Some Key Features in the Evolution of Self Psychology and Psychoanalysis

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Psychoanalysis, as every science and its application, has continued to evolve over the past century, especially accelerating over the last 30 years. Self psychology has played a constitutive role in that evolution and has continued to change itself. These movements have been supported and augmented by a wide range of emergent research and theory, especially that of cognitive psychology, infant and attachment research, rapid eye movement and dream research, psychotherapy research, and neuroscience. I present schematically some of what I consider to be the key features of the evolution of self psychology and their interconnection with that of psychoanalysis at large, including the revolutionary paradigm changes, the new epistemology, listening/experiencing perspectives, from narcissism to the development of the self, the new organization model of transference, the new organization model of dreams, and the implicit and explicit dimensions of analytic work. I conclude with a focus on the radical ongoing extension of the analyst’s participation in the analytic relationship, using, as an example, the co-creation of analytic love, and providing several brief clinical illustrations. The leading edge question guiding my discussion is “How does analytic change occur?”

Key words: self psychology; psychoanalysis; listening perspectives; dreams; transference; epistemology; implicit and explicit dimensions; analyst’s participation; analytic love; relational field theory

Psychoanalysis, as every science and its application, has continued to evolve over the past century, especially accelerating over the last 30 years. So remarkable are the changes that the intrinsic and extrinsic criteria, hallmark features used to define psychoanalysis (Gill, 1984) for most of the 20th century, in my view, are no longer viable in light of our current conceptualizations and understanding of the therapeutic process (Fosshage, 1997a, 2007b). At first conceived to be a unitary theory, psychoanalysis, now reinvigorated, features a pluralism of models that are vastly different in understanding development, pathogenesis, transference, dreams, and therapeutic action. Yet, even with this pluralism of models, there are general movements occurring within the field that reflect fundamental changes in paradigms. These movements have been supported and augmented by a wide range of research and theory, especially that of cognitive psychology, infant and attachment research, rapid eye movement (REM) and dream research, psychotherapy research, and neuroscience. As with any scientific and professional field, the tides of change take time to be absorbed and clinically integrated, and, as that process is occurring, new developments are underway. Change is what keeps a field vital.

The focus of this particular volume is the role and development of the theory of psychoanalytic self psychology in the overall expansion

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of the theory and clinical application of psychoanalysis. Heinz Kohut (1913–1981) was the founder of self psychology (Kohut, 1971, 1977, 1984). As with any psychoanalytic approach, self psychology has continued to evolve and now houses a number of theories. Yet some overarching postulates and sensibilities are fundamental to self psychology.

The authors of these articles have been asked to present our particular self-psychologically informed perspectives on theory and clinical work, emphasizing what has captured our interests and has been particularly useful to us. This, of course, is a task that thoroughness would require a number of books rather than an article. In light of this, I have chosen to present schematically some of what I consider to be the key features of the evolution of self psychology and their interconnection with psychoanalysis at large. To present schematically can be frustrating to the reader for it leaves so many important issues unexplored; yet, it does have its advantages, for it can provide an overall framework that serves as an orienting beacon for integrating detailed material.

For this article, I will briefly delineate the revolutionary paradigm changes and some of their clinical implications that have been taking place in psychoanalysis over the past 35 years, making clear the contributions of self psychology along the way. I have selected those areas that have held particular interest for me as follows: the new epistemology and listening/experiencing perspectives, from narcissism to the development of the self, the new organization model of transference, the new organization model of dreams, and the more recent work on the implicit and explicit dimensions of analytic work. This recent work on the implicit and explicit, in my view, is leading to a better understanding of the fundamental pathways to analytic change. I will then conclude with a focus on the radical ongoing extension of the analyst’s participation in the analytic relationship, using, as an example, the co-creation of analytic love, and providing brief clinical illustrations. The leading-edge question guiding my discussion is “How does analytic change occur?”

The First Paradigm Change: A New Epistemology

While Freud (1915) was well aware that “our perceptions are subjectively conditioned and must not be regarded as identical with that which is perceived” (p. 171), his observations and theories were embedded in the positivistic science of his day and generally emphasized the analyst’s objectivity and the patient’s transference distortions of reality. The revolutionary change in paradigms from positivistic to relativistic science, catalyzed by Heisenberg’s uncertainty principle, made unquestionably clear that the observer affects the observed, both perceptually and interactively. In response to this ongoing paradigm shift, Kohut, first in 1959, updated psychoanalytic epistemology by focusing on its method of observation. Kohut (1982) recognized “the relativity of our perceptions of reality,” “the framework of ordering concepts that shape our observations and explanations” (p. 400), and that “the field that is observed, of necessity, includes the observer” (Kohut, 1984: 41). Gradually emerging was the view that the analytic encounter creates an intersubjective or relational field that involves “the intersection of two subjectivities” (Atwood & Stolorow, 1984), a phrase that accentuates the subjectivity, in contrast to objectivity, of each participant. Deeming the patient’s subjectivity as the principal focus of the analytic endeavor, Kohut (1959, 1982) delineated how our method of observation relies on empathy and vicarious introspection, what he called the “empathic mode of observation,” and designated it as the method by which the field of psychoanalysis itself is defined (Kohut, 1977: 302).1

1Kohut’s (1977) conceptualized psychoanalysis broadly, omitting the more traditional concepts of transference and resistance that he recognized were subject to change: “… psychoanalysis is a psychology of complex mental states which, with the aid of the persevering empathic-introspective immersion of the observer into the inner life of man, gathers its data in order to explain them” (p. 302).
The Second Paradigm Change: Intrapsychic to Relational Field Theory

Throughout the history of psychoanalysis, a running battle has been waged between interpretation/insight and relational experience as focal points for therapeutic action (Fosshage, 2007a). Interpretation/insight gained its preferential momentum from the positivistic science and objectivism of the day that positioned the analyst to become the purveyor of objective “truth,” truth it was thought that the patient’s ego would know how to use to bring about needed psychological change. The subsequent ongoing transition in paradigms from positivistic to relativistic science or from objectivism to constructivism dethroned the analyst from a protected elevated position of objectivity and boldly confronted the analyst with an increasing recognition not only of the influence of the analyst’s subjectivity in constructing interpretations but also of the analyst’s participation in co-creating the analytic relationship.

