Intersubjective Self Psychology

A Primer

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Routledge
Taylor & Francis Group
LONDON AND NEW YORK

Chapter 4

The therapeutic action of Intersubjective Self Psychology, Part I[1]

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What is curative in psychotherapy from the perspective of Intersubjective Self Psychology?[2] In answer to this question, two modes of therapeutic action will be differentiated, generated by two different experiences in the therapeutic relationship, the work with the leading edge and the work with the trailing edge. Each mode entails a form of analytic engagement. I begin by introducing several concepts that constitute the clinical language of Intersubjective Self Psychology (ISP).

The patient

Patients come to treatment with their *hopes* and *dreads* (Stephen Mitchell, 1993), and with their *yearnings* and *fears*. These yearnings and dreads may be known to patients and thus conscious, or unconscious, preconscious, repressed, dissociated or disavowed, and thus not known to them.

Patients come to therapy because they *hope* that the therapist can help them. They hope that they can transcend the place where they feel stuck; they *yearn* for a new start. They come to therapy with the hope that they have found in the therapist the person who is going to provide, in the therapeutic relationship, the experiences that they need to be confident to abandon old strategies of self-protection, and pursue new ways of being in and engaging with the world. These experiences have their source in what Kohut (1971, 1977, 1984) discovered as specific, universal modes of engagement with the other required for self development, called selfobject bonds. Self object bonds take hold in the form of selfobject transferences when the patient sees the opportunity for such experiences of engagement in the therapeutic relationship.

The concept of the selfobject transference refers to the emergence in treatment of a specific, enduring sought after relational experience with the analyst that is necessary for the patient's self development to proceed. The selfobject transference is understood as a reinstatement of a needed bond with the therapist for the transformation and growth of the self. This bond had been available to the child to some extent in the original caregiving context but

not sufficiently enough to complete self development. The patient continues to yearn for it today.

The selfobject transferences are the prime constellation of what we define as the *generative transference*.[3] The generative transference refers to the dimension of the therapeutic relationship that promotes growth and healing. The generative transference is understood to constitute the *leading edge* in treatment. It entails the establishment of the development-enhancing experiences in the relationship with the analyst that the patient yearns for and needs to reinstate a process that results in the unfolding, consolidation and vitalization of the self experience.

However, as stated earlier, patients come to treatment not only with yearnings and hopes, they also come with their *dreads and fears*. They dread that they are destined to remain mired forever where they feel stuck. They fear that the experience they seek with the therapist will not be available to them, and they fear that they will receive the same faulty response from the therapist that they felt they were met with by the original caregivers, and now, from the world around them. They dread that what will prevail is a miss-attuned or inadequate selfobject experience or worse, a traumatic repetition of the original selfobject failure.

These dreads give rise to the *repetitive transference*, a term introduced by Stolorow, Atwood and Brandchaft (1987) to refer to all that traditionally has been called transference, to set it apart from what we refer to as the generative transference. The repetitive transference is defined as a revival and enactment of an unconscious significant maladaptive and enduring relational pattern from the past in the here and now of the therapeutic relationship. The repetitive transference is the centerpiece of what constitutes the *trailing edge* in treatment.

The trailing edge refers to all the relational patterns that result from the ingrained character structures and all the modes of relating that come into play when the patient anticipates or experiences a repetition of a traumatic experience from the past in the here and now of the therapeutic relationship. The trailing edge includes all the self-protective and restorative measures, the so-called defenses and resistances, that the patient relies on to protect the self experience from further injury and fragmentation.

In summary, the activation of hopes and yearnings characterizes the generative transference which constitutes the leading edge. The activation of dreads and fears characterizes the repetitive transference which constitutes the trailing edge.

The terms leading and trailing edge have been introduced by Kohut, although he never used the terms in his writings. It is Jules Miller (1985), one of his supervisees, who wrote that Kohut used these terms in supervision with him. Marion Tolpin a devoted and gifted student, and colleague of Kohut, was the first psychoanalyst to use these concepts in a paper. She

pointed out the importance supporting the 'tendrils of health' in therapy, but used the term 'forward edge' in place of leading edge.

Frank Lachmann (2001) re-introduced trailing and leading edge in his book: *Transforming Aggression*. Since then, forward edge and leading edge have been used interchangeably in the literature. We favor leading edge, as it is Kohut's choice, and it is the natural linguistic partner to trailing edge.

Self disorders

Kohut (1971) initially thought that self disorders come about when miss-attuned parental responses to the child, lead to faulty or inadequate selfobject experiences. As a result, a patient was thought to be seeking to establish the selfobject bond with the therapist that had been inadequate, insufficient or missing. In other words, in treatment patients would seek out whichever selfobject experience they had NOT adequately received in the original care-giving surround. Faulty mirroring experiences in childhood result in the need for reliable mirroring experiences in therapy; merging experiences with unreliable idealizable figures result in yearnings for a reliable idealizable figure with whom to merge and inadequate twinship experiences result in the search for 'good enough' twinship experiences to restore and maintain the self experience.

In *How Does Analysis Cure?* (1984) his posthumously published book, Kohut proposed a new and more complex way of thinking about self disorders. He introduced the idea of the *compensatory* selfobject experience. He stated that a self disorder comes about if, and only if, after a rupture in the primary selfobject tie, a reliable compensatory selfobject experience is not available or is faulty and fails as well. Any one of the three selfobject transferences can serve as the compensatory selfobject experience based on which self development can proceed and be completed.

