RELATIONAL SELF PSYCHOLOGY

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This paper is a modification of one co-authored with Barry Magid that took form in 2014 as the foundation for an IARPP Webinar on the ongoing dialogue between Self Psychology and Relationality. In this present version, the main focus is on evolution of Relational Self Psychology, with the dialogue between Self Psychology and Relationality, Barry and I had articulated, remaining an important background consideration.

Barry Magid and I had conceptualized Relationality, consistent with Stephen Mitchell’s (2000) vision, not as a single, unified theory, but instead as a sensibility comprising a set of interacting theories initially characterized by a recognition of the primacy of attachment and emerging over the years into compatible versions of mutuality and bi-directionality. Indeed, at present, as Jody Messler Davies (2014) has affirmed, the overarching umbrella of Relationality covers a wide set of perspectives running an historical and theoretical gamut that includes: a relational theory influenced by a Kleinian-Bionian position, a relational theory influenced by British Object Relations, a relational theory influenced by Relational Self Psychology, and a relational theory influenced by Interpersonal Theory.

Further, Contemporary Self Psychology, in its post-Kohutian evolution as a systems theory and a theory of Intersubjectivity, is now neither best understood as a theory of narcissism nor as a theory of empathy, but, rather, as a recurrently evolving relational theory in its own right, one whose evolution is due in part to a continuous dialogue with other relational theories. Thus, in this process of reflecting upon and responding to challenges levied against elements of traditional Self Psychology, the more current reach of Self Psychologists is expanded greatly into
a new Self Psychology, a Relational Self Psychology, encompassing: aspects of other contemporary psychoanalytic theories, modern notions of a dynamic systems sensibility, findings from infant and and neurobiological research, and understandings derived from existential and epistemological philosophy.

To begin, I will address core features of classical Self Psychology, emphasizing the principal areas in which the theory has evolved beyond Kohut’s (1971, 1977, 1979, 1984) original contributions. I will also, concurrently, display eight areas of interface between Relational Self Psychology and theories of embodied Relationality, showing how Relational Self Psychology connects with, augments, and even, at times, challenges corresponding conceptualizations in Relationality, where, then, the two might appear mutually compatible and permeable, with ideas flowing smoothly between them (e.g., formulations derived from Attachment Theory), and at other points, the resemblances are fainter, the co-mingling of ideas more difficult, or even resistant (e.g., the differing concepts of attunement and projective identification).

As will become evident, the core features of Kohut’s Self Psychology that are discussed here will appear intermingled within the eight areas interface between Self Psychology and Relationality. These core features include:

1. Self as central to clinical and theoretical concern.
2. The significance of selfobject function.
3. The centrality of empathy and introspection.
4. Aggression conceived not as drive but as a reaction to frustration and depravation.
5. Defensiveness as self protection.

While the text is somewhat changed, expanded, and rearranged, what follows significantly reflects what Barry and I had co-authored in several previous talks. The pronoun “I” replaces “we” for ease of presentation.
6. Psychoanalysis as a developmental process.

What follows is my exploration of eight areas of interface between the six core attributes of Kohut’s Self Psychology identified previously, emphasizing, as stated previously, their evolution into Relational Self Psychology and therefore connectedness with Relationality.

First: Self and Selfobject

Kohut (1971, 1977, 1979, 1984) insisted from the start that a person was first and foremost a locus of subjectivity, with subjectivity being present at birth and developing apace out of interactions with attuned caregivers. The self in Kohut’s conceptualization possessed an inherent, coherent internal design. In Relational Self Psychology, however, Self is no longer understood as preformed psychic structure, but instead, as a fluid, ever-changing set of emerging capacities for awareness, attachment, and affect. This emergent self develops through ongoing, bi-directional interaction with the caregiving surround: Kohut’s selfobject milieu.

Traditionally, Self Psychology had used the terms selfobject function or selfobject experience to convey the fact that the term selfobject does not refer to a person, but, rather, to the other’s provision of an essential, stabilizing constitutive function for the self’s well-being. Perhaps Kohut’s insistence on the idea of selfobject as function rather than person impeded the movement of classical Self Psychology from a one person to a two person model. Clearly Kohut himself always conceptualized Self Psychology as a one person perspective, explaining that a function is not a person, and therefore the psychoanalytic situation involves only one person, the patient, with the analyst in that situation limited to being a provider of needed developmental experience, not a full person in his or her own right. The Relational Self Psychologist has revised this classical Self Psychological construct in order to present a psychoanalytic situation peopled by two individuals, each with distinct and separate subjectivities. Only in this way, by
changing the analyst from function to full personhood, might a truly Relational Self Psychology be effected.

But yet Kohut’s (1971, 1977, 1979, 1984) truly inspired creation of selfobject as a single word rendered typographically-literal the essentialism of the self’s embedded existence. There is no such thing as a separate self, nor a separate self-experience, then; there is no Cartesian inner world of privileged, private access. An easy and obvious parallel appears in Winnicott’s (1947/1964) dictum: “there is no such thing as a baby” (p. 88). The infant’s growing sense of self, sense of other, and sense of surround all emerge together from within a self-selfother, intersubjective system. Benjamin’s (1988) picture of the co-emergence of self and other through mutual recognition—that is, I am who makes mommy smile; mommy is who makes me smile—offers a relational account fully in accord with Self Psychology’s original depiction of selfobject and self-selfobject matrix.

