J Relig Health (2019) 58:612–627
https://doi.org/10.1007/s10943-018-0613-3

PSYCHOLOGICAL EXPLORATION

Repetition Compulsion Revisited in Relational Family Therapy: The Discovery of Old in Order to Develop Something New

Christian Gostečnik[1,2] · Tanja Repič Slavič[1,2] · Tanja Pate[1,2] · Robert Cvetek[1,2]

Published online: 7 April 2018

Abstract Psychoanalysis has always been full of diversity and controversy, in the theoretical field and especially in the plasticity and variety of its modalities and approaches. Yet all these theories are based on the premise that individuals compulsively repeat their old psycho-organic content, both in their personal lives and in analysis; the premise of Relational Family Therapy is that old emotional, behavioral and bodily complications must first be repeated before being fully processed so that something new can be created.

Keywords Compulsive repetition of psycho-organic content · Blocked developmental needs · Transference-countertransference dynamics · Health dialog · Salvation process

Introduction

Analytical treatment, according to Freud, the founder of psychoanalysis, strongly corresponds with the resolution of bodily, sexual vibrations and in this respect the internal psychological dynamics and resolution of instinctual, sexual frustrations that are newly

✉ Christian Gostečnik
christian.gostecnik@guest.arnes.si

Tanja Repič Slavič
Tanja.RepicSlavic@teof.uni-lj.si

Tanja Pate
tanja@pate.si

Robert Cvetek
robert.cvetek@teof.uni-lj.si

[1] Department for Marital and Family Therapy, Psychology and Sociology of Religion, Faculty of Theology, University of Ljubljana, Presernov trg 4, 1000 Ljubljana, Slovenia

[2] Franciscan Family Institute, Ljubljana, Slovenia

created through the mechanism of repetition compulsion, while they can also repeat on the basis of the analytical transfer, they may also find resolution precisely on the basis of the transference (Freud 1895, 1933).

Despite that in later epochs of analysis, there was a marked deviation from Freud's instinct theory, the concept of repetition compulsion remains integral to analysis. Initially the analytical conceptualization developed along the lines of advocating the hidden core of psychopathology in the non-empathic and educational relationship between parents and children; it no longer involved the instinctive and conflictual arena of individual experience (Kohut 1984; Mitchell 1988, 2000, 2002; Winnicott 1988). These authors uphold that even adult individuals have a wounded and fragile child within, waiting for understanding, acceptance, compassion and validation in order to be able to develop. This is why some consider the analysand as one who seeks unfulfilled infantile yearnings (Winnicott 1988), or as one who tries to fulfill the structural deficit (Kernberg 1987). Others consider the analysand as one who tries to fulfill early yearnings for connections that were formerly absent and as such, are being sought for—at the same time also dreadfully feared—in the present relationship with the analyst (Klein 1975). Even the analyst's responsiveness is described as varied, for instance: neutral, empathic, absent, etc. At the same time, the atmosphere in analysis is described as abstinent, educational, and arousing anxiety (Freud 1961). To this regard, modern approaches mainly advocate analysis as being primarily affect regulatory (Schore 2003, 2012), a founding of mindfulness (Siegel 2011) or mutual regulation of emotions (Bruschweiler-Stern et al. 2010; Schore 2003, 2012; Siegel 1999, 2007, 2010; Stern 2004), as well as the essential relational dynamic of counter-transference (Maroda 2010; Scharff and Scharff 2014) to name only a few. We propose, in this contribution, a new approach, which at its core encompasses all the endeavors mentioned above. It also adds the novel, integrative relational family aspect, which considers the essence of the therapeutic relationship as lying in the dynamic of joint growth between the therapist and client and that which enables the analysand to put an end to the old complications and conflicts, with specific regard to the psycho-organic content that is elicited between the two (Cvetek 2015; Cvetek et al. 2006; Gostečnik 2017; Gostečnik et al. 2010; Gostečnik and Repič 2009; Pate 2015).

Psychosexual Fixation and Pathology

Sexual frustration is at the forefront: just as in Freud's analysis, as well as in the analysis of many of his students, the philosophies of whom in many ways, and through a variety of philosophical paths, have also infiltrated modern mentality (Mitchell 1988, 2000). Consequently, the individual, especially their relationship with the other, goes almost entirely unrecognized, even denied and refuted. In this context, the other is merely the object for fulfilling the individual's needs; and at the same time, the other can always be a source of the pathological frustrations that are aroused because of the individual's sexual frustration (Fishbane 2013; Mitchell 1988, 2000, 2002). This dynamic repeats itself all until the analysand resolves the earlier sources of the pathology in the analytical space. We soon realize that the instinct and conflictual or classical psychoanalytic model assumes that the body, with its drives, is either an instrument of pleasure or pathology. Later, analysis of derivatives of the unconscious in free associations, and subsequently also analysis of defense mechanisms (Freud 1911), replaces hypnotism as the basic tool for detecting memory, and yet the detection of memory, based on the transference and as a primary instrument for resolving also instinctive frustrations, remained the central task of the analyst (Mitchell 1988, 2002).

The instinct theory of motivation strongly affected the ensuing trend of analytical development and because of this was so difficult to challenge (Maroda 2010; Schwartz 2001; Siegel and Solomon 2013). Instinct theory provides us with a set of premises about what is reawakened in memory or what is repeated in the individual's present moment. Human organisms with their heritage of biologically based behaviors based off of innate factors produce pre-material, both constitutional and instinctual. Human rationality and the capacity for social consciousness produce the ability to regulate and sublimate prehuman and inhuman bestial instincts for higher social purposes (Freud 1914). Neurosis thus represents the bitter victory of instincts and irrationality. Libido withdrew from the world of real, useful, comfortable intentions and goals, and shifted to infantile incestuous images (Freud 1916). These are correlates to infantile parental images and desires to satisfy, and they trigger neurotic symptoms, which are then reawakened in analysis (Fishbane 2013; Poulton 2013). This also provides the basis upon which a very complex and often literally controversial clinical image of an individual is then composed (Maroda 2010). Said simply, the psychoanalytic situation, as conceptualized in the classical psychoanalytical model, is the scene of a battle between various instinctive forces that are repeated compulsively and fostered by the body and norms set by civilization, culture and religion (Freud 1917).