Let's illustrate this with a hypothetical example. Let's say a baby's primary self experience is organized around feeling mirrored by her mother. The baby bathes in her mother's joy as the mother administers to her daughter. She is seeing the gleam in her mother's eyes and feels affirmed. At age four however, her little brother is born and the daughter becomes painfully aware that her mother's attention has moved from her to the brother. For the daughter this constitutes a rupture in the mirror selfobject tie with the mother. This could result in a crisis in the daughter's self experience, creating a structural vulnerability in the self that could manifest as a disorder of the self in adulthood.

However, Kohut argues, if at this crucial point in time the father or other parent is available to the daughter as a solidly idealizable figure to merge with, the daughter's self experience or sense of self would not fragment; rather, it would continue to solidify in the merger experience with the idealized figure, and a self disorder would not result. Similarly, if at this point the

daughter would start a preschool program and would find a best friend with whom to form a solid twinship tie, a self disorder would not develop either. Either one of these lines of development, the idealizing or twinship experience, would make up, compensate, for the lost mirroring experience around which the self was originally organized.

While there would be certain vulnerabilities in the sense of self, fundamentally, Kohut argues, the self experience would be cohesive enough, depending on the relative strength of the compensatory selfobject experience so that a disorder of the self would not result. If, however, the other parent is absent, and thus a merger with a reliably idealizable figure is not available, or the parents just moved to a new neighborhood so that the daughter also loses her best preschool friend, which would mean that the twinship experience is lost as well, then a compensatory selfobject line would be lost as well. According to Kohut, then and only then, a self disorder would result.

This new conceptualization has far-reaching consequences for how we think about what is curative in therapy and how we go about facilitating a curative process. What are these consequences?

A first consequence is that in treatment patients do *not* necessarily or even primarily seek to revive the primary selfobject tie, the developmental line wherein the original rupture occurred; rather, patients will seek to establish the compensatory selfobject transference bond that will enable the development or consolidation of the self. This is where the patient's hope is found, this constitutes the generative transference, this is the leading edge. The rupture in the primary selfobject bond accounts for the dread of a traumatic repetition that gives rise to the repetitive transference. This constitutes the trailing edge that will manifest in the form of self protective measures and defenses.

This makes it critical that in the initial assessment of the patient, therapists not only seek to establish what the primary selfobject failures were, but also who, if anybody, came through for the patient and what that selfobject experience was. This points to the compensatory selfobject experiences that were most sustaining for the patient. These sustaining experiences will become the yearned-for compensatory selfobject transference that the patient will seek to unfold in the therapeutic relationship with the therapist, the generative transference. This will constitute the leading edge.

Based on the hypothetical example from above, the daughter might have gone through a depressive phase from age 4 to 6, due to the loss of the mirror tie with the mother. The depressive phase lifted when she went into to first grade and again found a best friend from whom she became inseparable all through middle school. A compensatory twinship selfobject tie was established. Only when she started high school, and again felt alienated from her peers because her friend had moved away, did the vulnerability in the underlying self structure become manifest and her sense of self unraveled, causing her to rely on cutting herself or binging and purging to shore up her fragmenting self experience.

This might be the time when her parents suggested that she seek therapy. Once there, she hoped to establish a twinship selfobject transference with the therapist in order to reinstate the compensatory line of development where it was disrupted. However, there might be significant resistances present in the treatment, due to the dread of retraumatization, i.e. abandonment, and thus the dreaded loss of twinship, which would need to be worked through for the leading edge to engage.

A second consequence of Kohut's new formulation of the disorders of the self is that regardless of how traumatic the primary selfobject failure or rupture in the primary selfobject tie, a cohesive, functional, stable self structure and an emotionally positively colored sense of self, continuous in time and space, can still develop, provided there was a reliable and sustaining compensatory selfobject bond available. This means that the central issue in the treatment of self disorders is essentially not how traumatic the primary selfobject failure was, although this plays a significant role in the trailing edge, but rather whether a reliable, stable, 'good enough' compensatory selfobject experience was available and at what point that compensatory selfobject line was derailed or disrupted.

The compensatory selfobject bond could be provided by a sibling or aunt or uncle, a grandparent or teacher or a best friend. In treatment, then, the therapist's work needs to be focused first and foremost on the revival of the compensatory line of development in the transference, and secondarily on the working through of the primary selfobject failure. The primary selfobject failure will come into the therapeutic relationship each time the compensatory selfobject tie is felt to be disrupted by the patient and the repetitive transference is revived, which will require working through. If a treatment is exclusively focused on the patient's trailing edge and the therapist fails to recognize the patient's yearning for the compensatory selfobject bond, the patient will, on an ongoing basis, feel thrust into the traumatic experience of the original selfobject failure that he desperately seeks to extricate himself from precisely with the compensatory selfobject bond.

To summarize, the primary selfobject failure or rupture gives rise to the patient's dreads in the transference and manifests in the repetitive transference, that is the trailing edge. The compensatory selfobject experience is powered by the patient's hopes and yearnings and manifests in the generative transference, that is the leading edge. Leading and trailing edge are in a figure-ground relationship, which means when the leading edge is in the foreground of the analytic relationship and is co-determining the therapeutic situation, the trailing edge is in the background, and vice versa.

Compensatory and defensive structures and strategies

The other clinically relevant differentiation that Kohut (1981) introduced is between *defensive* and *compensatory* structures. Defensive and compensatory

structures both serve the same purpose: they protect and maintain the self or shore up a person's vulnerable or fragmenting self experience. The difference is that compensatory structures are capable of undergoing a developmental transformation, and defensive structures are not.

