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Psychology of the Self in Psychoanalytic Psychotherapy

Psychology of the Self and the Treatment of Narcissism

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Psychology of the Self in Psychoanalytic Psychotherapy

In order to follow the psychology of the self we must keep in mind one goal of treatment described by Kohut (1977): to help the patient strengthen compensatory psychological structures, enabling the patient to become active and creative, and to work toward meaningful goals. Throughout his work Kohut places heavy stress on creativity. For some patients, creative life must take precedence even over relationships. Evidence of success appears in the patient's report of a sense of feeling alive, real, and worthwhile, so that "these attitudes and activities give me a sufficient amount of joy to make life worth living; they prevent the feeling of emptiness and depression" (p. 17).

Psychoanalytic psychotherapy and psychoanalysis can open an avenue to productive activity that permits this joyful self-realization. In Kohut's terms, "These activities could now be carried out effectively because the analysis had established a more firmly functioning structure of idealized goals, which served as organizers for the archaic ambitions of the revitalized grandiose self. And the analysis had also led to the strengthening and refinement of the already existing

executive apparatus" (p. 53). These essential transformations, according to the psychology of the self, do not result from intellectual insights or cognitive understanding, but come through transmuting internalizations brought about "by the fact that the old experiences are repeatedly relived by the more mature psyche" (p. 30). In healing disorders of the self, the therapist as an empathic and modulating self-object is the key to the patient's self-regulation despite optimal frustration and through transmuting internalizations.

Psychoanalysis and Psycho analytically Oriented Psychotherapy Compared

What it means for a patient to be "not suitable" for psychoanalysis takes on a new meaning in self-psychology. In ordinary practice when a patient is called "not suitable for psychoanalysis," the recommendation for psychoanalytically oriented psychotherapy is often made. The treatment procedure is now shifted to a less understood process with more idiosyncratic variations from one clinician to another and requiring the introduction of "parameters." This is called by some authors intensive psychotherapy, by others psychoanalytic psychotherapy or (Kohut) psychoanalytically oriented

psychotherapy. I shall use these terms interchangeably, depending on the authors under discussion.

An effort is made in psychoanalytically oriented psychotherapy to approach some of those goals that we might expect from a successful psychoanalysis, but these are selective, and therapeutic ambition is limited carefully. For various reasons, the patient may be seen less frequently. The therapist is more active and may even introduce questions and advice, thus "contaminating" the transference or diluting it, and leaving the procedure open to the charge that it relies more on suggestion or education.

Whether self-psychology oriented psychoanalysis is a form of psychoanalytically oriented psychotherapy or is a genuine psychoanalysis remains unanswered and is dependent upon the definition of "psychoanalysis." The distinction between psychoanalytic psychotherapy and psychoanalysis is extremely controversial, as a recent International Psycho-Analytical Association monograph (Joseph and Wallerstein 1982) demonstrates. Wallerstein concludes, "We seem not one bit closer to consensus on this question today than we were exactly a decade ago" (p. 122).

In psychoanalytically oriented psychotherapy, if no transference neurosis has formed and been worked through, it would be difficult to call the procedure a psychoanalysis, regardless of the frequency of the sessions. The most conservative traditional psychoanalysts argue that psychoanalysis conducted from the standpoint of self-psychology is not a genuine psychoanalysis. They find it offensive for self-psychologists to imply that the ambience of traditional psychoanalysis is any less pleasant or empathic than what they have to offer. Self-psychology, they say, is essentially unnecessary and simply repeats knowledge gathered from clinical experience by traditional analysts. Some would add that psychoanalytic self-psychology and all psychoanalytically oriented psychotherapy is only psychoanalysis conducted by an untrained analyst.

Kohut is more charitable toward psychoanalytically oriented psychotherapy. He attempts to make a distinction between psychoanalysis proper and psychoanalytically oriented psychotherapy, using a crucial geometric metaphor. He (Goldberg 1980, p. 532) argues that psychoanalysis proper "aims at bringing about changes in a *sector* of the self' of patients who are suffering from self-pathology disorders, while psychoanalytically oriented

psychotherapy "aims at bringing about changes in a *segment* of the self." He attempts to show that psychoanalysis affects the "depth of the psyche" while other forms of therapy only touch the surface. Thus he apparently means that a "sector" of the self reaches into the depth of the psyche, while a "segment" of the self is more superficial, or that sectorial changes in the self are attempted by psychoanalysis and are efforts to affect the depth of the psyche, whereas segmental changes are superficial and more likely produced by psychoanalytically oriented psychotherapy.