The first paradigmatic transformation in epistemology catalyzed a second paradigm shift from intrapsychic theory to relational (also called intersubjective or, now, systems) field theory (Atwood & Stolorow, 1984; Mitchell, 1988). Relational field theory posits that psychological development, pathogenesis, transference, and the analytic relationship are not primarily intrapsychically generated but emerge within and are largely shaped (or created) by relational systems. Self psychology, with its emphasis on the self–self/object matrix, was structurally a relational theory that was one contributor to this paradigm change. (While self psychology was structurally a relational theory, because Kohut was coming out of a classical intrapsychic tradition, it took a while for self psychology to become a fully relational theory.) The shift to relational or systems field theory is profound and far reaching (for systems theory see Stolorow, 1997; Coburn, 2002). Take, for example, the genesis of psychopathology. Rather than accounting for psychopathology as primarily intrapsychically generated as classical drive theory did, it is now viewed as primarily generated out of relational experience. Clinically a relational field perspective, in my view, prevents contributing to a “blaming” of the patient for creating their problems. Instead, it helps a patient empathically understand how these problems emerged out of their past relational experience.

In addition, absenting the analyst’s objectivity and revealing the analyst’s participation in co-creating the analytic relationship implicates relational experience to be the crucible of therapeutic action. I (Fosshage, 2005) recently wrote, “So important is the relational interaction that exploratory/interpretive analytic work is best subsumed as one, and only one, aspect of analytic relational experience that itself can only be understood within the context of that experience” (p. 517). A systems or relational field perspective reveals the participation of the analyst and the analyst’s subjectivity more fully in the analytic relationship than, to paraphrase Shakespeare’s Hamlet, “our philosophies ever dreamt possible.”

Listening/Experiencing Perspectives within a Patient/Analyst System

A central analytic task from a constructivist/systems perspective is for the analyst and patient to understand, as best as they can, through a collaborative “spirit of inquiry” (Lichtenberg, Lachmann, & Fosshage, 2002) “Who’s contributing what?” (Fosshage, 1994) to the patient’s and analyst’s respective experiences in the analytic interaction.

The empathic mode of observation refers to a listening perspective designed to understand as best as one can, through affect resonance and vicarious introspection, the analyst’s experience from within the frame of reference of the analysand. In addition to its epistemological significance, Kohut, in formulating the empathic listening stance, brought the
patient’s subjective experience more immediately into focus, a subjective experience that had heretofore been all too commandeered by the analyst’s “objective” point of view. All analysts variably use empathic listening in efforts to understand the analysand’s “experiential world” (Stolorow, Atwood, & Orange, 2002). Self psychologists (Kohut, 1982; Ornstein & Ornstein, 1985, among many others) and Schwaber (1981, 1998) have especially emphasized its consistent or primary usage as the basis of analytic inquiry and understanding, reflecting the asymmetrical focus on the patient.

While conceptualizing the empathic mode of inquiry was a profound breakthrough clinically, in my view it is precisely because of the complexity of the patient and analyst variable contributions to their interaction and the need to participate in different forms of relating that requires us to use other listening/experiencing perspectives, what I call the other-centered and the analyst’s self perspectives (Fosshage, 1995, 1997b, 2003). The other-centered perspective refers to the analyst’s experience of the analysand as “an other” in a relationship with the patient—what it feels like to be the other person. Information garnered from this perspective potentially informs us about how the analysand impacts others, about the analysand’s implicit patterns of relating, and about how the analysand is expansively establishing new ways of relating.

While the empathic and other-centered perspectives are focused on the patient, other occasions require the analyst to be reflective about his own subjective experience from his personal perspective, what I have termed the analyst’s self-perspective (Fosshage, 2003). When, for example, the analysand focuses on and inquires about the analyst’s subjectivity or the analyst’s reactions to the analysand, the analyst needs to reflect on and assess his subjective experience from his own (self) perspective and, at times, share directly his subjective experience to facilitate exploration of who is contributing what to the analysand’s experience as well as to deepen the relational encounter.

During moments of intersubjective relatedness (Benjamin, 1988, 1990; Fosshage, 1997b, 2003; Shane, Shane, & Gales, 1998), juxtaposition of the subjective experience of each can highlight differences and similarities between two subjectivities that can be clarifying as well as growth promoting. Countertransference, more accurately referred to as “the analyst’s experience of the patient” (Fosshage, 1995), may oscillate between as well as involve several of these listening/experiencing perspectives at any one time.

While understanding a patient and a patient’s experience is a central analytic task, this exploratory process from the vantage point of relational field theory is only one, albeit crucially important, aspect of analytic relational experience. Other dimensions of analytic relating will be delineated.

From Narcissism to the Development of the Self

Freud (1914) posited that we are born into a state of primary narcissism in which the libido is cathexed to the ego system. Within this model, the overall developmental direction is to withdraw the libido from the ego system and redirect it toward objects—thus enabling a person to outgrow his narcissism and to become object related. Note that a person is seen as giving up narcissistic or self concerns. It provides a theoretical underpinning for the prevalent social attitude, “Don’t be so concerned about yourself, be concerned about others.”