The genius and innovation of instinct theory is by all means in the discovery of transference (Freud 1912). Transference is the re-experiencing of original infantile desires and fears, only this time in the relationship with the analytic; it manifests primarily as an impasse in the psychoanalytic process in the form of resistance toward re-discovery of infantile desires and fears in their original historical context. In his extraordinary perseverance, Freud (1912, 1914) expanded the concept of transference from impasses in analysis to eventual healing; he discovered that the transferred feelings and images produced significant data despite that they were out of context (Mitchell 2002). Instead of remembering what was experienced vis-à-vis the father or mother, the patient transfers their historical desires into their relationship with the analytic (Freud 1916). Yet this relationship between the patient and analyst is not real and genuine, it is not a dialog; rather, a sort of pristine neutrality governs it. Interpreting transference (the replacing of these feelings and images back into their original context) otherwise produces "an affective experience from the past," and "reawakens the organic sensations," which connects the past with the present, and this is certainly an ingenious creation of the analytical mind (Fishbane 2013; Poulton 2013). What is lacking, however, is recognition of how the analyst in this process, with his or her experiencing, also contributes essential psycho-organic content. It is ultimately the dialog between the patient and analyst, the sacred psychic space they co-create—which was absolutely denied by Freud—that truly enables the analytical meeting (Mitchell 1988, 2002).

However, this apparent objectivity and neutrality—which the instinct and conflictual model of psychoanalytic technique ascribes to the analytic—is not only an obscure phenomenon; rather, it is demanded by the instinct and conflictual premise (Freud 1915). The patient's neurosis manifests as a closed system of instincts and defense mechanisms. The analyst's function is to interpret these conflicts, bring them to awareness, uncover memory and provide insight (Siegel and Solomon 2013). As this process unwinds, the patient experiences the analyst in terms of his or her own internal conflicts. Transference uses resistance to interrupt the analytical process; the analyst resists it by using the transference to work with the memory (Freud 1916). Freud went beyond mere intellectual discourse and soon, on the basis of clinical practice, determined that the phenomenon of transference at the same time presents an impending threat; after all, it often triggers a reaction

(countertransference) in the analyst, who—id stimulated, ego disrupted and superego under attack—is exposed to and weary from the patient's transference (Schore 2012). According to classical analytical theory, the analyst must thus unconditionally strive to conquer these deviations. Even though Freud encouraged analysts to tap into and use their own intuition and unconscious processes, he maintained that the analyst's emotional stance need be reliably calm, objective and neutral. The analyst represents the center of rationality, the main protagonist counter to irrationality and drives. The analyst is present as a function, as an objective interpreter and not as someone with his or her own desires and fears; this of course is radically different to the approach of the relational paradigm (Mitchell 1988, 2000, 2002; Schore 2003, 2012).

It comes as no surprise that clinical, empirical research became an undeniable necessity, as it provided the only means to prove change in the clinical process. Over the course of the last decade, this research has verifiably demonstrated the theoretical and clinical insufficiency of what were notorious theories; we might go so far as to say that we are now witnessing the dawn of a new era of psychoanalysis. In short, very specific concepts and therapeutic models have begun to dominate psychoanalytical reasoning in modern times, and they are gaining validity (Schore 2012). These new theories have very different premises, histories, central metaphors and clinical implications, however, for whatever variety of reasons, they are either still or increasingly prevalent (Fishbane 2013; Fosha et al. 2009; Maroda 2010; Mitchell 1988, 2000, 2002; Poulton 2013; Schore 2012; Siegel and Solomon 2013). Significant authors of the last three decade—Loewald (1980, 1988), Schafer (1997), Modell (1984), Schore (2003), Stern (1995, 2004), Fonagy et al. (2007), Fosha et al. (2009), Maroda (2010), Siegel (2011), Scharff and Scharff (2014), Schore (2003, 2012) and Siegel and Solomon (2013) etc.—would struggle to accept any of the past models, least of all just one exclusively. In conclusion, today, the majority considers their analytical work to be a complex combination of a variety of approaches that tend to overlap, while still retaining radical differences with each other. This applies not only to the basic approaches themselves, but also and especially to the track of reasoning applied and the corresponding core assumptions. The following will present the strongest trends that have validity in the post-Freudian era.

Recognizing and Repeating Blocked Developmental Needs

The model that deals with frustrated developmental needs (Clulow 2005; Kohut 1984; Winnicott 1988) could in fact be regarded as an analysis of repeating patterns of emotions and behaviors, their origins being in the infantile period, when these developmental elements were blocked or left unmet due to parental unavailability, neglect, or abuse. This is in fact an approach that focuses on developmental obstacles or unmet needs; it opposes instinct theory and is entirely a relational model. This model is almost exclusively focused on the early mother–child relationship; as such, this relationship is evaluated quite differently (Siegel and Solomon 2013). The creation of intrapsychic images and later relationships, as well as the entire spectrum of psychoanalytical conceptualizations, therefore focuses on the early mother–child relationship, considered the source of all psychopathology (Kohut 1984; Winnicott 1988). The analytical process of therapy in this model addressing obstructed development works to heal the paralyses and distortions that developed due to unfulfilling early relationships, and which then get repeated while creating the present (Siegel and Solomon 2013). It could hold that theorists of this model assume that the intrapsychic, as well as interpersonal relationship (however, this latter is frozen or concealed due to early trauma and affective complications), is repeated in

adulthood and reawakened in the analytical relationship or process. Winnicott (1988), Guntrip (1971) and Kohut (1984) are considered the primary authors of theories focusing on developmental obstacles, and while their approaches and reasoning of the analytic process in many ways overlap, they were certainly not identical.

Psychopathology, for Winnicott (1988), is a manifestation of developmental fixations that are repeated throughout adulthood. It is not only about the development of impulses and drives, rather the self, which develops from predetermined emotional needs. Parents produce certain emotional reactions and an affective atmosphere that is necessary for the self to develop and maintain a sense of integrity, continuity, vitality and coherence (Clulow 2005). If this responsiveness is lacking or absent, the natural process of maturation is obstructed. The vital and central part of the personality—or the true core of the child's subjectivity—stops developing. The "false," shallow psychological structure then builds around this buried core; it is in no way the true self. Winnicott (1988) warns analysts to avoid the "false assumption that an individual actually exists" (Winnicott 1988). Despite the continuation of chronological time, the individual in fact does not age psychologically and only remains frozen in terms of their developmental needs. Early unmet needs remain protected in the cocoon of defense mechanisms (Clulow 2005). New growth is only possible once the maternal functions are reacquired; these are indeed created by the analyst, reawakened in the therapeutic process (Mitchell 1988, 2002). While the main task of the classic instinctive and conflictual model is in the discovery and eventual failure to understand ourselves as bestial, the central theme of the obstructed development model is the rebirth and reanimation, the reawakening of our selves as children (Bradley 2000; Bruschweiler-Stern et al. 2010; Mitchell 1988, 2002; Schwartz 2001; Siegel 1999, 2007, 2010, 2013; Stern 2004, 2010).

