Chapter 11

Doing Psychoanalysis of Normal Development: Forward Edge Transferences

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This paper develops the idea of a "leading edge" transference, which was mentioned by Heinz Kohut in his supervision of Jule Miller (see Miller, 1985). In the early stages of developing his theory of selfobject transferences in his lectures to candidates (see Tolpin and Tolpin, 1996), Kohut also occasionally referred to patients' overlooked "forward moves," which remobilized still healthy strivings and needs of the child and adolescent self. For the time being, at least, I use the term *forward edge* childhood strivings and transferences—"leading edge" having been rendered less useful by its frequent use in advertising. I have also considered describing the transference remobilization of the "growth edge" or "growing edge" of development, loosely analogous to the normal functioning of the epiphyses (growth centers of the long bones) before their closure ends further growth. There may be other felicitous terms for what I have in mind. It is my impression that the theory of forward edge or growth transferences that I am proposing has validity for all psychoanalytic theories, not only for the theory of the self that informs this work. For example, Racker (1968, p. 150–154) described a "total transference," including a "prospective" element that has been overlooked.

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FORWARD AND TRAILING EDGE TRANSFERENCES: AN ENLARGED INTERPRETIVE FRAMEWORK

The title of this paper usually comes as a surprise to psychoanalysts. One friendly colleague put it this way, You can't do psychoanalysis of normal development—psychoanalysis is about abnormal development and psychopathology! My reply to such objections is, Yes, that is precisely the problem: theories of psychoanalytic treatment and practice (regardless of their many critical differences and the recent influence of developmental findings) place the strongest emphasis on abnormal development and psychopathology. Specifically, the problem for theory and practice I am referring to is created by our view of transference proper as a "pathogenic complex" (Freud, 1912, p. 104), "new [artificial] illness" (Freud, 1914, p. 154). (For an instructive paper on changing views of what constitutes the core childhood pathology that is repeated in transferences, see Cooper, 1987.)

In fact, the problem is twofold. First, the "new illness" view of transference is a source of theory-induced clinical blindspots, which prevent us from recognizing and analyzing *"forward edge" transferences—transferences of still remaining healthy childhood development in the unconscious depths, albeit in the form of fragile "tendrils" that are thwarted, stunted, or crushed.* Second, it places unintended iatrogenic limits on therapeutic action because we do not support struggling "tendrils" of health and facilitate their emergence and growth. Instead, we actually obscure them by assigning what remains of healthy development to the concept of "therapeutic alliance" or positive relationship with a "new object." As a consequence, tendrils of health are not fully reactivated in depth and are not accessible to a vitally important working-through process. It is this bit-by-bit and over again process that is the basis for expansion, integration, transformation, and stabilization of healthy aspects of the self into an altered psychic reality.

To repeat my main point: At one and the same time, theory-induced blindspots restrict our clinical vision of the patient's (and our own) psychic reality because first, they lead us to expect transference repetitions of nuclear childhood pathology and its later derivatives, and second, they obscure the subtle hints of *bona fide* transferences that derive their force and momentum from still-viable tendrils of healthy childhood motivations, strivings, expectations, and hopes of getting what is needed now from the forward edge transference to the analyst. (For a discussion about the early effort to include hope in the etiological equation, see French, 1958.)

Here it is crucial to stress that fragile tendrils of remaining healthy needs and expectations are not readily apparent on the surface. My clinical examples will show that we have to be primed to look for them in order to see them and tease them out from the trailing edge pathology in which they are usually entwined. For instance, tendrils of forward edge strivings have to be disentangled from manifestly pathological mergers, idealizations, grandiosity, "narcissistic entitlement" (Murray, 1964), rage, envy, depreciation, and, further, from intermediate defenses and compromise formations that protect the self the patient has built up and, at the same time, inhibit, restrict, and further compromise normal development.

When the joint analytic work required to see, interpret, and foster the healthy tendencies is done by both patient and analyst, we are likely to actualize these tendencies and revive the "urge to complete development" and to regain "developmental momentum," as noted by Bibring (1937) and Anna Freud (1965). In other words, the vague "curative factors" these authors adduced can now be grounded in the clinical theory of analyzable forward edge transferences that restart and reinvigorate an expectable developmental process.