In marked contrast, Kohut (1971), despite his coming out of a classical analytic background, became convinced on the basis of his clinical experience of the importance of the development of the self as well as the development of object relations and posited a narcissistic line of development separate and distinct from an object relational line of development. In The Restoration of the Self, Kohut (1977), eschewing drive and energy theory, rejected his notion of two separate lines of development and posited instead a
supraordinate theory of the self. He came to believe that the development and maintenance of the self is the central developmental task for all of us. (Kohut’s “self” includes prewired givens, as does Winnicott’s “true self.”) Contemporary self psychology has become more phenomenological so that we now refer to the consolidation and maintenance of a positive cohesive “sense of self.” While a very complex topic, there is considerable evidence of constitutional factors that we need to further delineate and include in our theory; see Fosshage, 2003). In contrast to Freud’s theory of narcissism, self-concerns in Kohut’s self psychology were primary and now legitimized. The social attitude described above, therefore, should be, “Let us tend to your self-concerns and, as you feel better about yourself, you will naturally become more concerned with others.” Loving oneself and others are reciprocally related; each enhances the other.

Kohut posited that development of the self occurs within a self–selfobject matrix. A child needs to be acknowledged and affirmed (mirroring selfobject needs) by a parent or parental surrogates to feel worthwhile and capable. A sense of capability, in turn, promotes ambitions. A child also needs from a parent a sense of protection, security and safety, and parents or parental surrogates who are people that have qualities a child admires and wants to be like, termed idealizing selfobject needs. Selfobject needs mature throughout a lifetime. A child’s idealizing selfobject needs, for example, mature from needing a powerful all-protective parent to a parent who has admirable qualities that become the source for the formation of ideals. In his last book, Kohut (1984) identified twinship to be a selfobject need, that is, an experience of essential likeness, whether it be part of a family community, a nation that vitalizes a sense of self. In contrast to Freud’s positing that the oedipal conflict and intergenerational conflict was prewired and central for all, Kohut claimed that intergenerational support of one’s progeny, not conflict, was the more natural state and that the parental oedipal selfobject responsiveness to the child’s competitive and sexual stirrings during the oedipal phase fostered growth or conflict. The self-psychology model makes clear that we are interdependent with one another throughout our lives. Infant research supports the notion that each person “self-regulates” and “interactively regulates” (Beebe & Lachmann, 2002). Attachment research (Main, 2000) has empirically established how attachment styles and disorders emerge out of early attachment (relational) experiences.

Pathogenesis is understood as involving problematic parental responses that thwart selfobject needs and the development of a positive sense of self, creating, in turn, negative self-feelings and images. The child sacrifices his/her own felt experience and accommodates to the parent’s view in an effort to maintain the attachment and hoped for selfobject tie. The term selfobject was subsequently redefined from a phenomenological perspective as a (self) vitalizing experience that enables us to address a greater range of experience, including solitary as well as relational experience (Lichtenberg, 1991; Lichtenberg, Lachmann, & Fosshage, 1992). Essentially we are referring to vitalizing and devitalizing experiences, a dimension of experience that is crucially important for the development and maintenance of a positive thriving sense of self.

Motivational theory, in my view, is central to any personality theory and serves as the theoretical fulcrum around which all else emanates. Jung was the first to posit a primary motivation of self-actualization (which always experientially felt right to me). Kohut postulated, as well, a fundamental striving to develop, to grow—a striving “to realize its [the self’s] nuclear program in the course of its life span” (Kohut, 1984: 42). In contrast to a model where the clinical focus is exclusively on posited omnipresent conflict and defense (ego psychology and modern conflict theory) or solely on repetitive pathological patterns, a focus that, when it becomes too singular, a patient can experience all too easily as critical and undermining, a clinical eye on and recognition of developmental
strivings, what self psychologists call the leading or forward edge of the patient’s communications (Miller, 1985; Tolpin, 2002), tends to fortify a patient’s developmental efforts—a clinical contribution of great import. A patient will experience the analyst as aligning himself with the patient’s efforts to grow. For example, behavior that can be framed as self-focused or narcissistically demanding, an infantile narcissistic omnipotence that the patient must renounce, can be understood as a patient’s efforts to get what one needs, efforts that are fortified to overcome negative expectancies based on past experience (for a fuller description of Kohut’s theory, including the concept of self and pathogenesis, see Fosshage, 1992, 2003).

Lichtenberg (1989) has subsequently developed a more particularized motivational systems model involving five basic needs and innate response patterns and their emergence within relational experience to become functional or dysfunctional motivational systems. They include psychological regulation of physiological needs, attachment/affiliation, sensuality/sexuality, exploration and assertion, and aversion. This model provides a more detailed understanding of shifting motivational priorities and has served as a centerpiece for developing guidelines for understanding and responding in the clinical situation (Lichtenberg, Lachmann, & Fosshage, 1992, 1996, 2002).

Transference

Transference is one of the pivotal, yet most controversial and changing, concepts in psychoanalysis today. Transformation of the concept emanates in large measure from the paradigm transitions from objectivism to constructivism and from intrapsychic to relational field theory.

Freud’s model of transference refers to the transfer or displacement of feelings, wishes, and attitudes related to infantile objects onto later objects, especially onto the analyst (Loewald, 1960). If transference emanates from the patient and “distorts” the patient’s perception of the analyst, then it follows clinically that the maintenance of anonymity, neutrality, and a blank screen best positions the analyst to avoid muddying the waters and to reflect back the analysand’s displacements and projections—an elegant intrapsychic model.