Like the "vertical" and "horizontal" splits (Kohut 1971), this is specious use of geometry.[1] A careful study of the meanings of "sector" and "segment" in the *Oxford English Dictionary* (1970) and the *Webster's New International Dictionary* (1961) does not support this differentiation either in the use of the terms in geometry or in other areas of discourse. To understand his concepts it is important to remember that Kohut is defining "sector" as depth and "segment" as surface layer.

In the discussion from Goldberg (1980), Kohut concentrates on the working-through process following the self-object transference.

The process is more extended in psychoanalysis, and leads gradually to the relinquishment of the archaic self-object with a consequent internal strengthening of the poles of the self, as well as the functions and skills on the gradient between them. In psychoanalytically oriented psychotherapy the transference interpretations are thought by Kohut to be less thorough and kept to a minimum, and they attempt to enable the patient to shift from the self-object analyst to other self-object figures "and to diminish his sensitivities sufficiently to enable him to make use of the self-object support that he can obtain from appropriate people in his surroundings without immediate withdrawal from them when they disappoint him" (p. 535). This outside self-object support can also be obtained from various societal institutions such as religions. The self-object transference is not resolved and the patient, if necessary, feels free to return for a temporary reactivation of this transference when external circumstances have been especially taxing.

Psychoanalytically oriented psychotherapy emphasizes the genetic-*dynamic* while psychoanalysis emphasizes the dynamic-g*enetic* in its ultimate aims, says Kohut (p. 536). He also concedes that "these differentiating lines cannot always be drawn sharply" (p. 535).

A TENTATIVE CLASSIFICATION OF TREATMENT MODALITIES

For didactic purposes and as a rough sketch only, and leaning on Gedo and Goldberg (1973), we can establish a hierarchy of treatment modalities associated with developmental phases as conceived of in traditional psychoanalytic theory, correlated with self-psychology. Phase one, from birth to six or eight months of age, represents the time from birth to cognitive self and object differentiation. Primary narcissism reigns supreme. "Primal repression" of Freud (Chessick 1980) is the crucial proto-mechanism of defense, and the primary anxiety is that of annihilation through overstimulation or flooding. Patients who have to regress to this phase experience overwhelming severe traumatic states or psychotic panics. The treatment of these cases is pacification, which represents the control of excitation, controlled catharsis, and, if necessary, the use of medications and hospitalization. The essence of pacification is that of tension reduction and mastery through partial discharge (Gedo and Goldberg 1973, p. 162).

A second phase of life, between eight months and three years, is the phase during which cognitive and affective self and object

differentiation progress to allow essentially irreversible cohesion of the nuclear self if this phase is successfully completed. During this phase the grandiose self and the idealized parent imago are utilized to deal with inevitable phase-appropriate disappointments in self-objects. Separation anxiety is the characteristic anxiety, magic is the kind of reality testing used, and massive projection and introjection are employed. The "bedrock" danger in this phase, from the point of view of self-psychology, is the disruption of the newly forming nuclear self. Patients who regress to such a phase present borderline or psychotic disintegration, and the treatment is that of unification. Such patients require external help for a cohesion of the self; we must provide reliable and consistently available self-objects and settings. An uninterrupted relationship with the therapist is crucial. As the therapist becomes a transitional object in the life of the patient, there occurs what Balint (1968) has called repair of a basic fault. The therapy is a real experience for the patient in which an uninterrupted relationship with a real object experienced as an archaic self-object occurs. The therapist sometimes must gently intrude as a real object into the life of the patient, but rather than gratification and pacification, it is usually sufficient to establish an uninterrupted

relationship.

The third phase of life, from three to six years, spans the time of the newly formed but incomplete cohesive self to the solid formation of the superego. For Freud, narcissism becomes more confined to the phallus, and castration anxiety is typical. Disavowal is at first the mechanism of defense as the repression barrier is still being formed, but the self and object are perceived as whole and different or separate and realistic most of the time. According to Kohut, the narcissistic personality disorders are developmentally fixed in this phase of life. Massive disruption of the self no longer occurs, but the archaic grandiose self and idealized parent imagos have not yet been properly integrated into the nuclear self so there is a tendency to retreat back to these upon narcissistic wounding, which produces the clinical features of the disorder. The treatment for them then is optimal disillusion, "confrontation with reality" (Gedo and Goldberg 1973, p. 164), or perhaps Kohut's kind of psychoanalysis in which stable narcissistic self-object transferences are allowed to form and are accepted and eventually interpreted. The patient, through transmuting internalizations, is gradually able to give up the narcissistic sense of entitlement. The grandiose self and the idealized

parent imago are properly integrated into the personality.