Compensatory structures are able to undergo a process of developmental transformation and become enduring adaptive dimensions of the person's self that enhance and solidify the self experience. They derive from genuine selfobject bonds but also from fulfilling engagements with work, as well as artistic, intellectual or scientific pursuits and hobbies, and other forms of personally meaningful activities such as engagements with literature, music, film, gardening, cooking, sports, humanitarian issues, etc. Involvement in any of these activities may serve a compensatory selfobject function around which the self experience can be organized, and the sense of self can be solidified.

Defensive structures are also manifestations of efforts to shore up, protect or restore the self, but they derive from activities such as drug use, skin cutting, binging and purging, hoarding, compulsive masturbation, sex or love addictions, obsessive-compulsive rumination as well as psychotic preoccupations and delusions, etc. The characteristic feature of defensive strategies is that they do not promote a developmental transformation of the self experience, which means they do not result in the strengthening of self-experience. They only temporarily shore up a fragile or fragmenting self experience and therefore need to be repeated rigidly and indefinitely without bringing about growth and transformation of the self experience. For instance, no matter how many times a person smokes crack after an experience of humiliating failure, or compulsively masturbates, or binges and purges, these activities, while temporarily shoring up a failing sense of self, will not ever result in the growth or transformation of the self experience.

The differentiation between defensive and compensatory allows for the differentiation between pathological and healthy forms of narcissism. In pathological narcissism, in the aftermath of traumatic selfobject failure in the original caregiving surround and due to the absence of a compensatory selfobject line of development, a person relies on connections to others and activities in strictly *defensive* ways that do not enable the development of the self. Instead, these bonds and activities require endless enactment and are rigidly clung to, just like addictions of any sort, gambling, sex, betting.

If these activities and connections to others are not recognized by the therapist as defensive but are thought to be compensatory and responded to as if they were genuine selfobject bonds, and are encouraged to proliferate, they become more entrenched and more rigid, without any transformation of the self taking place. This is the precise opposite of what takes place when a genuine selfobject bonds is engaged.

The pathological narcissistic that Kernberg (1975) describes, who *craves*[4] mirroring, twinship or idealization should not be confused with the narcissistic

patient that Kohut has in mind, who *yearns* for a mirror, idealizing or twinship selfobject transference in order to resume development where it was derailed. In the pathological narcissist, no developmental or transformational process is reinstated, because no compensatory line of development was available; rather, a specific narcissistic defense is enacted. Mirroring of defensive grandiosity does not result in the development of empathy (as it does in the mirroring of developmental forms of grandiosity); it results in the entrenchment of haughtiness.

In the language of ISP, defensive narcissistic cravings presented in the form demands, appear as though they are manifestations of the leading edge but are in fact expressions of the trailing edge. They are expressions of defensive maneuvers to protect against the threat of fragmentation stirred by the dread of renewed traumatic selfobject failure. Instead of engaging with them as if they were developmental yearnings they need to interpreted with the defensive function they serve.

When pathological forms of narcissism are not differentiated from developmental forms, defensively maintained narcissistic positions remain unanalyzed. This manifests in more deeply entrenched haughty grandiosity, pathological Mooni-like idealization of cult figures, and sycophantic twinship enactments. Engaging with a patient in ways to promote the unfolding of the selfobject transference bond is only indicated if the selfobject needs are compensatory, meaning emanating from a compensatory selfobject line of development. Pathological forms of narcissism come about precisely because a compensatory selfobject line of development was not available or too unreliable and fraught. This presents the person with too great a threat to the self. As a result, the person has no choice but to rely on the narcissistic defense that fends off the fragmentation of the self.

As is apparent, we contend that there are pathological forms of narcissism that must be differentiated from developmental forms. However, the way an intersubjective self psychologist works with these forms of defensive narcissism is different from traditional or Kernbergian analysis. With an ISP perspective, it is the role and function that the narcissistic defense plays in the maintenance and protection of the self that is interpreted. The therapist, schematically, might say to a pathological narcissist: 'Given that your father was a terrifying figure and you had no sense that he saw anything in you that he valued, I understand why turning to him as a person to look to for guidance felt too dangerous or damaging to you, after your mother sank into a depression and suddenly was emotionally absent, the one person who you felt had championed you, even if it had been for her own needs. As a result, you came to rely on and rigidly cling to an archaic fantasy of yourself as the greatest, infalible human – a genius – that constantly craves to be affirmed as such and at all times demands to be the center of attention.'[5] However, we concur with Kernberg that if defensively maintained narcissistic positions are not analyzed, but treated as if they were compensatory, the entrenchment of the narcissistic defense will result.

To say it colloquially: A therapist can mirror defensive grandiosity, accept a defensive idealization or share in defensive twinship until the cows come home. No developmental line will be reinstated along which self experience will unfold and the self structure will transform. Rather, the pathological narcissistic position will be reinforced.

The therapist

Not only patients come to the treatment situation with hopes and dreads, but so do we as therapists. Like the patient, the therapist brings his hopes and dreads to the therapeutic situation, and those hopes and dreads give rise to the therapist's generative and repetitive transference. Therefore, the therapist's leading and trailing edge codetermine the therapeutic situation.