The emergent model of transference, what I call the organization model, centers on the ongoing perceptual–cognitive–affective organization of our lives. A number of psychoanalysts (Wachtel, 1980; Gill, 1982; Hoffman, 1983, 1991; Stolorow & Lachmann, 1984/85; Fosshage, 1994; Lichtenberg, Lachmann, & Fosshage, 1996), integrating cognitive psychology, have focused on the formation of the predominant ways in which we have come to see ourselves and ourselves in relation to others. What has become central are these affect-laden, thematic, organizing processes, emergent from lived experience, that variably shape our experience through the use of four affective/cognitive processes: (1) expectancies, (2) selective attention, (3) attribution of meaning, and (4) interpersonal construction (Fosshage, 1994). Within this model, transference refers “to the primary organizing patterns or schemas with which the analysand constructs and assimilates his or her experience of the analytic relationship” (Fosshage, 1994: 271).

Many, if not most, contemporary psychoanalytic authors within the various relational approaches are in the process of transitioning into this new model of transference, ferreting out its implications. All relational analysts, using the term broadly, note and work with the patient’s repetitive organizations or constructions (Stolorow & Lachmann, 1984/85). A patient’s problematic expectancies (Lichtenberg, Lachmann, & Fosshage, 1996), established on the basis of past experience, tend to pull analyst and patient into repetitive vortices of interaction—what I call repetitive enactments. To explore and understand the meanings of the repetitive interaction serves to extricate patient and analyst from its grip and implicitly creates new
experience. Some American relational authors, Bromberg (1998) for example, believe that new experience only emerges through the analysis of repetitive enactments.

In self psychology a second selfobject dimension or class of transferences, however, is identified, which refer to a patient’s seeking needed selfobject experience. Thus, an analyst experiences a second type of interactive pull, the selfobject pull that involves a patient’s hoped-for expectancies to create with the analyst needed, growth-promoting, vitalizing experience—what I call vitalizing enactments (Fosshage, 1994, 1995). Not only must an analyst hear and understand what a patient is developmentally seeking but an analyst must also be sufficiently available to participate in co-creating the needed vitalizing experience (what Kohut, in 1977, called empathic responsiveness). While other relational psychoanalysts outside of self psychology have increasingly delineated the “new beginning” (Balint, 1968) and the curative impact of new relational experience, their emphases in addressing analytic change has tilted toward the exploratory extrication from repetitive enactments. In my view, the difference in emphases between contemporary self psychologists and other contemporary relational analysts is squarely anchored in motivational theory. Self psychologists, to reiterate, emphasize strivings to grow, to develop, to actualize. Other relational analysts tend not to address motivational theory in keeping with the postmodern antipathy to the consideration of human “essences.” As for all analysts, however, motivational assumptions are implicitly operative in their work and tend to coalesce around attachment strivings. Ghent (1990), an exception among American relational authors in addressing motivation, initially in 1990 posited a “central object-seeking motivation” (p. 110). Subsequently in a paper published posthumously, however, he posited two fundamental motivations, one for safety and the other for expansion (Ghent, 2002: 799), the latter corresponding more closely with the self-psychological view.

The analyst, thus, variably experiences two types of interactive pull from the patient: to engage with the patient in constructing familiar, repetitive, problematic interactions and to engage with the patient in creating the hoped-for vitalizing experiences. The term enactment, thus, must be expanded to include the repetitive as well as the growth-promoting vitalizing experiences.

Identification of what a patient is striving for, in my view, is one of the most significant clinical contributions of self psychology. To highlight the leading edge of the material, implicitly aligning with the patient’s strivings, facilitates psychological growth and the therapeutic process. In essence, we need to analyze the repetitive pull while at the same time be sufficiently available and responsive to the selfobject pull to enable patient and analyst to co-create needed vitalizing experience—two pathways to analytic change.

Among a number of centrally important clinical implications of the organization model of transference are issues related to ubiquity of transferential focus and transference/extratransference. Traditional clinical notions that all transferences must be brought into the analytic relationship and that clinical material must be understood as referring directly or indirectly to the transference are based on assumptions from the intrapsychic model of transference and potentially create a noxiously dominating analyst-centric climate. Within the organizing model of transference, it is understood that patient and analyst variably co-contribute to the patient’s experience of the analytic relationship. To assume and expect that all transferential themes will emerge in the analytic relationship negates the analyst’s contribution. Each analyst will affect the transference differently. It is quite possible that a particular analyst might not directly elicit all of a patient’s primary problematic organizing patterns or will not become as embroiled in some of the repetitive pulls. Some of the repetitive themes might be more powerfully addressed in so-called extratransferential relationships. Even
more important, to assume that extra-analytic material refers directly to the analytic relationship can easily blur differential experiences and inadvertently rivet the patient to the particular activated transference themes. If transference is defined, as Gill (1982) did, as the patient’s experience of the analytic relationship, then all of a patient’s communications within the analytic setting by definition have transference meaning. To solve this conundrum, I (Fosshage, 1994) have proposed that “the meaning . . . may not be related to the content but to the process of communicating” (p. 276). For example, when a patient is describing a shame-ridden abusive experience, most likely the patient is not experiencing the analyst as abusive at that moment (i.e., interpreting the content as applicable to the transference) but is experiencing the analyst as sufficiently safe and protective to be able to communicate the painful experience (that is, interpreting the process of communicating as having the transference meaning).