Analysts of the obstructed development theory strive to fix the developmental deficits that the child suffered while growing up. Winnicott (1988), for example, outlines the analytical process in terms of reawakening the subjective omnipotence of the true self. He views the fundamental dimension of early development moving from the initial sense of subjective omnipotence through ambivalent "transition" to eventual tolerance of the objective reality. This process is enabled only by a "good enough mother" (or primary caretaker), who due to her "primary maternal preoccupations" models the world right from the onset and thus actualizes the child's desires and fantasies. The mother slowly withdraws from this role of adaptation and thereby enables her child to be able to tolerate the inevitable disappointments that come from objective reality, as well as the remaining subjectivities beyond his control (Clulow 2005). If the mother fails to play this critical role well enough, the child, unable to integrate their own subjectivity, experiences the mother as intrusive. The core of existence is thus blocked, buried; and while committed, a false adaptation to external pressures is modeled. Psychological growth is thus suspended. The mother's inability to approach her child in the right way during this earliest period thwarts the child's self (Winnicott 1971). The analyst's empathic attitude and approach is certainly significant here, in that it can often trigger fierce resistance because the patient fears they will re-experience deep disappointment, this time when feeling attachment to the analyst. The analyst will thus have to be adept at identifying this resistance and the hidden, chilling fear of attachment at the root of it, before being able to create something new in the analytical process (Clulow 2005).

Kohut (1984) particularly sought to develop and clinically resolve this deficiency from childhood, which is then constantly recreated in adulthood; he likewise addresses the dialectic between narcissistic satisfaction and the unavoidable, heavy disappointments that gradually produce a capacity to tolerate more realistic experiences of the self and others,

through a process he calls "transmuting internalization." If parents fail to produce and protect the vulnerable and fragile atmosphere, the process ends with a forced adaptation to the objective reality. Winnicott (1988) is referring to a similar concept when he speaks of "intrusiveness," whereby various narcissistic segments split off and prevent further growth. The end result is a self that is experienced as void, plundered, fragile and fragmented (Kohut 1984). Both authors sought to create the conditions in analysis in which the patient will be able to avail themselves of their developmental deficits. This is particularly true by Winnicott (1971, 1988), who claims that the analytical process needs to create the missing parental functions both in the analytical setting as well as in the analyst; and further, that the analyst should strive to allow development to come to a halt and the maturation process to begin anew. His rich efforts describe several examples, from varying points of view, regarding the patient–analyst relationship and the myriad of interactions between them, all of which are interpreted as a reawakening of a normal, functional mother–child relationship.

Winnicott (1988) views the analytical process of healing the self as one in which the corrective environment enables the false, compensational adaptation of the self to dissolve; this in turn allows the halted development to begin anew. The tendency to regress is in this regard understood as the individual's capacity, which will guide him or her toward resolution and a healing. The analyst's ability to provide the maternal functions is critical in this reawakening. The analyst must be able to play the maternal role for the patient-child (Winnicott 1988). This of course means that all responsibility and agency for change in the patient is upon the analyst, who must create the conditions conducive to resolving the repetitive past (Clulow 2005). At the same time, this marks the essential difference between the obstructed developmental and instinctive conflictual models, that is, their emphases greatly diverge. The former takes "something old and creates anew" in the analytical setting, whereby the patient experiences the analyst as an object of conflicting desires from their past. The new elements in the analytical relationship (relationship, working alliance, etc.) are important tools through which the patient experiences and eventually discards these desires. This kind of frustration is a key factor for analytical change; the old is declined, canceled, thus enabling resolution of the conflict in an atmosphere that is essentially an abstinently analytical relationship (Maroda 2010; Mitchell 1988, 2000, 2002; Schwartz 2001; Siegel and Solomon 2013).

Contrary to the analyst's stance in the instinct model, the analyst in the obstructed development model must create, or structure, the analytical process so as to generate novel experiences for the patient, in fact those that were absent already during early development (Clulow 2005; Kohut 1984; Winnicott 1988). The old elements that reappear and continue to repeat, and which are a result of developmental deficits, need to be surpassed in analysis. If the classic model presents the patient as one of bestial drives, the obstructed development model views the patient as an authentic self, unformed, and waiting for the necessary conditions to develop (Clulow 2005). The analyst certainly cannot satisfy all these needs, however, he or she can respond to the patient's rage and disappointment with empathy, thus enabling the patient to at least begin resolving old developmental complications. Analysis is thus a reawakening of the authentic self; as such, the analyst needs to be both educational and empathic, all the while with the intention of allowing the patient their initial resistance, which can subsequently develop into something different and new, but it can be intimidating (Clulow 2005; Kohut 1984; Siegel and Solomon 2013; Winnicott 1988).

Analysis as a Healing Dialog

The relational family paradigm poses that the patient–analyst relationship creates the sacred and psycho-organic space where the basic healing dialog transpires (Gostečnik 2017). It is about two bodies that are feeling deep internal and external organic sensations, mental and emotional vibrations, all on the basis of which the dialog develops. The relational model, as developed by Mitchell (1988, 2000, 2002), integrating the basic theories of object relations with interpersonal psychoanalysis and corresponding with the main trends in self-psychology, as well as with certain elements of existential psychoanalysis and attachment theory, demonstrates a novel and radically different understanding of the individual. It diverges entirely from the instinct model, and the relational family paradigm embraces it as the basis for the intrapsychic level in its systemic configuration. The authors of this model developed their premises on the fact that tracing and preserving human relationships is a fundamental maturational process in the human experience. The relational family paradigm, contrary to the obstructed development model, while it does view problems and deficiencies in early relationships with parents as gravely influential upon subsequent relationships, it does not view them to be frozen infantile needs, as is posed in self-psychology or the obstructed development model. Rather, these deficiencies precipitate the complex process through which a child perceives the interpersonal world, and they are then are fully repeated in analysis (Fishbane 2013; Poulton 2013; Scharff and Scharff 2014; Siegel and Solomon 2013).

