dread while maintaining responsiveness to the patient's subjective life allows the patient to feel safe enough from the threat of repetition of trauma and/or selfobject failure and thereby encouraged to relax protective measures and defenses. In this environment, selfobject longings are revived and hope rather than dread becomes justified. The result is the evocation of selfobject needs in an intersubjective context wherein they might be met. As the leading edge of patient is met by the leading edge of the analyst, a transformative engagement between patient and analyst is activated. In this intersubjective field, the patient finds a sustained facilitating context for the unfolding of new psychic structures and growth.

ISP treatment should not be confused with a simply supportive process. Interpretation and working through of the trailing edge is a requirement for therapeutic success – even as it occurs in the context of a newfound sense of safety that relaxes the grip of the fearful past, allowing for the emergence and enactment of new, now-unencumbered hope. In other words, the therapeutic action of ISP consists of two interrelated processes: development of new psychological structures when the tie is intact and transformation of existing structure via interpretation when the tie is disrupted.

Although interpretations of the leading edge are not needed when patient and analyst are connected by the analyst's attuned engagement with the patient's leading edge, we contend that such leading edge interpretations at crucial times may significantly strengthen the intersubjective bond and promote forward development. In other words, the interpretation of the leading edge and of the generative intersubjective field can also strengthen the patient's self, at a time in the therapy when the patient is beyond the shame of identifying the specific nature of the therapeutic relationship. In doing so, the core of the patient's self-experience is enhanced and fortified. Furthermore, the patient is empowered by knowing what he or she needs. Getting help is easier when we can ask for what we need.

Whenever the selfobject tie is ruptured and the patient's dread is in the foreground, interpretation of the trailing edge becomes essential. The process of empathic, compassionate interpretation of repetitive transferential experiences serves to illuminate and bring to consciousness central protective organizing principles and self and object fantasies that constitute the person's character structure, and declares them to be eminently understandable from within the intersubjective context with the analyst. Such understanding re-establishes the selfobject tie, allowing the leading edge to move once again to the foreground. This process of interpretation brings about the transformation of existing structures, as described by Kohut in 1984.

When repetitive transferences of patient and analyst are worked through, the trailing edge dynamics recede and the yearned-for selfobject transferences of patient and analyst are able to unfold. This will constitute the

fortuitous intersubjective field within which the patient and the analyst receive the emotional nutrients that permit self-experience to evolve and solidify. The analyst is experienced as providing the needed selfobject experience that results in the acquisition and development of the patient's new or emergent self structures. The same holds true in the opposite direction: The analyst feels affirmed in his or her sense of competence and efficacy, which meets his or her longed-for selfobject experience and results in the acquisition and consolidation of the analyst's emergent self structures.

The unfolding of the leading edge in the intersubjective field is the foremost objective of ISP. We thereby have turned the therapeutic action of traditional psychoanalysis on its head and are proclaiming that the work with the trailing edge, while necessary, is not the sufficient condition for a curative action. The sufficient condition is the work with the leading edge. For it is the strengthening of the leading edge, and with it the hope and motivation for renewed self-actualization and healthy development, that is the driving force behind the therapeutic process.

Notes

1 The term fantasy is used here in keeping with psychoanalytic theorizing. Since selfobject bonds refer to the patient's subjective frame of reference, the term fantasy is used to denote the patient's experience of the tie with the analyst. The use of the term fantasy in no way implies a lack of reality; it only denotes that the reality is determined by the patient's subjective experience.

2 The terms "intersubjective" and "relational," in current psychoanalytic parlance, have overlapping but not identical meanings. "Relational" emphasizes interactions between people, whereas "intersubjective" refers to the subjective experience of the relationship, whether or not an interaction takes place. This subjective dimension is not included in the term "relational." For example, sitting with a patient in a catatonic state will constitute a specific intersubjective field but it would not be a relational experience. In this way relational experiences are always intersubjective but not all intersubjective experiences are relational. Intersubjective is the more encompassing term.