To continue to use the term transference provides continuity in our field; yet, it does not capture the organization model. While organizing patterns are established on the basis of past experience, they are not transferred but remain as an active, ongoing perceptual/organizing process. In addition, the core process of organizing activity in the new model precludes a categorical distinction between transference and nontransference, for both involve organizing processing. Organizing activity, instead, varies along a number of dimensions, for example, frequency of activation, accessibility to consciousness, and devitalizing to vitalizing. The term transference, as a categorical distinction, tends to connote perceptual distortion that, in turn, invalidates a patient’s perception and closes off inquiry as to the sources of the patient’s perception. Identifying organizing patterns opens up the process to find and explore the cues selectively attended to and the attribution of particular meanings. The cues attended to implicate the analyst’s participation. The analyst’s acknowledgment provides implicit validation that, in turn, lowers a patient’s aversiveness and opens up more reflective space for assessing the patient’s and analyst’s various contributions.

**Organizing Functions of Dreaming**

Kohut (1977) discovered what he called a self-state dream, a dream that serves the function of restoring and bolstering the self when the self is in the threat of fragmentation or dissolution. Importantly, he felt that this function was manifestly evident in the dream and that associations did not lead away from that function—a significant contribution to the dream literature. Anchored in his classical beginnings, however, Kohut accepted that all other dreams fit the classical model in which the manifest/latent content distinction is central. Self psychology, thus, was in need of a new model that better reflected its phenomenological perspective. Before I became immersed in self psychology, I had developed a new phenomenologically based dream model first published in 1983. Some theoreticians (Ornstein, 1987) attempted to stretch the concept of self-state dream to be all encompassing while at the same time adopting my model as a self-psychological model. More importantly, considerable change has been occurring in our understanding of dreaming. I refer to my model as the organization model of dreams, which I will briefly describe (several portions of the dream section have been previously published in Fosshage, 1997c, 2000).

Dream mentation, a process that occurs during sleep, centrally functions, as waking mentation does, to process information. When we dream, we use variably dual modes of cognition—the imagistic (sensory-dominated) mode and the verbal mode (Pavio, 1971, 2007; Fosshage, 1983, 1997c; Bucci, 1985, 1994). These modes appear in dreams in the form of sensory images and spoken and unspoken words. Just as words are placed in a logical coherent order to shape meaning and cognitive focus, so too are images sequentially ordered
to express meaning and to further affective
cognitive processing (Fosshage, 1983). Sensory
images tend to evoke more affect (see Epstein,
1994, for a review), which clarifies why dreams
(especially REM dreams that are more imagina-
tively dominated compared to non-REM
[NREM] dreams) can be so emotionally pow-
erful. Although contemporary dream models
differ, the view of dreams as centrally process-
ing information is, I believe, an increasingly convergent perspective evolving out of dream
and psychophysiological research, contemporary psychoanalytic theory, cognitive psychol-
ogy, and clinical work.

I refer to my particular model as the organi-
zation model of dreams because the core process
and function of dreaming is to organize data.
I posit, more specifically, that dream men-
tation, like waking mentation, develops, main-
tains, and restores psychological organization
and regulates affect (Fosshage, 1983, 1997c). In
its variable use of imagistic and verbal modes
of mentation during REM and NREM cycles,
dreaming, like waking mentation, ranges from
elemental cognition (e.g., momentary replay of
an event) to the most highly complex forms of
mentation (e.g., efforts at complex emotional
as well as intellectual problem solving). I will
briefly delineate this model (a more complete
description, including clinical guidelines, can
be found in Fosshage, 1983, 1987, 1988, 1989,
1997c; Lichtenberg, Lachmann, & Fosshage,
1996).

Dream Functions

Dream mentation, like waking mentation,
can contribute to the development of psycho-
logical organization through the creation or
consolidation of a new solution or synthesis. In
contributing to development, new perceptual
angles and new percepts of self and other may
emerge. New ways of behaving and new rela-
tional scenarios may be imagistically portrayed.
Dream mentation, in addition, often continues
the unconscious and conscious waking efforts
at conflict resolution.

Dreaming, like waking mentation, can serve
to maintain and restore psychological organi-
sation and self-cohesion. Maintenance refers to
the modulation and continuation of ongoing
psychological organization, whereas restoration
addresses a more severe state of psychological
disorganization. Regulation of affect
(Kramer, 1993) in these dreams is central. When we have insufficiently expressed our
anger and aversiveness in reaction to a per-
ceived threat during the day, for example, we
may attempt to set the situation right (self-
righting) in our dreams through expression of
anger (regulating affect) and restoration of self-
equilibrium.

In dream mentation, as in waking menta-
tion, we use (and reveal) our primary pat-
terns of organizing experience. Images of
self, other, and self-with-other are intricately
portrayed. Dream mentation, like waking
mentation, can reinforce or transform these
patterns.

Our dream efforts to develop, maintain, or
restore psychological organization vary in their
efficacy, and affects are central in assessing these
efforts. The nightmare, for example, reveals a
poignantly unsuccessful attempt to cope with
a high-anxiety-producing stimulus or conflict.
In addition, the dreamer's overall motivational
aims may conflict. For example, developmental
strivings may conflict with strivings to maintain
familiar psychological organization and corre-
sponding attachment patterns. Consider, for
example, someone who returns in a dream to
a disempowered victimized position that is fa-
miliar and habitual but at a considerable cost
in terms of vitality.

Dream Content

Freud's (1900, 1923) distinction between
manifest-latent content, pivotal in his model,
is based on drive theory in which the latent
drive impulses or infantile wishes are disguised
and transformed into the manifest dream in
order to preserve sleep. Eschewing drive and
energy theory, however, makes it no longer
theoretically necessary to posit the ubiquity of defensive or disguising operations in dream formation (Fosshage, 1983, 1987). Although the postulation that all dreams involve a defensive (disguising) transformation of the underlying latent content is unique to the classical model, differentiating it from all other dream models, the manifest-latent distinction is deeply embedded in psychoanalysis (as well as in our culture) in interpreting dreams, resulting in ubiquitous translations of dream imagery. Unfortunately, these translations typically increase the analyst’s influence, at the expense of the dreamer and the dream experience, in understanding dreams.