Before turning to the clinical examples of healthy tendrils that are overlooked in their transference potential, I want to briefly mention two interconnected historical trends that delayed the discovery of analyzable transferences of health, indelibly shaped the theory and technique of psychoanalytic practice and its accent on repetitions of pathology, and continue to interfere with our doing psychoanalysis that reactivates and strengthens normal self-development.

Delay of the Discovery of Analyzable Transferences of Health: Demarcation of Positive Alliance and New Object Relationship from Transference as New Illness

Psychoanalysis originated in studies of illness—Freud initially discovered the childhood depth of transference while, as a physician, he was investigating and trying to cure his patients' pathology. The initial trend to base analytic understanding of transference proper on a disease model of childhood development continued when Freud (1937) and other pioneers treated patients whose disorders posed challenges to successful analytic treatment. Their lack of success was attributed to their patients' "narcissistic resistances"; to "bedrock" factors such as psychic "inertia" and "adhesiveness of the libido"; to unconscious superego resistances and "negative therapeutic reaction"; to

constitutional factors that led to ego deficits and distortions; and to primitive early object relations, archaic defenses, and splits.

This phase of "pathomorphic" theory led to the second major historical trend which still dominates many sectors of the field—namely, the demarcation of transference proper (a new edition of childhood illness) from *unobjectionable positive transference* (Freud, 1915), the therapeutic split in the ego (Sterba, 1934), and the *positive identification/positive relationship* with the idealized analyst described by Zetzel (1956), Stone (1961, 1981), Greenson (1965), Greenson and Wexler (1969), Gutheil and Havens (1979), Renik (1995, 1996, 1998, 1999), Meissner (1996), Shane, Shane and Gales (1997), Hausner (2000), and Novick and Novick (2000). In this connection also see Bacal (1985, 1990) on optimal responsiveness. And for early active therapy see Ferenczi (1920). Friedman (1969) wrote a penetrating review of the concept of therapeutic alliance.

In spite of their many differences, these authors conceptualize a "real relationship" with the analyst variously as a "real person," an "ally," a "therapeutic partner," or a "working partner"—that is, a "new (*nontransference*) object" with whom a development-fostering, development-correcting experience takes place. In my view, the historical trend of conceptualizing alliance, real relationship, and new object was a constructive transitional effort to fill the analytic "vacuum" caused by too-exclusive emphasis on transference as childhood pathology. Stone (1961) was particularly eloquent in describing the "psychological vacuum" in the psychoanalytic situation, which was often a "severe impediment [for] initiation and productive continuation of a psychoanalytic process" (p. 116). My point is that filling the vacuum by encouraging alliance, real relationship, and real love (Novick and Novick, 2000) also interferes with the full therapeutic process, which depends on transferences of reanimated health.

The major theoretical trends outlined above converge in clinical practice. They are mutually reinforcing, continuing a one-sided emphasis on repetition of trailing edge developmental pathology while at the same time short-circuiting the in-depth reanimation of transferences of health. This topic requires a great deal more discussion, including the attitude of suspiciousness toward health as a resistance. (For example, see Brenner, 1979, and Stein's 1981 "serious concern," [p. 871] with the analytic trend to see what appear to be a patient's positive or healthy attitudes instead of recognizing them as hiding resistance.) The last point about the theory and technique of doing psychoanalysis that I want to emphasize before leaving these historical trends is: as far as a more thorough-going and enlarged therapeutic process is concerned, analysis of the forward edge of transference

is as important, at the very least, as analyzing revived trailing edge pathology.

Clinical Examples of Unseen Forward Edge Tendrils

I want to turn now to three clinical examples published in the psychoanalytic literature of overlooked healthy strivings that can be reanimated in fully developed transferences, provided that the strivings or tendrils are recognized for what they are. Brief vignettes from the treatment of two adult patients show that tendrils of health are easily mistaken for either oedipal or preoedipal pathology and that the pathological emphasis discourages growth of the tendrils and the development of a stable forward edge transference.

