

in *Self Psychology, Vol. 2*, ed. A. Goldberg (New York: Guilford Press, 1986, pp. 273-279).

An earlier version of chapter 3 appeared in *The Annual of Psychoanalysis* (1984/85, 12/13:19-37. New York: International Universities Press).

An earlier version of chapter 5 appeared in *The Annual of Psychoanalysis* (1984/85, 12/13:105-119. New York: International Universities Press), and the clinical illustration also appeared in *Psychotherapist's Casebook*, ed. I. Kutash and A. Wolf (San Francisco: Jossey-Bass, 1986, pp. 43-54).

Portions of chapter 6 appeared in *Progress in Self Psychology, Vol. 1*, ed. A. Goldberg (New York: Guilford Press, 1985, pp. 194-201).

Earlier versions of chapter 8 appeared in *Empathy II*, ed. J. Lichtenberg, M. Bornstein, and D. Silver (Hillsdale, NJ: The Analytic Press, 1984, pp. 333-357) and in *The Borderline Patient, Vol. 2*, ed. J. Grotstein, M. Solomon, and J. Lang (Hillsdale, NJ: The Analytic Press, 1987, pp. 103-125).

We thank the editors and publishers of these journals and books for giving us permission to include this material in our book.

And, finally, we wish to express our gratitude to Paul E. Stepanky for his valuable editorial guidance, and to Lawrence Erlbaum and Joseph Lichtenberg for their enthusiastic support of this project.

STOLOROW, BRANCHFT, ATWOOD (1987)
PSYCHOANALYTIC TREATMENT: AN INTERSUBJECTIVE
APPROACH

1

Principles of Psychoanalytic Exploration

The essentials of an intersubjective approach to psychoanalysis were defined in our¹ earlier book (Atwood and Stolorow, 1984), *Structures of Subjectivity*:

In its most general form, our thesis . . . is that psychoanalysis seeks to illuminate phenomena that emerge within a specific psychological field constituted by the intersection of two subjectivities—that of the patient and that of the analyst. . . . [P]sychoanalysis is pictured here as a science of the *intersubjective*, focused on the interplay between the differently organized subjective worlds of the observer and the observed. The observational stance is always one within, rather than outside, the intersubjective field . . . being observed, a fact that guarantees the centrality of introspection and empathy as the methods of observation. . . . Psychoanalysis is unique among the sciences in that the observer is also the observed . . . [pp. 41-42].

[C]linical phenomena . . . cannot be understood apart from the intersubjective contexts in which they take form. Patient and analyst together form an indissoluble psychological system, and it is this system that constitutes the empirical domain of psychoanalytic inquiry [p. 64].

The intersubjectivity principle was applied to the developmental system as well:

¹Throughout this book we will use the words "we" and "our" in referring to works written by one of us, two of us, or all three of us.

[B]oth psychological development and pathogenesis are best conceptualized in terms of the specific intersubjective contexts that shape the developmental process and that facilitate or obstruct the child's negotiation of critical developmental tasks and successful passage through developmental phases. The observational focus is the evolving psychological field constituted by the interplay between the differently organized subjectivities of child and caretakers . . . [p. 65].

It is our central aim in the present book to flesh out the implications for psychoanalytic understanding and treatment of adopting a consistently intersubjective perspective. In the course of this study, the intersubjective viewpoint will be shown to illuminate a wide array of clinical phenomena, including transference and resistance, conflict formation, therapeutic action, affective and self development, and borderline and psychotic states. Most important, we hope to demonstrate that an intersubjective approach greatly facilitates empathic access to the patient's subjective world and, in the same measure, greatly enhances the scope and therapeutic effectiveness of psychoanalysis.