The relational family paradigm (Gostečnik 2017) does not lessen the significance of expanding awareness. Rather, its central mechanism is to consider analytical changes in the exchange of basic structures from the patient's relational psycho-organic familial world—because this is where interpersonal communication is possible and where individual members, through right-hemisphere bodily dynamics, express the most important information regarding a sense of belonging, feeling loved, desired, etc. However, before being able to fully attune to and feel the patient in his or her entirety, the analyst must first feel their psycho-organic content, which mainly manifests through bodily sensations. It is more than just revealing organic, sexual impasses and frustrations, in fact it is about recognizing and accepting the patient's psycho-organic states; these are then the building blocks for the analytical dialog and joint growth between the analyst and patient (Cvetek et al. 2006; Gostečnik 2017; Gostečnik et al. 2009).

To summarize, authors of relational models depict an analytical process quite different from instinct theory. In particular, they emphasize the various extents of the relational matrix: organization of the self, object relations and transactional models, as well as systemic principles. For instance, self-psychology, or organization of the self (Kohut 1984; Winnicott 1988) enables the patient to discover, re-establish and fully experience those parts of the self that were previously discarded, hidden and disowned. The analyst needs the relationship to be structured along the old parameters. Anxiety and disappointment are anticipated right where they were ever experienced, and concealing various other parts of the patient's experience. The analyst touches upon those parts of the patient's life that are full of anxiety. The analyst's participation in a new form of interaction enables the patient to face hitherto unknown aspects of their experiencing, to name them and process them (Clulow 2005; Kohut 1984). The patient is then able to adopt a different personality in their experiencing of the analyst and others (Mitchell 1988, 2000, 2002; Siegel and Solomon 2013).

Similarly, the relational authors Fairbairn (1956) and Racker (1968) describe this same kind of transformational process of internal object relations or representations of intrapsychic images, which are in many ways founded on the psychobiological states and their affects (Schore 2003, 2012) and they compose the constitutive elements of the psyche. According to these theories, the self develops complementary with the character structure of significant others. Areas of deprivation, limits and intrusions cause the child to unconsciously attach to that particular emotional content in their parents; simply put, it is the part that facilitates connection. And this content is initially flavored with bodily sensations (Siegel 1999, 2007, 2010; Siegel and Bryson 2011). This connection then becomes a tool for preserving feelings of connectedness and relationships with others (Fosha et al. 2009; Siegel and Solomon 2013). Early relations, especially internal and external organic sensations, are unconsciously preserved as an intense internal presence (Bruschweiler-Stern et al. 2010; Stern 2004, 2010). Current relationships with others are experienced in terms of projection, as intrapsychic images and psycho-organic structures, and then ultimately, completely new experiences are structured through reintegration into unvarying, old configurations (Cummings and Davies 2010). Analytical change comprises a change of these internal psycho-organic structures, and consequently relations. The analyst, whom the patient experiences as a characteristically bad object, an other, becomes a different type of other, through the process of interpretation, and ultimately someone who can help (Scharff and Scharff 2014).

Internalization of this experience enables the patient to let go of their compulsive connection to old relational forms, to their attachment to deficient intrapsychic psycho-organic images. The intrapsychic field of his or her relational matrix thus transforms. The individual does not only experience their self as a new personality, but also as someone in an entirely new environment (Fairbairn 1958). Similarly, analysts of the interpersonal tradition focus on the manner in which the analytical process facilitates change in the individual's transactional models (Bruschweiler-Stern et al. 2010; Stern 2004, 2010). Anxiety forces the individual into repetitive, constrictive models of interaction with others, and then to form rituals that predetermine the experience of the self, as well as of others. These models are articulated and clarified during the analytical process, and this helps the patient to try something new, to place themselves in different interpersonal situations, ones that are conducive to a richer experience of the self and others (Bruschweiler-Stern et al. 2010; Stern 2004, 2010). These changes in transactional models take place beyond the walls of the analytical situation, during which the analyst consistently brings attention to the stereotypical models and how they compulsively play out, as well as during analysis while the analyst and patient, together seek out and co-create a way of being with each other beyond these set models (Bruschweiler-Stern et al. 2010; Cummings and Davies 2010; Sullivan 1953).

Mitchell (1988, 2000, 2002) claims that these three models clarify varying approaches to the same process whereby patients reduce anxiety and generate a sense of safety by maintaining old models, illusions and stereotypes of behavioral patterns. These illusions and models are familiar, and they facilitate preserving the feeling of loyalty and connection (Clulow 2005). So, intrapsychic images generated by psychobiological states (Schore 2003, 2010) and the corresponding affects and regulatory systems are sticky and repetitive because they are familiar, and because they help to minimalize anxiety. The joint etymological source of the terms "family" and "familiar" is the Latin word "famulus," which means "servant" and "slave" in a household; it emphasizes the direct link between human connections (Mitchell 1988, 2002). Maintenance and coherence of the self, and preserving safe models of interaction, all links to generating a sense of safety and security in the

connection with others, regardless of how painful, dangerous or destructive these relationships may be (Clulow 2005; Poulton 2013). Quite generally, the goal of all three relational theories is aimed at answering the question: Why do people consistently, continually and repetitively re-enact the same conflicts and traumas in their relations with others (Bruschweiler-Stern et al. 2010; Clulow 2005; Cummings and Davies 2010; Fosha et al. 2009; Mitchell 2000, 2002; Stern 2004)?