Thinking of self not as an inner structure but as a recursive pattern of capacities and expectations allows for the further argument that this pattern is located not inside the person, but instead arising from within the system of self-selfobject milieu. The concept of selfobject facilitates the deconstruction of notions of internal psychological structure versus external, or even internal, objects. Our capacities—such as, for example, for affect regulation and for self and interactive other regulation—exist neither inside nor outside of self; rather, they arise, are constituted by, or fail, as part of a self-selfobject unit, or system. I would argue, then, that Self Psychology has been increasingly clarified as grounded in languages of process rather than structure; dynamic systems rather than either internal objects, projections, or representations; nonlinearity rather than linearity; and the intersubjective rather than the intrapsychic.
One limitation in Kohut’s (1971, 1977, 1979, 1984) original presentation of the self-
selfobject unit is that it is conceptualized as uni-directional rather than bi-directional; that is, the
empathic analyst was seen exclusively as a provider of functions for the patient’s self, and the
patient as merely a passive recipient of the analyst’s attentions. In contrast, in Relational Self
Psychology, self-selfobject relations are conceptualized as bi-directional and intersubjective,
which is why, as I just said, the concept of analyst as function rather than as separate subjectivity
has been reconceived, with each member of the dyad reconstituted as capable of providing
functions for the other. So, while a mother/analyst does indeed provide selfobject functions for
the infant/patient, the infant’s/patient’s responsiveness, health, growth, and development
reciprocally provide selfobject functions for the mother/analyst, supplying, for example, ongoing
affirmations of her sense of herself as good enough caregiver.

Second: Therapeutic Action

Any system contains the ever-present potential for disruption. In fact, Kohut (1971,
1977, 1979, 1984) established disruption and repair as the essence of therapeutic action in Self
Psychology. Disruption and repair involve the following:

1. The analyst’s inevitable empathic failure;
2. The patient’s experience of optimal (tolerable) frustration, not overwhelming
   (intolerable) frustration, resulting from that empathic failure;
3. The analyst’s acknowledgement that empathic failure as a source of the rupture between
   them; and
4. The patient’s experience of the analyst’s acknowledgement of empathic failure as serving
   to repair the ruptured bond, with the empathic repair facilitating further development.
The significance of rupture and repair in therapeutic dyad has its origins in Self Psychology (Kohut, 1979, 1984), and was only later confirmed and augmented by findings from infant research (e.g., Beebe & Lachmann, 1994; D. N. Stern, 1985; E. Tronick, 1989). Subsequently, clinical understanding of the concept of disruption and repair expanded across many contemporary theories, including these central facets: that the rupture-repair cycle is inevitable; that its essential role in the unfolding transference and countertransference relationship cannot, and indeed should not, be avoided; and that the cycle of rupture and repair represents the curative process of analysis. It is paralleled in those theories of Relationality in which enactment is conceptualized as playing a necessary, unavoidable, and central role in the therapeutic process.

Third: Idealization, Aggression, and the Negative Transference

I turn now to the concept of idealization as an example of Kohut’s radical departure from classical and Kleinian (1932, 1957) thought that has had widespread influence in the field. Although drive theory conceptualizes idealization as serving a secondary role as a defense against aggression, Classical Self Psychology conceives of idealization (or, more precisely, the idealizing selfobject function) as constituting one of three essential developmental needs that emerge in childhood in many forms and at many levels over the course of life. In earliest development, the requirement of an idealizable selfobject function is essential for the establishment of a safe base experience, generating thereby a sense of comfort and security in the infant and growing child. Later in development, the idealizing selfobject serves as an essential source for establishing necessary ideals and standards for living one’s life, which may be seen as a core aspect of all positive transference, as well as forming the base for idealizing selfobject
transference, specifically. Perhaps Benjamin’s (1991) formulation of the need for “identificatory love” (p. 284) by children of both sexes occupies a parallel position in Relationality.

In his writings (e.g., 1971, 1972) about archaic narcissism, Kohut spoke of the frustration of the grandiose self’s wishes for omniscience, and for omnipotent control over others. Earlier, Kohut (1972) had referred to the patient’s propensity to express these wishes in analysis as the “positive narcissistic transference” (p. 363): an oxymoronic notion of transference derived from classical Freudian metapsychology. This transference manifestation was then established by Kohut as a prime diagnostic feature of the narcissistic personality disorder. Brandchaft and Stolorow (1984) extended Kohut’s formulation by suggesting that what has been perceived as borderline personality disorder may be best understood as an iatrogenic byproduct of the analyst’s failure to provide necessary empathic attunement for the narcissistic patient in the clinical setting. Chronic misattunement, in their view, leads to the patient’s experience of fragmentation and to negative transference configurations. Thus, the intrapsychic pathology of borderline personality disorder, typically accompanied by such primitive defenses as splitting and projective identification, is reconceptualized by Brandchaft and Stolorow as a pathogenic consequence of the analyst’s malattuned treatment of the patient in the dyad, a disruption in the dynamic system. This makes more clinical sense, these authors argue, than perceiving the disorder to be solely a product of the individual’s pathological ego functioning.

Brandchaft and Stolorow’s (1984) concept of the borderline personality as byproduct of the breakdown of a heretofore stable selfobject milieu became a landmark in a systems and relational theory. At the same time, it also created a seemingly impermeable theoretical barrier to use of the projective identification concept within Self Psychology, indeed, a shibboleth, demarcating Self Psychology from Object Relations Theory.
The by-product of Brandchaft and Stolorow’s (1984) theoretical position is clear; individuals who had been perceived previously as treatment-resistant might emerge from an apparently unmoving negative transference, once provided with an empathic treatment milieu wherein an idealizing transference is welcomed and allowed to develop. This is particularly true when the analyst is prepared to acknowledge to the patient the impact of his/her own previous empathic failure.