The concept of intersubjectivity has evolved in our thinking through a series of stages. The significance of the intersubjective perspective first became apparent to us in a study of the interplay between transference and countertransference in psychoanalytic therapy (Stolorow, Atwood, and Ross, 1978). There we considered the impact on the treatment process of phenomena arising out of the correspondences and disparities that exist between the analyst's and the patient's respective worlds of experience. An attempt was made in particular to characterize the conditions under which such phenomena may obstruct or facilitate the unfolding of the psychoanalytic dialogue. At this early stage we already were focusing on interactions between patients' and therapists' subjective worlds, but the more general concept of the intersubjective field within which psychoanalytic therapy takes place had not yet been articulated.

We then were led to an investigation of the situation that arises in treatment when there is a wide but unrecognized disparity between the relatively structured world of the analyst and an archaically organized personal universe of the patient (Stolorow, Brandchaft, and Atwood, 1983). Such a disjunction, we showed, often results in chronic misunderstandings wherein the archaic experiences communicated by the

patient cannot be comprehended because of the analyst's unconscious assimilation of them to his own, differently organized subjectivity. The analyst's responses may then be experienced as grossly unattuned, precipitating a spiral of reaction and counterreaction that is incomprehensible to both parties. When the analyst fails to decenter from the structures of experience into which he has been assimilating his patient's communications, the final result is a view of the patient as an intrinsically difficult, recalcitrant person whose qualities perhaps render him unsuitable for psychoanalytic treatment. We thus had begun to understand in a very specific context how the analyst's picture of the patient's attributes crystallizes within the interplay between two personal universes.

A subsequent application of this kind of analysis to the so-called borderline personality appeared in a paper (Brandchaft and Stolorow, 1984) that forms the basis of chapter 8 in the present book. The earlier work offered a critique of the view that corresponding to the term "borderline" there is a discrete, stable, pathological character structure rooted in internal instinctual conflicts and primitive defenses. The clinical observations often cited as indicative of such defenses and conflicts were shown to be evidence of needs for specific archaic selfobject ties and of disturbances in such ties. The defining features of borderline conditions were thereby disclosed as products of a specific intersubjective situation. When a shift in this situation occurs whereby the needed understanding is felt to be present, the borderline features tend to recede and even disappear, only to return when the selfobject bond is again significantly disrupted. At that point we had recognized how the context of relatedness established between analyst and patient plays a *constitutive* role in forming and maintaining the particular psychopathological configuration that is designated by the term "borderline."

The intersubjectivity concept is in part a response to the unfortunate tendency of classical analysis to view pathology in terms of processes and mechanisms located solely within the patient. Such an isolating focus fails to do justice to each individual's irreducible engagement with other human beings and blinds the clinician to the profound ways in which he is himself implicated in the clinical phenomena he observes and seeks to treat. We have now come to believe that the intersubjective context has a constitutive role in *all* forms of psychopathology, ranging from the psychoneurotic to the overtly psy-

chotic. This role is most readily demonstrated in the most severe disorders, wherein fluctuations in the therapeutic bond are accompanied by dramatically observable effects. In chapter 9, we offer a conceptualization of psychotic states from this point of view, with emphasis on failures of archaic selfobject ties in the specific function of validation of perception. The intersubjective context is of equal significance, however, in less severe forms of psychopathology, for example, in anxiety neuroses, depressions, and obsessional and phobic disorders. The exploration of the particular patterns of intersubjective transaction involved in developing and maintaining each of the various forms of psychopathology is in our view one of the most important areas for continuing clinical psychoanalytic research.

PSYCHOANALYTIC KNOWING AND REALITY

A basic and largely unchallenged philosophical assumption that has pervaded psychoanalytic thought since its inception is the existence of an "objective reality" that can be known by the analyst and eventually by the patient. This assumption lies at the heart of the traditional view of transference, initially described by Breuer and Freud (1893-95) as a "false connection" made by the patient and later conceived as a "distortion" of the analyst's "real" qualities that analysis seeks to correct (Stein, 1966). Schwaber (1983) has argued persuasively against this notion of transference as distortion because of its embeddedness in "a hierarchically ordered two-reality view" (p. 383)—one reality experienced by the patient and the other "known" by the analyst to be more objectively true.