In response to this question, object relations theory claims that relational patterns are repeated because they preserve the initial psycho-organic connection formed with the significant other, or caregiver, from early childhood (Bruschweiler-Stern et al. 2010; Poulton 2013; Silverstein 2007; Stern 2004, 2010). Anything new is unconsciously recognized and considered frightening and perhaps even threatening, as it would require new ways of interacting and reacting, and a relinquishing of the old relational models in which the individual felt safe, connected and protected, regardless of their possibly traumatic nature. The idea here is that at least the individual was in any relationship at all—whatever the cost—and enduring in it simply because he or she could not survive without it (Poulton 2013). At the same time it represents the only manner of relating known, and if it happened to be pathological, then this is the recurring manner in which new situations and interactions with new people will be created, just to be connected. The blocked developmental model, advocated mainly by self-psychology theorists (Kohut 1984; Winnicott 1988), claims that the main unconscious human experiencing and drive is to preserve cohesion of the self. The individual repeats old models of behavior with the unconscious hope that someone will understand and empathically reflect his or her wants and needs (Simonič 2015). Whatever is new and novel is actually also dangerous, because it transpires beyond recognition and personal experience, which is where the individual recognizes their self as a cohesive entity. From the perspective of interpersonal analysis, these theories explain the dynamic of repetition compulsion of old models as viewed from the individual's unconscious search for familiarity and interpersonal control of the environment by repeating similar relational models, all learned in the early developmental period (Bruschweiler-Stern et al. 2010; Cummings and Davies 2010; Stern 2004). Individuals unconsciously fear facing and dealing with new forms of relationships; they find them threatening—because they most fear feeling lonely, isolated and unprotected—and the old and familiar models provide them with interpersonal connection, regardless of how painful or traumatic and problematical these relationships may turn out to be (Mitchell 1988, 2000, 2002; Mitchell and Black 1995).

This leads us to believe that all these three models approach the dynamic of repetition compulsion through the lens of primary, familiar and relational models; while they all touch upon defensive states, they are paying attention to varying proposed themes. All three theories intersect on the basic premise that the individual reactivates archaic and primary relational models with the purpose of preserving safety and protection, of avoiding feelings of guilt and anxiety, and of preserving a sense of a cohesive self (Mitchell 1988, 2002; Schore 2012). So ultimately, these three theories see the individual who comes to therapy as someone whose intention is to find something new and something old. The patient is experiencing something dysfunctional in their life and an initial goal of therapy is to define what is wrong, to seek resolution and hope that they will generate something new with the analyst. The patient in analysis thus unavoidably seeks out something new in an old and familiar manner; therapy is structured along old relational lines and the patient strives to include the analyst on the basis of pre-structured ideas of how people truly connect and let each other feel felt by the other (Bruschweiler-Stern et al. 2010; Fonagy et al. 2007; Fosha et al. 2009; Mitchell 2002; Siegel and Solomon 2013). The analyst has

several options available, that is, varying roles that she or he can activate. These roles vary through the configuration of therapy sessions or even in a single hour (Mitchell 2000; Schore 2003, 2010; Siegel 1999, 2007, 2010; Siegel and Bryson 2011; Siegel and Solomon 2013). It is of utmost importance that the analyst creates a sacred space for the exchange of all these significant relational configurations; this is often the only way to reach the deep, frozen themes that block the sixth sense, or intuition, as well as the seventh sense, which is what ultimately truly enables critical retrospection (Fosha et al. 2009; Maroda 2010; Robins 2010; Schore 2003, 2010; Siegel 2007; Siegel and Bryson 2011; Siegel and Solomon 2013).

Of course, fundamental questions arise here: where does the analyst place herself with regard to these premises and hope? What does she strive to achieve? How does she endeavor to loosen the ties of the relational strings? Right off, we answer this question from the standpoint of the instinct model. As we have already seen, the classic stance places the analyst outside the patient's relational matrix, where she seeks out the archaic, conflicting elements and strives to help the patient part with their infantile promises and desires (Mitchell 1988, 2000, 2002). The other three theories we address here have radically different views on this matter. For example, the blocked developmental theory also places the analyst outside the individual's relational matrix, and tries to guide the patient toward something new, yet in a very different way (Clulow 2005; Kohut 1984; Mitchell 2002; Winnicott 1988). While the patient is actively included in the dialog, this theory holds precisely the analyst entirely responsible for this analytic dialog. Mitchell (1988, 2000, 2002) makes a revolutionary step forward and places the analyst in the middle of the structure of repetitive relational configurations. The challenge to find a way out of this complex relational field demands a joint, collaborative analyst-patient effort to notice, reveal and understand these relational configurations, and to discover new channels through which they can include and connect with one another; the belief is that only this can facilitate critical change in analysis (Mitchell 1988, 1993, 2000). Similarly, the relational family paradigm takes another radical step forward and places the analyst in the very core of the analytical situation; the analyst must first experience the fundamental affective, psycho-organic structure of the family system, with all the corresponding and significant physical sensations. Only once the analyst becomes a part of the patient's experience—albeit with her own psycho-organic responses and vibrations—is it possible for the analyst to introduce something new to the relational family configuration by guiding the entire system through new forms of creating relational configurations (Gostečnik 2017).

It is noteworthy that this type of approach to the analytical situation evolved not only in theory, but as the result of various theoretical and clinical traditions and it was resoundingly described by authors such as Levenson (1983), Racker (1968), Gill (1994), Sandler (1987), Mitchell (1988, 2000, 2002), Schore (2003, 2012), Fonagy et al. (2007), Fosha et al. (2009), Siegel and Solomon (2013), Stern (1995, 2004, 2010) and Scharff and Scharff (2014) etc. For each of these authors, the analytical process was inscribed deeply in the relational canvas. There is no perceivable way that the analyst could possibly avoid taking on a role in the configuration of the patient's relational matrix; the analyst always plays a certain role, no matter how hard she may try to stay detached from the patient's world. Even the effort itself to avoid playing a role is a manifestation—in manner and relational form—of the patient's repertoire of roles and characteristics. The patient's subjective experience is thus the analyst's predetermined role and an imperative for therapy. The common denominator of all these theories is that the analyst must always take the stance of a specific analytical perspective and endeavor to consistently reflect her questions regarding all the analytical data during the therapy session and create something new on

the basis of the old format. The relational family paradigm (Cvetek 2015; Gostečnik 2017; Gostečnik et al. 2008, 2009; Pate 2015) adds to this how important it is to maintain the psycho-organic space, where a constant battle to understand this transpires between the analyst and patient; after all, it is the most efficient representation of the patient's repetitive relational configurations.

