Blurring the Boundaries between Contemporary Psychoanalytic Theories:
Does the New Research Bring an End to Our Old Beloved Distinctions?

Those of you who saw Tony Kushner’s play *Angels in America* may remember a scene in which a character asks, “How do people change?”

And the answer comes back:
“It’s not very nice. God splits the skin with a jagged thumbnail from throat to belly … plunges a filthy hand in … grabs hold of your bloody tubes and … pulls ’til all your innards are yanked out and the pain! We can’t even talk about that …” (cited in Teicholz, 1996).

So how can that ugly description of change have anything to do with my topic today? – my topic concerning the theoretical blurring of boundaries among contemporary psychoanalytic paradigms?

Well, we’re always looking for ways to work with our patients that will bring change to their lives, but without the jagged thumbnails and without the filthy hands. And although my experience has been that psychotherapy often does engender pain, more or less in keeping with the pain suffered during the patient’s initial development, we still try to make the treatment no more painful than it absolutely has to be, for our patients and ourselves.

Since the theory we use to guide us can make a difference in this, let’s look at what’s happening in psychoanalytic theory today. The concepts I’ll be discussing will be familiar but I hope I’ll be putting them together in ways that can guide us at the more difficult or painful moments in the work with our patients.

Over the past 30 years the cumulative findings of empirical research from diverse academic disciplines have engendered what I would call a peaceful revolution in psychoanalytic theory and practice (Teicholz, 2012). The research has come from the fields of cognitive and developmental psychology; from attachment and trauma theorists; from infant-caregiver observation; and from neuroscience providing new understanding of the implicit and explicit memory systems (Renn, 2012).
What’s funny is that neither Relational analysis nor Self Psychology initially welcomed these scientific studies (Teicholz, 2009). Kohut (1977) insisted that psychoanalysis should be defined by what we can learn from empathy alone, empathy understood as a complex, cognitive-affective and dialogic process. Relational analysts rejected empirical findings on the basis of a postmodern questioning of traditional views of truth and reality (Hoffman, 1991, 1992; Aron, 1996; Teicholz, 1999)). Both Self Psychologists and Relational analysts now seek the elusive, co-created and hard-won truths that can emerge only from direct intersubjective experience (Stolorow, Brandchaft & Atwood, 1987; Beebe & Lachmann, 1988a, 1988b; Lachmann & Beebe, 1996b; Hoffman, 1998; Teicholz, 2012). In the 20th century, scientific findings were often mis-used to pathologize those who didn’t fit the statistical norms; so today’s analysts prefer intersubjective truths that are unique to the individuals or dyads who wrestle with them and not necessarily generalizable to the lives of others.

But strangely, the new science supports a postmodern view of both inner and outer realities. Our earlier expectations of lock-step developmental stages have given way to recognition that there’s far greater diversity than we once thought in the pace, paths and outcomes of how human beings grow and give expression to their unique individualities. From infant observation and attachment research as well as from neuroscience there’s evidence for constant influence between interacting individuals whether these are infant-caregiver or patient-analyst pairs. This bi-directionality of influence (Beebe, 2005) lends a degree of unpredictability to psychic process throwing into question everything we thought we knew about human development while highlighting the “soft-assembly” (Harris, 2009) aspects of our individual personalities as much as the universal in human experience.

Additionally the historical differences between theories are dissolving as the research supports the tenets and clinical recommendations of Relational analysis and a contemporary Self Psychology coinciding with Intersubjective Nonlinear Dynamic Systems Theory as depicted by Lichtenberg, Lachmann, Fosshage (1996) and others. Until recently the competing theories were seen as alternative ways to conceptualize human development and change. But the new research suggests that all contemporary theories have gotten
many things right, altogether providing a more comprehensive view of development and clinical process.