In the analysis of a child, a more detailed look at the therapeutic process demonstrates a resurgence of his still-valid developmental needs (barely recognizable as such) for expectable self–selfobject experiences. After many frustrating months of trying to uncover the unconscious roots of the child's pathological narcissism, the analyst's understanding of the child's lack of expectable control over himself and his world and his spontaneous (unrecognized) selfobject functions (mirroring, idealized, and twinship) began to fit together with the child's valid needs. With the ever-increasing mutuality and reciprocity of patient and analyst, an unseen selfojbect transference took root and silently played a critical role in the cure. That is to say, although it was not recognized, interpreted, or reconstructed, a forward edge transference infused the therapeutic process. The transference experience at one and the same time loosened the vise of the child's trailing edge transference pathology on his self-organization and reanimated his thwarted and stunted forward edge development. These interdigitating processes went on together to set derailed development back on a forward track.

An Unnoticed Forward Edge Transference: Seeing Pathology Where There Is Health

In an invaluable account of his consultations with Heinz Kohut, Jule Miller (1985) described learning how Kohut worked and actually analyzed selfobject transferences. Miller described a patient of Kohut's who suffered from contentless depression, restlessness and anxiety, feelings of great uncertainty about himself, and troubling homosexual fantasies and feelings. Kohut pointed out that the patient seemed to feel stronger and had some sense of mastery when he was connected to the analyst he admired and looked up to. When the analyst went away or failed to understand him, the strengthening connection was disrupted. The patient then felt ravenous, like he could eat the analyst's

couch or the pictures off the wall; he was exhausted and unsure of himself, or he felt like an untethered spaceman adrift forever in outer space. At such times, the patient went to pornography shops in search of an improved sense of being anchored and alive that he experienced when the transference was in place. In other words, at times of disruption of an unnoticed idealizing transference, the trailing edge transference (depression, anxiety, self-doubt) and "intermediate" (defensive) sequences (for example, devouring food and pornography to overcome his lassitude) came to the psychological fore.

An analytic hour illustrates the basis for Kohut's identification of leading edge tendrils of a quiet idealizing transference that the analyst could not see because of the implicit, prevailing pathology-oriented analytic milieu. The hour provides a microscopic glimpse of the self–selfobject experience: the analyst misunderstands the patient's enthusiasm and inadvertently precipitates his deflation (the trailing edge of his development); at the same time, the misunderstanding temporarily (in this instance) interferes with the patient's use of the analyst as the "idealized parent imago" with whom he is trying to accomplish his developmental goals—to recover from his deflation/depression, maintain his revived enthusiasm, and take in (internalize) the increased sense of his own importance and effectualness that he feels in the strengthening idealizing bond and make it his own.

The patient arrived at an hour eager to tell Miller something he had just heard about a performer he knew Miller liked. Miller did not see or respond to the patient's excitement and enthusiasm. The eagerness and enthusiasm were, to Kohut, the signs of the patient's more alive self-experience, of his expectation and hope that the analyst would appreciate the message and the messenger, that he would share in an experience the admired analyst enjoyed. Instead, his eagerness was interpreted as a manifestation of unconscious competitive, rivalrous impulses with the analyst-father (trained in ego psychology, Miller thought the patient was trying to one-up him, as it were, as though he were saying, "I know something you don't know").

At first, the "good" patient allied himself with the all-knowing analyst (Stone, 1961, began the discussion of bondage to the omniscient analyst) and complied with the interpretation. However, in agreeing with the analyst, he sounded stilted and formalistic, saying that, yes, the idea that he was competing with the analyst had some "cogency." For Kohut, the patient's stilted agreement was an affective signal, a signal that just when he was most enthusiastic (instead of depressed and anxious) he was most vulnerable to being deflated by the inexact interpretation. His stilted agreement is also an example (in my view) of the patient's wish/need to cooperate and maintain the needed

relationship with the analyst—although he is injured, he joins forces with the analyst (therapeutic alliance), the injury goes unnoticed and unrepaired, he looks at himself through the analyst's eyes (observing ego and working alliance), and he continues to feel deficient.[1]

Fortunately, however, a grain of the patient's forward edge of development remained—a tendril of healthy self-assertion and the expectation that his injury would be attended to by the analyst. Following his *compliant,* "Yes, competition has cogency," the patient said *spontaneously.* "What you said sure punctured my balloon." In other words, there was a remaining tendril of still-healthy independent initiative and self-assertion entwined with the pathological identification with the "aggressor" who deflated him. Like a healthy child who protests deflation just at the moment when he expects and hopes to feel enhanced, the patient turned toward the analyst and used a powerful metaphor (his punctured balloon) to express his deflation. And like a healthy child who expects that his injury will be understood and thereby ameliorated, the patient was still able to trust the analyst enough to expose his injury and to continue to expect and hope that his injury would be understood as valid and (thereby) healed. The example demonstrates that a failure to understand is still a route to recognition of the real possibility that an analyzable, self-esteem facilitating, forward edge transference can be established—a transference, when seen and interpreted, that gradually assists the chronically deflated, uncertain adult to join in the experience that supports regained developmental momentum.