A fundamental assumption that has guided our work is that the only reality relevant and accessible to psychoanalytic inquiry (that is, to empathy and introspection) is *subjective reality*—that of the patient, that of the analyst, and the psychological field created by the interplay between the two. From this perspective, the concept of an objective reality is an instance of the ubiquitous psychological process that we have termed "concretization"—the symbolic transformation of configurations of subjective experience into events and entities that are believed to be objectively perceived and known (Atwood and Stolorow, 1984, ch. 4). *Attributions of objective reality*, in other words, are con-

cretizations of subjective truth. Analysts' invoking the concept of objective reality, along with its corollary concept of distortion, obscures the subjective reality encoded in the patient's productions, which is precisely what psychoanalytic investigation should seek to illuminate.

A good example of this obscuring effect can be found in the persisting controversy over the role of actual childhood seduction versus infantile fantasy in the genesis of hysteria. What proponents of *both* of the opposing positions on this issue fail to recognize is that the images of seduction, *regardless* of whether they derive from memories of actual events or from fantasy constructions, contain symbolic encapsulations of critical, pathogenic features of the patient's early subjective reality.

Our view of the nature of psychoanalytic investigation and knowledge differs sharply from those of a number of other authors who, like ourselves, have been significantly influenced by Kohut's empathic-introspective psychology of the self. Wolf (1983), for example, proposes that "we oscillate between extrospective and introspective modes of gathering data" (p. 685), observing sometimes from outside and sometimes from within the patient's own subjective world. Shane and Shane (1986) argue that psychoanalytic understanding derives not only from the subjective world of the patient and the intersubjective experiences in the analytic situation, but also from "the objective knowledge possessed by the analyst of the patient's life and of human development and human psychological functioning" (p. 148). And Basch (1986) contends that psychoanalytic explanations must be grounded in experimentally validated, objectively obtained knowledge of brain functioning.

In contrast with these views, our own perspective incorporates and seeks to push to its limits Kohut's (1959) proposition that the empirical and theoretical domains of psychoanalysis are defined and demarcated by its investigatory stance of empathy and introspection. Accordingly, anything that is not *in principle* accessible to empathy and introspection does not properly fall within the bounds of psychoanalytic inquiry.

Thus, unlike Wolf (1983) we hold that psychoanalytic investigation is *always* from a perspective within a subjective world (the patient's or analyst's); it is always empathic or introspective. When an analyst reverts to experience-distant formulations (a frequent, inevitable, and often countertransference-motivated occurrence), or insists that his

formulations possess objective truth, he is not operating in a psychoanalytic mode, and it is essential for the analyst to consider the impact of this shift in perspective on the analytic dialogue.

Unlike Shane and Shane (1986), we do not believe that the analyst possesses any "objective" knowledge of the patient's life or of human development and human psychological functioning. What the analyst possesses is a subjective frame of reference of his own, deriving from a multiplicity of sources and formative experiences, through which he attempts to organize the analytic data into a set of coherent themes and interrelationships. The analyst's frame of reference must not be elevated to the status of objective fact. Indeed, it is essential that analysts continually strive to expand their reflective awareness of their own unconscious organizing principles, including especially those enshrined in their "objective knowledge" and theories, so that the impact of these principles on the analytic process can be recognized and itself become a focus of analytic investigation.

In light of the foregoing discussion, it will come as no surprise that we are in fundamental disagreement with Basch's (1986) belief that psychoanalytic explanations must be grounded in a knowledge of brain functioning. We contend that brain functioning does not even fall within the domain of psychoanalysis, because it is inaccessible, in practice and in principle, to the empathic-introspective method of investigation. It is our view that psychoanalytic theory should, at all levels of abstraction and generality, remain within the realm of the experience-near. To that end, we have attempted to develop guiding explanatory constructs—such as the concept of an intersubjective field—uniquely appropriate to the empathic-introspective mode of inquiry. These constructs are concerned with organizations of subjective experience, their meanings, their origins, their mutual interplay, and their therapeutic transformation.

