Transcending Interactional Tension: Commentary on Steven Stern’s “Needed Relationships”

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Steven Stern has proposed an integration of what Mitchell (1988) has labeled the relational-conflict perspective (Stern's Paradigm I) and the developmental-arrest perspective (Stern's Paradigm II). Although his undertaking is a laudable effort in which we share an interest (Tansey and Burke, 1989; Burke and Tansey, 1991), we find ourselves in strong disagreement with both the theoretical and technical implications underlying his argument. We focus our objections on three main points: his distinctions between “needed” versus “repeated” relational patterns; his extension of the concept of projective identification; and his conceptualization of his “true integration.”

Our clinical experience has led us toward an ever-increasing appreciation for the complexity of the therapeutic exchange and the simultaneity of “needed” and “repeated” dimensions of the therapeutic relationship. Although Stern mentions an “interweaving” in passing several times, fundamental to his argument is a sharp dichotomy between old, pathogenic, inauthentic, repeated therapeutic relationships requiring “mastery” and “transcendence” on the part of the analyst and new, healthy, authentic, needed therapeutic relationships that the therapist must strive to provide. In a clinical example used to illustrate his understanding of the “complex interweaving,” he describes his patient as alternating between an “unappealingly needy and whiny” presentation and one that is “appealingly vulnerable, forthright, and expressive.”

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We argue that in each of these presentations of self, there are both new and old, healthy and
pathogenic, needed and repeated, authentic and inauthentic elements operating simultaneously. Stern suggests that the unappealingly needy side of his patient, with its aversive countertransference impact, must be endured and “narcissistically survived” by the therapist so that the appealing side can be met with warmth. Our task, as we see it, is not so simple. Might not the appealing presentation contain elements of “old,” repetitive, inauthentic compliance? Simply because the therapist responds warmly in no way guarantees the absence of a simultaneous darker (ambivalent) side to this interaction. Similarly, how can we know that the patient's whiny presentation does not contain elements of a “new,” needed, authentic trust in the therapist's reliability and tolerance? Stern's neat dichotomies do not appear to do justice to the complexities of human interaction.

The dichotomy between “needed” and “repeated” aspects of the therapeutic interaction is pivotal to Stern's thesis and his attempt to integrate the two models of therapeutic action. Stern proposes that the therapist is faced with the inevitable challenge of becoming entangled in reenactments with the patient. These “repeated” relational patterns from the patient's past (Stern's Type I Paradigm), if mastered and “transcended” by the therapist in some undefined fashion, provide a platform from which both patient and therapist can more directly address the “needed” elements of the relationship (Stern's Type II Paradigm). By arriving at this second level of needed interaction, Stern argues that the therapist has the opportunity to provide “a different kind of relational connection … necessary to reinitiate psychic growth.”

According to Stern, Type I reenactments are preliminary to the ultimate Type II “underlying relational needs” and “new affective responses” from the analyst. Because existing definitions of projective identification are traditionally associated with the therapist's disruptive, complementary identifications experienced when the therapist and patient have assumed opposing roles in a relational configuration, Stern deems it necessary to create a further dichotomy by proposing a special form of projective identification, Type II, which the patient employs “to elicit needed empathic responses or psychological functions from the therapist as wished-for new object.”

Our major objection to Stern's “true integration” concerns the technical implication that the therapist (and patient) must strive to leapfrog over the interactional tension generated by conflictual enactments to get to the really important matters of the needed relationship. Once this hierarchical emphasis is placed on the therapeutic process, the rush is on to get to the promised land. The vision is of a less ambivalent therapist who is somehow able, all on his own, to “get space from his complementary countertransference,” see through the current conflictual interaction, remember “the traumatized child within the patient,” and “shift to a new affective state.” There is something a bit magical about the expectation that the therapist, once he or she recognizes the needed response, can leave behind the difficult, ambivalent countertransference experience in favor of a conflict-free interaction that the patient has been secretly looking for all along.

In our view, understanding enactments reduces the restrictive influence of old relational patterns
on both participants. The outcome of this process is less entanglement, not necessarily less ambivalence. The therapist's task is not “to transcend this temptation” to speak to the patient from inside the immediate relationship. Within the entanglement lies the power of the therapeutic process. How did the patient and therapist arrive at these positions? What is it like for each to be there? How do they negotiate another way of relating to one another? Stern does not believe that the therapist's often disruptive complementary identifications are the stuff from which empathy can be fashioned. Only concordant identifications, according to Stern, can lead to an empathic appreciation of the patient.

We have spent much effort battling this notion (Tansey and Burke, 1989). We believe that complementary identifications, as well as concordant identifications, can lead to an empathic outcome. Empathy is a process, not a single type of identificatory experience on the part of the therapist. We believe that the therapist's complementary experience (e.g., anger, frustration), if managed well, can potentially lead to “needed,” empathic contact in understanding the patient. The therapist does not have to rush to an emotional position outside or above the immediate interaction to achieve an optimal empathic outcome. The task is to use the emotional information encoded in that immediate role relationship to engage in collaborative inquiry with the patient rather than to feel he has to transcend his disruptive feelings on his own in order to “feed back” empathy to the patient.

Lastly, we argue that Stern's attempt to integrate the relational-conflict and developmental-arrest models is more additive than synthetic. There is an unmistakable parallel between Stern's style of theorizing and his view of the therapeutic process. Stern searches for a way to reduce the inherent tension between the two theoretical paradigms by simply adding them together sequentially in a developmental trajectory (“repeated” followed by “needed”). This bears a striking resemblance to the removal of conflict and ambivalence within and between the participants in his view of the empathic process. For the relational theorist, it is human nature to be highly conflicted about change—even change that, to the outside observer, would seem wholly desirable. This view is fundamentally at odds with the developmental-arrest view that, given a sufficiently empathic environmental response, the patient will seek change with a single-minded purpose. In his heart, Stern appears to accept the latter view, whereas we find that it does not square with our own clinical experience.

References