The final phase of childhood, between six to eight years of age and puberty, is the phase of consolidation of the ego and the solid formation of the repression barrier after the superego has been formed. The reality principle becomes prominent. The person, now with a firm sense of self, is guided by the ego ideal and pushed by ambitions. Moral or guilty anxiety is typical, repression occurs as the characteristic basic mechanism of defense, and we have the era of the formation of infantile neuroses of Freud. The treatment of disorders that are represented by regression to this phase is the classical psychoanalytic method. It is based on the structural theory using interpretation of the transference neurosis, in which there is strengthening of the ego, mitigation of the severity of the superego, and small quantities of dammed-up inner energies are discharged. Sublimation capacities are developed and become crucial to future success in adult functioning.

To illustrate the distinction between a therapy of disillusionment and a traditional psychoanalytic treatment, one patient who had collapsed in an earlier traditional psychoanalysis said, “In my previous

treatment the child inside the adult was encouraged to diffusely come out but in treatment with you the adult inside the child is *determined* to come out."

Gedo and Goldberg (p. 107) add a fifth phase of life from completion of puberty through adulthood, called the "era of the fully differentiated psychic apparatus." Signal anxiety is typical at this time and narcissism has been transformed into wisdom, empathy, humor, and creativity. Difficulties during this time are hopefully resolved by careful introspection and even self-analysis. An outstanding detailed example of this is offered by Calder (1980).

Some Critical Comments

None of the theories of narcissism are wholly satisfactory, and the above delineation and integration of various points of view is easy to criticize; its value is only as a rule of thumb for clinical work. The first two sections of this book already include some objections to Freud, Fairbairn, Klein, and Balint. Kernberg assumes much capacity on the part of the infantile ego for splitting and the formation of self and object representations during a period Piaget has claimed to be

without such capacities. I believe the tremendous rage that appears in therapy apparently attached to split-off self- and object-representations actually is a kind of psychic telescoping. When the id presents derivatives of itself, it presents itself via images or representations that have been produced by the ego. Malevolent projective representations, such as devils, influencing machines, or the evil psychotherapist, are utilized by the ego in the presentation of affect in the transference, but it is adultomorphic to assume that such specific self- and object-representations are already present in the psyche of the infant.

This issue is fundamental to such elaborate neo-Kleinian interpretations of the paranoid process as that of Meissner (1978b), who mentions Kohut's theories only in passing and without discussion of the fundamental opposition between drive psychology and self-psychology. Compare Meissner's views with Kohut's (1971, Chapter 1 and pp. 255-256) quite different approach to paranoid delusions. For Kohut (p. 10), "their establishment follows the disintegration of the grandiose self and of the idealized parent imago." In psychoses, the destruction of these "structures" is followed by a secondary reorganization of their disconnected fragments into delusions, which

are then rationalized by the remaining "integrative functions" of the psyche.

Positivists and empiricists would insist that our introspective notion of "self" is just a bundle of perceptions or representations that we habitually (according to Hume) put together as an unwarranted abstraction into an entity. Kohut wandered into the area of philosophy and moved to a higher level of abstraction in much of the more experience-distant and holistic concepts of self-psychology, which will appeal more to the religious and philosophical-minded and perhaps less to the clinician. For example, Jaspers already in 1913 devotes a section of his *General Psychopathology* (1972) to a discussion of our awareness of the self, using a combined psychiatric and existential point of view.

Kohut's emphasis on middle-age empty depression based on the depleted self (1977, p. 243)—the world of unmirrored ambitions and devoid of ideals—has a long tradition in psychoanalysis (Jung 1933) and philosophy. Wollheim (1984), for example, borrowing heavily from Freud and Melanie Klein rather than Kohut, argues in his existential philosophy that a holistic notion of the self as a process

with projects is central to a person's "finding life worthwhile," which in turn is "a matter of the opportunities it promises him for the satisfactions of those desires or plans of his which he thinks important" (p. 246). Like Kohut he distinguishes this from "finding life worth living" (p. 244), which has to do with the balance of pleasure and pain in life.