Therapists also yearn for certain affirming experiences with their patients. We yearn to be seen as capable and effective therapists, as competent listeners and incisive interpreters, as empathic, insightful, smart, caring, and solid therapists. We yearn for these qualities to be validated in order to maintain our sense of self as competent therapists. These needs, in conjunction with more specific personal, selfobject needs – individual therapists may be more organized around grandiosity or idealization or twinship – codetermine our selfobject transference needs and constitute our leading edge.

Ideally, our selfobject needs are on a mature level relative to the patient's needs, based on the fact that we underwent our own analysis and training. This means that our self-experience or sense of self is expected to be sufficiently solidified so we are capable of responding to the patient's selfobject needs and are able to promote the patient's goals and objectives. If our self object needs are on a more mature level, we are not unduly subject to disruption or fragmentation of the self experience when our own selfobject needs are not adequately met in the analytic dyad. This is also one of the reasons why it is important for us as therapists to have in our own lives sources of sustaining selfobject experiences, both personally and professionally, like friends and loved ones, as well as supervisory and peer group support, but also meaningful non-professional engagements with literature, music, recreation, and worthy causes that are commensurate with our needs. Nevertheless, the notion of the therapist's emotional maturity does not hold true in any absolute way, and at a given moment in the therapeutic process the therapist's selfobject needs may be more urgently felt and thus more dominantly shaping the analytic dyad than the patient's selfobject needs, whose selfobject needs on an ongoing basis are permitted to structure the therapeutic relationship.

It is reasonable for the patient to expect that our capacity to understand ourselves in the therapeutic situation is solid enough so that we are in a position to engage optimally with the unfolding repetitive and/or generative transference of the patient and carry out our analytic function without undue interference from our own subjectivity, including our leading edge yearnings.

As therapists, being human or all too human, we also experience our own dreads about the work. We may fear that we will come away from the therapeutic encounter experiencing ourselves in ways that replicate self states that derive from traumatic relational patterns from our own past, leaving us feeling inadequate, overwhelmed, inept, exposed, depressed, enraged, guilty or ashamed. These dreads, when realized, lead to the activation of our repetitive transference patterns in relation to our patients, resulting in disjunctions and disruptions in the therapeutic relationship. This is to say that the therapist's experience is also shaped by his repetitive transference that structures the analytic relationship and constitutes the therapist's trailing edge. This is what traditionally is referred to as the therapist's countertransference. If as a young adult in High School the therapist felt ostracized by his peers, he is likely to struggle to maintain his emotional equilibrium in the therapeutic situation if a patient seeks to establish a twinship transference relationship, since for the therapist this revives the painful experience from his High School years.

The therapeutic situation

Since both therapist and patient bring to the therapeutic situation their respective leading edge hopes and trailing edge dreads, the therapeutic situation is most adequately conceptualized as an *intersubjective field* (Stolorow, Atwood & Brandchaft, 1987) created by the intersection of the emotional, experiential worlds of patient and analyst.

The central claim of the theory of intersubjectivity as developed by Stolorow, Atwood and Brandchaft (1987) is that all psychological phenomena, from the emotionally healthy self states to the most severe forms of disorders of the self, are co-determined by the intersubjective field within which they occur. This captures the fundamental context dependence of all emotional or psychological phenomena (Stolorow & Atwood, 1994).

Consequently, and this intersubjectivity theory's most radical formulation, any self state that either patient or analyst experience in the therapeutic situation cannot be understood apart from the intersubjective context within which it occurs (Stolorow & Atwood, 1994).

In the language of ISP, we conceptualize the therapeutic situation as constituted by the intersection of the leading and trailing edges of the patient emotional world with the leading and trailing edges of the therapist's emotional world. What we seek to analyze and work through (trailing edge), and engage and unfold (leading edge), are generated by this complex intersection and emerge in the therapeutic situation. The therapeutic situation is a bi-directional field of reciprocal mutual influence (Stolorow, 1997), wherein the leading edges and trailing edges of patient and therapist are co-determined, ever shifting in a figure-ground relationship.

What is curative

From the perspective of leading and trailing edge, psychoanalysis as originally conceived by Freud, is a trailing edge theory: it is centered on working through the patient's repetitive transference. The psychoanalytic method is focused on resolving the internal conflicts of the person as they manifest in the transference relationship with the analyst by making what is unconscious (repressed) conscious via insight. Therefore, we can say: the therapeutic action of classical psychoanalysis derives primarily from the work with the trailing edge.

Already at its inception, Freud realized that in order to analyze the neurotic transference, something in addition to the repetitive transference needed to be in place for the analysis to work. The patient had to have what Freud referred to as the 'unobjectionable positive feelings' (Freud, 1912) toward the analyst. Those positive feelings accounted for the fact that the patient, even in the throes of the repetitive transference, would be open to the analyst's interpretations and engage in the process of exploration. The unobjectionable positive feelings toward the analyst formed the basis for what later came to be called the 'working alliance' (Greenson, 1967).

As psychoanalysis began to widen its scope and began to address preoedipal conditions, narcissistic and borderline states, which are what we would call moderate to severe self disorders, working through the negative or repetitive transference came to be understood as the heart of analytic work. Much of the innovation in psychoanalytic theory and practice came from refinements in and amendments to the technique of working with transference. But, it was also in relation to the pre-oedipal conditions that the idea of the analyst as a *new object* (Winnicott, 1965) emerged, which means the analyst as the 'good enough' object (Winnicott, 1955) and thus not the negative transference object.