Even with some of the past differences among contemporary theories (Teicholz, 1998, 1999) we could see self and relationship as an endless feedback loop of lived experience, with relationship creating selves and selves creating relationships. Kohut’s (1971, 1977, 1984) concept of self was often misunderstood to signify a singular and bounded entity. But his concept of selfobject left no doubt that in his mind the self was a complex, fluid, permeable and ever-changing process, evolving only in interaction with others. Kohut’s self-selfobject system was in constant flux, shifting among multiple self-states under the influence of relational engagement. Thus all contemporary theories as well as neuroscience see the self as originally constituted and constantly revised through intersubjective processes. In the relational context of individual development, affective exchanges between self and other contribute to psychic structure as well as to brain function and chemistry (Schore, 2003a, 2003b).

In other words self and relationship are just two sides of the same co-constructed coin, with affect the predominant organizing (or dis-organizing) experience in their emergence (Bucci, 2001). Bucci (2001) writes that based on repeated interactions with caregivers the self becomes organized and is constituted by memory structures forged through emotional experience. This is the neuroscientist’s rendering of Kohut’s self-selfobject relationship (1971, 1977, 1984) or of Stolorow, Brandchaft and Atwood’s (1987) intersubjectivity. It also comes close to describing what Winnicott (1960) meant when he wrote that there’s no such thing as a baby: there’s only a baby with a caregiver.

Neurobiologists now confirm these views by conceptualizing the self as an open system, continuously forming larger and more complex systems in interaction with others (Sander, 2002; Tronick, 2007). It’s because the self develops only in intimate exchange with another, and because minds are permeable, fluid and ever-changing that psychotherapy, involving as it does an emotionally intimate relationship between two people, can engender psychic change. We now understand that tiny changes in any part of a system can set into motion a
multiplying series of intertwining and unpredictable changes throughout the entire system, most of them un-chartable.

But at the same time that we recognize the un-chart-ability of far-reaching changes in dyadic systems, each psychoanalytic theory continues to privilege specific desired outcomes in its clinical treatments. One of *Self Psychology*’s primary treatment goals is to strengthen the patient’s sense of self through the integration of previously split-off experience a process believed to be facilitated by attuned engagement in the therapeutic dyad (Kohut, 1971). The failure of such integration, often a dissociative response to earlier trauma (Kohut & Seitz, 1963), can contribute to an unbearable sense of isolation triggering enactment of the split-off experiences in the form of self-destructive or violent behaviors as described by Paul Renn in 2012. But Renn also suggests that certain *kinds* of therapeutic interactions can foster integration, such as for example in treatment the repeated elaboration of the earlier traumatic experiences where they are often relived but can also be shared, witnessed and modulated. Relational analysis and contemporary Self Psychology alike center their treatments on the development of a more complex, multifaceted and integrated sense of self through such interactions over time, with an increasing capacity for intimate relatedness and therefore diminished isolation, fragility and explosiveness (Kohut, 1984; Mitchell, 1993, 1997; Teicholz, 1999; Renn, 2012).

Thus far I’ve been highlighting areas of *agreement* among contemporary theories, all supported by the latest research. But of course there have been areas of *disagreement* as well; and one way to look at the disagreements is in terms of their differential focus on two intertwined kinds of intersubjectivity, namely the mutuality of *regulation* in Self Psychology (Lachmann & Beebe, 1996b) and the mutuality of *recognition* in Relational theory (Benjamin, 1988, 1990).

In Relational theory recognition refers to appreciation for the unique psychic life or mind in both self and other. This capacity is called “intersubjective relatedness” in the writings of both Stern (1985) and Ogden (1992) and intersubjective relatedness is a psychic achievement quite compatible with Kohut’s (1984) ultimate goal of treatment, the opening of pathways to mutual empathy. With empathy each individual *does* recognize the unique
mind of the other but with an emphasis on mutual sharing, understanding and resonance rather than on conflict or difference. By contrast Relational analysts, in their privileging of mutual recognition and difference over regulation and attunement (Benjamin, 1988; Mitchell, 1997) have tended to see the negotiation of interpersonal conflict as more central to psychic growth than do most Self Psychologists.