In my view, dreams directly reveal—through affects, metaphors, and themes—the dreamer’s immediate concerns. Developmental, organizing, and regulatory processes are all directly (manifestly) observable in the dream structure (Fosshage, 1983). Rather than positing a manifest and latent content distinction, assuming a priori that disguising transformation is ubiquitous during dream formation, I use the term dream content (Fosshage, 1983, 1987). In my view, dream images are chosen primarily not for the purposes of disguise but for their evocative power and actual usefulness in thinking imagistically about the issue at hand, much as a waking person selects words to further the process of thinking meaningfully about internal concerns.

In eschewing the manifest-latent distinction and positing that dream content is directly revelatory, I am not suggesting that dream meanings are readily apparent. Dreams are often elusive and difficult to understand. Their elusiveness, in my view, is related to six factors: poor dream recall; lack of clarity in the dreaming process itself; metaphorical nature of the dream (Ullman, 1969); difficulty in understanding the meanings of images from a waking perspective; difficulty making sense when juxtaposing two different (i.e., waking and sleeping) mentational states; and a less than optimally facilitative intersubjective context in which the dream is told and explored.

Dream images need to be assessed for what they reveal, metaphorically and thematically, not for what they conceal. With this emphasis, each dream image, as used within the context of the dream scenario, can be appreciated better for what it conveys. For example, the “I” in the dream identifies the dreamer and the object images represent the dreamer’s images of the other. Not assuming that object images are projections of the dreamer’s self gives us access to the dreamer’s images of others, self-with-others, and important relational patterns. Exploration may reveal that aspects of the dreamer are projected onto the other; yet eschewing the common assumption that object representations are self-representations enables us to illuminate the patient’s self-with-other relational patterns as well as the aspects of the self projected onto the other.

Clinical Guidelines

From today’s perspective, we recognize that patient and analyst variably co-contribute to understanding the patient’s dreams. Clearly, we wish to maximize the influence of the dreaming experience itself in arriving at a co-constructed understanding. To this end, I suggest five guidelines for analytically working with dreams.

The first guideline is to listen as closely as possible to the patient’s experience within the dream.

Analytic inquiry is initially aimed to fill out the dreamer’s experience within the dream—the second guideline. I might ask, for example, “What were you feeling when that occurred in the dream?” “What were you experiencing?” Inquiry into the dreamer’s experience facilitates the dreamer’s involvement and affective reconnection with the dream experience. This focus on the dreamer’s experience implicitly validates its importance and increases the dreamer’s conviction about its meaningfulness.

Dream imagery is not to be translated or seen as standing for something else but is to be understood metaphorically and thematically—the third guideline. When dreaming is viewed
as an integrative and synthetic mentalational process, the task is to illuminate more fully, through the dreamer’s associations and elaborations, the particular meaning of an image as it is used within the context of the dream. Each image is like a word within a sentence, and sequences of images are like sentences and paragraphs that tell a story. The image can be understood fully only as it is used within the dream context, for the context shapes the meaning.

Affect-laden images of self, other, self-with-other, and relational scenarios can all be identified. The overall drama from beginning to end has immense communicative power about the dreamer’s innermost struggles and strivings. Once the dream’s scenarios are identified, our analytic task shifts to identifying (when unclear) if, where, and when these themes have emerged in waking life or how they are connected to waking experience—the fourth guideline.

As a fifth guideline, I never assume that the content of the dream directly relates to the transference unless the analyst appears in the dream or the dreamer immediately associates to the analyst. Otherwise, the process of communicating the dream to the analyst—rather than the content—most likely carries the transference meaning. In analyzing a dream, relational patterns emergent in the dream need first to be identified and subsequently to be connected by the patient to waking life. If we sense that one of these patterns is occurring in the analytic relationship as well, even though the patient has not mentioned it, we can simply inquire, “I wonder if you are experiencing that here too?” The transference, in the sense of applying the content of the dream to the analytic relationship, can thus be addressed without translating dream imagery and without minimizing the patient’s dream or associated experience involving relationships outside the analytic relationship.

This phenomenologically grounded approach to dreams elaborates and validates the dreamer’s experience and, therefore, enhances conviction as to the meaning of the dream. This approach helps to empower the dreamer to turn to his/her own dream experience for understanding the meaning of the dream rather than relying on the analyst’s interpretive translations.

**Implicit and Explicit Domains of Learning, Memory, and Knowledge**

Most cognitive science models differentiate between two, at times three, memory systems (Epstein, 1994). I will focus on those models that differentiate between two domains of learning and memory—implicit/nondeclarative and explicit/declarative. These memory systems differ in type of information processed, principles of operation, and neurological structures, and, yet, often more than one system is involved in performing particular tasks (Schacter & Tulving, 1994). Whereas the explicit/declarative memory system involves the processing of information that an individual can consciously recall and “declare to remember” (Davis, 2001: 451), the implicit/nondeclarative memory system involves the processing of information typically outside an individual’s awareness, does not require focal attention for encoding, and, therefore, is less accessible to conscious recall. The implicit/nondeclarative system includes several memory systems, one of which is called procedural memory. While explorations of implicit procedural memory was first applied to behavioral sequences—for example, riding a bike, playing tennis—beginning in the early 1990s, applicability of the implicit memory system was extended to include social learning, specifically to learned patterns of relating (Clyman, 1991; Grigsby & Hartlaub, 1994). The Boston Change Process Study Group (2005; Stern et al., 1998) has delineated how learning at an implicit level of awareness, called “implicit relational knowing,” is psychoanalytically changed.