The preoedipal patient was thought to need something from the analyst, something more than the provision of insight, a new experience, that compensated for what had been missing from the patient's early childhood experience and from the self structure. Without the provision of a new experience with the analyst the patient was thought to remain mired in the negative transference. For this not to occur, the analyst had to be a 'good enough' object.

The notion of the 'good enough' analyst implies that who we are as analysts and how we interact with our patients, rather than how our patients *experience* us as analysts, has an impact on the outcome of treatment and thus co-determines the therapeutic action. Nevertheless, to think about how the analyst could facilitate or promote healthy strivings in the patient and what might be needed from the analyst in the analytic dyad to make that possible, was frowned upon and viewed as diluting the pure gold of analysis with the tin of psychotherapy. At most what

was tolerated was the introduction of parameters, wherein the analyst was said to function as an auxiliary ego to the patient's defective one, at least for a time, until said 'parameters' were no longer necessary and thus could be resolved via interpretation. Everything else was seen as providing a 'corrective emotional experience' (Alexander, 1950) and thus was declared as un-analytic. It is hard to understand, rather, we would say, incomprehensible, what the analyst as new object is providing if not a corrective emotional experience. In fact, we argue that even the interpreting analyst is in and of itself already providing a corrective emotional experience in that he is at that moment not reacting to the patient as the original caregivers have.

In traditional psychoanalysis, working with the leading edge, the idea of actively engaging and working with the healthy dimensions of the person, and thinking about how analytic work could promote or strengthen this aspect of the person has been neglected; at best, it has been viewed as an unintended side effect and at worst frowned upon as 'unanalytic.' As stated before, it is the work with the trailing edge that was considered analytic and curative.

Surprisingly, this model of the therapeutic action still largely holds true in self psychology. In *How Does Analysis Cure?* Kohut (1984) goes to great length to describe the therapeutic action as the result of the insight that interpretation provides into the disruption-repair cycle, which means the interpretation of the trailing edge.

What I am proposing here is a reversal: to turn the classic psychoanalytic theory of cure, including Kohut's theory of cure, on its head and say: in ISP, the primary therapeutic action derives from the engagement in and development of the leading edge. Working with the trailing edge, albeit inevitable and necessary, and transformational in its own right, is in the service of our primary objective, which is the unfolding and development of the leading edge.

From the perspective of ISP, a cure is brought about through the systematic engagement and development of the patient's leading edge transference as it unfolds in interaction with the analyst's leading edge. This work inevitably also entails the workthrough of the trailing edge as a necessary step in the process.

The work with the trailing edge is indeed the necessary, albeit not sufficient condition for a curative experience to unfold. The sufficient condition is the work with the leading edge. This model of what is curative implies that there are two different kinds of therapeutic action in the therapeutic context. One type of therapeutic action derives from the experience when the generative selfobject transference is intact and the leading edge is in the foreground, and patients have the experience that they receive the emotional nutrients from the therapeutic context – mirroring, twinship or idealizing – that are needed for self development to proceed. A second type of

therapeutic action derives from the analyst's interpretation when the selfobject tie is disrupted, the repetitive transference is activated and the trailing edge is in the foreground. The analyst's interpretations then focus on illuminating the repetitive transference in an effort of working through the disruption, and restore the tie.

Stolorow and Atwood, in their chapter on cure in: *Psychoanalytic Treatment: An Intersubjective Approach* (1987), provide the theoretical formulation to conceptualize the two different forms of therapeutic action. They differentiate analytic work between transforming existing self structures and building new ones. The transformation of existing structure occurs via interpretation of what prevails when the selfobject tie to the analyst is severed, that is when there are ruptures in the intersubjective field. The building of new structures takes place when the selfobject tie to the analyst is intact. That is when the patient has a sustained experience of being met with his selfobject transference yearnings.

The transformation of existing self structures occurs via the interpretation of the repetitive transference. The development of new self structures occurs via the engagement of the generative transference. To reformulate this in the language of leading and trailing edge: The transformation of existing, maladaptive self structures occurs via the interpretation of the trailing edge as it evolves in the intersubjective field in interaction with the analyst's trailing edge. The development of new and healthy self structures occurs via the engagement and unfolding of the leading edge in the intersubjective field as it evolves in interaction with the analyst's leading edge.

In conceptualizing the curative process in this way, we are taking a step that Kohut was not yet able to take himself, at least not conceptually, even though he was clearly there in his clinical work. As mentioned above, when Kohut discussed the curative process, he still focused on the trailing edge and defined what is curative as providing insight and offering interpretations on the rupture in the self-selfobject bond. Yes, such interpretative work was defined as in service of restoring the tie, but Kohut did not yet offer a theoretical explanation for what happens next, when the tie is intact.

If Kohut's conceptualization of what is curative held true it would be incomprehensible why it would be beneficial to have lasting periods when the selfobject bond is intact, since no therapeutic benefit is presumed to derive from this experience. It would therefore be advisable to create as many disruptions as possible, since the therapeutic action is supposed to derive solely from the working through of such disruptions.

Clearly, this is not what we do in treatment – nor did Kohut – nor is it advisable as it would undo the tie that patient and therapist have worked hard to establish and seek to maintain. That is the engagement with the patient's leading edge and is the optimal condition for emotional and structural growth to occur. Kohut could not yet go there in the theoretical

formulation of what is curative for fear of being accused that self psychology is promoting the idea of a corrective emotional experience. In his case this would have had significant negative consequences professionally.