It is important to note that Kohut did not dismiss the idea that competitiveness could have cogency for the patient. However, in this "bit" of the analytic process, pathogenic competitive wishes were secondary, not part of the leading edge of this patient's development. Rather, in a tendril of an idealizing transference, the patient, Kohut said, was like a proud, excited boy, running to tell his admired father a

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[1] Compliance (alliance) with the analyst's point of view is a frequent form taken by an unanalyzed (selfobject) transference and the patient's intense wish and need for help. After all, the patient turns to the analyst with the hope of being helped and wants to, and usually tries to, make use of the interpretations. (A patient of mine told me that, if I told her to hang by her toes in order to get better, she would do it!) Contrast Miller's patient's form of ready compliance followed by (healthy) protest with Kohut's (1979) patient Mr. Z. The latter initially fought Kohut's interpretations of narcissistic oedipal victory. (The prolonged protest against being misunderstood was also a tendril of remaining health.) However, when Kohut was unrelenting in his attack on the patient's "narcissistic entitlement" (before he discovered selfobject needs and transferences), Mr. Z eventually resigned himself, submitted, and complied. This was the form of compliance that repeated the pathogenetic masochistic relationship with his overpowering and development-stifling mother and the origin of his perverse fantasies.

special tidbit, a boy who expected to be enjoyed and admired—the experience (repeated over and over) that eventually heightens self-esteem, self-certainty, and self-firmness. The interpretation was a "downer," like a pathogenic repetition or rebuff of his valid needs to join in with his father and to be enjoyed, that contributed to the persisting childhood anxiety about his own worth. In this instance, the analytic accent on the trailing edge (pathological rivalry and competition) obscured the forward edge transference—the patient's healthy expectations for the kind of uplifting experience and mirroring approval that could ultimately strengthen his own capacity to maintain and restore a sense of buoyancy, even in the face of inevitable injuries and deflation.

A VOYEURISTIC SYMPTOM AND A THWARTED ATTEMPT AT A CONSTRUCTIVE FORWARD MOVE

Guntrip (1961) described a failed attempt at analysis: the patient initially sought treatment and then fled. In a retrospective reassessment of the flight, Guntrip realized that his guiding theory of infantile wishes directed to (internal) archaic objects "missed the real point" (p. 53). The real point, in his language, was the patient's attempt to make a "constructive forward move" to remain attached. The "real point" in forward edge transference terms is the importance of recognizing crushed tendrils of a mobilizable selfobject transference in a manifestly pathological adult symptom—a symptom that signifies the effort to forestall further fragmentation of the cohesive self, rather than a regression to a normal libidinal stage of security. Guntrip's example follows.

A shy, schizoid professional man in his forties sought analysis because of an embarrassing symptom—"he was intensely preoccupied with breasts and felt compelled to look at every woman he passed." There were other "childish feelings [not specified] he intensely disliked admitting" (p. 34). The patient told Guntrip he believed that his preoccupation with breasts was somehow connected with his cold and unresponsive wife who was like his mother. He always thought of his mother as "buttoned up tight to the neck." Guntrip attributed the patient's symptom and his distress and embarrassment to a regressive process that revived infantile oral wishes for security at the breast (pp. 49, 50). With interpretations to this effect (not specified), the patient's breast preoccupation subsided. Guntrip took the disappearance of the compulsive looking at women's breasts as a sign of analytic progress. Soon, looking was replaced by a "spate of fantasies," so compulsive and all-absorbing that they interfered with the patient's work.