The relational family paradigm thus encompasses all these fundamental themes and adds the refinement of the psycho-organic structure together with core affects and their regulation. Furthermore, it includes the religious, sacred perspective. While all these analytical approaches (except the instinct model) already also include the feeling of sacredness, as a spiritual experience or something that transcends, they do not explicitly express it. All these models also implicitly respect and take into account the body, or bodily sensations, core affects and their regulation; the relational family paradigm actually articulates it. The relational family paradigm is completely founded on the analytical and theological understanding of humans as sacred beings that yearn for salvation from old structures; and as such, repetition compulsion is merely the manifestation of the intention to find resolution (Cvetek 2012, 2014; Gostečnik 2011, 2017; Gostečnik et al. 2009, 2010; Gostečnik and Repič 2009; Simonič and Klobučar 2017; Vidmar 2014; Vodičar 2016). It also takes into account all psycho-organic sensations and the perspective regarding right hemisphere to right-hemisphere communication (Schore 2003, 2012); this interpersonal communication between the analyst and patient builds the fundamental information, forming the basis for intuition, the sixth sense and largely also the seventh sense, which ultimately yields the perspective of humanity in full.

Conclusion

Information, content and the affective tone are highly significant in the relational model developed my Mitchell (1988, 2000, 2002); he understands the depth of their impact, as regards their roles and the analyst's stance toward the patient. Interpretation is not a complex relational event just because it changes something in the patient's internal world, nor because it dissolves impasses in the developmental process; actually, it proffers something significant about the analyst's position in challenging the patient, and about the relational style that can develop between them. While the relational family paradigm (Gostečnik 2017) values interpretation, it does not have a primary role just for its insight; rather, on the basis of the sacred relationship or the psycho-organic space between the analyst and patient, it configures anew the old relational family model and provides the chance for new balance or change to transpire. It is about healing old and repetitive relational configurations, psycho-organic content that serves to maintain systemic homeostasis, while at the same time blocking it and preventing development and growth. Symptoms are understood as a "cry" from the entire family system, which is in desperate need of change. In effect, the analyst is very active, all the while remaining an empathic teacher and listener, one who uniquely and authentically re-experiences the system of relationships predominantly on the basis of her own countertransferential content (Maroda 2010) and bodily sensations, or right-hemisphere communications (Schore 2003, 2012), as she endeavors to establish a more functional regulatory system for core affects. Basically, the analyst first becomes part of the patient's system and only then, and together with the patient, strives to restructure how the patient recognizes and takes in the old repetition compulsion and then together create something new.

The relational family paradigm assumes that while engaging in conversation with an other, we are also working internally, creating and transforming. This kind of unique communication encompasses more than merely spoken words; in fact it is primarily about right-hemisphere communication (Schore 2003, 2012), it is about how we fundamentally impact and transform each other. Behavior and co-creation in analysis will arise from this right-hemisphere interaction (Mitchell 1988; Schore 2012; Siegel and Solomon 2013). It is therefore imperative in the analytical relationship to find voice for this, so as to facilitate a useful interpretation, which in itself encompasses a passionate struggle: how to use the transference-countertransference configuration, right-hemisphere communication, organic sensations, intuition and the seventh sense to create a functional and regulatory affective dynamic? Already decades ago, Levenson (1983) characterized this process as a supportive transformation, while Racker (1968) refers to it as managing the countertransference. It is in fact a bi-level process. The patient must fall into transference before he or she can find a new way out of it. Similarly, the analyst must first experience the countertransference (Maroda 2010), find herself within it, find herself also in the patient's organic sensations, her own core affects, before they can begin to develop and co-create new directions. Of course, all these mechanisms, which play fundamental roles in creating the psycho-organic space between the analyst and patient—such as transference-countertransference (Maroda 2010), projective and introjective identification (Scharff and Scharff 2014), right-hemisphere communication, affect regulation (Schore 2003, 2012), etc.—are all dialogical in their core.

In the relational family paradigm, the analyst is the one who creates the psycho-organic and sacred space between the patient and analyst, as a co-author and co-creator of a passionate drama that encompasses love and hate, intimacy and distance, intrusion and rejection, victim and abuser, and at the same time being the most essential co-creator of change, which comes with the grace of salvation. Regardless of which path is chosen, the analyst will always fall into the patient's predetermined category, and this is also how the patient will experience the analyst in his or her own relational world. This is where the struggle begins to attain a new way of being, both for the patient and the analyst—to find a new way of being with the patient, a way in which no one need, or will, be dissolved or removed, misguided or rejected, a victim or abuser. The challenge is in finding authentic voice with which we speak with the patient, a voice that is more personal and less modeled through psycho-organic relational configurations and with limited options from the patient's relational world. This provides the patient the chance to expand his or her relational matrix (Maroda 1991, 2010; Siegel and Solomon 2013). The relational family paradigm tracks a constant oscillation between old and new psycho-organic relational configurations, between the articulation of passion and organizational structures from the patient's phenomenology and the introduction of the analyst's perspective (not so much as one that is more real or mature, rather just different and perhaps useful). The analyst is constantly central to the process of the patient's integration; together, and through affect regulation, they co-create new relational configurations.

The goal is to expand the psycho-organic space and all of the patient's relationships with a richer, fuller, more dialectic experience of their entire system; it requires providing the patient the opportunity to transcend their own repetition compulsion of old patterns and to experience novel relational forms that are healthier and more functional. The patient's experience of the interpersonal psycho-organic space, or the sacred arena between the patient and analyst, is the experience of something that transcends; after all, it is an interactive meeting between two individuals, or between the analyst and the patient's entire relational system from the past. The problem, however, no longer lies in the relationship

with past significant others, but rather in how to connect, to surrender, to dominate, to merge, to master, to love, to be loved, to use and be used in the present or the here and now; between the analyst and patient, who co-create the new psycho-organic space and lay it out with new content. The desire and passionate yearning for novelty and for surrender is no longer understood as coming from the patient's or relational family dynamic, nor as a derivate of instinct that needs to be rejected, nor as authentic growth requiring conditioning; rather, the desire is seen as the patient's relational struggle to connect with the analyst in a way that together they may form something new.

We, as relational beings, actually invest our lives in searching for the good in this promise, while at the same time remaining vaguely aware of the danger and deception of it. The relational family approach is thus a promise to achieve something novel and different, although this promise cannot be fulfilled until the patient's psycho-organic relational configuration of their entire family system is changed. Change occurs only once the analyst experiences the patient's fundamental features, which based on the relational family paradigm is best facilitated by the countertransferential relationship, right–right-hemisphere communication with the patient, and careful attention to all the bodily sensations that are awakening in their psycho-organic space. So the analytical circumstance organizes itself around the patient's relational family conflicting desires and the patient's organic vibrations, together with a fear of analysis itself, which in almost every case the patient can experience as a surrender to an illusionary and complete care, a product of the analyst's interpretation. At the same time it is experienced as a terribly frightening situation, one where the most fundamental affective and conflictual relationships from the patient's history are being repeated, often colored with unnerving bodily sensations and barely functional regulatory mechanisms.