These sometimes contrasting theoretical emphases -- on regulation and attunement in Self Psychology versus on recognition, difference and conflict in Relational Analysis -- have had consequences for the clinical approaches in the two theories as well. Self Psychologists see the analyst’s affective resonance or her empathic understanding as enhancing the patient’s capacities for self and mutual affect regulation as well as increasing the patient’s access to previously split-off experience which can then be integrated and interactively engaged. The greater emphasis among Relational theorists has been on the analyst’s expression of her disjunctive subjectivity (Slochower, 1996) which requires the negotiation of difference or conflict and highlights the analyst’s unconscious participation in enactments as an ongoing aspect of treatment. But Davies (2006) suggests that interpretation of such enactments can open new windows to the patient’s unconscious seeming thus to place less emphasis on how the analyst’s unconscious contributes to what gets enacted in the treatment (Mitchell, 1997; Aron, 1996; Renik, 1998).

Self Psychologists similarly acknowledge enactments but tend more to search for their own contribution unconscious or otherwise, especially when the patient feels hurt by that contribution. Usually, only after acknowledging the here-and-now injury in the treatment relationship does a Self Psychologist seek to link the patient’s current feelings of hurt to childhood experiences in which similar affects may have been evoked.

But all theories are evolving today with, I think the new research tending to bring the formerly divergent theories into closer alignment. For instance Benjamin in 2004 began to argue for what was earlier a uniquely Self Psychological approach, namely that the analyst take explicit responsibility for how she has unintentionally hurt the patient (Kohut, 1971, 1977, 1982, 1984). And currently, all contemporary theorists seem to embrace Kohut’s
(1984) concept of disruption and repair now one of Lachmann and Beebe’s (1994) three principles of salience in infant-caregiver interaction.

In fact there are many authors today who might argue for both affective attunement and authentic self-expression on the part of the analyst, conceivably fostering recognition and regulation. And let’s not forget that the phrase “mutual regulation” always refers to mutual affect regulation. Decades of infant-caregiver research now suggest that affect regulation plays a major role in human development, for instance with all three of Lachmann and Beebe’s principles of salience directly or indirectly involving affective experience and its regulation. I’m sure you’re familiar with these principles but I’ll repeat them just for the purpose of highlighting the common thread of affect regulation running through all of them: 1) ongoing regulation, referring to repeated interactions that over time create an affective holding environment eventually internalized by the patient; 2) heightened affective moments, referring to points of more intense emotional engagement between patient and analyst; and 3) disruption and repair, in which mutual affect attunement is repeatedly ruptured but with the attunement reliably restored to its previous or even improved levels.

In Self Psychology it’s through mutual attunement that affective regulation is achieved. But research has found that the optimal degree of attunement does not coincide with perfect affective tracking. (This is from Beebe, Lachmann, & Jaffe, 1997). Rather it coincides with mutual affective tracking somewhere in the middle zone. Thus the most secure children turn out to have enjoyed only moderate attunement while the least secure have often grown up in caregiving dyads marked either by neglect or by relentless emotional tracking. Fonagy, Gergely, Jurist & Target (2002) also imply there might be developmental gains in moderate attunement, through their notion of “markedness” (308-314). In marking the caregiver responds to the infant’s facial expressions, sounds, and gestures with only approximate or slightly exaggerated mimicry rather than with exact imitations. I think these interactions “mark” the caregiver as affectively attuned but also as distinct from the infant producing a complex experience I see as compatible with both Self Psychological attunement and Relational difference.
In keeping with this “both-and” approach to attunement-and-difference, Lachmann’s initial focus on affect attunement (Lachmann & Beebe, 1996b) has more recently been matched in his work by an equal emphasis on spontaneity, surprise, and humor, these latter qualities being seen as no less facilitative of human development than attunement (Lachmann, 2000, 2008). Still, whereas for Relational analysts, spontaneity and humor are valued primarily as pathways to differentiation and recognition (Hoffman, 1998; Benjamin, 1988, 1990, 1995, 2004; Mitchell, 1993, 1997) in Lachmann’s (2000, 2008) work they’re valued for fostering a sense of intimacy, which while potentially including recognition can also contribute to affect regulation. In particular Lachmann sees these relational qualities – of spontaneity, surprise and humor - as having the potential to enliven the patient affectively or to enhance self-esteem and mood, all of these outcomes connected more with affect regulation than with recognition. I have argued elsewhere that all of Kohut’s selfobject functions -- mirroring, twinship and idealization – involve both regulation and recognition (Teicholz, 2006; 2009).