The fantasies that replaced the voyeurism were variations on the same theme. In these fantasies, the patient retired to an isolated sea coast, built himself a strong house, and walled it off from the life going on outside. The series of fantasies came to a climax Guntrip did not understand at the time: the patient built himself an impregnable castle on top of what Guntrip (under the influence of his theory) described as a breast-shaped mountain and walled it around with impassable defenses. "The authorities camped round about and tried to storm the citadel but were quite unable to break in" (p. 50). Sometimes he emerged in disguise to inspect the outside world, but no one could get in contact with him. "Finally [Guntrip wrote] he saw me coming up the mountain side, hurled great boulders at me and drove me off. One or two weeks later the patient suddenly broke off the analysis, using a passing illness of his wife's as an excuse" (p. 50). At this point of final rupture Guntrip thought the patient's regressive wishes were going even farther—from wanting to be at the breast, he now wanted to be safe inside the womb. Then he reconsidered his views.

Guntrip's belated understanding was profound: he saw the incompleteness of the theory of wishes to return to earlier oral, anal, or incestuous modes of "erotic happiness." The "orality" involved in looking at breasts was not a wish; it expressed the patient's attempt to "stay born," to actively struggle to "stay in object-relationships" as a separate ego (p. 50) and go on living (p. 53). In short, Guntrip realized the symptom reflected the "real point" of the patient's disorder and his turning to the analyst: he was attempting, with part of his personality, to make a *"constructive . . . forward move"* (p. 5; italics added) to protect himself (his remaining self) from the danger of nonexistence. In self psychological terms, Guntrip critiqued himself and realized he failed to see that the patient was urgently searching for a self–selfobject bond—the self that remained was trying to stay attached, to save himself from an overwhelming fragmentation that threatened an already enfeebled self.

Commentary on the Case

Looked at in the light of the need to restore a failing self, the patient actively *turned to* Guntrip and looked for the selfobject functions—the "psychological milk"—he needed to strengthen an endangered self. The need for a cohesion-promoting self–selfobject bond was sexualized and took the form of a compulsive voyeuristic symptom to regain cohesion. That is to say, the need to take in cohesion-restoring sustenance was sexualized (the need and the fulfillment were symbolically represented as the "good breast"); the symptom was both an unconscious emergency defensive measure and the clue to the forward edge—trying to remain attached to go on as a self.

The patient initially complied with the analyst's interpretation of his regressive wishes and suppressed the symptom. The fantasies that followed suggested that he felt criticized for his "childish needs" and experienced the interpretation as a further assault from which he had to protect himself. He withdrew and began to fortify himself with his own mental devices—the needed fantasy of being strong and invulnerable. Then he withdrew from the inadvertent analytic assault altogether. The unseen tendrils of a maturational push to get help and hold on to his very being could not take hold.

The vignette highlights a critical issue for all therapies, whether analysis or psychotherapy, whether long-term and intensive or short-term and brief: it is essential to understand remaining health and revived needs for selfobject functions, no matter how fragmented or sexualized the expression of the need is. When we learn to see the consequences of self-fragmentation and understand the turn toward the breast/selfobject as a fragment of health, of clinging to life, we can begin to interpret it as such. Then, "the interrupted maturational push . . . will begin to reassert itself spontaneously as it is reactivated in analysis in the form of [forward edge] selfobject transferences" (Kohut, 1984, p. 78) that are strengthened through interpretation and genetic reconstruction.

AN "OXYGEN-PROVIDING" FORWARD EDGE TRANSFERENCE

The Manifest Disorder Looked at Through a Self-Psychological Lens

When he was almost eight years old, Matt was referred for analysis (Egan and Kernberg, 1984) at the strong recommendation of his school. (A year of once-weekly psychotherapy had not led to improvement.) Looked at from the standpoint of normal development of the self: (1) Matt suffered from symptomatic and characterological difficulties that are hallmarks of an already entrenched form of pathological grandiosity (regardless of theoretical orientation, none of us would mistake these for the normal development of narcissism or, as I would prefer to say, for the normal development of the self); (2) the grandiosity is not simply a defense against feelings of helplessness and inadequacy—it is a sure sign of more primary "structural deficits"—of failures in the expectable transformation of naïve childhood grandiosity into reliable pride and self-esteem; and (3) the primary psychological task of the treatment is to foster the process that fills in the deficits enough for normal development to resume—a process that takes place in

connection with seeing and responding analytically to the still-remaining healthy idealizing and mirroring needs that he demonstrates in his first meeting with the analyst.

