III

APPLICATIONS TO THERAPEUTIC MODLITIES

6

Toward a More Optimal Selfobject Milieu: An Intersubjective, Self Psychological Approach to Family Treatment

Carla Leone, PhD

Acknowledgments: I would like to thank James Sands, PhD, Diana Beliard, PhD, and especially Jill Gardner, PhD, for their support and helpful comments on previous drafts of this paper.

Portions of this chapter were previously published in the *Journal of Clinical Social Work*, vol. 29, pp. 269–289, and are reprinted here with permission of the publisher, Springer Science and Business Media.

INTRODUCTION

The emphasis in contemporary psychoanalytic theory on the contexts in which experience emerges and is co-created leads naturally to a greater focus on the quality of patients' primary relationships. In the treatment of children and adolescents, this means increased recognition of the importance of family work as a crucial component of the treatment.

Yet conjoint work can be a daunting task, especially for those used to the relative safety and predictability of individual treatment—and those whose psychoanalytic training did not include training in conjoint modalities. Working with two adults in couples therapy can be difficult enough, but family work involves people of very different ages, roles, and developmental levels. "Can I really hold all those people well enough?" the therapist/analyst may worry. "What if they mistreat each other and I can't stop it?" These and other concerns can understandably lead psychoanalytically trained clinicians to avoid or underutilize parent-child or larger family conjoint modalities.

Contemporary self psychology and intersubjective systems theory (Stolorow & Atwood, 1992) provide a theoretical framework that can "hold" the therapist as she struggles with the multiple demands and challenges of family treatment. The concepts of selfobject experience, affect attunement, and optimal responsiveness (Bacal, 1998) add to our understanding of what family members of all ages need from each other emotionally—and what they may need from their family therapist as well. Self psychological views of narcissistic injury, aggression, and defensiveness (Kohut, 1972, 1984) also make the theory particularly applicable to the treatment of troubled relationships, which frequently involve one or more of these.

The concept of experience as co-created and emergent from an intersubjective field (Stolorow & Atwood, 1992) draws the therapist's attention to the complex verbal and nonverbal, conscious and unconscious influences on family interactions. Increased awareness of the unique unconscious organizing processes that affect subjective experience and behavior and of the processes of reciprocal mutual influence that comprise interactions help us better understand why family members experience each other and interact with each other as they do. This framework can also shed light on our own responses to patients and their families.

From this theoretical framework comes a treatment approach designed to help family members function as a more optimal source of selfobject experience for each other, individually and together. Through the addition of the family therapist as an additional source of such experience and the establishment of a therapeutic dialogue with and between family members, family members' experience and needs can be clarified and their unconscious organizing frameworks and implicit relational patterns can be identified, explored, and understood. New relational experiences between the therapist and family members and eventually between family members can gradually lead to the development of new, more adaptive organizing frameworks and patterns of relating.

LITERATURE REVIEW

Interestingly, there is considerably more literature on the application of self psychology and/or intersubjective systems theory to couples or marital therapy (Howard, 2004; Leone, in press; Livingston, 1995, 1998, 2001; Mitchell & Wilson, 1998; Ringstrom, 1994, 1998; Rubalcava and Waldman, 2004; Schwartzman, 1984; Shaddock, 1998, 2000, 2002; Solomon, 1985, 1988a, 1988b; Solomon & Weiss, 1992; Trop, 1994, 1997) and to group therapy (Bacal, 1985, 1992; Harwood, 1983; Harwood & Pines, 1998; Livingston, 1999, 2004; Livingston & Livingston, 2006; Schwartzman, 1984; Shapiro, 1991; Stone, 1992, 2001; Weinstein, 1987, 1991) than to family therapy, es-

pecially recently. This may be due at least in part to the historical division between psychoanalysis and family systems theory,[1] but it is unfortunate since this approach is certainly at least as useful with families as it is with couples and groups.

Ornstein (1981, 1985) was the first to address the application of Kohut's ideas to work with children and families, with her "child centered family treatment" model. Eldridge and her colleagues later addressed the application of self psychology to understanding child abuse (Eldridge & Finnican, 1985) and to work with high-risk parents of young children (Eldridge & Schmidt, 1990). More recently, Beebe and her colleagues have incorporated findings from infant research into a psychoanalytic approach to work with mothers of infants that is grounded in self psychology (e.g., Beebe, 2003). Other relevant works include a paper on the application of self psychology and intersubjectivity theory to work with parents of children with learning disabilities (Amerongen & Mishna, 2004), and Joelson's (2005) recent description of the treatment of a young girl and her mother.

Only a handful of papers have specifically discussed family therapy from a self psychological or intersubjective perspective (Jacobs, 1991; Shaddock, 1997; Unger & Levene, 1994), including the previous version of this paper (Leone, 2001) and my previous discussion of the treatment of conflictual siblings (Leone, 2004). The present paper seeks to highlight and integrate this previous work and build on it in several areas.

FAMILIES AS A SOURCE OF SELFOBJECT EXPERIENCE AND SELFOBJECT FAILURE

People need and seek selfobject experience—experience that is strengthening, restorative, or vitalizing—in all intimate relationships, including family relationships. Children clearly need empathically attuned selfobject responses from their parents and caretakers, but the self psychological view of lifelong, ongoing selfobject needs means that all family relationships can have a selfobject dimension.

Parents seek affirming, affect-regulating, twinship and other selfobject experiences from their children and from the experience of parenting (Eldridge & Finnican, 1985; Eldridge & Schmidt, 1990). They may idealize their children and feel soothed and comforted by them at times, and may feel a profound sense of essential likeness and belonging with their children that is like no other. Siblings and extended family members also need such experiences from each other (Leone, 2004). Finally, the family as a whole can provide family members with the experience of being affirmed by and belonging to an entire group of others. Families can also be idealized for their ancestry, heritage, or other admired characteristics.

Although he did not discuss families or family therapy specifically, Kohut referred to individuals being "born in to a matrix of responsive selfobjects" (Kohut, 1985, p. 257). The healthy family can be seen as such a matrix: a web of relationships that individually and together serve as a source of self-object experience for family members (Unger & Levene, 1994). The family ideally functions as a team of individual selfobject relationships, such that family members can access different selfobject experiences from different members. Also, when any one family member is less available as a source of selfobject responsiveness, another family relationship may provide it instead.

Unfortunately, many families do not function this way. Rather than a crucial source of selfobject experience for family members, families can instead become a source of selfobject failures and narcissistic injuries. These are especially painful because they occur in the very place—the family—that self-object experience is typically most needed and expected. Many of the affective, behavioral, and interpersonal difficulties commonly seen in children and families presenting for treatment can be understood as stemming from chronic misattunements or selfobject failures between family members. For example, in the case of the teenage girl described below, her presenting problems of moodiness, irritability, depression, and frequent conflicts with others were understood as related to chronic, co-created selfobject failures in her family and, to a lesser extent, her peer group. The case will be introduced here and discussed further throughout the paper.