The analyst, in the analytical relationship, and without really wanting or being aware of knowing, will soon sense that voice from the patient's past, the one that deeply scores and aggravates, basically in order to identify—through projective and introjective identification—with the patient's intrapsychic images, physical sensations, and core affects from the past. The real struggle, the one for the analyst's authenticity, begins once the analyst becomes aware of having taken on the form of someone significant in the patient's life, thus enabling the countertransference. At this point the analyst must endure, so that the patient will be able to fully play out the core affects of experiencing their self in the dynamic of being with an other. This is what will allow the analysis to begin, this is where the interpersonal sacred psychic space will develop for the patient and analyst to resolve the past issues in dialogical form, and this will give possibility for a new one. Overall, there are no new discoveries here. It is simply a gradual process of resolution through the analyst's perception of core affects, the affective mental constructs, the interpretative activity and identification of bodily sensations that finally allow a new way of affect regulation.

Funding This study was funded by Slovenian Research Agency (Project No. J5-6825).

Compliance with Ethical Standards

Conflict of interest All authors have no conflict of interest.

Ethical Approval This article does not contain any studies with human participants or animals performed by any of the authors.

References

Bradley, S. J. (2000). *Affect regulation and the development of psychopathology*. New York: The Guilford Press.

Bruschweiler-Stern, N., Lyons-Ruth, K., Morgan, A. C., Nahum, J. P., Sander, L. W., Stern, D. N. S., et al. (2010). *Change in psychotherapy: A unifying paradigm*. New York, NY: W. W. Norton & Company.

Clulow, C. (2005). Partnership and marriage. In E. Rayner, A. Joyce, J. Rose, M. Twyman, & C. Clulow (Eds.), *Human development: An introduction to the psychodynamics of growth, maturity and ageing* (pp. 213–230). London: Routledge.

Cummings, E. M., & Davies, P. T. (2010). *Marital conflict and children: An emotional security perspective*. New York, NY: Guilford Press.

Cvetek, M. (2012). Čustveno odpuščanje v medosebnih odnosih [Emotional forgiveness in interpersonal relationships]. *Bogoslovni vestnik, 72*(2), 281–295.

Cvetek, M. (2014). *Živeti s čustvi: Čustva, čustveno procesiranje in vseživljenjski čustveni razvoj [Living with emotions: Emotions, emotional processing and lifespan emotional development]*. Ljubljana: Teološka fakulteta.

Cvetek, M. (2015). Vloga čustvenega procesiranja v relacijski zakonski in družinski terapiji. In B. Simonič (Ed.), *Relacijska družinska terapija v teoriji in praksi* (pp. 35–48). Ljubljana: Teološka fakulteta, Univerza v Ljubljani in Frančiškanski družinski inštitut.

Cvetek, R., Kompan Erzar, K., Erzar, T., & Gostečnik, C. (2006). Relational family therapy. In J. S. Scharff & D. E. Scharff (Eds.), *New paradigms for treating relationships* (pp. 51–61). New York, NY: Jason Aronson.

Fairbairn, W. R. D. (1956). A critical evaluation of certain basic psycho-analytical conceptions. *British Journal for the Philosophy of Science, 7*(25), 49–60.

Fairbairn, W. R. D. (1958). On the nature and aims of psychoanalytic treatment. *International Journal of Psychoanalysis, 39,* 374–385.

Fishbane, M. D. (2013). *Loving with the brain in mind*. New York, NY: W. W. Norton & Company.

Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2007). *Affect regulation, mentalization, and the development of the self*. New York, NY: Other Press.

Fosha, D., Siegel, D. J., & Solomon, M. F. (Eds.). (2009). *The healing power of emotion: Affective neuroscience, development, and clinical practice*. New York, NY: W. W. Norton & Company.

Freud, S. (1895). Project for a scientific psychology. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 1, pp. 283–398). London: Hogarth Press.

Freud, S. (1911). Formulations on the two principles of mental functioning. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 218–226). London: Hogarth Press.

Freud, S. (1912). The dynamics of transference. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 97–108). London: Hogarth Press.

Freud, S. (1914). Remembering, repeating and working through. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 147–156). London: Hogarth Press.

Freud, S. (1915). Papers on metapsychology. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 14, pp. 159–260). London: Hogarth Press.

Freud, S. (1916). Introductory lectures on psycho-analysis. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 15–16, pp. 9–469). London: Hogarth Press.

Freud, S. (1917). *Mourning and melancholia* (Vol. 14). London: Hogarth Press.

Freud, S. (1933). New introductory lectures on psycho-analysis. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 22, pp. 5–185). London: Hogarth Press.

Freud, S. (1961). The ego and the id. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 19, pp. 12–59). London: Hogarth Press (Original work published 1923).

Gill, M. M. (1994). *Psychoanalysis in transition*. Hillsdale, NJ: Analytic Press.

Gostečnik, C. (2011). *Inovativna relacijska družinska terapija [Inovative relational family therapy]*. Ljubljana: Brat Frančišek, Teološka fakuleta in Frančiškanski družinski inštitut.

Gostečnik, C. (2017). *Relational family therapy: The systemic, interpersonal, and intrapsychic experience*. New York, NY, US: Routledge/Taylor & Francis Group.

Gostečnik, C., Repič, S. T., Cvetek, M., & Cvetek, R. (2009a). The salvational process in relationships: A view from projective-introjective identification and repetition compulsion. *Journal of Religion and Health, 48*(4), 496–506.

Gostečnik, C., Repič, S. T., Cvetek, M., & Cvetek, R. (2010). Hidden mission of the psyche in abuse and addiction. *Journal of Religion and Health, 49*(3), 361–376.