A person’s senses of self and others are derived from past, present, and anticipated future lived experience, with past experience
“housed,” if you will, within the implicit and explicit memory systems (Foschage, 2005). Implicit mental models affect explicit memory, and explicit memory cues evoke implicit memories. The concept implicit mental models, emerging out of experimental research in cognitive psychology, converges with the neuroscience concept of neural memory networks or maps (Foschage, 2005). With the integration of cognitive psychology into psychoanalysis, it is not surprising that these concepts resonate closely with a number of psychoanalytic terms—for example, internal working models (Bowlby, 1973), principles or patterns of organization (Wachtel, 1980; Stolorow & Lachmann, 1984/85; Foschage, 1994; Sander, 1997), pathogenic beliefs (Weiss & Sampson, 1986), mental representations (Fonagy, 1993); expectancies (Lichtenberg, Lachmann, & Foschage, 1996), and, now, implicit relational knowing (Stern et al., 1999).

While the “implicit and explicit dance” (Foschage, 2004) in the psychoanalytic arena is extremely complex and far from clear, we know that implicit procedural learning occurs through relational processes often out of awareness and explicit/declarative learning occurs through the more traditional psychoanalytic emphasis on exploration and expanded awareness. Our understanding of implicit procedural learning and memory highlights the fundamental importance of ongoing relational experience within the psychoanalytic encounter, much of which may never see the light of day in terms of explicit analytic focus. The fact that new procedures of relating are learned in the analytic relationship and are central to therapeutic change implicates the magnitude of the analyst’s participation and the importance of the analyst’s explicit and implicit procedural relational knowing and capacity for intimacy.

The current cutting-edge focus is on assessing how implicit and explicit processing and memory are interconnected (Stern et al., 1998; Lyons-Ruth, 1999; Boston Change Process Study Group, 2005; Foschage, 2005). An issue pivotal for the consideration of therapeutic action centers on the potential accessibility of implicit learning to consciousness. Implicit relational knowing that is not accessible to consciousness can only be changed through new implicit relational learning that either gradually transforms previous implicit knowing or establishes new implicit mental models that become more dominant to offset earlier established models. Stern, Lyons-Ruth, and their colleagues have focused on and are delineating this avenue of change. New implicit relational learning corresponds with Loewald’s (1960) emphasis on new object experience and Kohut’s (1984) noting that ongoing selfobject experience creates change.

Clinical evidence suggests, however, that implicit procedural knowledge varies with regard to access to consciousness. Implicit procedural learning that, for example, begins with an explicit/declarative focus, gradually established as procedural memory appears to be more available to consciousness in spite of the fact that it functions at a nonconscious level of awareness. Exploratory/interpretive focus on this type of implicit procedure, for example, a negative self-percept, can contribute to its suspension or deactivation, facilitating the establishment of a new self-percept based on new implicit and explicit relational experience.

To summarize, two basic change processes involving implicit procedures and explicit attitudes, in my view, occur in the psychoanalytic encounter. In some instances implicit relational procedures never see “the light of day” (i.e., conscious awareness is never brought about through an exploratory process) and are gradually altered, by accommodation or diminished activation, through repetitive, new, implicit, relational experience. In contrast, when implicit mental models are potentially accessible to consciousness, the “spirit of inquiry” (Lichtenberg, Lachmann, & Foschage, 2002) illuminates both the autobiographical scenarios of the implicit memory system and the mental models of the implicit memory system that contribute to a
sense of self and self-with-other. This process, explicitly and implicitly, over time increases reflective capacity that enables a patient to deactivate or suspend the older implicit and explicit organizing patterns so that new implicit and explicit models based on current relational experience can be gradually established in both memory systems for lasting change. The foreground and background shifts that comprise the dance between the implicit and explicit systems provide an important key to understanding and facilitating the psychoanalytic process (Fosshage, 2005).

**The Analyst’s Participation**

Contemporary analysts of the various relational approaches have been expanding the view of the analyst’s participation to include the complex subjectivities of both participants and to expand the range of the analyst’s participation.


Contemporary interpersonalists and American relationists have contributed substantially to expanding the expression and revelation of the analyst’s subjectivity in the analytic encounter (Fosshage, 2003). Ehrenberg (1992), an interpersonalist, describes “the intimate edge” of the analytic encounter. Amongst the relationists, Renik (1998) describes the new position of the analyst as “getting real.” Aron (1996) invites an analysand to be curious about the analyst’s subjectivity. Benjamin (1988, 1990) emphasizes that the mutual recognition of separate subjectivities can be growth promoting. Hoffman (1998) speaks of those moments when the analyst “throws the book away” and responds in a highly personal way.

In the expansion of the analyst’s participation, we recognize that anything we do verbally or nonverbally, consciously or unconsciously, is a communication and reveals something about us. We now struggle about what consciously to self-disclose, what to communicate in an effort to facilitate an analysand’s development (Bacal, 1998; Lichtenberg, Lachman, & Fosshage, 2002). As an example of this expansion and as a final topic, I now turn briefly to the issue of love in the analytic relationship.

**To Love and To Be Loved**

To love and to be loved is central in developing and maintaining vitalizing self-experience (portions of this section were borrowed from Fosshage, 2007c). To love and to feel love involves a deep empathic knowing, liking, respect for, and caring. With various shadings, nuances, and emotional valences, love experience ranges from parental love, to caregiver’s love, to friendship love, to romantic love.