Pathological Grandiosity as a Sign of Structural Deficits

Matt's intelligence was superior but his school work was mediocre. He had no friends and, in fact, "everyone at school hated him" (Egan and Kernberg, 1984, p. 42). He treated his teacher as though she were his colleague, and he mistreated his peers, with whom he was totally out of step. Awkward, anxious, and ashamed to do anything physical, Matt was unable to participate with them in any everyday eight-year-olds' play. He could neither ride a bike, swim, skate, nor throw a ball. He was domineering, arrogant, and demeaning with schoolmates and with his five-year-old brother. He ordered them around like slaves or possessions and they either avoided or scapegoated him. Matt's problems were longstanding: he had had problems with other children at nursery school and day camp, and he was unable to acquire in-phase skills. It seems likely that extreme self-consciousness about his body played an extremely important role in his physical awkwardness and inhibitions. For example, he could not participate in swimming lessons because he would not undress and put on a bathing suit in front of other boys at camp.

Failures of Expectable Mirroring and Idealization, and Deficits in the Proud Self

Matt's father, a publisher of some standing, was a shadowy man in the family. Deferring to his articulate wife, he let her speak for him. Both parents agreed that Matt was a "magnificent" child, and both actively encouraged the hypertrophy of his intellect and discouraged physical activity. Both derived great pleasure from his intellectual precocity. In fact, they were so impressed with Matt that they had to overcome their reluctance to have a second child, worried that no sibling could compare favorably to Matt or compete with him. Neither parent seemed worried about his awkwardness and inhibitions, his friendlessness, and his isolation.

Matt's mother, according to the analyst, was exceedingly controlling, intrusive, and demanding, on the one hand, and doting, fostering over-closeness, and encouraging of his arrogance, on the other. Unaware that her expectations for control over Matt's body-mind-self were out of phase, she appeared oblivious to her psychological impact

on her child and their often stormy battles over dominance and control. For example, thinking that her demand for control over her child was necessary and correct, she complained that Matt's insistence on wearing his belt too tight made her angry and frustrated.

The mother's failure to recognize that she undermined the child's autonomy and the father's inability to provide alternative mirroring that resonated with a growing boy's independent initiative were compounded by both parents' inability to recognize his needs for a noncoercive form of connectedness with his brother and his peers. These are simply gross markers that show the serious and ongoing deficiences and faults in the child's selfobject environment that undermined healthy strivings, the forward edge of the self, and the push to complete normal development.

Matt's developmental history—the history of his self–selfobject experiences—suggests that he suffered primarily from thwarted needs and expectations for *expectable* selfobject responsiveness. Thus, he failed to establish, maintain, and restore a genuine sense of pride in himself, of in-phase control over himself and others. The lack led to arrest and fixation on pathological grandiosity, to distortion of his selfobject needs, and to deprivation of a genuine in-phase sense of feeling effectual, of deriving "accomplishment pleasure" from his body-mind-self, from who he was and what he could do. The thwarted mirroring needs and the lack of pride in himself did not stop there: his lack of a reliable source of self-esteem and pride in himself made him exceptionally vulnerable to feeling deflated, ashamed, and painfully exposed. To protect himself from these dangers to the self, Matt *hid* his vulnerability and shame. (His refusal to undress at age five is an overt manifestation of hiding himself from exposure.) As will be seen shortly, for many months, he defensively hid his vulnerability and his needs to be helped to catch up.

Can the Forward Edge of Development Be Remobilized?

Although the aim of the defensive effort to hide the vulnerable self is to protect whatever self-organization there is, this defensive measure, like others, also aggravates the primary self-esteem disorder and leads secondarily to greater vulnerability and to a vicious cycle of more rejection and more failure. Thus Matt was doubly deprived. For example, because he was too uncomfortable and ashamed of himself and his body to learn to swim, he was deprived of obtaining pleasure from his own body and what he could accomplish; then, unable to keep up with peers, he was deprived of the self-expanding pleasures of kinship and

was thrown back even more into the world of his parents. Matt was caught in a vicious intrapsychic cycle—a "prisoner" (Miller, 1981) of his particular developmental deficits, his greatly intensified childhood mirroring needs, and the defensive measures he used to save the only self he had.