For Kohut, if one has successfully undergone a transformation of narcissism, a certain inner peace results in middle age. The same result is claimed even by Hegel (Taylor 1975), but based on the person's realization that the unfolding of the self in this transformation represents an emanation of universal *Geist.* At this point the person's longing for integrity will no longer be "doomed to frustration," the person suffering what Hegel calls the "unhappy consciousness," and the person will be able to accept the transience of life and feel empathy with other selves. In fact, Butler (1984) even claims that, "Hegel's dialectical method is a version of the method of empathic understanding" (p. 19).

Kohut has carried psychoanalysis away from nineteenth-century empirical natural sciences and—as he (1978, p. 751) admits—deeper

into the realm of humanistic philosophical thought, a tendency that Freud constantly tried to restrain within himself. Each psychotherapist has to decide how far to go in this direction, which is represented by his or her reliance on empathy or vicarious introspection.

Kohut offers a more clinically useful approach to the preoedipal disorders, especially in psychotherapy, than the Kleinians. He carefully avoids the retrospective adultomorphic errors of attributing to the baby all sorts of formed cognitive representational concepts of self, object, superego, penis, breast, and so on. This remains controversial, but clinicians must make choices about their approach every day, and these choices will have a profound effect on how they practice psychotherapy. Rotenberg (1983) presents an overview of the treatment of personality disorders based on self-psychology compared with that based on ego psychology; he emphasizes the differences in clinical technique contingent on one's choice of orientation.

We are forced by immediate exigencies with patients to make crucial decisions regarding our approach and we may utilize one or the other of controversial theories. The therapist should make these choices deliberately, based on a firm understanding of all the options

available, and watch carefully for subsequent clinical material in an ongoing effort to validate interventions. Consultation with experienced colleagues is always desirable.

Implications for Clinical Practice

A number of implications for the practice of intensive psychotherapy are represented by those didactic and tentative distinctions I have made. Some people use formal psychoanalysis for pacification and unification, and conversely, interpretation of a transference neurosis can occasionally occur in a less frequent psychotherapy if the conditions are appropriate. This implies a continuum theory of psychoanalysis and psychoanalytic psychotherapy which is opposed to the differentiation theory of some traditional psychoanalysts. Furthermore, the issue arises as to whether traditional psychoanalysis is suitable for developmental defects or structural disabilities in addition to neuroses which are based on repressed infantile conflicts; Anna Freud (1971) was dubious about such suitability. Self-psychologists argue that they have now developed a technique which makes psychoanalysis applicable to deficit disorders.

I am not referring here to what might be called repair of the self, which represents restoring it to the best it once was. This sort of therapy might be a three-month, short-term psychotherapy which does not focus on transference and reorganization or formation of a newly organized self. In fact, some analysts claim controversially that the only legitimate forms of psychotherapy are brief psychotherapy for repair and formal psychoanalysis. For a historical review of this unresolved dispute, see Sachs (1979).

The skill of the therapist is a major factor in determining whether intensive psychotherapy can be more than an interminable supportive self-object relationship for a patient. There is a danger in pushing the differentiation theory; it is often presented in a way pejorative to psychoanalytic psychotherapy, suggesting psychotherapists believe that any practice is permissible. That which the patient wants and has the capacity to accomplish, together with that which the therapist is able to perform, determine whether the patient gets a full-scale psychoanalysis or psychotherapy. As Kohut indicates, a combination of the empathic capacities of the therapist and the degree of cohesiveness of the self (so that even the most minor empathic failures do not bring about total disruption of the treatment each time)

determines whether the patient is capable of a “sectorial” or a “segmental” treatment.

Self-psychology shifts our perspective to the inside of the patient —we ask ourselves what the patient is experiencing. We examine those feelings that the patient stirs up in the therapist. We ask ourselves what or whom the patient is asking us to be or how we are being utilized by the patient as a self-object. In intensive psychotherapy we are careful to be consistently available, which allows the patient to make use of us for repair of the self. Whether we then go on to eventually interpret and work through these self-object transferences distinguishes psychoanalysis from intensive psychotherapy. In psychotherapy, as Kohut explains, rather than concentrating on interpretation of these self-object transferences, we encourage the patient to displace them to friends, family, and various social organizations, providing the patient with a much-needed empathic matrix that eventually can take the place of the therapist.