CLINICAL EXAMPLE—INTRODUCTION

"I'm not the problem, she is," fifteen-year-old Kate tells me in our first session, referring to her mother. "She's crazy!" Kate presented as an attractive, angry, depressed-looking teenage girl who was reticent at first but fairly quickly warmed to her subject of complaining about her mother. She described her mother as constantly critical of her dress, friends, academic performance, and so forth, and reported that the two frequently engaged in screaming matches which at times involved mother threatening to leave the family. "I do give her attitude," Kate admitted readily, "and I feel bad about it, but she deserves it!"

Kate had been brought for treatment at her mother's insistence, due to what her mother described as Kate's rude and unpleasant "attitude" and their increasingly frequent and intense conflicts. Mother reported that she and Kate had been very close until the last year or two, a description with which Kate generally agreed. The presenting problems reportedly developed approximately one year prior to the family seeking treatment, about the time Kate entered her freshman year of high school.

Kate was the daughter of middle-class, well-educated parents, both of whom were employed in professional careers. She had one older stepbrother, the product of her father's first marriage, who was married and living out of state. She had had a number of medical problems as a child, requiring several short hospitalizations, but had recovered fully (medically) and was in good health at the time of the treatment.

Kate's mother, Mrs. S., was a slim, attractive, intense, immaculately groomed woman who seemed to dominate my office and our interaction. She asked a number of questions about my credentials and approach and repeatedly emphasized that Kate needed a therapist who would take her firmly in hand and "teach her coping skills" rather than "one of those therapists who just listens, smiles, and nods."

Mrs. S. reported a history of depression and anxiety related to a very conflictual relationship with her own mother—a relationship she was determined not to replicate with Kate. She described her mother as very critical, hostile, and "crazy." She had adored her father, who she felt had taken good care of her in all areas except for protecting her from her mother.

Mr. S. was a relatively quiet, contained man who seemed caring and concerned but very stressed by work-related difficulties. The couple had been married for seventeen years and appeared to have a loving and committed relationship that was marked by periodic conflict and fighting. Rather than engaging in the conflict as Kate did, however, Mr. S. seemed to take a more soothing, deferential stance toward his volatile wife, taking pains to avoid upsetting her. He said he was worried about Kate, who seemed unhappy, and about the frequent conflict between Kate and her mother because "I know it's not good for either of them."

As noted above, Kate's difficulties were understood in this model as related to previous and current selfobject failures within and outside of the family. Both parents clearly loved her and wanted the best for her, but were having great difficulty empathically appreciating her experience and needs and responding to her accordingly. The reasons for such selfobject failures and the basic tenets of a self psychological, intersubjective treatment approach will be detailed, before returning to a description of the work with Kate and her parents.

CAUSES OF SELFOBJECT FAILURES IN THE FAMILY

Selfobject failures and misattunements in the family have multiple origins—detailed below—which must be identified and targeted in family treatment. These failures and injuries are seen as co-created (not necessarily in a symmetrical manner) and emergent from an intersubjective field.

State of the self of family members: First, relationships are highly influenced by the extent to which each participant has developed a positive, cohesive sense of self and an adequate ability to regulate and integrate affect. People who have not done so (like Kate and her parents, especially Mrs. S.) are more intensely dependent on others for affirmation, validation, and help with self-regulation. They are more reactive to injuries or selfobject failures, have more difficulty responding to feedback nondefensively, and are either too overwhelmed by their own affective experience (like Mrs. S.) or too affectively deadened (like Mr. S.) to grasp and respond to the experience of others. More simply, people have difficulty providing for others what was not available to them.

Family members' organization of experience: People whose experience of others is negatively colored because of previous painful or negative relational experience (negative transference) also have difficulty responding to others in an optimal manner. Transference, in this model, is understood as family members' unconscious organizing principles about themselves, others. and relationships, which color their current experiences of each other. Thus, early disappointments or selfobject failures can leave individuals especially prone to expect and selectively attend to similar disappointments in future relationships. This was certainly the case with the S. family, as Mrs. S.'s early experiences with a highly critical mother left her prone to perceiving criticism even when it had not been intended. Her reactions to criticism were also painfully heightened.

Learned relational patterns: Unconscious organizing processes—or transference—not only influence how we perceive and experience others, they also affect our behavior in interactions. Early patterns of interactions with parents and others that the developing child witnesses and is part of become part of the child's typical patterns of relating—implicit or unconscious "procedures for being with" others (Lyons-Ruth, 1999).[2] These influence, for example, how we respond to others when upset or hurt, how anger is expressed, how we signal or cue others to our needs and respond to such cues from others, and so on. In the case of Kate and her mother, despite Mrs. S.'s conscious desire to avoid replicating the troubled interactions she'd experienced with her own mother, once upset or injured she often found herself engaged in a painfully similar interactional "dance" with Kate.

Physiological characteristics: Physiological characteristics, such as temperament (Chess & Thomas, 1986), psychosis (Cozzarelli & Silin, 1984), or neurocognitive deficits (Palombo, 1985) can also affect the degree of successful empathic attunement between individuals in a number of ways. These disorders or deficits can interfere with an individual's ability to self-regulate and to perceive cues from others accurately. They can also cause people's subjective experience to be so idiosyncratic or unusual that it is more difficult for others to grasp and respond to. The match or degree of

similarity of various temperament characteristics between any two particular individuals can also influence the ease with which they can easily understand and respond optimally to each other. For example, the fact that Mrs. S. was faster-paced, more intense, and more reactive than Kate contributed to their difficulties understanding and responding to each other.

Overall selfobject milieu: People have difficulty responding optimally to others when their own selfobject needs are not adequately met. The ongoing lack of an adequately responsive, reliable selfobject milieu is eventually likely to result in depletion, anger, or self-focus for anyone, even people without significant self-deficits, maladaptive ways of organizing experience or problematic implicit relational patterns.

By overall selfobject milieu I am including the quality of relationships outside the family, such as relationships with peers, teachers, and co-workers, as well as the impact of larger societal and cultural influences on the family—which Altman (1995) has termed the social-cultural "third" in psychoanalytic treatment. These include the impact of poverty, discrimination, immigration, and so on. A fuller discussion of the impact of these factors on family relationships is beyond the scope of this paper, but certainly they influence family members' abilities to respond optimally to each other.

Selfobject failures also frequently lead to other selfobject failures in families (and other systems), often in an escalating, vicious cycle. Lack of adequate selfobject experience for one family member leaves that person injured, angry, or depleted and thus less ability to provide needed responsiveness for other members. The others then become injured, angry, or depleted and have less to offer the first person, and the cycle continues or spirals in a domino-like effect. This often occurred with Kate and her family.