In order to highlight Relational Self Psychology’s perspective on idealization, aggression, and the negative transference, I find it useful to review Kohut’s 1979 paper, the *Two Analyses of Mr. Z*. This paper comprises what Kohut came to call his *specimen case*, namely, the case in which he illustrates and elucidates his now fully formulated clinical theory of narcissistic personality disorder. The paper tells about Mr. Z, a patient who had experienced two separate analyses with Kohut, each lasting for 4 years, and separated by a 4-year period between them. In each analysis, Mr. Z begins in an idealizing transference, but then, once fully engaged in treatment, his experience of Kohut quickly becomes transformed into angry demandingness prompted by Mr. Z’s rage at his own disappointed narcissistic expectations. Kohut demonstrates how, in analysis one, he had worked and conceptualized as a classical analyst, and how his work and conceptualization changed in analysis two, once he had invented Self Psychology. Clearly, Kohut had first endeavored to stay with the old classical model that had been so dear to him, so much a part of his life, and then, only reluctantly, had allowed himself to recognize his new ideas developing within him, and had finally instantiated in his mind his novel understanding of this pathology. During the first analysis, then, Kohut was the consummate classical analyst, viewing Mr. Z’s pathology and his grandiosity and narcissistic demands as manifestations of a fixation on a pre-oedipal mother, and of defenses against oedipal competitiveness and castration fears. No
matter how Mr. Z would protest, rage, act out, and then become deeply depressed and suicidal, Kohut stuck to his classical ideas. He had a theory, he knew his theory was correct, and he knew that all of Mr. Z’s protests, no matter how violent, were simply manifestations of a defense and resistance that needed to be interpreted steadfastly. In retrospect, the rage, acting out, and depression may be seen neither as manifestations of resistance, as classical theory would suggest, nor as an expression of primitive aggression, envy, or even as a need to destroy the analysis, as might be hypothesized by a Kleinian, Kernbergian, or other Object Relational perspective. Instead, these dysphoric expressions were perceived as the iatrogenically-induced byproducts of an unempathic classical analytic stance.

The story of the two analyses make an interesting narrative. What success there was in the first analysis of Mr. Z hinged on an unintended empathic interpretation offered by Kohut, one that lent hope to Mr. Z and that provided a turning point in the treatment. On the strength of that interpretation, Mr. Z had felt deeply understood for the first time, and from that point onward, complied productively with Kohut’s vision. In that accommodative state, Mr. Z became the patient that Kohut needed him to be. His rage attacks ceased abruptly, and he became calmer and less insistent upon justifying his anger of being misunderstood. The analysis came to an apparently successful conclusion, but was, in large part, a failure; the narcissistic pathology was not understood and worked through, but was buried instead. The second analysis was approached with new Self Psychological understanding and came to a considerably more successful conclusion. The opening phase was much like that in the first analysis, with Mr. Z angry and argumentative, but Kohut evaluated and interpreted those dysphoric affects differently. While in the first analysis Mr. Z was perceived as defensive, now Kohut listened to him empathically: that is, listened from within Mr. Z’s perspective, rather than listening from his...
own, with what Kohut had come to appreciate as outworn theory. Instead of resistance, anger, and envy, Kohut saw these manifestations as Mr. Z’s painful efforts to establish a replica of Mr. Z’s childhood situation, taking at face value Mr. Z’s experience of that situation. The changes in clinical understanding were many, important among them being Kohut’s new comprehension of the selfobject transference, but perhaps the most significant change was his new listening position as being situated within Mr. Z’s experience, rather than deriving from Kohut’s own theoretical expectations.

As I say, it’s an interesting narrative, Kohut’s intention being to demonstrate a change of theory born of empathic listening and understanding. He was attempting to establish his deeply held conviction that the analyst who facilitates the development of a sustained selfobject transference—characterized by features of mirroring, twinship, or idealizing configurations in the transference—may likely be rewarded with experiencing the alchemy of an unanalyzable borderline patient (and arguably Mr. Z was just that) being transformed before his eyes into a patient with an analyzable narcissistic personality disorder, or disorder of the self. Likewise, and importantly, the patient’s unconscious defensive processes such as splitting (hitherto deemed intrapsychic) are re-conceptualized in terms of the state of the system, the system being either in a state of stability or in a state of disruption. I will look again at these phenomena in terms of differences between Self Psychological and Object Relations theory shortly.

Now to aggression. When Self Psychology was new to the psychoanalytic scene, it was sometimes suggested that it lacked a theory of aggression. It is clear now to all Relationalists that a theory of aggression need not be based on the premise of an inborn aggressive drive. Kohut (1971, 1977, 1979, 1984) conceptualized the potential for aggression as inherent in the human being, activated as a force both in life and the clinical setting that is reactive to
experiences of frustration or deprivation. He distinguished between two main strands of aggressive response. The first strand takes the form of ordinary anger that emerges and is resolvable without residual pathogenic effect once the motive for the anger has been addressed satisfactorily. The second strand, and the central focus of Kohut’s theoretical and clinical concern, was termed narcissistic rage. Kohut postulated that narcissistic rage emerges in response to injury, damage, or humiliation experienced by the self. In contrast to normal anger, narcissistic rage can rarely be resolved in a satisfactory way, but, more often than not, remains active in the aggrieved person because the damage that has been sustained by the self is not easily, if ever, sufficiently understood and successfully worked through. Currently, narcissistic rage is conceptualized as a response consequent to any threat to a person’s sense of self, to his physical or psychological experience of safety, to his personal integrity, or to his very existence.