Goldberg (1985) has described a long-standing tension in psychoanalysis between realism, subjectivism, and relativism. That we place ourselves squarely within a subjectivist and relativist tradition is readily apparent from passages in *Structures of Subjectivity* (Atwood and Stolorow, 1984) that elucidate our conception of psychoanalytic understanding:

The development of psychoanalytic understanding may be conceptualized as an intersubjective process involving a dialogue be-

tween two personal universes. . . . The actual conduct of a psychoanalytic case study comprises a series of empathic inferences into the structure of an individual's subjective life, alternating and interacting with the analyst's acts of reflection upon the involvement of his own personal reality in the ongoing investigation [p. 5].

The varied patterns of meaning that emerge in psychoanalytic research are brought to light within a specific psychological field located at the point of intersection of two subjectivities. Because the dimensions and boundaries of this field are intersubjective in nature, the interpretive conclusions of every case study must, in a very profound sense, be understood as *relative* to the intersubjective context of their origin. The intersubjective field of a case study is generated by the interplay between transference and countertransference; it is the environment or "analytic space" . . . in which the various hypotheses of the study crystallize, and it defines the horizons of meaning within which the truth-value of the final interpretations is determined. An appreciation of this dependence of psychoanalytic insight on a particular intersubjective interaction helps us to understand why the results of a case study may vary as a function of the person conducting it. Such variation, an anathema to the natural sciences, occurs because of the diverse perspectives of different investigators on material displaying an inherent plurality of meanings [p. 6].

Thus, the reality that crystallizes in the course of psychoanalytic treatment is an *intersubjective reality*. This reality is not "discovered" or "recovered," as is implied in Freud's (1913) archeological metaphor for the analytic process. Nor, however, would it be entirely accurate to say that it is "created" or "constructed," as some authors have claimed (Hartmann, 1939; Schafer, 1980; Spence, 1982). Rather, subjective reality becomes *articulated* through a process of empathic resonance. The patient comes to analysis with a system of developmentally preformed meanings and organizing principles, but the patterning and thematizing of his subjective life is prereflectively unconscious (Atwood and Stolorow, 1984, ch. 1). This unconscious organizing activity is lifted into awareness through an intersubjective dialogue to which the analyst contributes his empathic understanding. To say that subjective re-

ality is articulated, rather than discovered or created, not only acknowledges the contribution of the analyst's empathic attunement and interpretations in bringing these prereflective structures of experience into awareness. It also takes into account the shaping of this reality by the analyst's organizing activity, because it is the analyst's psychological structures that delimit and circumscribe his capacity for specific empathic resonance. Thus analytic reality is "old" in the sense that it existed before as an unarticulated potential, but it is also "new" in the sense that, prior to its entrance into an empathic dialogue, it had never been experienced in the particular articulated form that comes into being through the analytic process.

We agree with Schwaber (1983) that what the analyst "knows" in the psychoanalytic situation is no more "real" than what the patient "knows." All that can be known psychoanalytically is subjective reality—the patient's, the analyst's, and the evolving, ever-shifting intersubjective field created by the interplay between them. This avowedly subjectivist and relativist position should not, however, be taken to mean that we believe that any psychoanalytic interpretation or explanatory construct is as good as the next. In *Structures of Subjectivity* (1984) we argued that psychoanalytic interpretations must be evaluated in light of distinctively *hermeneutic* criteria. These include

the logical coherence of the argument, the comprehensiveness of the explanation, the consistency of the interpretations with accepted psychological knowledge, and the aesthetic beauty of the analysis in disclosing previously hidden patterns of order in the material being investigated [pp. 5–6].

With regard to evaluating theoretical ideas, we suggest the following criteria: (1) Does a psychoanalytic framework permit greater inclusiveness and generality than previous ones? Does it encompass domains of experience mapped separately by earlier, competing theories, so that an enlarged and more unified perspective becomes possible? (2) Is the framework self-reflexive and self-corrective? Does the theory include *itself* in the empirical domain to be explained? (3) Most important, does the framework significantly enhance our capacity to gain empathic access to subjective worlds in all their richness and diversity?