Lack of knowledge: In some cases people fail to provide adequate selfobject experiences for each other in part because they simply do not know what is needed or how to provide it. This lack of knowledge is usually secondary to other difficulties, such as an inadequate selfobject milieu (e.g., no one to ask or learn from) or entrenched organizing principles that interfere with the ability to take in new information. However, in some cases, new information can help people respond more optimally to each other. This may include information about what particular others feel or need, or general information about developmental or cultural norms, alternative discipline methods, physiological factors, and so on (Suskind, 1998). For example, as will be seen in the example to follow, Mr. S. benefited from information about what his wife and daughter needed from him when they were fighting. Later in the treatment, Mrs. S. also benefited from having Kate's behavior framed in terms of normal adolescent development.

In sum, selfobject failures in the family occur for a number of reasons. In many multiproblem families, several causal factors are involved for many

or all of the family members. In other cases, only one factor may be relevant for one member. Either way, the treatment must identify and target these underlying causes of selfobject failures before family members are able to learn new and better ways of responding to each other.

FAMILY THERAPY: INCREASING SELFOBJECT EXPERIENCE IN THE FAMILY

How Does Family Therapy Cure?

From the perspective of self psychology, family therapy helps by improving the ability of family members, individually and together, to function as a source of selfobject experience for each other, as appropriate to the ages, capacities, and roles of each. How this goal is achieved depends on the causes of the selfobject failures, outlined above.

Specifically, when failures in empathy and responsiveness appear to be due to deficits in self-esteem and/or affect regulation, the treatment must facilitate the development or remobilization of these capacities. These occur through new relational experiences between the therapist and family members, and hopefully eventually between family members, that gradually lead to the internalization of functions initially provided by others. This process can also be thought of as the reorganization of the experience of the self and the development of new implicit procedures for processing affect.

Difficulties resulting from family members' particular ways of organizing experience and/or problematic implicit relational procedures are addressed through the gradual illumination, understanding, and transformation (Stolorow, Brandshaft, & Atwood, 1987) of those phenomena. New relational experiences destabilize existing implicit relational patterns (Lyons-Ruth, 1999) and organizing frameworks and lead to the gradual development of new organizing principles and new relational patterns.

When problems are due to a lack of sources of selfobject experience for one or more family members, the treatment naturally focuses on broadening and strengthening the current selfobject milieu, beginning with the addition of the therapist as a reliable source of selfobject responsiveness. Finally, educating, coaching, or advice-giving interventions are most indicated when misattuned responses are primarily due to a lack of knowledge or skill, and not primarily to one of the other factors just listed. Several of these types of interventions may be needed in any given case.

It is notable that the curative processes or goals just described differ from those of most other models of family therapy, as well as from those of most individual psychoanalytic treatment. Family systems theories focus prima-

rily on changing the dynamics or behavior of the family through structural, strategic, or behavioral interventions (approaches which may also be understood as improving the selfobject functioning of the family), while placing less emphasis on the intrapsychic characteristics of the individual family members that may underlie their relationship difficulties. Conversely, psychoanalytic treatment of individuals generally focuses on addressing intrapsychic issues—and perhaps problems in relating as they are replicated in the treatment relationship—without addressing the ability to be more empathically responsive to particular others. Incorporating aspects of both approaches, self psychology–based conjoint treatment involves improving participants' abilities to provide needed selfobject responses for each other by addressing both the intrapsychic and interpersonal causes of selfobject failures between them.

When to Do Family Therapy and with Whom?

In contrast to the one-patient/one-modality world of individual treatment, in the treatment of children and families there are both more potential patients and more possible treatment options. These include individual treatment for one, some, or all family members, parenting-oriented sessions or couples therapy for the parents, conjoint treatment for some or all family members, and so on. In many cases, it is hard to decide who should be seen, how often, in which modalities, and by whom. While these decisions are rarely easy, careful consideration of the underlying causes of the difficulties and assessment of family members' abilities to address these issues effectively in each possible modality can help guide the clinician through the maze of treatment options to those likely to be most effective.

Overall, family intervention in one form or another is indicated whenever the presenting problems appear to be caused or maintained to a significant degree by a lack of adequate selfobject responsiveness between family members. The greater the impact of the failures on the identified patient's optimal functioning, the more family work is indicated. However, in this model, family intervention does not necessarily mean sessions with all family members present. Traditional systems-based family therapy understandably required the presence of all members of the family system so the therapist could observe and intervene in the theorized problematic system's dynamics. However, the present goal of helping family members become more attuned and responsive to each other's selfobject needs may be accomplished by meeting with family members individually, in subsystems, or all together, depending on the following considerations.

First, the treatment should focus most intensively on the primary selfobject breakdowns in the family—the relationships that appear to be the most troubled or most impacting the presenting problems. This is usually, but

not always, the parent-child relationship(s). While certainly helpful and informative at times, the presence of siblings or other family members, with their own needs and subjectivities, can dilute or distract from the focus on the most significant selfobject breakdowns or failures. In other cases, when the primary misattunements occur between siblings or between a number of family members, sibling or larger family sessions would be indicated.

Second, the format of the family work naturally depends on the particular treatment goals of a given period of the treatment. Establishing a selfobject relationship and therapeutic dialogue between the therapist and each family member, understanding and making sense of each member's subjective experience, illuminating unconscious organizing principles or transference-countertransference phenomena, identifying needs, and so on, can be done in either separate or joint sessions, depending on family members' willingness and abilities. However, directly modeling or facilitating more attuned interactions—or establishing new implicit patterns of relating between family members—is only possible in joint sessions. Family members' implicit or procedural patterns of relating also only become evident when seen in action, live and in color.

Third, successful work in joint sessions generally requires that participants share the goal of improving their relationship and be able to work toward this goal without constant traumatic selfobject failures during sessions. Family members are sometimes too angry, depleted, injured, or needy to be able or willing to respond empathically to each other, or even to tolerate witnessing the therapist's empathic responses to another. In such cases, conjoint sessions can do more harm than good. When traumatic injuries or failures occur in the therapist's presence, the tie to the therapist is jeopardized as well.

Rather, the goal of improving the degree of attuned responsiveness between family members can often best be achieved by initially seeing individuals or subsystems separately, then bringing them together once they become more able to work constructively on improving their relationship. The separate work may take anywhere from several years, in the case of individuals with very severe deficits or entrenched problematic relational patterns, to a few minutes in the case of those who can fairly quickly reaccess their well developed capacities to regulate self-esteem and self-right. As will be discussed further below, Kate was seen individually and her parents were seen separately for six months before the first conjoint session was held.