Kohut (1971, 1977, 1979, 1984) also theorized about the role of healthy competitiveness and assertiveness, affect states he conceptualized as playful, developmentally necessary, and expansive, distinguishable from states of normal anger and, especially, from states of narcissistic rage. This leads me to a consideration of Kohut’s views on the Oedipal complex. Kohut saw an Oedipal phase in normal development as being both universal and inevitable, but he distinguished the normal Oedipal phase from Oedipal conflict, which he deemed pathological. Kohut argued that Oedipal conflict occurs when, during the course of the normally emerging Oedipal phase, the child is confronted repeatedly by threatened or threatening parental responses, responses both to the child’s normal, healthy, affectionate interest in the parent of the opposite sex, and to his normal, healthy, competitive feelings toward the parent of the same sex. Such inappropriate, unempathic, parental responses to stage-appropriate childhood gestures generate experiences of fragmentation, turning the child’s normal affection and competitiveness into
drive-like strivings of lust and rage, earmarks of the classical Oedipal conflict. Thus, rage and lust are pathological responses to a poorly attuned selfobject surround during the Oedipal phase. The fact that Oedipal conflicts are common in development does not mean that they are optimal, nor even normal, Kohut averred. Dental cavities are also common, he said, but, like Oedipal conflict, they are not an aspect of a healthy developmental course.

Through these formulations, Self Psychology accounts for both primitive reactive rage and normal healthy assertion, and for both primitive reactive lust and normal healthy affection. And while aggression is accounted for in the theory as potential, it remains available to the individual as reactive to aversive experience; as in most Relational theory, there is no recourse to the concept of aggressive drive.

How deeply do these Self Psychological formulations on aggression deviate from the understandings prevalent in Relationality? Mitchell, too, wrote about aggression, not as drive but as an inborn capacity to react when the individual is frustrated or deprived, and this postulate seems consistent among Relationalists in general. But Mitchell was also clear that it is in the clinical situation where Self Psychology’s views on aggression differ from his own. While the Self Psychologist is principally concerned with looking for the immediate cause of an aggressive response and mitigating that aggression so that the self experience of fragmentation can be reduced, restoring the self to strength and coherence, Relationalists are more interested in aspects of the aggressive self per se. using the concept of multiple selves, rather than the concept of one cohesive self. Mitchell taught that the experience of an aggressive self should not be diminished or dampened in the clinical situation, but instead it should be investigated and understood in its own right, and allowed to develop so that aggression can become a useful tool for the individual’s self expression. As a Relational Self Psychologist, I believe there is much of value...
to be learned from this clinically-based perspective offered by Mitchell, one that I myself have described as, at times, essential to the clinician.

**Fourth: Empathy**

Kohut delivered his final talk in Berkeley in 1981, 3 days before he died. There, for one last time, he tried to clarify what he meant by *empathy*, and the *empathic listening perspective*, which so many of his own colleagues as well as his critics continued to misunderstand. In his terms, empathy is *not* compassion, it is *not* a positive or sympathetic feeling the analyst cultivates within himself/herself, it is *not* merely feeling what the patient is feeling. Once again, from the podium in Berkeley, Kohut insisted that by empathy, he is describing no more than a tool for data-gathering: that is, a particular observational stance, one characterized by entering into and experiencing the world from within the patient’s perspective. Kohut was attempting to distinguish the empathic listening stance from an observational stance positioned outside the dyad, a stance that presumes to represent an objective, more correct, scientific view. From that external vantage point, as he tried to illustrate in the *first* analysis of Mr. Z, the classical analyst imagines himself to be interpreting to the patient what is objectively true, correcting the patient’s own inevitably flawed perspective. It is clear that Kohut was trying to illustrate in the *second* analysis of Mr. Z was the empathic observational stance and its clinical value.

That said, and despite Kohut’s clinical prescription, Relational Self Psychologists do not *only* listen to the patient and respond empathically; rather, empathy serves as a guide for selecting among the wide variety of ways we engage with our patients that best accords with the patient’s different and differing needs as these needs are perceived in the dyad in that moment. The *empathic listening stance* does not preclude the analyst from observing and responding to the patient from alternative perspectives as well as from the empathic perspective. In Fosshage’s
(2003) terms, the analyst may either listen and respond from an Other Centered Position, that is, as an other in the patient’s life such as a spouse or a child; or the analyst may listen and respond from a Self Centered Position, that is listening and responding from his/her (the analyst’s) own perspective. For example, the analyst certainly will listen and respond from a Self Centered position when he/she feels some sense of anger or resentment toward the patient, perhaps during an enactment, and feels the need to express those feelings. Or the analyst may listen and respond from an Other Centered position when he/she wishes to reflect back to the patient what the patient’s partner may have experienced in a particular heightened moment between them. But, and this is the significant point, listening empathically from within the patient’s perspective (as distinct from responding empathically) always and inevitably contextualizes our understanding of how we might best respond to our patient in any given situation as we select from among potential responses, whether we choose a response derived from an empathic mode, from a self-centered mode, or from an other-centered mode.