A common error in the misunderstanding of self-psychology is the belief that patients will be satisfied and happy if only the therapist does not make gross empathic lapses. This ignores the fact that certain

patients are frightened of forming a self-object transference due to their fear of merger and loss of autonomy, and must continuously devalue the therapist even if they allow themselves to secretly form a merger transference. Thus, the unhappy complaining patient who is continuously devaluing the therapist and the therapy but who is coming regularly and showing favorable changes in external circumstances, should not necessarily bring about a lowering of the therapist's self-esteem or lead to therapeutic despair. Again therapists must ask themselves in what fashion they are being used and whether the patient's use of the therapy is showing evidence of an improved self-cohesion and consequent improvement in ego functioning.

If the therapist realizes what sort of self-object transference has formed and can accept it, this will aid the patient in control and regulation, a channeling of excitation, and a setting of realistic goals through the idealizing transference, all of which produce a restored narcissistic equilibrium. The therapist will spot this restored equilibrium even if the patient does not report it, and it enables the patient to show functional improvement in psychotherapy even without interpretation of transferences.

The converse—that therapy will break up if the therapist is either unable to recognize the needs of the patient or tries to use the patient for personal self-object needs—is also true. In the case of the adolescent Dora (Freud 1905a), Freud grossly missed the total subjective experience of Dora (Wolf 1980) when he interpreted her reported disgust during the time she was kissed by Herr K. as hysterical and resulting from sexual excitement. Freud was not thinking of or showing vicarious introspection with a young girl's experience here. Dora was 14 years old at the time Herr K., 40, surprised her with a kiss. A strong argument could be made by psychiatrists experienced with adolescent patients that her disgust was age-appropriate; it was Freud's countertransference arising out of his intense commitment to his sexual theory that Wolf believes probably caused him to lose empathic understanding of this adolescent girl. Or perhaps there were deeper reasons involving Freud's attitude toward women.

Self-psychology (Kohut 1971, p. 119n) teaches that, in adolescence, sexual activity serves primarily narcissistic purposes by

enhancing self-esteem and does not merely consist of the explosion of pubertal drives. Especially when self-pathology is present, it often represents an escape from unbearable feelings of self-depletion and deadness. August Aichhorn (1955), Kohut's (1978) analyst, facilitated the formation of an idealizing transference in his delinquent adolescent patients (Kohut 1971, pp. 161-164) through his unusual intuitive skills as a therapist and his charismatic personality.

Self-psychology has many ideas to offer to those psychotherapists who work with adolescents. Their preoccupation with sexuality and the typical adolescent oscillation of moods are better understood in terms of the vicissitudes of disturbed narcissistic equilibrium that are apparently inevitable at this stage of life, at least in our culture. Adolescence represents an important transformational aspect of the unfolding life curve of the self; it begins with the dissonance of puberty and the recapitulation of oedipal conflicts and offers a period of potential freedom to become an authentic self, with post-adolescent idealized ethics and values. For this reason Kohut (1971) calls it "a decisive final step" (p. 43) in the establishment of nuclear psychological structures.

The clinician must avoid confusing the frantic search of the individual with a fragile sense of self for soothing and self-consolidating activities, which may be quite dangerous, with the search of the late adolescent to find a philosophical or "authentic" self, a search that already requires a cohesive and relatively firm self in Kohut's sense (discussed in Chessick 1985a). The precipitation of an "identity" in adolescence in turn enables a final firming and cohesion of the patient's self—an important task of adolescence which is only beginning to be explored by self-psychologists such as Wolf, Gedo, and Terman (1972).

"DIFFICULT" OR "RESISTIVE" PATIENTS

Basch (Stepansky and Goldberg 1984) tells us that when Kohut's (1971) *The Analysis of the Self* was first published, the verdict of the elder statesmen of psychoanalysis was "clever, but not psychoanalysis" (p. 25). According to Basch, Kohut's work became utilized in many ways although no "official" recognition of his achievement was forthcoming. Instead, the "establishment" stopped condemning Kohut as unanalytic but now claimed that he presented nothing new.

Kohut's work encourages us to deal with patients who previously would have been sent for supportive treatment by using instead more psychoanalytically oriented uncovering methods. (Some Kleinians and North American psychoanalysts have been advocating this for many years.) Patients with archaic self-object transferences who are intense, labile, and highly vulnerable to disruption, can now be better tolerated and understood, in turn leading to the receding or disappearance of the more florid psychopathology in some cases and allowing some patients formerly labeled borderline or even psychotic to become analyzable.