Fourth and finally, a related issue involves family members' expectations or preferences about treatment modalities. Family members often enter treatment with particular images of how the treatment will or should be conducted—which may differ from those of the therapist. Examples include parents who expect their child to be seen individually and do not wish or expect to be part of the treatment themselves, parents who want to be part

of all sessions and feel offended or excluded when the child is seen alone, and children or teens, like Kate, who want individual treatment with no conjoint work with parents or others. In such cases, insisting on treatment modalities or participants that differ strongly from family members' expectations or wishes is likely to be experienced as a narcissistic injury or selfobject failure by the therapist and is thus contraindicated. As it was in Kate's case, it is often necessary to work over time toward the modality the therapist believes will be most effective, once family members' concerns and preferences have been carefully understood and responded to.

TREATMENT METHODS IN FAMILY THERAPY

Equal empathic immersion: One of the hallmarks of self psychology is its emphasis on the therapist's empathic immersion into the patient's experience from within the patient's subjective perspective. Not surprisingly, then, self psychological family work involves empathic immersion and inquiry into the unique subjective experience of each family member being treated. This is admittedly a tall order, especially when family members have opposite or conflicting experiences of the same event or of each other. However, just as parents of several children find a way to empathically appreciate the experience of each one, sometimes simultaneously, sometimes in turn, so can the family therapist endeavor to do so as well.

It is particularly important that the therapist's empathic understanding be fairly equal across family members, so that a greater understanding of or identification with one member does not interfere with appropriate attuned responsiveness to the selfobject needs of the others. While naturally some patients or family members (usually the identified child patient) will be easier for the therapist to understand than others (especially abusive or neglectful parents), it is crucial that the therapist recognize this imbalance and redouble her efforts to appreciate the experience of the less-well-understood person.

With Kate and her parents, I found it much easier to understand and respond to Kate's experience than to her mother's. I had been an adolescent daughter myself at one time, but had not yet been the parent of one. Kate also was very idealizing of me and easygoing, while Mrs. S. was often critical and demanding. As will be seen in the description below, I struggled mightily with this issue and believe that addressing it was crucial to the success of the treatment.

Helping family members better understand themselves and each other: Through the process of empathic inquiry and the establishment of a "therapeutic dialogue" (Ornstein & Ornstein, 1986) with each family member being seen, the therapist helps each one explore, clarify, and make sense of his or her

subjective experience, especially the experience of and reactions to other family members. She listens especially for themes that reflect underlying selfobject needs and seeks to highlight and clarify these, especially the experience of more vulnerable affects such as needs and longings, pain, and hurt (Livingston, 2001).

The therapist consistently conveys interest in and curiosity about family members' current experience—especially about how it came to be—and encourages similar curiosity in family members. This process leads to the gradual illumination of the impact of previous relational experience on each member's current experience—or of each one's unconscious organizing principles and implicit patterns of interacting. The therapist can also draw attention to patterns she notices evolving in the room between family members or between herself and family members. "Something important seems to be happening between us," she might say. "I think maybe I hurt your feelings a minute ago, and now you're shutting down like you learned to do as a child?"

Facilitating new relational experience in the family: This process of interested curiosity, exploring and "making sense together" (Buirski & Haglund, 2001) in each other's presence is, in itself, often a new relational experience for family members. Simply translating conflicts into the language of unmet needs and longings and encouraging the expression of more vulnerable affects can lead to a gradual shift in family members' experience of each other and ways of being with each other. So can shared humor and shared experiences of the therapy or the therapist. Finally, just witnessing firsthand the therapist's differing experience of each family member can lead to a shift in family members' experience of each other: the therapist's more positive or more integrated experience can be contagious. For example, I believe that Mrs. S.'s experience of Kate became more positive more through Mrs. S.'s exposure to my more positive experience of Kate than from any verbal interpretations or comments of mine.

The conjoint therapist can also facilitate new experience between family members by gently encouraging, orchestrating, or "coaching" positive interactions between them and empathically limiting negative ones. Such orchestrating or coaching can occur in separate sessions with individual family members or subsystems, such as when anticipating and planning for an impending joint session. It can also occur during joint sessions, as when the therapist cues, reminds, or gently suggests an alternative way of interacting. For example, the therapist might say, "Seems like what your mom needs to hear from you is that you understand what hurt her, Kate, and maybe that you're sorry about it. And I think you do understand and do feel badly, so could you try to tell her?" In this way the therapist can gently encourage new relational behaviors.

When it comes to interrupting or limiting unhelpful behaviors, it is of course important to do so carefully, to reduce the chances of family members feeling criticized, shamed, or narcissistically injured by the limit. It often helps to first highlight the offending person's legitimate feelings and needs and the possible reasons for the problematic behavior before gently limiting it. It is also important to emphasize that the purpose of the limit or suggestion is to help the person be more easily heard and understood. "I know how furious you are, and how much you need to say this, but still, we've got to help you say it in a way that increases your chances of getting what you need here," the therapist might say.

CLINICAL EXAMPLE—TREATMENT DESCRIPTION

Course of treatment prior to session to be presented—individual work with Kate: During the six-month period of weekly individual work preceding the first conjoint session, Kate had developed a positive transference to me with both mirroring and idealizing components. She used the therapy to discuss various "fights" and disappointments with her friends and her mother, as well as anxieties and other feelings about boys she had crushes on. We gradually sketched out a life narrative that began to make sense of how Kate's current difficulties with self-esteem and relationships had developed. This included exploring the contribution of the early medical problems, the loss of a best friend who had moved away at a crucial time, and eventually, her experience of mother as critical, demanding, and disappointed in her.

Little by little, Kate began to recognize the ways her self-doubt was contributing to her difficulties with peers. She became more aware of her need for constant affirmation and reassurance, her hypervigilance to her standing in the peer "pecking order," and her intense reactivity to slights or rejections by peers, all of which made her less appealing to them. She also began to recognize that her angry outbursts and outrage when she felt mistreated or insulted by others reflected these underlying injuries and unmet needs, as well as behavior learned from her mother, but only further alienated others and worsened the relationship problems.

Although initially Kate had strongly resisted joint work with her mother, adamantly insisting that mother would never change and much preferring to focus on self-esteem and peer issues, she became slightly more amenable to the idea as time went on. As she felt more understood and attended to in the individual work, she became slightly less moody and irritable and less pessimistic and negativistic in general. She also began to see a bit of her own contribution to the mother-daughter conflict, and, perhaps most important, had started to see a bit of change in her mother, discussed below.

If it had been left entirely up to Kate, she would probably never have requested a family session; however, she eventually agreed with my suggestion that it she would be more likely to achieve the goals she had for herself (e.g., feel better about herself, decrease her self-doubt and angry outbursts, etc.) if she could get more of what she needed from her parents. She therefore reluctantly accepted my recommendation for some joint sessions, to be held *in addition to* her regular weekly time—not instead of it.