The most important self psychological author who transcends the focus on the interpretation of the trailing edge and explicitly addresses the topic of working with the leading edge in the discussion of the therapeutic action is Marian Tolpin in her pioneering paper 'Doing Psychoanalysis of Normal Development' (2002). Tolpin opens her paper by stating that traditional psychoanalysts, with their focus on the trailing edge, 'place[s] unintended iatrogenic limits on therapeutic action because we do not support struggling 'tendrils of health' and facilitate their emergence and growth' (p. 168). She then proceeds to develop ideas on how in psychoanalytic practice we can support 'struggling tendrils of health', the leading edge.

The other author who is important in this context is Howard Bacal who introduced the concept of *optimal responsiveness.* He defined the self psychological stance of the therapist as seeking to be optimally responsive to the patient's evolving selfobject needs. After Bacal, therapists were no longer solely defined in their work by the directive of frustrating the patient's regressive libidinal and aggressive wishes, as Freud proposed, nor by the directive of being 'optimally frustrating', as Kohut suggested, meaning non-traumatically frustrating. Rather, the new guideline for self psychological therapists is to be 'optimally responsive' to the evolving selfobject needs of the patient.[6] Lessem and Orange (1993) noted that the selfobject bond that develops between patient and therapist is a major curative factor.

Even the theory of Intersubjectivity in its current form of intersubjective systems theory, although having clearly spelled out what the therapeutic action is when the tie is intact, is primarily focused on the interpretation of the disruption-repair cycle and disinclined to promote the idea of actively engaging in facilitating the therapeutic process when the tie is intact, that is, when the leading edge is in the foreground. Chris Jeanicke (2015) in his poignant treaty entitled *The Search for a Relational Home; An intersubjective view of therapeutic action* describes, in a gripping and deeply personal way, the therapeutic benefit that derives from working through the therapists and the patients co-created failures. He states: 'it is my contention that in order to conceptualize the notion of cure, we must develop a new perspective on the notion of failure' and he states that 'failure and suffering are integral parts of our subjectivity' (p. 2). And Robert Stolorow, on the back of the same book, writes: 'What is unique about the book is its emphasis on the critical importance of failure, both the patient's and the analyst's in furthering the therapeutic process.'

Working through of failures of patient and therapist indeed represent unique opportunities of transformational experiences for patient and therapist, and are important dimensions of the therapeutic process; but to state

this is to keep the focus on the work with the trailing edge. It does not differ from Kohut's strained effort to demonstrate that self psychology is not any different from traditional psychoanalysis in that the therapeutic action was only to derive from the repeated interpretations of the disruptions in the self-selfobject matrix – whether created by the patient or the therapist – and not from the emotionally beneficial experience when the tie is intact and no interpretations are required.

As Intersubjective Self Psychologists, we don't have the constraints that Kohut was confronted with and are free to give the work with the leading edge its proper place in the conceptualization of what is curative. We want to be able to understand and explain what the therapeutic action consists of when the tie is intact! And we want to develop the guidelines that organize our clinical practice when working with the leading edge (see Chapter 8).

When the leading edge is engaged, and the tie is intact, as Stolorow, Atwood and Brandchaft (1987) proposed, structure building takes place. The therapeutic action that results from a sustained experience of engagement of the patient's leading edge with the therapist's leading edge is the development of new psychic structures. This may manifest in the patient's newly developed or increased capacity to organize and regulate affect, develop, and solidify new self states of competence, empathy, humor, wisdom, sorrow, and vitality, and an emergent sense of agency.

These new dimension of the self develop and solidify because the patient has the sustained experience in the intersubjective field of the analyst's *attuned engagement* with the patient's generative transference. We are introducing 'attuned engagement' to differentiate it from optimal responsiveness and highlight that the analyst not only responds but plays an active role in engaging the patient's leading edge experience in the transference. The analyst has to *show up and actively engage with the patient's leading edge yearnings* to generate for the patient a reliable and sustained experience of merger with an idealizable figure or a sustained and reliable experience of mirror or twinship. Such sustained experiences of self-selfobject bonds between patient and therapist provide the developmental opportunities to acquire new self structures and solidify emergent ones.

The longer phases of attuned engagements by the therapist with the patient's leading edge last in uninterrupted ways, the greater the therapeutic action. It is in these periods that patients' selfobject yearnings and hopes are realized. The selfobject transference bonds are intact and the generative transference is unfolding, that facilitate the development and consolidation of the patient's self experience. This is the corrective emotional experience that derives from the work with the leading edge and provides healing.

We now can conceptualize the therapeutic action as consisting of two separate but interrelated processes:

1. Attuned engagement of the generative transference when the therapeutic relationship is intact and;
2. Empathic interpretation of the repetitive transference when the therapeutic relationship is disrupted.

Attuned engagement with the leading edge of the patient when the tie is intact and empathic interpretation of the trailing edge when the tie is disrupted, constitute the therapeutic action of ISP.

It becomes apparent that empathic interpretations of the trailing edge also entail a leading edge experience for the patient, since they are precisely not repetitions, and therefore also result in structure building and vice versa. A sustained experience of feeling met in the leading edge will provide the emotional safety for the patient that allows the therapist to make trailing edge interpretations that will not get rebuffed by the patient or generate ruptures. An example of this might be a 'borderline' patient who may be able to hear and take in an interpretation of their proclivity to rage when the tie is felt to be intact. Yet that same patient would flat out reject the same interpretation when a disruption had occurred, resulting in the intensification of the patient's rage and protective defensiveness.