**The Analysand’s Love of the Analyst**

From the beginning psychoanalysts have attempted to unravel the nature of the analysand’s love of the analyst. Whereas Freud (1915) thought that the analysand’s transference love was anchored in perceptions and feelings of the previous caretakers, he then added that this is true in “every state of being in love” (p. 168), diminishing the difference and the possibility of distinguishing between mature healthy love and neurotic transference-based love.
If to give and receive love is central to development and maintenance of vitality, then its emergence in the analytic relationship is not surprising and needs to be welcomed and understood. Loving experience in the analytic relationship always has its forerunners, and our task is to illuminate, for the purpose of gaining freedom, those implicit and explicit patterns that constrict and encumber the vitalizing experience of loving.

The Analyst’s Participation in Mutual Expressions of Love

Beginning with Freud and Ferenczi, a battle has been waged between those who have been wary about and those who have emphasized the analyst’s love for the patient as central to therapeutic action (Shaw, 2003). Even more controversial has been the analyst’s expression of love for the patient with understandable concerns about seduction and exploitation of the patient for the analyst’s needs. Loewald (1960), however, spoke eloquently in likening the analyst’s position to a parental role in that the parent out of “love and respect for the individual and for individual development” (p. 229) helps to foster the child’s growth.

As for any analytic participation, whether expressive or silent, dangers exist. In mutual expression of giving and receiving love, the dangers, in my view, are essentially twofold in nature: (1) the analyst’s needs for love take priority over the patient’s welfare and (2) the analyst is unavailable to co-create the developmentally needed loving experiences. Let me share some of my personal experience as an analyst in the clinical situation.

While my natural inclination as a psychoanalyst has been to participate more fully, to be more open, and to be less anonymous than the classical model and my classical training would have had it, I, nevertheless, have struggled over the years to extricate myself further from what I consider to be constricting remnants of my training. This was certainly true in the late 1980s when I became increasingly frustrated in finding a way to respond to patients who, during especially mutually touching and poignant moments, would genuinely express “I love you.” To accept a patient’s feelings with simply a note of acknowledgement felt, to me, to be an unsatisfactory, nonparticipatory, and nonfacilitating response. To remain interpretively focused asymmetrically on the patient and the patient’s capacity to love likewise extricated me from the interaction, diminishing the importance and emotional potency of the relational experience for both the patient and myself. To use different, less revealing, less intense, less risky words, like “fondness” or “liking,” on these occasions to convey how I felt toward the patient, even though I experienced love for the patient, did not feel authentic or reciprocal and felt undermining of the mutuality of the moment. I remember the day in 1990 when, at the end of a deeply emotionally touching session, my patient at the door said genuinely, “I love you.” Feeling strongly the same toward her, I responded simply, “I love you too.” I closed the door, and the traditional analytic models came crashing down in my head. I thought to myself, “What have I done now? Was I seductive? Was I sexualizing the relationship? Did I lose my analytic position?” I consoled myself, noting that it was a mutually genuine exchange, a moment of mutual love that, in this instance, did not feel particularly erotic, an experience, I felt, that would be especially helpful for this patient to build new percepts of herself and self-with-other. For the patient it so happened that this moment became one nodal experience of loving and feeling loved, thus validating its importance and making it transformative for me as well.

From today’s perspective might our exchange be viewed as a poignant “moment of meeting” (Stern et al., 1998)? In this moment two human beings emotionally touch one another and, in this instance, express their love and caring for one another—not expected as part of the traditional analytic role but now potentially legitimizied by contemporary
psychoanalysis through the increased recognition of the importance of relational experience and implicit procedural learning in analytic work.

Multiple variables, of course, enter into the consideration of the analyst's reciprocating expressions of love—including ages, genders, sexual orientations, emotional moment, and the many meanings and comfort level that expressions of love can have for each member of the dyad. Crucially important in these mutual encounters is that the analyst is authentic (Frank, 1999), that is, the analyst is in touch with and speaking on the basis of their affective experience.

A question that usually comes to the fore quickly in discussions of this topic is, "What if the analyst is not feeling love even though the patient has expressed his or her love?" In my view, if an analyst does not feel reciprocal love on these occasions, then he or she, of course, cannot express it and remain authentically engaged, centrally important in analytic interaction.

I illustrate with a brief clinical vignette. Sometime ago a person began analytic treatment with me saying that she had heard me speak, liked it, and had followed my presentations for the last 12 years. She had found herself on occasion even getting angry with me during those 12 years for not greeting her and, finally, realized that I did not know her. When she told me that she had had a relationship with me for the past 12 years, I responded, "I am sorry that I had missed out." After 3 months of analytic work, she caught me totally by surprise when at the door she said, "You know, Jim, I love you." I spontaneously threw my arms up in surprise and exclaimed, "What so fast?" I could not believe that she loved me so quickly. But then it came to me and I added, "Oh you have 12 years on me. I need a little time to catch up." Each of us had been "true" to ourselves. This experience set the stage so that the patient could more readily believe me down the line when I one day was able to reciprocate and tell her that I loved her.

Conclusion

I have focused schematically on a number of topics to delineate the remarkable change that is occurring in psychoanalysis at large in which self psychology has played an important constitutive role. I have also attempted to convey some of the ongoing change that is occurring within self psychology, currently a major psychoanalytic approach. The topics I chose were the new epistemology, listening/experiencing perspectives, from narcissism to the development of the self, the new organization model of transference, the new organization model of dreams, recent work on the implicit and explicit dimensions of analytic work, and the ongoing extension of the analyst's participation in the analytic relationship. While I recognize that I have presented these important topics all too schematically, I hope that I have conveyed something of the substantial changes that are occurring within self psychology and psychoanalysis, enough to stir interest in the reader to pursue some of these topics further.

Conflicts of Interest

The author declares no conflicts of interest.

References