Course of treatment prior to session to be presented—work with Mr. & Mrs. S.: It was clear to me from the initial intake telephone call from Mrs. S. and from the first few minutes of the initial session that conjoint mother-daughter work was not yet appropriate, so I did not propose it. I hesitated to even suggest parenting sessions because I sensed Mrs. S. might well be offended by any implication that Kate's difficulties were not solely a result of poor coping skills. I therefore framed the sessions as standard parent-therapist "conferences," similar to parent-teacher conferences. This allowed Mrs. S. to initially view the sessions as an opportunity to convey to me what she felt I should be covering with Kate individually, rather than as an opportunity to explore her own issues, thereby protecting her fragile self-esteem. With Kate's awareness and consent, I also had a number of telephone conversations with Mrs. S. between sessions, contacts in which she was sometimes more able to take in a very carefully phrased idea more easily than she was in person.

As of the time of the session detailed below, six parent sessions had been held, three with both parents and three with Mrs. S. only because Mr. S. was out of town. As noted earlier, I initially experienced Mrs. S. as quite intimidating, difficult, and offensive, especially when I had thoughts or ideas about what she might do differently with Kate (which was constantly!) but felt I couldn't convey them because she wasn't interested in them or would be injured by them. I was very aware of how much more identified I was with Kate than with Mrs. S. and repeatedly struggled to address this imbalance by immersing myself more fully in Mrs. S.'s experience and internal world.

After a great deal of struggle and consultation, I eventually discovered that it helped enormously if, when interacting with Mrs. S., I closed my eyes a minute, forcibly blocked images of Kate from my mind and pretended to myself that Mrs. S. was my individual adult patient whose daughter I had never met. This shifted me out of my other-centered (Fossaghe, 1997) or "Kate-centered" perspective and allowed me to eventually understand Mrs. S.'s demanding, off-putting behaviors as the best way she knew to try to help and reconnect with the daughter she so loved and needed. Focusing on the intensity of Mrs. S.'s love and hopes for her daughter and their relationship led naturally to discussions about Mrs. S.'s childhood experiences with her own mother.

Occasionally, after a moment or period in the session in which Mrs. S. seemed to have felt particularly well understood and supported by me, when I sensed she might be able to take it in without injury, I would tentatively float a brief thought, almost in passing, about Kate's experience or about how Mrs. S.'s childhood experience might be affecting her reactions to Kate, and then quickly revert to a stance more within Mrs. S.'s own perspective. On occasion, I misjudged and had to quickly shift to repairing the resulting empathic rupture between us, but gradually Mrs. S. was able to take in a sound bite or two of my ideas without apparent injury.

Although she still experienced the problem as primarily in Kate, Mrs. S. was agreeable to conjoint sessions, which she saw as an opportunity to show the therapist how horrible Kate could be even when she (mother) was "doing everything right." Approximately six months into the treatment, the first family session was held after both mother and daughter complained about another "huge fight" they had recently had.

Description of family session: Both Kate and Mrs. S. glare at me as they enter the office, accompanied by Mr. S. Kate's body language and expression makes it clear that she would rather be anywhere else, while her mother appears visibly enraged and disgusted. Mrs. S. sits down in her usual seat, directly opposite the therapist, which she does not realize is also Kate's usual spot for her individual sessions. Disconcerted, Kate takes the chair next to me, across from her parents, shooting me a look (unseen by Mrs. S.) that says, "See! What did I tell you? She's already taken my chair!"

Mrs. S. begins by reporting that she and Kate had just had a fight during the drive to the session and that she (Mrs. S.) is now questioning whether the therapy is doing any good. Kate angrily responds that just last week mother said things were better and launches into a description of the incident in question. Kate is angry and blaming and portrays mother as the primary villain or cause of the problem. Angrily interrupting, Mrs. S. insists that what "really happened" was quite different: she had not spoken in the hostile manner Kate portrayed, Kate had "started it" and provoked Mrs. S.'s response.

Listening to this exchange, I feel as though I have two adolescent (or preadolescent) girls in my office, rather than an adult and a teen. I can easily grasp Kate's experience as she describes what happened and privately agree that Mrs. S. should not have said what Kate says she did. I feel a rush of sorrow and sympathy for my vulnerable fifteen-year-old patient and a flash of exasperation with Mrs. S. for her limitations. "Not an auspicious beginning," I think to myself wryly. "Five minutes into the session and already you're siding with the child and enraged with the mother."

Aware that my reactions are understandable but still a significant danger sign, I try to force myself back to an empathic, subject-centered perspective (Fosshage, 1997) toward Mrs. S. When Kate pauses, I catch each family

member's eye in turn, nod, and hold up a finger to signal, "wait just a second while I think a minute." I close my eyes briefly and deliberately try to call up a visual image of Mrs. S. as a little girl with an extremely critical and largely unavailable mother—a mental "channel change" from my current image of the adult woman who is parenting poorly. My previously developed understanding of Mrs. S., formed in our separate sessions, thankfully comes flooding back to me, rescuing me from my anger at her and overidentification with Kate.

I am then back in touch with my view that Mrs. S.'s early experiences left her with significant deficits in her ability to regulate affect and self-esteem and a natural need to defend against or protect herself from further threats to the self. They also resulted in an unconscious organizing framework of herself as inadequate and of others as often dangerous and unfair. I remember how much Mrs. S. needs her daughter's positive regard to counter these feelings and see that she is naturally experiencing Kate's description an almost intolerable narcissistic injury that replicates traumatic earlier injuries. Finally, I note that Kate is being quite provocative, blaming, and hostile herself, due to the teen's similar, although less severe, self-deficits and organizing framework.

Having reaccessed an internal sense of equal empathic connection with both of my patients of the moment, I open my eyes. Only a few seconds have passed, but my brief "time out" and obvious thoughtful concentration has slowed things down and altered the pressured and intense mood in the room very slightly. I attempt to summarize the subjective experience of both mother and daughter, trying to match each one's affective tone, saying something like: "Sounds like you felt your mom let you down big-time . . . (Kate nods) . . . you really hated what she said and though it was very wrong (vehement nod) . . . and now you want her to understand how bad you felt so you can begin to fix things (Kate gives me a look that says "you're stretching it a bit here, but I'll go along with you") . . . while you, Mom, know the feeling because you're feeling pretty let down yourself right now, maybe like all the blame's being pinned on you as this terrible mother when you feel your behavior was very justifiable, very provoked?"

Mrs. S. nods vigorously, gives her daughter a pointed glare, and states again (in sum) that she only said what she did because Kate had first said something to deserve it. She adds that it is about time Kate stops blaming everything on mother and starts taking responsibility for her part of things. Kate, outraged, vehemently denies this and accuses, "You're the one who always refuses to see what you do!"

I hold Kate's gaze here, trying to convey my understanding with my eyes and expression and motion to her, "I'm coming to you in a minute." I then try to empathize with and legitimize her mother's experience, saying something like, "Of course you want Kate to see her part in these things, how she

hurts you or provokes you or sets you off. We all want our actions to be understood in context. Obviously you react to something," I say emphatically, trying for a slightly toned-down version of Mrs. S.'s outraged tone, "it certainly doesn't come out of the clear blue sky!"