There are, in principle, four different intersubjective constellations generated by the intersection of leading and trailing edge of patient and therapist, creating different opportunities for therapeutic action for patient and therapist.

I. We have a potential for therapeutic action when the trailing edge of the patient meets up with the leading edge of the therapist. In this case, the therapeutic action lies in the provision of interpretations that address the trailing edge of the patient's experience in the relationship with the analyst. The patient, who is mired in a repetitive transference with the analyst, requires interpretations that illuminate his subjective world, which the therapist is able to offer because she is in a generative transference with the patient and feels on top of her game, practicing her craft. Such interpretations of the patient's trailing edge, where on the mark, result in the transformation of the patient's existing self structures and in the development and consolidation of the therapist's leading edge self experience as the therapist feels effective with his interpretation and feels like she has traction. In the patient, existing self structures are being transformed while in the therapist emergent self structures are being consolidated. This is what therapists and psychoanalysts ideally have done all along.

Patients will feel more hopeful and motivated to change when the analyst's relatively more mature selfobject needs to be empathic, and understanding is expressed in the service of interpreting the patient's trailing edge dreads and her accompanying defensive and self-protective efforts. Such interpretations of the patient's fear and self-protectiveness challenge her negative expectations and encourage hope for the yearned-for engagement from and with

the therapist. As a result, the patient feels more confident and motivated and this contributes to the therapist feeling more cohesive and vital in turn.

II. We also have for potential for therapeutic action, although less conventionally so, when the trailing edge of the therapist's transference meets up with the leading edge of the patient's transference. Less conventionally so, because for there to be any therapeutic action, this intersubjective constellation requires the therapist, who is mired in his repetitive transference, to be open to, and accept, the interpretations of his trailing edge by the patient. The patient may be able to offer by virtue of being engaged in her generative transference with the therapist. In this intersubjective constellation, the patient sees that the therapist needs help, because the therapist is enacting his repetitive transference. The patient is able to offer help because she is in a generative transference with the therapist. The patient experiences herself in the role of the therapist and comes to feel valued and values herself for providing to the therapist mired in his trailing edge and thus in the role of the patient. Such interpretations by the patient of the therapist's trailing edge result in the transformation of the therapist's existing structures and entail a consolidation of newly developing or emergent self structures in the patient. Those structures may be the patient's emergent capacity for empathy, insight and self-reflection when earlier she might have felt overwhelmed by the impact of the rupture caused by the therapist's enactment of her railing edge and been thrust into a trailing edge repetitive transference.

In this case, the therapeutic action for the patient results from the experience of being able to offer interpretations of the therapist's trailing edge. This would constitute a leading edge experience and result in a structure building experience for the patient. For the therapist in this situation, the therapeutic action derives from the interpretations the patient provides of the therapist's trailing edge, bringing about a structural transformation of the therapist's self experience.

III. The treatment is most at risk to come to a therapeutic impasse and thus for there not to be any therapeutic action, when the trailing edge of the patient meets up with the trailing edge of the therapist. In this case both parties are caught up in their respective enactments of their repetitive transferences, creating an intersubjective stalemate in the therapeutic relationship. In this case, both patient and therapist are enacting with each other their trailing edge transference dramas and react to each other as if each were the traumatic transference figure from their respective pasts. Both patient and therapist feel profoundly misunderstood by each other and, as Stolorow states, each of them addresses him- or herself to an intersubjective situation that does not exist for the other. Neither patient nor therapist recognize themselves in the way that each of them experiences the other.

These are the classic impasses so often experienced in the treatment of so called borderline patients, and in their starkest form, can be very disconcerting for both parties involved. However, variations of such disjunctive intersubjective constellations occur in most every therapeutic relationship because repetitive transferences of the patient have a strong pull to generate repetitive transferences of the therapist and vice versa.

The productive continuation of these treatments is predicated on either therapist or patient or better yet both parties being able to 'decenter' Stolorow (1984) from their trailing edge self experience of each other and, with the help of the other, analyze and work through the intersubjective constellation. Ulman and Stolorow (1985) have aptly coined this phenomenon 'the transference/countertransference neurosis' that is alive in the intersubjective field, and which more recently Atlas and Aron (2018) have entitled dramatic enactments.[7] When we are able to work our way through such intersubjective impasses (and granted, sometimes we are not) we come to feel not only that we have weathered a storm, but that we have grown, a growth that both speaks to the transformation of existing old structures and the emergence of new ones. This is what Atlas and Aron (2018) mean when they speak of 'generative enactments.'

IV. We have the greatest potential for therapeutic action and for a curative treatment experience when the leading edge of the patient meets up with the leading edge of the therapist. In this facilitating intersubjective context, the yearned-for selfobject experience of the patient matches the yearned-for selfobject experience of the therapist, creating an intersubjective field that is conducive to structure building in patient and therapist. In this case the generative transferences are solid for both parties and self-affirming experiences are shared in both directions, solidifying the self experience of patient and therapist. Every phase in analysis where the work progresses without obvious disruptions but is emotionally alive and deep, is an expression of this fortuitous intersubjective field. This is what most powerfully constitutes a sustained corrective emotional experience, resulting in the acquisition and consolidation of new emergent self structures.