I wish to address another misconception about empathy: that the empathic stance can only engage the patient’s conscious, but not his unconscious, experience. Yet it seems to me that when a relational analyst such as Philip Bromberg (2012) describes how he is able to enter with neutrality into the varying points of view of his patients’ different and dissociated multiple selves, we are witnessing the employment of empathic listening par excellence. Again, how Bromberg responds may, and in fact, does, differ, depending upon what he perceives to be in his patient’s best interest, but I can’t help but imagine that it is his empathic listening that informs that decision as well. The Relational analyst (in this instance, Bromberg) appreciates the legitimacy of the perspectives of each of his patients’ multiple selves; he does not presume to preside over or choose from among competing positions. The perspective of one self may
privilege, say, security from re-injury on the one hand versus the potential for new intimacy on the other, and the Relational analyst must remain neutral to each of these perspectives. For Bromberg, just as for the Relational Self Psychologist, the patient’s unconscious in this scenario consists of the patient’s hitherto unrecognized and unarticulated hopes and dreads when faced with new experience. How a person comes by their particular hopes and dreads is the work of analytic exploration, with the analyst proceeding in an inquiring, non-judgmental manner in Self Psychology, just as in Relationality—or in any other theory, for that matter—that does not presume to know or to pre-judge the results of its exploration before it gets started, nor to know which of the choices a patient faces is the right one for the patient to make. Such an approach recognizes that taking an empathic perspective is addressing the patient’s experience from within the particular self that is present in the moment, and preserving an analytic stance of self state neutrality, rather than arbitrarily choosing the right way to feel, think, or perceive the world. It is from this empathic stance that the analyst understands (and sometimes interpretatively communicates) the needs and defenses of each self or self state. Whether the analyst adopts an attitude of non-intrusive reserve, attuned listening, or passionate engagement is determined by the analyst’s assessment of the apparent needs and requirements of each of the (often shifting) self states of the patient as perceived empathically by the analyst at that moment in time. Theory does not dictate this response. Empathy thus offers the analyst the means for assessing what, for a particular patient in a particular self state, counts to that patient as feeling held, heard, or responded to. This recognition of empathy as self-state neutrality establishes an important conceptual bridge between Kohut’s cohesive self, in which many differing self states may emerge, and Bromberg’s and other Relationalists’ multiple selves.
But perhaps that need for a conceptual bridge is more apparent, more language-based, than real. For Self Psychology, the goal for the individual is to achieve an experience of self state coherence and cohesion rather than an experience of fragmentation, whereas for Relationality, the preservation of individual integrity for each of the multiple selves is most important. Yet Bromberg (2012) stated that the goal is to achieve the experience of being one self while actually being many, bringing the Self Psychological and the Relationalist positions into some conformity.

Again it is interesting to consider how close Kohut’s language of fragmentation is to Bromberg’s (2012) and D. B. Stern’s (2004) concepts of dissociation. When Bromberg speaks of the goals of analysis as being to replace dissociation with the ability to hold conflict, I can understand him to be describing a self with sufficient cohesion to withstand the tensions of conflict without fragmenting. To repeat, when Bromberg talks about normality as feeling like one self while actually being many, can that not be seen as akin to the experience of self-cohesion in Self Psychology? In Self Psychology, conflict is not conceptualized as pathogenic in itself; it is only when the degree of conflict is so severe that a sense of fragmentation ensues that conflict is considered pathogenic. Can these, then, not be understood as close to parallel concepts?

Fifth: Post-Kohutian Expansions of Empathy: From Empathy to Intersubjectivity

I now turn to the integration of a systems sensibility into Self Psychology, particularly the Intersubjective Systems Theory of Stolorow and others (e.g., Stolorow, 1995; Stolorow, Atwood, & Brandchaft, 1994; Stolorow, Atwood, & Orange, 2008), such integration facilitating a Relational Self Psychological perspective.
First of all, Stolorow argued that Kohut’s concept of empathy as vicarious introspection is pervaded by an isolated mind doctrine that bifurcates the subjective view of the person into inner and outer, so that the mind becomes pictured as an objective entity looking out at the world from which it is estranged. For Kohut, vicarious introspection is required to bridge the gap between the two isolated minds of patient and analyst in the analytic situation, but in Stolorow’s world, no such bridging is required, as the two minds are not isolated from one another; they are always already connected to one another in the system they share.

Stolorow also criticized Kohut’s view of empathic immersion. Stolorow contended that Kohut understands immersion to be neutral and objective, with the analyst being able to leave his own subjective world aside so that he/she may gaze on the inner experience of the patient with a vision purified of his/her own subjectivity. This ignores the inherently intersubjective nature of psychoanalytic understanding to which the analyst makes an ongoing, unavoidable, and indispensable contribution.

I am not sure that Kohut (1971, 1977, 1979, 1984) actually meant to suggest that the analyst was capable of leaving his own subjectivity behind, but whether or not Stolorow’s criticism is accurate, Intersubjective Systems Theory (IST) undoubtedly opens up new perspectives within or beyond the classical form of Self Psychology, generating the Relational Self Psychological Model.

There’s far too much to say about this, but I’ll simply call attention to the fact that IST postulates two distinct levels of discourse: the theoretical/explanatory level, concerning the level of system, and the phenomenological/subjective level concerning the level of the subjectivity of patient and analyst, in addition to the intersubjective relationship between them. I’ll limit myself to some comments about the first, the theoretical/explanatory level, wherein the focal point of the
understanding and concern is always the dyadic system of patient and analyst, not the individual worlds of patient and analyst. On this systemic level, the patient’s self experience is conceptualized as always already inseparable from the other in their system of mutual influence. In systems thinking, one cannot say who does what to whom, or where a particular thought, feeling, or emotion has originated; self and other are unified.

It’s of interest that Steven Mitchell (2000), too, saw the patient/analyst dyad as the indivisible center of psychoanalytic concern, and that Thomas Ogden also was creatively concerned with the dyadic system. Ogden (2004) wrote that just as Winnicott had spoken of there being no such thing as an infant (apart from maternal provision), Ogden would say that there was no such thing as an analysand apart from the relationship with the analyst. Ogden wrote about the vicissitudes of the analyst’s experience of being simultaneously within and outside of the system of unconscious intersubjectivity of analyst and analysand, the third subjectivity being termed by him the Analytic Third. I will expand on Ogden’s original concept of the Analytic Third later in this paper as I explore Ogden’s concept of reverie as a contrast to Kohut’s empathic stance, but the crucial point here is that Relationality shares with Relational Self Psychology an interest in the clinical varieties of dyadic systems of thought.