"Exactly! That's just what I've been trying to tell her!" responds Mrs. S. approvingly. I hold her gaze intently and nod, hoping the connection will "hold" her for a minute while I turn to Kate. Aware that she may have felt a bit "sold out" by my previous comment, I add quickly, "And naturally, Kate, you want the same thing, am I right? For your mom to understand how she can hurt you and upset you and trigger you, maybe without meaning to (I nod to Mrs. S., to soften what might be a hurtful message), which then leads to some of what you say or do?"

Kate agrees and elaborates briefly, in a slightly softened but still huffy manner, that she knows they both are part of the problem, she wasn't saying she wasn't. (Note that Kate's ability to make a statement like this is an indication of her readiness for or capacity to participate in conjoint work. She is able to acknowledge and agree with part of her mother's statement, however minimally. She is also able to tolerate my empathic response to her mother without experiencing it as an empathic rupture or selfobject failure by me, a significant change from her abilities at the beginning of treatment.)

I flash Kate an approving look and say that being able to admit to being part of the problem is an important step toward the goal of reconnecting and learning to express anger differently. I continue, "Seems like what we really need to do here is understand what you each say or do that hurts the other, and why something that might seem fairly minor to one of you—like a minor suggestion, criticism, broken rule, or whatever—could be felt by the other to be so big and so hurtful."

After some elaboration on this both Kate and Mrs. S., I gradually say some version of the following, in bits and pieces. To Mrs. S.: "Of course you're hurt—the little girl who used to think you could do no wrong and used to rely on you so much is now in your face, telling you how you're wrong and how you've hurt her and how things are your fault. That's got to be so horrible for you—you heard enough of that as a child, you don't need it from your own daughter now, of all people! Especially since you've so much wanted something so much better than that with her." (Mrs. S. nods and chokes up.) And to Kate: "Here's your own mother, who you've always looked to for support. . . . and somewhere along the line you start to feel she's constantly telling you what's wrong with you instead of what's right with you . . . I can really see how this would be so awful for both of you—you both so much need this relationship to make you feel better, not worse." Here I am trying to empathically appreciate both patients' experience and begin to provide a new view of the problem, shifting from a view

of one or the other as at fault to one of mutual underlying needs and narcissistic vulnerabilities.

Once mother and daughter have calmed a bit, I try to address Mr. S.'s role in the family. He has been sitting quietly, listening but somewhat disengaged, consistent with his view of the problem as primarily between his wife and daughter and not something he can do much about. With my encouragement, he talks briefly about how much he wants his wife and daughter to "work this thing out" because he loves them both and knows they love each other. He notes, too, that his efforts to help usually only get him "in trouble" with one or both of them, and make things worse, so he now just tries to "stay out of it." Kate and Mrs. S. respond by expressing considerable resentment about Mr. S.'s "spineless," "chicken" behavior and his refusal to "stand up to" the other.

Again trying to empathically appreciate both perspectives, I say that of course Mrs. S. and Kate would each want Mr. S. to side with them. "People naturally want their partners or parents to defend them, take a stand for them and back them up," I tell them. "On the other hand, Dad," I joke with Mr. S., "having been in your position at times, like today, I certainly know how it feels to care about both of these women and have them both want you to take their side against the other." All three smile, acknowledging the parallel. Mr. S. agrees and elaborates briefly, giving another example of this pattern.

"Of course you want to stay out of the fray if all that happens when you get in it is that they both end up mad at you, too!" I tell him. "I can't blame you for wanting to keep yourself out of trouble" (we smile at each other), "but we all know that's not really what they most need from you when this happens. You only resort to it because you don't know what else to do that would actually help rather than make things worse." (Mr. S.: "That's true.") "Seems to me what they need from you and me both at these times is to feel that we really understand how they feel. Then they need some help figuring out how they are hurting each other or setting something off in each other and maybe some help finding a middle ground where they can each get at least some of what they need when they have opposite needs. Easier said than done, obviously, but that's the goal we'll work toward together."

Here I'm trying to help Mr. S. learn to provide important selfobject experiences for his wife and daughter, especially when they are temporarily unable to access such experience from each other. Here my goal is mainly to provide an initial framework, enough to interest Mr. S. and set the stage for our future work. Knowing that Mr. S. somewhat of a therapy skeptic, I am hoping my advice and identification of goals will establish the sessions as a place he can get help with things he struggles with, as opposed to merely a place for his wife and daughter. My use of humorous validating statements is also an effort to help him feel more relaxed and understood.

Course of treatment after session presented: After this session, joint sessions were held approximately every other week for several months, in addition to Kate's weekly individual sessions and intermittent parent sessions. Mrs. S. gradually became more aware of the impact of her mother's criticism on her current reactions to Kate's "attitude" or criticism and how her intense need to feel that her relationship with Kate was very different than her relationship with her own mother made it hard for her to tolerate almost any expression of negative feelings by Kate. She never made the changes she probably could have made if she had been willing to enter an intensive individual treatment (she'd had a bad experience with treatment in the past and adamantly refused to try again). However, she did come to see that despite her intense desire to be different than her mother (and even though she had succeeded in many ways), the hostile, critical patterns of interaction between she and her mother were encoded within her and could be triggered or reactivated in similar situations.

Kate, too, came to see how any criticism from her mom could feel intolerable because she (Kate) was so afraid that there was something wrong with her—so afraid that her difficulties with Mrs. S. and her peers were in fact due to her own inadequacies. Although she understandably did not want her more positive experience of her maternal grandmother "messed with" too much, she did come to understand that her mother's reactivity had to do with Mrs. S.'s own history rather than to a problem within Kate. She also recognized that although she hated the way her mother expressed rage, she could behave in a similar manner when threatened and became determined to change that.

Although initially they simply hated themselves all the more when these dreaded similarities became apparent, Kate and her mother eventually came to see this kind of repetition as understandable and natural, but not inevitable. They began to see the need to convey their anger, disappointment, or negative feedback more carefully, so as to avoid stimulating these negative repetitive processes in each other. We worked particularly hard on the idea of resisting the "magnetic pull" of their old familiar, reactive, impulsive interactions when injured or angry and trying instead for a more reflective, thoughtful dialogue once they had calmed down and the adrenaline had stopped flowing.[3] We agreed that the treatment goals required both of them to at times to behave in ways that felt "counterintuitive" or against their gut impulses.

Finally, as the treatment progressed, Mr. S. became better able to express his understanding of "both sides of the story," when his wife and daughter were at odds. Mrs. S. and Kate also became more able to examine, understand, and eventually reduce their insistence that Mr. S. side with them against the other during conflicts.