A psychoanalytic framework centering on the concept of an intersubjective field fares well by all three criteria. We intend to dem-

onstrate in subsequent chapters (1) that an intersubjective approach can incorporate and synthesize the experience-near insights of both conflict psychology and psychoanalytic self psychology into a broader, more inclusive framework; (2) that a theory of intersubjectivity is inherently self-reflexive and potentially self-corrective, because it always includes a consideration of the impact of the observer *and his theories* on what is being observed; and (3) that the concept of an intersubjective field is a theoretical construct precisely matched to, and uniquely facilitative of, the empathic-introspective mode of investigation. Thus, we hope to convey how an intersubjective perspective can extend our capacity for empathic understanding to widening spheres of human experience.

BASIC PRINCIPLES

It is our view that two overarching principles guide the conduct of psychoanalytic treatment in all its phases and vicissitudes. The first maintains that the fundamental goal of psychoanalytic therapy is the unfolding, illumination, and transformation of the patient's subjective world. The second asserts that the transformational processes set in motion by the analytic engagement, along with their inevitable derailments, always occur within a specific intersubjective system. In this chapter we describe briefly how the basic technical precepts of psychoanalysis derive from these two cardinal principles, leaving detailed illustrations for subsequent chapters.

The Analytic Stance

The analytic stance has traditionally been defined in terms of some concept of neutrality, which is usually roughly equated with the "rule of abstinence"—the analyst must not offer his patients any instinctual satisfactions (Freud, 1919). This technical injunction derived from the theoretical assumption that the primary psychopathological constellations with which psychoanalysis was concerned were products of repressed instinctual drive derivatives. Gratification, according to this thesis, interfered with the goals of bringing the repressed instinctual wishes into consciousness, tracking their genetic origins, and ultimately achieving their renunciation and sublimation. Following

Kohut (1971, 1977, 1984), we have found that the central motivational configurations mobilized by the analytic process are not pathological drive derivatives but thwarted and arrested developmental strivings. A stance demanding the repudiation of such strivings in the service of "maturity" repeats and further entrenches the original developmental derailments (Stolorow and Lachmann, 1980).

Adopting an intersubjective perspective makes it immediately apparent that abstinence—the purposeful frustration of the patient's wishes and needs—could never be experienced by the patient as a neutral stance. Indeed, relentless abstinence on the part of the analyst can decisively skew the therapeutic dialogue, provoking tempestuous conflicts that are more an artifact of the therapist's stance than a genuine manifestation of the patient's primary psychopathology. Thus, an attitude of abstinence not only may fail to facilitate the analytic process; it may be inherently inimical to it (Wolf, 1976). We would therefore replace the rule of abstinence with the precept that the analyst's interventions should, as much as possible, be guided by an ongoing assessment of what is likely to facilitate or obstruct the unfolding, illumination, and transformation of the patient's subjective world. Such assessments require careful analytic investigation of the specific meanings that the analyst's actions or nonaction come to acquire for the patient.

What stance on the part of the analyst is most likely to create an intersubjective context in which the unfolding, illumination, and transformation of the patient's subjective world can be maximally achieved? We believe that such a stance is best conceptualized as an attitude of *sustained empathic inquiry*—an attitude, that is, that consistently seeks to comprehend the meaning of the patient's expressions from a perspective within, rather than outside, the patient's own subjective frame of reference (Kohut, 1959).

Like the rule of abstinence, the empathic stance decisively shapes the therapeutic dialogue, but in an entirely different direction. Sustained empathic inquiry by the analyst contributes to the formation of an intersubjective situation in which the patient increasingly comes to believe that his most profound emotional states and needs can be understood in depth. This, in turn, encourages the patient to develop and expand his own capacity for self-reflection and at the same time to persist in articulating ever more vulnerable and sequestered regions of

his subjective life. Equally important, it progressively establishes the analyst as an understanding presence with whom early unmet needs can be revived and aborted developmental thrusts reinstated. The attitude of sustained empathic inquiry is central in establishing, maintaining, and continually strengthening the selfobject transference bond with the analyst (Kohut, 1971, 1977, 1984)—an essential ingredient of the psychological transformations that constitute therapeutic change. This strengthening is especially likely to occur when inquiry is extended to realms of experience that the patient believes are threatening to the analyst (Brandchaft, 1983).