I will turn, as a final observation on empathy, to a significant though little-commented upon feature of Kohut’s (1981) last talk on that topic: the fact that Kohut added in his remarks a most confusing conceptual complication to the meaning of empathy by alluding directly to its dual nature as he perceived it, noting that empathy is both a mode of observation and, as it turns out, an agent of repair. While contending forthrightly, on the one hand, that empathy is fundamentally an observational stance, Kohut at the same time acknowledged that empathy carries, in and of itself, a healing function. To this day, Self Psychologists struggle to balance
and make sense of these two visions of empathy embedded finally in Kohut’s writings: that is, the outspoken and often emphasized vision of empathy as the analytic stance of “vicarious introspection” (p. 459), and the far less visible and only covertly articulated vision of empathy as imparting an invaluable and reparative feeling of being understood. Perhaps it helps to remember that being listened to from an empathic vantage point can create a feeling of being understood, and that that experience serves, in itself, a selfobject function, one that stabilizes, organizes, and regulates self experience. From this standpoint, one might say that empathic interpretations function by helping a patient to map his/her experience onto an organizing, meaningful, narrative grid. Rather than function to uncover what has been hidden, such interpretations enable the patient to make sense of something, the potential for which, or the essence of which, had always been there, but had remained unknowable, perhaps, in D. B Stern’s (2004) terms, unformulated. What had been quite literally unspeakable might then be put into words.

Sixth: Further Post-Kohutian Expansions of Empathy: From Empathy to Impact, to Recognition, to the Third, and to the Problem of Projective Identification

A significant contribution to the Relational Self Psychologist’s understanding of empathy comes from Relationality’s evolving expansion of the meaning and application of that experience, enlarging our perception of what it takes for some patients to know that they really have been heard and understood, and facilitating their capacity to experience connection with the other who is serving such selfobject functions.

Respecting the developmental legitimacy of the patient’s emergent grandiose self experience, and maintaining a regardful, helpful, non-intrusive presence, might indeed (consistent with Kohut’s teachings about the classic mirroring transference), in some instances,
actually be sufficient to meet the patient’s needs, and might be seen by the analyst himself as sufficient (accurately or inaccurately) in even more instances. But it is also true that in the evolutionary perspective of Slavin and Kriegman (1998) who consider “why the analyst needs to change” (p. 247) and in the version of intersubjectivity introduced by Benjamin, that each reveals, in its own individual way, that many patients require a far more actively engaged level of responsiveness than is conveyed by mirroring alone. For one thing, Benjamin notes that the analyst’s visible facial and gestural display of feelings and reactions offer a primary indicator for the patient that his/her story has had an impact, but hopefully not an impact that is too overwhelming for the patient to tolerate. Fonagy (2003), too, theorized about what he termed marked mirroring in this same vein. Registering for the patient not too much, and not too little, but just the right degree of responsiveness has great importance to the patient, serving as an indicator that the patient has been understood, but that the patient has not been overwhelmed. This element inherent in the reciprocity and mutuality of a two-person process, a contribution of Relationality, had never been conceptualized in Kohut’s Self Psychology.

The concept of the analyst’s need to change is also an important contribution coming from the relational understanding that has made an impact on Relational Self Psychology. As Slavin and Kriegman (1998) have written, deep analysis of the patient, particularly the traumatized patient, often forces into the analyst’s awareness pathogenic issues that the analyst believed had been resolved heretofore in his/her own analysis. Or, issues that had heretofore remained dissociated in the analyst’s mind are catapulted into his consciousness as they emerge from within the mutually interactive system he is now engaged in with his patient. These unwanted feelings may interfere with the satisfactory resolution of the patient’s pathology. The analyst must change, then, in order that the patient may be helped. Slavin and Kriegman averred;
the analyst must explore areas of trauma within himself, integrate dissociated areas into his consciousness, fully expand his awareness, and successfully address his conflicts, so that both patient and analyst can move forward and achieve resolution. Analytic work with patients that demands from the analyst engagement in the change process itself obviously goes beyond and requires more for cure than what Kohut had foreseen in his theory of Self Psychology, requiring the expansion of Self Psychology into the two person relational model I have been attempting to describe here.

Moreover, I can identify an additional formulation originating in Object Relations theory that has enriched Relational Self Psychology. The patient’s urgent need is not just to feel understood; often it is also to make the analyst feel, along with him, that which he himself is feeling, to render the analyst just as frustrated, angry, confused, or aroused as the patient is. And it is vitally important that the analyst can tolerate, and show that he can tolerate, those same feelings. The analyst can do this in part because he can imagine a different outcome, not a repetition of the disruption of vital selfobject ties by unacceptable or unbearable affect (as the patient himself is prone to dread), but instead, the analyst can imagine a positive new experience for the patient. In this way, the analyst enhances the patient’s capacity for the containment of affect, both by modeling it and by providing such containment as a selfobject function. Envisioned in this way, that the patient’s experience of having a visible impact on the other constitutes for the patient an added dimension of feeling understood, permitting the Relational Self Psychologist to perceive and accept such transference phenomena. While these phenomena have been attributed to the concept of projective identification, I would suggest that perhaps, by adding a Self Psychological dimension to that Object Relations perspective, the phenomena can also be conceptualized in a more experience-near and metapsychologically more simple form as