The most important diagnostic question to be asked is whether the child or adult patient can respond to and connect with an emotionally available therapist, that is, a therapist who can grasp and respond appropriately to his in-phase needs. Put in more theoretical terms, can the child, met partway by the therapist's selfobject functions, establish any of the development-remobilizing forward edge transferences? The form of the transference and the defensive measures used to ward off the dangers of the transference (intense shame, humiliation, fragmentation, and depletion) are critical indicators of whether the forward edge strivings and forward developmental momentum can be remobilized. Specifically, the questions for Matt are: (1) Are his needs and strivings for expectable mirroring, idealization, and/or twinship experiences (any one of these can be the route to self-expansion and restoration) still sufficiently intact to be remobilized? (2) Is mutuality and give and take, resiliency, ability to recover from injuries and bounce back (self-right) and regaining initiative still a viable potential? How do we answer these questions clinically?

The Forward Edge of the Selfobject Transference: Matt's Wish to Keep Up

When Matt first met the analyst, he started by demonstrating an aspect of the trailing edge of his development, namely pathological accommodation to his parents' complaints about him: he quickly and dutifully listed his bad habits, such as picking his nose and wiping his fingers on his sleeve, picking his fingernails, keeping his desk messy, and covering the door to his room with papers and signs. (He listed relatively minor complaints, to be sure, considering the school's concerns.) However, after the litany of his bad habits that said, in effect, "see what a mess I am," Matt proffered a "tendril" of health. The analyst noted it in his case report but did not see its significance as a bit of remaining healthy self with its own agenda, rather than that of parents trying to heal their own hidden sense of defectiveness with a "magnificent" child and his intellectual prowess.

The tendril that eventually formed the core of a reparative selfobject transference was Matt's immediate, intense interest in the analyst, in what he had and what he was. This is the form that the tentative reaching toward the analyst took: Matt noticed flowers on the analyst's

desk and asked if they were real. In a great hurry (the reason will be apparent) he did not wait for an answer. Hurrying on, he noted that the analyst's clock was eight minutes ahead of his watch. *"I wish,"* he said, *"[that] my watch could keep up with your clock"* (italics added). The analyst noted (to himself) that Matt was expressing his competitiveness (cf. the vignette Miller, 1985, reported). When we place the needs of the healthy self in the center of our analytic thinking, the wish can be understood as a powerful metaphorical expression (unconscious) to catch up and keep up, so he could live psychologically in the world, instead of in his own mind and the world of his parents, where he was trapped. The wish was of such great importance to him that he repeated it three more times in the first session!

This minute bit of a future-oriented agenda denotes a remobilizable forward edge to be given impetus in an expectable self–selfobject environment. Matt, indeed, is a self-proclaimed mess (the expression of the trailing edge of his development and the defensive measures he needed for protection from intense shame for being behind). However, his own agenda includes a search for the real, for the alive world from which he is barred ("are the flowers real," he asks), and it includes the welcome wish/hope that he'll get in sync with the analyst and "catch up." The analyst did not welcome the tendrils because he did not understand them as such. (I might say, "Yes, I can see you really want your watch to catch up with mine.") The lack of response led Matt to a more ambiguous overture to the analyst—at one and the same time, a tendril of a forward edge transference to an idealizable, accessible parent and a defensive denial of his inadequacy: Matt asked the analyst if he were in publishing. The analyst parried the question with a question that most analysts learn is intended to preserve analytic anonymity and neutrality—the "Why do you want to know?" question. More often than not, it is far from neutral as far as the patient is concerned—usually it is construed to mean, "Keep out," that is, an unintended rebuff.

"Are you in publishing?" could be motivated by an effort to whistle in the dark and boast after telling his parents' complaints, or as I would think, the question can possibly mean, "Are you approachable as a real, alive father?" In any case, the analyst's "Why do you ask?" inadvertently discouraged the forward edge—Matt gave voice at this point to the lonely grandiose fantasies of the most pathological aspect of his development: he announced that he himself is president and editor-in-chief of a publishing company, that he has a number of men working for him, and that he has trouble keeping them on the job. They quit (i.e., his peers won't play).