Case discussion: The case of Kate and her parents illustrates how the concepts from self psychology and intersubjective systems theory can inform

the treatment of family relationship difficulties, as they do the treatment of couples and groups. In particular, the case illustrates how an emphasis on understanding each person from within his or her own perspective can allow the therapist to stay empathically attuned even to several family members who have very different or conflicting experiences of an incident or of each other. By focusing on clarifying each one's subjective experience, translating or reframing conflicts into the language of underlying emotional needs, and focusing on how each person's experience developed over time—rather than on who is more objectively right or wrong—the therapist can help family members out of the battle over "the facts" and into an understanding of each other's experience and underlying needs.

The session described illustrates the therapist's efforts to respond to the differing selfobject needs of three patients in one session, simultaneously and sequentially. Both mother and daughter needed to feel understood and validated in their opposite accounts of an incident, while Kate's father needed help staying emotionally engaged and in learning a new skill or idea. All needed help reducing their anxiety and hopelessness about ever being able to resolve such incidents, as well as a framework for understanding what they needed from each other and why they experienced each other as they did. By providing a solid theoretical framework for understanding and making sense of family members' behaviors and needs, contemporary self psychology and intersubjective systems theory can assist the family therapist in this challenging task.

SUMMARY AND CONCLUSION

Self psychology and intersubjective systems theory are readily applicable to work with various systems, including families. The concepts of selfobject experience and of the family as a selfobject matrix can help clinicians understand more clearly what family members need and seek from each other and from therapists. When family interactions are understood in terms of selfobject needs, narcissistic vulnerabilities, unconscious organizing principles, and implicit relational patterns, even the most chaotic, abusive, resistant, or otherwise challenging families begin to make more sense, and the road to repair and growth becomes clearer.

REFERENCES

Altman, N. (1995). *The analyst in the inner city: Race, class and culture through a psychoanalytic lens. (Relational perspectives book series, Vol. 3)*. Hillsdale, NJ: The Analytic Press.

Amerongen, M., & Mishna, F. (2004). Learning disabilities and behavior problems: A self psychological and intersubjective approach to working with parents. *Psychoanalytic Social Work, 11*(2), 33–54.

Bacal, H. (1985). Object-relations in the group from the perspective of self psychology. *International Journal of Group Psychotherapy, 35*(4), 483–501.

Bacal, H. (1992). Contributions from self psychology theory. In R. H. Klein & H. S. Bernard (Eds.), *Handbook of contemporary group psychotherapy.* Madison, CT: International Universities Press.

Bacal, H. (1998). Optimal responsiveness and the specificity of selfobject experience. In H. Bacal (Ed.) *Optimal responsiveness: How therapists heal their patients.* New Jersey: Jason Aronson.

Beebe, B. (2003) Brief mother-infant feedback: Psychoanalytically informed video feedback. *Infant Mental Health Journal, 1*, 24–51.

Buirski, P., & Haglund, P. (2001). *Making sense together: The intersubjective approach to psychotherapy.* Jason Aronson Press.

Bowlby, J. (1979). *The making and breaking of affectional bonds.* London: Tavistock.

Chess, S., & Thomas, A. (1986). *Temperament in clinical practice.* New York: Guilford Press.

Cozzarelli, L., & Silin, M. (1984). Therapeutic interventions with families with young psychotic children. *Clinical Social Work Journal, 12*, 140–151.

Eldridge, A., & Finnican, M. (1985). Applications of self psychology to the problem of child abuse. *Clinical Social Work Journal, 13*, 50–61.

Eldridge, A., & Schmidt, E. (1990). The capacity to parent: A self psychological approach to parent-child psychotherapy. *Clinical Social Work Journal, 18*(4), 339–351.

Fosshage, J. (1997). Listening/experiencing perspectives and the quest for a facilitative responsiveness. In A. Goldberg (Ed.), *Conversations in self psychology: Progress in self psychology, vol. 13* (pp. 33–55). Hillsdale, NJ: The Analytic Press.

Gardner, J. (1992). Personal communication.

Gardner, J. (1995). Supervision of trainees: Tending the professional self. *Clinical Social Work Journal, 23*(3), 271–286.

Gottman, J., & Silver, N. (2000). *Seven principles for making marriage work.* New York: Three Rivers Press.

Harwood, I. (1983). The application of self-psychology concepts to group-psychotherapy. *International Journal of Group Psychotherapy, 33*(4), 469–486.

Harwood, I., & Pines, M. (Eds.). (1998). *Self experiences in group: Intersubjective and self psychological pathways to human understanding.* London: Jessica Kingsley Publishers.

Herzog, B. (2004). Reconsidering the unconscious in template theory: Shifting relational states, activators and the variable unconscious. Presented at the twenty-seventh Annual International Conference on the Psychology of the Self, San Diego, CA.

Howard, S. (2004). An attachment systems perspective treatment of a bicultural couple. In W. Coburn (Ed.), *Transformations in self psychology: Progress in self psychology, vol. 20* (pp. 151–168). Hillsdale, NJ: Analytic Press

Jacobs, E.J. (1991). Self psychology and family therapy. *American Journal of Psychotherapy, 45*(4), 483–498.

Joelson, A. (2005). A girl, her mother and her analyst. Paper presented at the twenty-eighth Annual International Conference on the Psychology of the Self, Baltimore.
Kohut, H. (1972). Thoughts on narcissism and narcissistic rage. In P. Ornstein (Ed.), *The search for the self* (pp. 615–662). New York: International Universities Press, 1978.
Kohut, H. (1984). *How does analysis cure?* Chicago: University of Chicago Press.
Kohut, H. (1985). *Self psychology and the humanities: Reflections on a new psychoanalytic approach.* New York: W.W. Norton & Co.
Lachmann, F. M., & Beebe, B. A. (1996). Three principles of salience in the organization of the patient-analyst interaction. *Psychoanalytic Psychology, 13*, 1–22
Leone, C. (2001) Toward a more optimal selfobject milieu: Family psychotherapy from the perspective of self psychology. *Journal of Clinical Social Work, 29*(3), 269–289.
Leone, C. (2004) Friends or foes: Treating the sibling relationship from the perspective of self psychology. Presented at the twenty-seventh Annual International Conference on the Psychology of the Self, San Diego.
Leone, C. (in press). Couples therapy from the perspective of self psychology and intersubjectivity theory. *Psychoanalytic Psychology.*
Livingston, M. (1995). A self psychologist in couplesland: A multisubjective approach to transference and countertransference-like phenomena in marital relationships. *Family Process, 34*(4), 427–439.
Livingston, M. (1998). Conflict and aggression in coupes therapy. *Family Process, 37*(3), 311–321.
Livingston, M. (1999). Vulnerability, tenderness, and the experience of selfobject relationship: A self- psychological view of deepening curative process in group psychotherapy. *Int. J. Group Psychoth., 49*(1), 1–21.
Livingston, M. (2001). Vulnerability in couples therapy. In M. Livingston (Ed.), *Vulnerable moments: Deepening the therapeutic process.* Northvale, NJ: Jason Aronson Press.
Livingston, M. (2004). Vulnerability, affect and depth in group psychotherapy. *Psychoanalytic Inquiry, 23*(5), 646–677.
Livingston, M., & Livingston, L. (2006). Sustained empathic focus in group psychotherapy. *International Journal of Group Psychotherapy, 56*(1), 67–85.
Lyons-Ruth, K. (1999). The two-person unconscious: Intersubjective dialogue, enactive relational representation, and the emergence of new forms of relational organization. *Psychoanalytic Inquiry, 19*, 516–617.
Mitchell, S. (1988). *Relational concepts in psychoanalysis*. Boston: Harvard University Press.
Mitchell, S. (1997). *Influence and autonomy in psychoanalysis.* Hillsdale, NJ: The Analytic Press.
Mitchell, V., & Wilson, D. (1998). Extramarital affairs in mid-life: The splintered mirror. Paper presented at the twenty-first Annual International Conference on the Psychology of the Self, San Diego.
Ornstein, A. (1981). Self-pathology in childhood: Developmental and clinical considerations. *Psychiatric Clinics of North America, 4*(3), 435–453.
Ornstein, A. (1985). The function of play in the process of child psychotherapy: A contemporary perspective. *Annals of Psychoanalysis, 12–13*, 349–366.