Commented [RH9]: This is a bit vaguely worded – can you please review and rephrase?
affect attunement. However, I recognize that Relationalists have used the concept of projective identification to encompass a far wider range of phenomena that can be translated into a Self Psychological model. In particular, projective identification is conceptualized as the mechanism behind many transference-countertransference complementarities, especially ones in which a traumatized patient seems to draw the analyst into the position of the perpetrator of re-traumatization. This is especially manifest in feelings of shame, wherein an abused patient harbors a sense of shame at what has been done to him, shame that the actual perpetrators do not allow themselves to feel. The analyst, in this scenario, is also seen as subject to feeling inexplicable emotions of shame and guilt in the presence of the patient, as if she herself were the perpetrator of the trauma. Whereas Kohut tells us we must be prepared to acknowledge the inevitability of empathic failure, Benjamin has pointed to the inevitability of re-traumatization, and warns those who would presume that they can therapeutically step into the role of the all good, all containing object, that these efforts are doomed to be an inescapable analytic Appointment in Thebes. We can heal the other, says Benjamin, perhaps directing her remarks most pointedly to Self Psychologists, not by providing what was missing, but by being willing, as the original caregivers were not, to acknowledge our failure to give what was needed, and, as well, to acknowledge our inevitable re-enactments of the original trauma.

This phenomenon was not addressed by Kohut and constitutes in my mind a major theoretical and clinical advance. While Self Psychology, in an effort to remain conceptually consistent and experience near, may continue to eschew a theory of projective identification, it is nevertheless challenged to come to terms with these instances of complementarity. It is undeniably the case that Kohut did not place the inevitability and the individuality of countertransference reactions at the core of his theory in the same way that Relationalists
typically have done. Kohut’s discussion of countertransference was focused on the problem of
the analyst’s intrusion into or interference with the unfolding transference. He spoke of how an
archaic mirroring transference, for example, requires that the analyst tolerate being used as a
selfobject function, serving as an attuned ear, while having to suppress his own urge to make
interpretations so that he can make his presence known, or so that he can feel alive and known in
the process. There is little place for the expression of the analyst’s own subjectivity in this
picture. Likewise, with idealizing transferences, Kohut spoke of what he felt was his own typical
tendency to demur, or to be self-deprecatting, in the face of the patient’s urgent need to
experience him as an extraordinary figure. In Kohut’s vision, the analyst who cannot sustain the
idealization may be vulnerable to potentially shattering the patient’s developmentally necessary
fantasy of the analyst’s omnipotence. Again, on the one hand, Kohut did not speak of the need
for the analyst to utilize his own emotional reactions in the service of staying attuned to the
patient’s subjectivity, in the way that has become commonplace in Relationality. But on the
other hand, perhaps Kohut’s emphasis on the dangers of analytic narcissism, the analyst’s
temptation to assert his own identity at the expense of the patient’s needs, and the analyst’s
desire to employ and display the full range of his interpretive skills, regardless of the patient’s
more urgent need for quiet attunement, can offer a useful corrective to those for whom the
imperative for authenticity threatens to justify lapses of empathy.

Another important Relational concept quite absent from Kohut’s Self Psychology, but
one that might possibly provide a useful alternative listening stance within the armamentarium of
the Relational Self Psychologist, is reverie, a concept that Thomas Ogden has brought vividly to
the literature, most specifically in his 2004 paper, The Analytic Third. Here Ogden presented
detailed clinical material describing how he “relies heavily on his Reverie experiences to
recognize and verbally symbolize what is occurring in the analytic relationship at an unconscious level” (p.). Ogden described very clearly and in detail the use he makes of his own reverie as he listens to his patient’s free associations, moving into his own associational world and staying there for much of the reported session, allowing the unconscious subjective communication between the analyst and his patient to occur, and only at times removing himself from himself to check into what was happening for his patient, and finally offering his patient the understanding he gleaned from what he conceptualizes as the unconscious intersubjective communication that emerged between them. Ogden begins the 2004 paper by describing himself realizing, as his patient speaks to him, that he, Ogden, is looking at an envelope that had been on his desk for several days, noticing for the first time indications that the letter had been part of a bulk mailing, and feeling disappointed that it wasn’t the confidential communication he had thought it to be, and further, that he was feeling suspicious about the genuineness of the intimacy that he had felt to be present between himself and his correspondent. Continuing his reverie, he associates to, among other things, Charlotte’s Web, Wilbur, and Templeton, wondering what these and other of his later associations described in detail (e.g., his car, the closing time of the garage where his car is housed, his fear that he will get there too late and will hence be abandoned, left without transportation) have to do with what is going on unconsciously between the patient (who had gone right on associating) and himself. The paper is a wonderfully close and articulate portrayal of Ogden’s experience of, and utilization of, reverie, making, ultimately, a most convincing connection between his own musing being the unconscious intersubjective connections between his patient and himself, what Ogden calls the analytic third. Ogden then offers an interpretation to the patient, which is confirmed first in the session, and then further confirmed the next day by
a dream the patient had had the night before. This is a compelling demonstration of another way of listening, one that is in striking contrast to Kohut’s Empathic introspective mode.

While Ogden is trusting that his apparently random private associations derived within the context of his patient’s verbal associations will yield insights into the unconscious intersubjective connections between himself and his patient, Kohut is trusting that his stance of listening empathically in an effort to enter into the conscious subjective experience of his patient, deliberately willing that his own subjectivity remain in abeyance, will yield insight into the patient’s inner world of subjective experience (see the earlier discussion of Mr. Z). The differences between these two approaches, then, involve first, one analyst’s (Kohut’s) attempt to place in the background his own subjective experience while focusing on that of his patient, and the other (Ogden’s) attempt to place in the foreground his own private associations while backgrounding those of his patient; and second, one analyst’s (Kohut’s) focus on the patient’s conscious subjectivity and the other analyst’s (Ogden’s) focus on the unconscious intersubjectivity between himself and his patient. In my view, each approach requires some measure of faith and confidence in a particular form of therapeutic action, and the differences are fascinating. Each has value, obviously, and no one method can provide the truth of experience, either subjective or intersubjective. Kohut’s original version of empathy as vicarious introspection maintains, from a systems perspective, the illusion of separateness, privacy, and internality of the patient’s (and the analyst’s) subjective world. Ogden may be credited with taking the interdependence of the self and selfobject milieu to its logical conclusion in a systems model, allowing himself, in reverie, to dissolve our ordinary bounded sense of inside and outside, self and other. However, it seems to me that the therapeutic validity of the analyst’s reverie must always return to and be grounded in empathy. That is, the relevance of the analyst’s unconscious

Commented [RH12]: Can you clarify this – what was the interpretation? How was it confirmed? How did it relate to the reverie? This seems like an important way of solidifying the example.
musings must ultimately feel relevant to the patient, not just the analyst, and can only be validated by the patient’s feeling of being more deeply understood and connected than he had been before.