In fact affect regulation has now become a major focus of infant-caregiver research as well as a central feature in the neuro-scientific study of the brain, such as in the work of Bucci (1997, 2007, 2011) and Schore (2003a, 2003b, 2011). Given the importance now attributed to affect regulation from so many viewpoints it makes sense that renewed psychoanalytic interest in trauma, defined as the experience of overwhelming and unprocessed affect, cuts across all contemporary theories. By definition the affect accompanying trauma cannot be regulated because of its excessive intensity in relation to the strength of the psyche under attack. Trauma, in other words, is any emotional experience that cannot be psychically contained but only enacted or dissociated.

The human psyche has an evolved capacity (Slavin & Kriegman, 1992) to dissociate or split-off from conscious awareness the un-digestible experiences of trauma. Such splitting can preserve at least a modicum of functioning in realms of living not directly associated with the original trauma. Thus Kohut (1971), Tolpin (2005), and Bucci (2011) have all highlighted the adaptive aspects of splitting even while acknowledging the extent to which it can interfere with the individual’s psychic life and relationships. In fact Kohut’s (1971)
emphasis on *psychic cohesion* was directly related to his observation that dissociation and fragmentation were ubiquitous, mostly to detrimental effect. He saw splitting as a universal response to inescapable childhood trauma either acute or cumulative (Kohut & Seitz, 1963). In his view trauma was part of the human condition, and dissociation a near-universal response to it. But he also believed that repeated experiences of relational attunement and empathy could foster *healing* of these traumatically induced splits or wounds (Kohut, 1982, 1984).

Looking at trauma and dissociation from an *Interpersonal* viewpoint, Bromberg (1980) suggests there’s a *dialectic between empathy and anxiety*. I think what Bromberg means by this is that patient and therapist move *between* the patient’s anxiety and the therapist’s calming empathy, a viewpoint quite compatible with Kohut’s (1971) idea concerning cycles of disruption and repair (although Bromberg does not acknowledge this compatibility).

Davies and Frawley’s (1992) concern with trauma-and-dissociation led to their groundbreaking work on the psychic ramifications of childhood sexual abuse and its impact on transference/countertransference in treatment. So all these authors acknowledge multiple dissociated self-states (Kohut & Seitz, 1963; Bromberg, 1996; Davies, 1997, 1998) and all seek a process through which analytic treatment might bring the rigidly split-off states back into mutual exchange with the individual’s more abiding sense of self toward greater fluidity, complexity and wholeness.

In any event we see that most contemporary models of treatment include the goal of helping patients toward a better integration of painful experiences that were earlier dissociated. Such integration enables patients to go forward in life with greater access to, and therefore better guided by the *feelings* that constitute their affective worlds. Most importantly, in the therapeutic dialogue these feelings are registered *directly* between patient and therapist and according to Lyons-Ruth (1999) need not be “translated” into explicit or symbolic language in order to have a therapeutic effect. But beyond the direct experience, feelings may *also* be given verbal expression and linked to their triggers in the here and now as well as to their origins in early childhood experience. Such linking between
past and present, or between feelings and their contexts can serve to deepen and amplify the here-and-now affective experience and enhance the patient’s sense of wholeness, continuity or resilience.