Gostečnik, C., & Repič, T. (2009). Relational marital paradigm. *American Journal of Psychotherapy, 63*(1), 1–12.
Gostečnik, C., Repič, T., & Cvetek, R. (2008). Redemptive experience in relational family therapy: A Christian perspective. *Journal of Religion and Health, 47,* 386–397.
Gostečnik, C., Repič, T., & Cvetek, R. (2009b). Potential curative space in relational family therapy. *Journal of Family Psychotherapy, 20*(1), 46–59.
Guntrip, H. (1971). *Psychoanalytic theory, therapy and the self*. New York, NY: Basic Books.
Kernberg, O. F. (1987). Projection and projective identification: Developmental and clinical aspects. *Journal of the American Psychoanalytic Association, 35,* 795–819.
Klein, M. (1975). *Envy and gratitude and other works 1946–1963*. London: Hogarth Press.
Kohut, H. (1984). *How does analysis cure?*. Chicago, IL: University of Chicago Press.
Levenson, E. (1983). *The ambiguity of change: An inquiry into the nature of psychoanalytic reality*. New York, NY: Basic Books.
Loewald, H. (1980). *Papers on psychoanalysis*. New Haven: Yale University Press.
Loewald, H. (1988). *Sublimation: Inquiries into theoretical psychoanalysis*. New Haven, CT: Yale University Press.
Maroda, K. J. (1991). *The power of countertransference: Innovations in analytic technique*. New York, NY: Wiley.
Maroda, K. J. (2010). *Psychodynamic techniques: Working with emotion in the therapeutic relationship*. New York, NY: Guilford Press.
Mitchell, S. A. (1988). *Relational concepts in psychoanalysis*. New York, NY: Basic Books.
Mitchell, S. A. (1993). *Hope and dread in psychoanalysis*. New York, NY: Basic Books.
Mitchell, S. A. (2000). *Relationality: From attachment to intersubjectivity*. New York, NY: The Analytic Press.
Mitchell, S. A. (2002). *Can love last? The fate of romance over time*. New York, NY: W. W. Norton & Company.
Mitchell, S. A., & Black, M. J. (1995). *Freud and beyond: A history of modern psychoanalytic thought*. New York, NY: Basic Books.
Modell, A. (1984). *Psychoanalysis in a new context*. New York, NY: International Universities Press.
Pate, T. (2015). Relacijska družinska terapija in dinamika otrokove kronične bolezni v družini. In B. Simonič (Ed.), *Relacijska družinska terapija v teoriji in praksi* (pp. 135–149). Ljubljana: Teološka fakulteta, Univerza v Ljubljani in Frančiškanski družinski inštitut.
Poulton, J. L. (2013). *Object relations and relationality in couple therapy: Exploring the middle ground*. New York, NY: Jason Aronson.
Racker, H. (1968). *Transference and countertransference*. New York, NY: International Universities Press.
Robins, S. P. (2010). *Exploring intimacy: Cultivating healthy relationships through insight and intuition*. Lanham: Rowman & Littlefield Publishers.
Sandler, J. (1987). *Projection, identification and projective identification*. Madison: International University Press.
Schafer, R. (1997). *Tradition and change in psychoanalysis*. Madison, CT: International Universities Press.
Scharff, J. S., & Scharff, D. E. (2014). *Psychoanalytic couple therapy: Foundations of theory and practice*. London: Karnac Books.
Schore, A. N. (2003). *Affect regulation and the repair of the self*. New York, NY: W. W. Norton & Company.
Schore, A. N. (2010). Relational trauma and the developing right brain: The neurobiology of broken attachment bonds. In T. Baradon (Ed.), *Relational trauma in infancy: Psychoanalytic, attachment and neuropsychological contributions to parent-infant psychotherapy* (pp. 19–47). New York, NY: Routledge.
Schore, A. N. (2012). *The science of the art of psychotherapy*. New York, NY: W. W. Norton & Company.
Schwartz, J. (2001). *Cassandra's daughter: A history of psychoanalysis*. London: Penguin.
Siegel, D. J. (1999). *The developing mind: Toward a neurobiology of interpersonal experience*. New York, NY: Guilford Press.
Siegel, D. J. (2007). *The mindful brain: Reflection and attunement in the cultivation of well-being*. New York, NY: W. W. Norton & Company.
Siegel, D. J. (2010). *The mindful therapist: A clinician's guide to mindsight and neural integration*. New York, NY: W. W. Norton & Company.
Siegel, D. J. (2011). *Mindsight: The new science of personal transformation*. New York, NY: Bantam Books.
Siegel, D. J. (2013). *Brainstorm: The power and purpose of the teenage brain*. New York, NY: Penguin Group.

Siegel, D. J., & Bryson, T. P. (2011). *The whole-brain child. Revolutionary strategies to nurture your child's developing mind*. New York, NY: Delacorte Press.
Siegel, D. J., & Solomon, M. F. (2013). *Healing moments in psychotherapy*. New York, NY: W. W. Norton & Company.
Silverstein, M. L. (2007). *Disorders of the self: A personality-guided approach*. Washington, DC: American Psychological Association.
Simonič, B. (2015). Ranljivost sodobnih družin in spodbuda k materinski rahločutnosti v pastoralni skrbi za družine [Vulnerability of modern families and an encouragement of maternal sensibility in pastoral care of families]. *Bogoslovni vestnik, 75*(3), 487–494.
Simonič, B., & Klobučar, N. R. (2017). Experiencing positive religious coping in the process of divorce: A qualitative study. *Journal of Religion and Health*, *56*(5), 1644–1654.
Stern, D. N. (1995). *The motherhood constellation: A unified view of parent-infant psychotherapy*. New York, NY: Basic Books.
Stern, D. N. (2004). *The present moment in psychotherapy and everyday life*. New York, NY: W. W. Norton & Company.
Stern, D. N. (2010). *Forms of vitality: Exploring dynamic experience in psychology, arts, psychotherapy and development*. New York, NY: Oxford University Press.
Sullivan, H. S. (1953). *The interpersonal theory of psychiatry*. New York, NY: W. W. Norton & Company.
Vidmar, T. (2014). New dimensions of understanding of lifelong learning from Antiquity to Comenius. *Review of European studies, 6*(3), 91–101.
Vodičar, J. (2016). Pojem žrtve v vzgoji: iz skrbi k odgovornosti [The concept of victim in upbringing: From concern to responsibility]. *Bogoslovni vestnik, 76*(2), 373–383.
Winnicott, D. W. (1971). *Playing and reality*. New York, NY: Basic Books.
Winnicott, D. W. (1988). *Human nature*. London: Free Association Books.