The gross identification with his publisher father is not merely "grandiose" and a continuation of denial of weakness in fantasy beyond the

age when it is in-phase (A. Freud, 1965). Gross identification, sometimes a precursor of the actual inner capacities we eventually acquire for ourselves, in Matt's case is a signal that he needs the strengths and support of a substantial father; lacking these, he *is* the father in fantasy. Again, in theoretical terms, there is now a "vertical split"—on the one hand, a weakened, shame-prone self that nevertheless still needs genuine mirroring, idealization, and twinship experiences to sustain further growth, and on the other hand, an isolated, walled-off, manifestly pathological, grandiose self that is inaccessible to change unless treatment remobilizes the forward edge tendrils that poked up at the very beginning of the treatment.

Inadvertent Repetition of the Trailing Edge

In the first eight months of the treatment, the theoretical tilt to recognizing pathology and overlooking health led to accenting the trailing edge: the analyst wanted Matt to talk about his problems and worries, he probed for dreams, and he interpreted the meaning of drawings Matt made. Matt's response to these well-intended efforts to ferret out his pathology was not unlike Guntrip's patient's response: *he had himself and his inner world.* In other words, he resorted to unconscious defensive efforts to ward off the threatened invasion of his fortress-mind, the feared exposure of his vulnerabilities, and the self-shattering shame. The defensive measures to avoid these dangers to the self hardened. Being an eight-year-old, he did not hurl boulders. Instead, he became enraged, withholding, and withdrew into the books he brought to his hours. "I prefer to read," he told the frustrated analyst. Or he warded off what he perceived as invasion and attack by isolating himself in self-absorbed elaborate drawings. The weakened self sought illusory mastery and effectance pleasure in pathological grandiosity with its unmistakable arrogance, tyranny, and pseudo self-sufficiency. Matt was good at shutting the analyst out, hour after hour, and the thwarted needs and strivings of the healthy self and its forward edge were nowhere to be seen.

A Frequent Countertransference: Anger as a Signal of the Analyst's Failure to Understand

In the context of assessing the strengths and weaknesses of the child-self, the early course of the treatment demonstrates the point I am making about psychoanalytic theory: we are more inclined by our training to see and address pathology and to overlook or fail to grasp the meaning of still healthy strivings. When we place the self and its valid needs in the center of our clinical thinking, we are more likely to

recognize the thwarted needs and strivings, the primary psychological configurations that give rise to overt grandiosity, rage, arrogance, depreciation, competitiveness, and the entire spectrum of self-disturbance. Matt's overt grandiosity and his covert hiding of his vulnerable self got worse as the thwarted needs of a psychologically deprived self went unrecognized.

For eight long months, Matt lorded it over the analyst—he came out of hiding behind his books and drawings only to counterattack. He berated the analyst if he were a minute late, he ordered him around, and he went to great lengths to show that the analyst was of absolutely no importance to him. You will not be surprised to learn that Matt's therapist began to feel like Matt's peers. He felt angry and "progressively more helpless, useless, and weak. [His] speech was more hesitant and tentative and his comments more vague and imprecise. [He] came to dread the sessions as he foresaw yet another hour of being made to feel worthless, bored and irritated" (Egan and Kernberg, 1984, p. 47).

The point I want to emphasize is that the therapist responded with what I have come to see as *frequent countertransference signals*: all of us can use such feelings as anger, dread, floundering, and so on to alert us to the fact that *we have not yet understood a disdainful patient who makes us feel useless and ineffectual.* Pathomorphic theory (see Emde's [1981] important contribution on the problem with psychoanalytic theories of normality that are based on pathological development) prompted the analyst, in this case, to look for what was wrong with Matt. Matt's lordliness, his self-protective "resistance" to further infringement on what little control he had over himself and his world, worsened as he experienced in his treatment a new version of his mother's invasiveness instead of a resonant response to his agenda to keep up. Reproducing the pathogenic experience with his mother in a trailing edge transference was not therapeutic. The way out of the analyst's feeling of anger and ineffectualness and of Matt's helplessness and fear of further humiliation lay in accessing the forward edge of the transference.

A Glimpse of the Structural Deficit: Recognition of Matt's Injury and Powerlessness

After eight or nine months of suffering from the anger and dread of ineffectualness as a therapist, the analyst explained Matt's lordliness (grandiosity as a defense) as a way of making the analyst feel helpless and useless because Matt himself felt powerless and helpless. (To put this in theoretical terms, the grandiose defense signals a deficiency in the internal structure that confers a usable sense of strength and