The dyadic back-and-forth *exchanges* of affect in treatment, with or without words tend to expand and *complexify* the patient’s psychic experience contributing to what most of us today think of as a *two-person unconscious* (Lyons-Ruth, 1999), an enriched reservoir of unconscious experience we can draw on in our daily living whether alone or in the presence of others. As Tronick (2007) tells us, the brain is an open biological system which like all other biological systems moves toward both complexity and cohesion. These *dual* developmental goals, of cohesion and complexity resonate with aspects of both Self Psychology and Relational Psychoanalysis as do our intertwining experiences throughout life of regulation and recognition. Meanwhile Relational analysts and Self Psychologists alike view the therapist as an optimally-engaged partner responding to the patient with an admixture of attunement and authentic self-expression, even though sometimes privileging one of these modes of engagement over the other based on a *conscious* understanding of the patient’s momentary needs and capacities. But of course the therapist is also constantly acting on the basis of *non*-consciously perceived (and non-consciously communicated) self-states in both patient and analyst. Thus *implicit* as well as explicit exchanges between patient and analyst create an incessant back-and-forth of mutual influence at emotional, procedural, pre-symbolic and right-brain levels (Bucci, 1997, 2011; BCPSG, 1998, 2002; Lyons-Ruth, 1999; Beebe, 2005), all of these, modes of experience in which we now know that much of our psychic growth and healing occur.

Today most of us see ongoing regulation and mutual attunement – *including* their inescapable ruptures and repairs -- as the fundamental building blocks of subjecthood, along with repeated opportunities for authentic relational engagement in which heightened affect is shared and difference negotiated. In these interactions each partner contributes to the very substance of the other’s mind, always to some degree open to expansion and revision.
Furthermore neuroscientists have recently discovered mirror neurons (Decety & Jackson, 2006) that become activated soon after birth, suggesting an inborn capacity to register even at the level of neurological firing the feelings and intentions of others. Within days of birth this “empathy” in the neurological domain is matched at the behavioral level as infants engage in mutual mimicry with their caregivers, readily exchanging imitative gestural, postural, and facial expressions as well as sounds. Trevarthen (2005) sees these active mimicking behaviors in infants as forerunners to empathy and playfulness as well as to the later exploration of unique psychic worlds in self and other. These findings suggest that early forms of empathy operate almost from the start of life but that for optimal development they must be met by matching expressions of empathy from the human environment. Only then can they evolve into more mature forms of affective resonance and understanding that include recognition and appreciation for the distinct and unique subjectivity of others.

With each developmental step forward the infant may feel exhilarated by her newfound capacities but may also be rendered more vulnerable during these successive transitional periods. At such times a transient increase in empathy from the environment enables the infant to consolidate any still-shaky developmental achievements and makes it possible for the child to go on to meet the next set of challenges (Kohut & Seitz, 1963; Stern, 1985). Similar vulnerabilities may arise in adults at times of disequilibrium in the psychoanalytic change process, with transient increases in empathy required in these later contexts as well.

In addition to the now proven benefits of empathic meetings of minds, attachment theorists have identified a certain kind of interchange between infants and their caregivers that they see as essential for later secure attachment. They call these exchanges “collaborative communication” (Lyons-Ruth, 1999, p. 591) by which they mean an interchange marked by openness and inclusion. What collaborative communication includes is the mutual expression of the full range of human emotion both positive and negative. And, because of its inclusion of genuine affective expressiveness in an attuned context I would suggest that Lyons-Ruth’s collaborative communication encompasses both
the mutual attunement of Self Psychology and the expressive authenticity of Relational analysis.

We now have probably a broad consensus concerning the necessity of mutual attunement in early development to foster an individual’s healthy psychic progression. But we also have both Stern (1985) and Ogden (1992) arguing for recognition of “mind” in self and other with Benjamin (1988) adding an emphasis on difference. We have Lichtenberg’s (1989) aversive motivations as well as Lachmann and Beebe’s (1996) heightened affective moments and Boston Change Process Study Group’s (1998) now moments. We have Lachmann’s (2000) systems-perturbations and his violations of expectations as well as Bromberg’s safe surprises (2009). Each one of these concepts suggests a rationale now confirmed by science for the judicious but authentic expression of the analyst’s disjunctive subjectivity while she keeps in mind the therapeutic purpose and context of the spontaneous exchange -- and while also keeping in mind that in all these theories it’s either stated or assumed that in order to promote psychic growth, the experience of authentic relational engagement must occur in a dyad where a bond of empathic understanding and affective resonance is already well-established and will be established again and again after its inevitably repeated losses.