Benjamin’s (2004, 2009) elaborations on the analytic third seem to offer other, more experience-near, modes of attunement than Ogden’s reverie.

Kohut focused on self-disordered patients for whom empathic inquiry was itself sufficient to re-establish the selfobject experience. Benjamin, however, has expanded Self Psychology’s concept of the narcissistic injury and fragmentation potential in the self disordered patient, specifically describing the breakdown of dyads into complementary roles of doer and done to. For Benjamin, the restoration of the self, particularly in the case of trauma, must go hand in hand with the restoration of a sense of a lawful world and co-creation of a moral third beyond complementarity. From a Relational Self Psychology perspective, I can see versions of the third as potential expansions of selfobject function, restoring self cohesion in the aftermath of fragmenting trauma. It is a fruitful conceptual interface wherein attunement, mutuality, and recognition have the potential to enrich and expand our understanding of empathy and the process of healing and repair.

**Seventh: Psychoanalysis is a Developmental Process: Systems Sensibility**

The understanding of psychoanalysis as a developmental process, which was Kohut’s significant original contribution, is facilitated by assimilating a systems sensibility wherein the self-selfobject matrix is perceived as a dynamic system. The overall functioning and stability of a system can be perturbed—and restored—from many directions, and the forces that re-stabilize a system do not necessarily have any direct relation to those that originally perturbed it. A lump of clay wobbling on a potter’s wheel can be stabilized and shaped by the potter’s hands in many
different ways and positions, none of which simply reverse the initial forces that shaped the wobbly lump. Likewise, the restorative function of empathy is not in any way a simple one-for-one replacement of a missing experience of parental attunement, nor does the therapist strive to achieve a corrective emotional experience that presumes to supply the love the patient had failed to receive in childhood.

A systems approach to self-development also has important implications for how the role of psychopharmacology is envisioned. It has sometimes been suggested that a response to, say, anti-depressants prove that the depression was really chemically or was biologically based all along, while depressive symptoms that respond to psychotherapy are thus shown to have been merely psychological in origin. These assumptions seem misguided on a number of counts. Since we are not mind-body dualists, all psychological phenomena may be describable in the more experience-near language of subjectivity, or in the more experience-distant language of neuroscience. That is, it may be more useful to describe a phenomenon at one level of discourse than at another, but one level of discourse is no truer than the other. Furthermore, the elements of a given system combine in such a way that the properties that emerge are not predictable from the nature of the original elements themselves. The subjective experience of the self is just an emergent property, one that has eluded any reduction to its neurological substrates. In psychoanalytic complexity (Coburn, 2014) terms, the self is incompressible.

From a systems point of view, just as I can say that what stabilizes a system has no necessary connection to what originally perturbed it, so, too, it is impossible to predict in advance the perturbations or permutations that may evolve from within a complex system. One’s mood may change in response to either feeling understood or taking Prozac. Moods are the subjective manifestation of a complex system of interactions at many levels, and
psychoanalysis need not cede any ground to neuroscience as *deeper* or more discerning of what’s *really* going on. Nor, on the other hand, should psychoanalysis attempt to remain aloof from neuroscientific findings. Kohut’s concept of compensatory structure legitimizes the psychoanalytic treatment of so-called *biologically-based* conditions such as schizophrenia, manic depression, or major depression, in the face of the opposing contention that such conditions result from flaws in brain chemistry and therefore can only be appropriately treated by psychopharmacology. But, on the other hand, love may simply not be enough.

**Conclusion**

In this rather free-flowing essay, I have argued that a Contemporary, Relational Self Psychology informed, for example, by dynamic systems theory, attachment theory, infant research and other relational theories, offers a fully relational model of the mind, of transference phenomena, and of therapeutic action. Kohut’s concepts of self, selfobject function, selfobject transference, and the vicissitudes of disruption and repair provide a basis for furthering current understanding of intersubjective systems theory. Furthermore, empathy, correctly understood, and augmented by Relational theory’s contribution of the importance of making an impact on the other, allows the alternative of an experience-near re-conceptualization of phenomena otherwise only explained by experience-distant metapsychological theories of internal objects and projective identification. Moreover, Kohut’s developmental model allows for the smooth integration into psychoanalysis of the findings of experience-near infant research and attachment theory. His conception of holistically functioning, cohesive self experience provides a way for imagining those aspects of person that function as a *container* for multiple dissociated or conflicting self states. Finally, I want to express my conviction that, just as Relationality has offered invaluable enrichment to Self Psychology (potentially the expansion into Relational Self

Commented [RH14]: Why not use the most currently accepted terms – bipolar disorder and major depressive disorder?
Psychology), Self Psychology, both in its original and in its expanded forms, may provide vital enhancement for Relationality. Most important, Relational Self Psychology and Relationality can now be recognized not as competing theories, but as complementary expressions of the larger Relational sensibility.