Ornstein A., & Ornstein, P. (1986). Empathy and the therapeutic dialogue. In *The Lydia Rappaport lecture series* (pp. 3–16). Northhampton, MA: Smith School of Social Work.

Palombo, J. (1985). The treatment of borderline neurocognitively impaired children: A perspective from self psychology. *Clinical Social Work Journal, 13*, 117–128.

Ringstrom, P. (1994). An intersubjective approach to conjoint therapy. In A. Goldberg (Ed.), *Progress in self psychology, volume 10*. Hillsdale, NJ: Analytic Press.

Ringstrom, P. (1998). Competing selfobject functions: The bane of the conjoint therapist. *Bulletin of the Menninger Clinic, 62*(3), 314–325.

Rubalcava, L. A., & Waldman, K. M. (2004). Working with intercultural couples: An intersubjective perspective. In W. Coburn (Ed.), *Transformations in self psychology: Progress in self psychology, vol. 20* (pp. 127–150). Hillsdale, NJ: Analytic Press.

Schwartzman, G. (1984). Narcissistic transferences: Implications for the treatment of couples. *Dynamic Psychotherapy, 2*, 5–14.

Shaddock, D. (1997). An intersubjective approach to conjoint family therapy. In A. Goldberg (Ed.), *Progress in self psychology, volume 23*. Hillsdale, NJ: Analytic Press.

Shaddock, D. (1998). *From impass to intimacy.* Northvale, NJ: Jason Aronson Press.

Shaddock, D. (2000). *Contexts and connections.* New York: Basic Books.

Shaddock, D. (2002). Couples therapy as therapy: Fostering individual growth in conjoint contexts. Paper presented at the twenty-fifth International Conference on the Psychology of the Self, Washington, DC.

Shapiro, E. (1991). Empathy and safety in group: a self psychology perspective. *Group, 15*(4), 219–224.

Solomon, M. (1985). Treatment of narcissistic and borderline disorders in marital therapy: Suggestions toward an enhanced therapeutic approach. *Clinical Social Work Journal, July*, 141–156.

Solomon, M. (1988a). Self psychology and marital relations. *International Journal of Family Psychiatry, 9*, 211–225.

Solomon, M. (1988b). Treatment of narcissistic vulnerability in marital therapy. In A. Goldberg (Ed.), *Progress in self psychology, volume 4*. Hillsdale, NJ: Analytic Press.

Solomon, M., & Weiss, N. (1992). Integration of Daniel Stern's developmental theory into a model of couples therapy. *Clinical Social Work Journal, 20*(4), 377–393.

Stolorow, R., & Atwood, G. (1992). *Contexts of being: The intersubjective foundations of psychological life.* Hillsdale, NJ: Analytic Press.

Stolorow, R., Brandshaft, B., & Atwood, G. (1987). *Psychoanalytic treatment: An intersubjective approach.* Hillsdale, NJ: The Analytic Press.

Stone, W. (1992). The place of self psychology in group psychotherapy: A status report. *International Journal of Group Psychotherapy, 42*, 335–350.

Stone, W. (2001). The role of the therapist's affect in the detection of empathic failures, misunderstandings and injury. *Group, 25*(1), 3–14.

Suskind, D. (1998). *Working with parents: Establishing the essential alliance in child psychotherapy and consultation.* Northvale, NJ: Jason Aronson.

Trop, J. (1994). Conjoint therapy: An intersubjective approach. In Goldberg, A. (Ed.), *Progress in self psychology, volume 10*. Hillsdale, NJ: Analytic Press.

Trop, J. (1997). An intersubjective perspective on countertransference in couples therapy. In M. Solomon & J. Siegel (Eds.), *Countertransference in couple therapy.* Hillsdale, NJ: Analytic Press.

Unger, M. T., & Levene, J. (1994). Selfobject functions of the family: Implications for family therapy. *Clinical Social Work Journal, 22*(3), 303–316.
Weinstein, D. (1987). Self psychology and group psychotherapy. *Group, 11*, 143–154.
Weinstein, D. (1991). Exhibitionism in group psychotherapy. In A. Goldberg (Ed.), *The evolution of self psychology: Progress in self psychology, volume 7*. New York: Guilford Press.
Wolf, E. S. (1988). *Treating the self: Elements of clinical self psychology.* New York: Guilford press.

NOTES

1. Since family systems theory developed largely in opposition to psychoanalytic theory, family work has historically been seen in some circles as "not psychoanalytic" or not the province of psychoanalytically oriented clinicians. I believe this has severely limited exploration of the application of psychoanalytic concepts to family work.

2. The concepts of learned relational patterns or implicit relational procedures as I use them here is generally consistent with the work of Stolorow and his colleagues, discussed above, as well as Herzog's "relational templates" (Herzog, 2004), Lachmann and Beebe's (1996) interaction structures, attachment theory's internal working models (Bowlby, 1979) and the work of Mitchell and other relational theorists on relational patterns (e.g., Mitchell, 1988, 1997). For the purposes of this paper, the nuances of the distinctions between these concepts are not relevant.

3. Based on his empirical research with couples, Gottman and his colleagues (e.g., Gottman & Silver, 2000) have found that it can take at least twenty to thirty minutes for the physiological effects of adrenaline (increased heart rate, increased respiration, etc.) to return to normal once adrenaline has been released into the blood stream. I have at times shared this finding with conflictual couples and families and encouraged them to wait at least that long after an escalation before trying to discuss the problem more calmly.