In fact whether we look at the formerly competing theories in terms of their different stances on empathy versus authenticity, in terms of our interminable discussions concerning attunement versus the negotiation of conflict, or in terms of a once but no longer forced-choice between cohesion and multiplicity – we realize that none of these contrasting emphases ever had to be seen as mutually exclusive. The best analytic writers have always acknowledged that the clinical focus will shift responsively among the various approaches from one patient to the next as well during the course of any given analysis (Teicholz, 1999).

Beebe (2005) has broken down for us some of the more abstract psychoanalytic concepts with her micro-analysis of relational interactions. Schore (2011) helps us understand at the level of interacting biochemical, hormonal, and neuronal functions what in the past we conceptualized primarily in psychological terms. Other new findings from
neuroscience surprisingly emphasize our need for a cohesive sense of self in the face of an otherwise overwhelming multiplicity. Rotenberg (2004) writes of what he calls the creative right-brain function of integrating past, present and future thus linking the notions of creativity and integration which were not so long ago seen almost as opposites by postmodern analyst who tended to celebrate chaos and even fragmentation over integration and cohesion. Now neurobiologists such as Rotenberg (2004), Schore (2011) and Siegel (1999, 2003) all write of the need for a cohesive autobiographical narrative in order to forge a cohesive sense of self, the latter having become a marker of mental health in the views of these neuroscientists as well as in Kohut’s longstanding view (1971, 1977, 1984).

Lyons-Ruth (1999) even describes research suggesting that the capacity in prospective parents to create a cohesive autobiographical narrative for themselves is predictive of their future child’s security of attachment. Inversely, prospective parents whose autobiographical narratives are less cohesive tend to have children who are psychically disorganized and less securely attached. Findings such as these underscore the asymmetry that prevails in spite of the bi-directionality of infant-parent and patient-analyst influence (Lachmann & Beebe, 1996b; Aron, 1996; Lyons-Ruth, 1999).

Lyons-Ruth shines further light on this power-differential through her concept of “scaffolding” (p. 583). In scaffolding, she says, the “developmentally advantaged” partner lends strength and function to the “developmentally less advantaged” (p. 583). Thus while the processes between the infant/caregiver and patient/analyst dyads are not identical, today’s researchers are united in emphasizing the similarities more than the differences between initial developmental processes and later psychic change. Mitchell (1988) long ago questioned “the developmental tilt” (p. 136) that he saw in Winnicott’s and Kohut’s writings. He problematized it. But today’s neuroscientists and infant-caregiver researchers argue that the interactive processes -- their sensory, affective and synaptic registrations; their influences on the brain’s chemistry as well as on psychic development -- are similar, regardless of the age or developmental level of the partners.

We earlier mentioned that postmodern theorists initially rejected scientific empiricism, in part because the “authority” of the research findings suggested universalities that
became constricting of human freedom, or became destructively prescriptive for sub-
groups that did not “fit in” (Teicholz, 1999, 2009). But the new research presents a view of
reality that coincides with what postmodern theory itself would lead us to expect: namely
we find a psychological world in which nothing is fixed or bounded and in which any
relational truth we arrive at -- the only kind of truth we can know -- has been co-created
through our mutual participation in the intersubjective contexts of our interactions with
others, including the interactions between patients and their analysts.

I’ll suggest one example in which different theories might produce similar clinical
results, such as for instance the emergence of mutually regulated affect in the therapeutic
dyad. In their clinical writings Interpersonalists such as Bromberg and Ehrenberg have
described sharing with a patient some unexpected feeling that has arisen in the therapist
himself, asking the patient whether he’s aware of anything in his own experience that might
relate to the therapist’s feeling. Such a question can be asked in a compassionate, respectful
and modulated way, conveying interest and caring for the patient’s well-being. The
question could conceivably invite collaborative dialogue and could be felt by the patient as
an expression of empathy or a genuine desire in the therapist to understand. Such an
interpersonal exchange might therefore set mutual regulation in motion between patient
and therapist even while the contemporary Self Psychologist might invite collaborative
dialogue differently, for instance through silent affective resonance or through complex
statements of affirmation and empathic understanding. It’s possible that both these
approaches whatever their differences do engage the patient in an ongoing regulatory
communication in the affective realm.