This formulation of the empathic stance and its impact on the analytic process renders the traditional concept of a therapeutic or working alliance (Greenson, 1967; Zetzel, 1970) as an extratransference phenomenon unnecessary.² What formerly have been considered manifestations of a working alliance can, from an intersubjective vantage point, be understood in terms of the specific transference bond that becomes established in consequence of the patient's consistent experience and expectation of being understood. Similarly, the assumption of an absence of a working alliance is replaced by the investigation of disruptions of the transference tie.

Sustained empathic inquiry into the patient's subjective reality promotes the unhampered unfolding of patterns of experience reflecting structural weakness, psychological constriction, early developmental derailment, and archaic defensive activity. The illumination of these patterns occurs in concert with a developing transference bond in which preempted developmental processes are revitalized. Ordinarily, this bond undergoes transformation from more archaic to more mature forms as the analysis progresses (Kohut, 1984), with genuine collaboration between patient and analyst toward a common goal of understanding becoming an increasing possibility (Stolorow and Lachmann, 1980). This concept of a developing and maturing empathic bond must be sharply distinguished from a pseudoalliance based on the patient's compliant identification with the analyst's point of view in order to safeguard the therapeutic relationship. Such pseudoalliances are achieved at the *expense* of empathic inquiry, as cen-

²We are grateful to Chris Jaenicke for bringing this point to our attention.

tral experiential configurations believed to be out of harmony with the analyst's requirements are disavowed and sequestered from the analytic process.

Making the Unconscious Conscious

From an intersubjective perspective, how shall we conceptualize the time-honored aim in psychoanalysis of making the unconscious conscious? In *Structures of Subjectivity* (1984) we approached this question in our formulation of the "prereflective unconscious"—the shaping of experience by organizing principles that operate outside a person's conscious awareness:

In the absence of reflection, a person is unaware of his role as a constitutive subject in elaborating his personal reality. The world in which he lives and moves presents itself as though it were something independently and objectively real. The patterning and thematizing of events that uniquely characterize his personal reality are thus seen as if they were properties of those events rather than products of his own subjective interpretations and constructions. . . . [P]sychoanalytic therapy can be viewed as a procedure through which a patient acquires reflective knowledge of this unconscious structuring activity [p. 36].

From this standpoint, "making the unconscious conscious" refers to the interpretive illumination of the patient's unconscious organizing activity, especially as this becomes manifest within the intersubjective dialogue between patient and analyst. We refer here to the ways in which the patient's experiences of the analyst and his activities are unconsciously and recurrently patterned by the patient according to developmentally preformed themes.

We emphasize that the patient's experience of the analytic dialogue is *codetermined* throughout by the organizing activities of *both* participants, with the analyst's organizing principles shaping not only his countertransference reactions but his interpretations and other therapeutic interventions as well. The patient's unconscious structuring activity is eventually discerned in the *meanings* that the analyst's activities—especially his interpretive activity—repeatedly and invariantly come to acquire for the patient. Thus, the patient's uncon-

scious organizing principles become illuminated, first, by recognizing and comprehending the impact of the analyst's activities and, second, by discovering and interpreting the meanings into which these activities are recurrently assimilated by the patient. It is a paradox of the psychoanalytic process that the structural invariants of the patient's psychological organization are effectively illuminated and transformed only by careful analytic investigation of the ever-shifting flux of the intersubjective field encompassing the therapeutic dyad.