The patient feels more confident and able to make changes when he or she feels that the analyst with understanding, hopefulness and encouragement engages with his newly emergent self experience. In this facilitating intersubjective context, the patient's experience of the matching of his or her longed for selfobject needs, with the therapist's relatively more mature selfobject needs, creates the conditions for the patient's adoption of new models and patterns of self-experience and relating. In this case both participants experience the generative intersubjective field as solid and self-affirming, and as a result both feel their self-experience is enhanced. Every therapeutic relationship, where therapist and patient feel reliably connected

and emotionally engaged in the generative transference can be understood as an instance of this type of fortuitous generative intersubjective field.

While for heuristic purposes I have separated these two forms of therapeutic action, in clinical work, both dimensions will always be present in a figure-ground relation. Every structural transformation also entails the development of new structures and every new structure will also entail structural transformations.

In summary, the therapeutic action in ISP comes from two sources, and our attention needs to be focused on both the work with the trailing edge and the work with the leading edge. When the trailing edge is the central theme that is alive in the intersubjective field, the therapeutic intervention required from the therapist is interpretation, i.e. empathic exploration and illumination of the repetitive transference which causes disruptions in the intersubjective field, along with the dreads that are revived and the protective measures that are relied upon to restore or repair the tie that is felt to be ruptured. Such interpretations, from an empathic perspective, result in the transformation of existing structures. This manifests in the ever deepening understanding of the underlying central organizing principles and attendant unconscious fantasies, and the deepening understanding and dissolution of dissociated aspects of the self experience.

The prototype of such an interpretation follows the following model:

> Since you experienced me to be distracted and thought I was contemptuous when you spoke about the anxiety that you felt when thinking about asking your boss for a raise, I understand why you retreated and were consumed with images of disjointed body parts which you tried to deal with by making sure that all the shoes were lined up properly.

Such an interpretation might include a reference to the therapist's own experience, like: 'When you brought up confronting your boss, I felt a twinge of my own anxiety about this, which made me retreat from you and might account for your experience that I felt contempt for you, especially since we have come to understand how helpless you felt in the face of the repeatedly humiliating experience of encountering your father's contempt for you when he was in one of his drunken states.'

When the leading edge is the salient intersubjective dynamic alive in the intersubjective field, the therapist is experienced by the patient as optimally engaged with (his) central selfobject transference yearnings. They are engaged in a mutually generative transference and the therapeutic action is structure building. This is the objective of ISP, and the therapist's goal is the development and maintenance of this curative intersubjective constellation. All forms of engagement by the therapist with the patient during this phase of the treatment are in the service of promoting the maintenance of the leading edge transference. The patient experiences this as the generative

intersubjective field conducive to the ever deepening unfolding of his or her leading edge. To do so, the therapist's engagement with the patient's leading edge needs to derive from a detailed and nuanced understanding of the yearned-for generative transference of the patient, and subsequent communications by the therapist need to be in keeping with the understanding of the central self-selfobject experience the patient seeks to maintain in the intersubjective field.

Although interpretations of the trailing edge are important and necessary because they result in the transformation of existing structure, they are nevertheless primarily a means to an end. The end is the unfolding of the leading edge. It is this two-step process of structural transformation via interpretation of the trailing edge/repetitive transference and structure building via attuned engagement with the leading edge/generative transference that constitutes the therapeutic action of ISP and brings about therapeutic transformation, healing, growth and cure.

Psychotherapeutic practice guided by the idea that the work with the leading edge is the goal of therapy, looks fundamentally different not only from analytic work in the classical sense but also from traditional self psychology and the therapeutic work based on intersubjective systems theory. The intersubjective self psychologist is actively seeking to engage and maintain the leading edge transference and develop a generative intersubjective field in order to foster the 'tendrils of health' in the patient.

If we subscribe to this idea, we need to develop our understanding of what constitutes the work with the leading edge much beyond the point where we are today. The whole complex of how to engage with the patient in such a way that promotes the unfolding of the leading edge transference in the intersubjective field, and how to conduct clinical work so as to foster the tendrils of health or emergent self, needs to be explored and articulated more extensively. This will be the topic of Chapter 7.

Notes

1 My thanks go to my colleague Harry Paul, whose friendship of 40 years has provided the context for an ongoing, mutually rewarding clinical dialogue that has fostered my understanding of the significance of the leading edge in treatment, which is the basis for the reconceptualization of the therapeutic action presented in this chapter.

2 For a comprehensive presentation on the topic of the modes of therapeutic action in psychotherapy in general see Martha Stark (1999).

3 Galit Atlas and Lewis Aron (2018) in their book, *Dramatic Dialogue*, introduce the concept of *'generative enactment'*, which is comparable to our term of 'generative transference' in that it refers to a progressive dimension imbedded in the enactment. However, in our formulation the generative transference refers to an intrinsically progressive striving of the patient for the needed experience in the

relationship with the therapist to resume self development, and does not constitute a repetition or enactment.

4 I thank Blethyn Hulton for proposing this terminological differentiation between to crave and to yearn for.

5 For in depth study on how to analyze defense, see Kohut's (1981) chapter on this topic in *How Does Analysis Cure?*

6 Keep in mind that 'optimally responsive', at a particular point in the patient's therapeutic relationship, could mean to be non-traumatically frustrating. In other words, optimally responsive should not be confused with simply accommodating the patient or worse, pathological accommodation, on the part of the therapist.

7 Atlas and Aron also describe the leading edge of patient meeting the leading edge of analyst as enactment. This is what Atwood and Stolorow (1984) label an intersubjective conjunction. Enactment, like intersubjective conjunction entail an unconscious dimension, whereas the intersubjective constellation leading edge of patient and therapist that we describe is actively and consciously in pursuit of the most generative intersubjective field.