One other way to look at the different emphases among contemporary theories may
take us back at least to Winnicott in 1955 with his insistence on “clinical varieties of
transference” (p.295). Referring to our earliest experiences Winnicott distinguished
between two kinds of “environmental adaptation to [the infant’s] need,” one kind “good
enough” (p. 296) in his view, the other not. When the environmental adaptation to the
infant’s need has not been good enough, Winnicott says, there develops only “a pseudo-self,
which is [nothing more than] a collection of innumerable reactions to a succession of
failures of adaptation” to the infant on the part of the human environment. What Winnicott calls the pseudo-self Kohut might’ve called primitive selfobject relating, and today we might call a failure in the emergence of subjecthood or subjectivity.

So I’m wondering whether the historical differences in emphasis, especially between the more traditional Self Psychologists at one pole and the more Interpersonally-leaning Relationalists at the other, when looked at as a spectrum of responses might present us with a full range of distinctive but essential stances to be used selectively depending on the current state of the patient’s subjecthood but also on whether or not it seems the patient might’ve suffered significant failures of environmental adaptation in his primary caregiving relationships – what Schore (2002) as well as Cortina and Liotti (2010) have called early relational trauma.

With patients whose trauma was milder or occurred later, and who therefore have achieved a more solid sense of self as well as intersubjective relatedness (Stern, 1985; Ogden, 1992; Teicholz, 2001) we can often rely on what may seem a more Relational or Interpersonal approach, an approach in which the two partners – each a robust subject in her own right -- can more spontaneously share their experiences with each other in exchanges where difference, aversive-ness and even conflict can be explored and negotiated toward the mutual expansion of their shared psychic experience.

But of course when the patient’s sense of self or subjecthood has remained very fragile and is more vulnerable to fragmentation, a more Kohutian approach may be required, especially in the earlier phases of a treatment. This latter approach is one in which the analyst for the most part just immerses herself in the patient’s experience and tries to stay there -- or as close to there as she possibly can without invoking Fosshage’s (1995) recommended oscillation between different listening stances.

This renewed argument, for staying within the patient’s experience in some cases, is given striking support by Schore (2002) as well as by Cortina and Liotti (2010) – all these authors writing from a neurobiological perspective. They tell us emphatically that subjectivity, subjecthood or the self does not develop in individuals who have suffered early relational trauma. Subjecthood cannot develop, they say, in individuals whose primary caregiving
relationships were characterized by disorganized rather than secure attachment and whose lifelong experience was therefore marked by a lack of secure attachment. In these cases the more usual intersubjective interests and capacities -- such as curiosity about one’s own affective life or that of others – are absent and the therapist’s efforts toward more sustained empathic immersion is often the only way to begin trying to connect, an effort that is sure to be a lengthy, difficult and even painful process.

Thus, how we work with each patient, and which aspects of our own experience we draw on as analysts is going to be very different depending on the relational experiences that the individual patient has had growing up, and the timing of those experiences. If as analysts we offer up our alterity, or if we make observations as an “outside other” to a patient hanging on to a mere thread of her own subjectivity, we should not be surprised to find fragments of that patient’s psyche on our office floor (to speak metaphorically for a moment). Meanwhile if we offer only empathic immersion in relation to a patient with a more robust sense of self -- a patient with a subjecthood she can take much more for granted -- that patient may push for more from us and we are likely spontaneously to respond. In fact if we have a varied practice with a broad range of patients I think we are likely to make use of all contemporary psychoanalytic theories and their emphases over time. Our way of working will likely cover a wide range of interactions and many different kinds of stances and messages, not only across our practice as a whole but in the work we do with each patient at different times and different situations in their lives (Teicholz, 2006). For all these reasons I feel that arguments about the relative benefits of different contemporary theories, unless they’re referring to a specific clinical and relational context, are potentially futile or even harmful.