This paradoxical feature of psychoanalytic inquiry is well illustrated by the analysis of dreams. On one hand, "the dream constitutes a 'royal road' to the prereflective unconscious—to the organizing principles and dominant leitmotifs that unconsciously pattern and thematize a person's psychological life" (Atwood and Stolorow, 1984, p. 98). On the other hand, as we have previously demonstrated (Atwood and Stolorow, 1984), the meaning of dream symbols is grasped only by locating them within the specific intersubjective contexts in which they take form in the analytic dialogue.

Analysis of Transference and Resistance

Analysis of transference and resistance is central to an intersubjective approach to psychoanalytic treatment. As was implied in the foregoing paragraphs, analysis of transference, from our perspective, consists in the investigation of the manner in which the patient's experience of the analyst and his activities is recurrently and unconsciously organized according to preestablished patterns (see chapter 3). The aim of transference analysis is the illumination of the patient's *subjective reality* as this crystallizes within the intersubjective field of the analysis. Any assumptions of a more objective reality of which the transference is presumed to be a distortion not only lie outside the bounds of psychoanalytic inquiry; they constitute a pernicious obstruction to the psychoanalytic process itself.

An especially important aspect of transference analysis, emphasized by Kohut (1971, 1977, 1984) and exemplified throughout this book, is the analysis of *disruptions* of the selfobject tie to the analyst that becomes established. Such analysis seeks understanding of these ruptures from the unique perspective of the patient's subjective world—the events that evoke them, their specific meanings, their impact on the analytic bond and on the patient's psychological organization, the

early developmental traumata that they replicate, and, especially important, the patient's expectations of how the analyst will receive the reactive affect states that follow in their wake. Consistent analysis of these complex disjunctive experiences, including the patient's anticipations of how the analyst will respond to their articulation, both illuminates the patterning of the patient's unconscious organizing activity and repeatedly mends and expands the ruptured selfobject tie, thereby permitting the arrested developmental process to resume.

Resistance analysis, in our view, is coextensive with the analysis of transference (see chapters 3–7). In resistance, the patient's experience of the therapeutic relationship is organized by expectations or fears that his emerging emotional states and needs will meet with the same traumatogenic responses from the analyst that they received from the original caregivers (Kohut, 1971; Ornstein, 1974). Thus, resistance is always evoked by some quality or activity of the analyst that for the patient heralds an impending recurrence of traumatic developmental failure, and it is critical for the progress of treatment that this be recognized and articulated. Resistance, in other words, cannot be understood psychoanalytically apart from the intersubjective contexts in which it arises and recedes. As we attempt to show in subsequent chapters, this basic principle holds true for any psychological product that emerges within a psychoanalytic process.

2

Reflections on Self Psychology

As is readily apparent throughout this book, our intersubjective approach to psychoanalysis owes an enormous debt to Kohut's psychoanalytic psychology of the self. Indeed, the theory of intersubjectivity might be seen as a development and expansion of psychoanalytic self psychology. Our aim in this chapter is twofold. First, by critically examining the theory of self psychology, we hope to bring the assumptions underlying our own approach more clearly into view. And second, by clarifying what we believe are the shortcomings in some of its concepts, we hope to highlight, broaden, and refine self psychology's essential contributions to psychoanalysis.

What are these essential contributions? To our minds, they are threefold and closely interrelated: (1) the unwavering application of the empathic-introspective mode of investigation as defining and delimiting the domain of psychoanalytic inquiry, (2) the central emphasis on the primacy of self-experience, and (3) the concepts of selfobject function and selfobject transference. These three principles constitute the foundational constructs upon which the theoretical superstructure of self psychology rests. The foundational pillars are essentially sound, but, as we will attempt to show, this is not necessarily true of the architecture that has been built upon them. We wish first to draw out briefly certain implications of the aforementioned basic principles of self psychology that have not received sufficient attention.

1. The empathic-introspective mode of investigation refers to the attempt to understand a person's expressions from a perspective within, rather than outside, that person's own subjective frame of reference. In his early landmark position paper, Kohut (1959) argued that this investigatory mode defines and delimits the field of psychoanalysis—that only what is potentially accessible to empathy and introspection falls within the empirical and theoretical domain of psychoanalytic in-