One more thing though, before I end this monologue: I truly believe, and I think you do too that as therapists we can be warm, engaged and genuine with all of our patients regardless of their early history or current problems. Warmth, engagement and authenticity are qualities of relating (Teicholz, 2006) that can imbue any communication and should probably infuse everything we do in our work.
Thus the distinction I’m making here is not between being generally warm and affectively expressive versus being cold and inexpressive. The question is rather whether or not we’re going to directly involve the patient in any affective difficulties we might be having as therapists while trying to process the emotional fallout from their trauma as it gets expressed in our relationships with them. In other words I’m grappling with the question of whether -- if we’re annoyed, angry, shocked, or despairing in response to a patient -- are we going to take these feelings up with the patient directly? Or are we going to try to use those feelings of ours in some other way?

For instance let’s think about a patient who as a child suffered relational trauma in his primary caregiving relationship. And now he quite understandably keeps all people, including his analyst at a distance by relentlessly demeaning and attacking them. So, if I am his analyst should I point his behavior out to him and tell him how it makes me feel? -- i.e., diminished, frustrated, hurt, resentful, angry? Or might I be more helpful by trying to make sense with him of the attacking behavior in the context of his early experience? Will the treatment and the patient’s life go better if I let him know, however tactfully, how destructive his behavior is? Or might things go better if I am as accepting and patient as I can be in response to this behavior that has caused him nothing but pain and loss in his life outside the transference as well as in. Making sense of feelings and behavior usually involves a complex, multifaceted and deep understanding of the circumstances under which the behavior first emerged as well as an understanding of the other options that were open to the individual -- or not -- at that time. I have found that when I am able deeply to arrive at such understanding, then my feelings of anger, shock or despair tend to resolve. And when I can share this kind of understanding with the patient it seems to modify the feelings in him as well. I believe such an understanding can only be reached through a stance from within the patient’s experience. Usually when I’m stuck in painful feelings with a patient for too long it’s a red flag announcing to me that I have thus far failed to achieve the necessary understanding. But I would also add that any spontaneous interchanges -- any humor and improvisational interaction we can engender in the therapeutic dyad on the way
to such understanding -- can serve important affect-regulatory functions even while signaling that we’re already part-way to our goal.

I think when we have created a safe enough environment for a long enough time in the therapeutic relationship -- when we have accompanied and witnessed the patient in his original relational trauma as it has been relived in the treatment situation, but without blaming the patient for the trauma’s ramifications in his life and relationships, and without ourselves remaining traumatized -- when we have repeatedly interacted with the patient in his states of high alarm or inconsolable grief but have been able to mirror these states, ourselves expressing them with slightly less intensity and toxicity than how they were given to us, then the patient may begin to experience his own affect with slightly less intensity and toxicity as well (Teicholz, 2014). And if this modulating affective trajectory can be sustained over time, then the patient – no longer so terrorized by the feelings related to his trauma -- may no longer have the same need to release the affective pressure he feels in ways that interfere with his own happiness; will no longer have to ward off intimacy in the old off-putting ways. By that time of course, any interpersonal feedback from me, or any confrontation would be entirely superfluous.

This is my personal understanding of the findings from the most recent research in neuroscience and infant-caregiver observation. And I offer it up for your consideration, your acceptance or your argument against it.

Reference List


Psychoanal. Psychol., 5:305-337.


Judy Guss Teicholz: “Blurring the Boundaries Between Contemporary Theories”


Judy Guss Teicholz: “Blurring the Boundaries Between Contemporary Theories”


Tronick, E. (2007). *The Neurobehavioral and Social-Emotional Development of Infants*
Judy Guss Teicholz: “Blurring the Boundaries Between Contemporary Theories”


Judy Teicholz
Cambridge, MA