Stolorow (Stepansky and Goldberg 1984) illustrates the typical self-psychology approach to the so-called negative therapeutic reactions, which are understood from this orientation to be based on "intersubjective situations in which the patient's self-object transference needs are consistently misunderstood and thereby rejected" (p. 48).

Even "resistances" in intensive psychotherapy or psychoanalysis are understood differently by self-psychologists, as discussed by Kohut (1984) and Wolf (Stepansky and Goldberg 1984). Self-psychologists

interpret resistances as manifestations of the patient's fear of "humiliation or rejection or some other form of depreciation" and this fear makes them "sensitively cautious" against self-revelation (Wolf, in Stepansky and Goldberg 1984, p. 152). This caution does not represent defense against the drives but "against self-object failures which may fragment the self." Wolf calls these "measures of obligatory self-protection." Actually Wolf feels that a patient should not be labeled borderline until there have been trials of analysis "by more than one or two analysts" (p. 153) because he believes the disruptions in the treatment of these patients can often be brought to an end "by interpretation and explanation" (p. 155), allowing a stable self-object relationship to form eventually; again, the skill and empathic attunement of the analyst are very important. There are at least two potential traumas to which the self is exposed, "the loss of a needed self-object response" and the "intrusion of the self-object across its boundaries into its own core." Wolf explains that "the more fragile the self-structure, the more vulnerable the self and the more distorted the self's defensive maneuvers against the potential danger" (p. 152). From the point of view of self-psychology, the more the therapist learns about his or her patient-assigned function as a self-object in the

treatment, the better the therapist will be at practicing psychotherapy.

COUNTERTRANSFERENCE

Self-psychology also has a great deal to say about transference and countertransference, as summarized by Wolf (1979). Gunther (1976) offers a new self-psychology-based view of the origin and meaning of countertransference: "Countertransference phenomena serve as compromise formations designed to restore disturbances in the analyst's own narcissistic equilibrium" (p. 206). This explains in a less moralizing or pejorative fashion various reports that have been presented of analysts acting out their narcissistic, sexual, or aggressive wishes with patients; the periodic violent denunciations of the field of psychoanalysis by previously traditional and now renegade analysts and their offering of what Gunther calls a "salvational ideology"; and the occasional news of the tragic, sudden depressive disintegration or suicide of a promising analyst or established psychotherapeutic clinician. Gunther's paper provides an unusually ample bibliography. He maintains that countertransference arises not from a moral failure but as the result of the "endangered position of the analyst" in being traumatically flooded by the patient's narcissistic needs. Any

interference with the analyst's empathic function may lead to regression to earlier forms of narcissistic gratification and concomitant aggression, which produce countertransference phenomena in an effort to restore narcissistic equilibrium.

In Gunther's view countertransference behavior is already the result of a narcissistic wound in the analyst's professional self-expectation. Especially in preoedipal cases there are dangers to the core stability and self-esteem regulation of the analyst's cohesive adult self due to the continuing, relentless archaic demands of the patient for the self-object analyst's perfection. Countertransference arises as the result of inevitable narcissistic humiliation or disappointment in the analyst's own professional self-expectations in a relationship involving regressive restimulation and archaic demands. Gunther concludes:

> The disequilibrium in the analyst's own narcissistic integrity . . . may now be acknowledged as a significant additional source of countertransference stimulation. The clinician's manifest symptomatic behavior may therefore constitute a compromise formation related to narcissistic regression and serving the function of *defense,* rather than necessarily constituting a primary *cause* of the disruption of his optimal analytic focus. (p. 222)

Thus, the psychology of the self offers a better understanding of the dangers in the long-term practice of psychotherapy or psychoanalysis for the therapist.

Basch: "Doing Psychotherapy" from a Self-Psychological Perspective

Basch (1980) presents the optimal ambience of psychotherapy from the self-psychological point of view; the holding and comforting tone that is set with patients throughout when compared with other published case reports,[2] argues implicitly that psychotherapy or psychoanalysis informed by self-psychology does indeed undergo a certain benign shift in ambience.

Basch's "how-to-do-it" book provides us with six extensive clinical illustrations, gives some alternative responses, and explains the value or disadvantages of each. The book has been criticized as utilizing the concepts of self-psychology "to avoid exploration of the sexual conflicts of the patient" (Waldron 1983, p. 626). Basch's explanation of the clinical material, argues Waldron, "suffers from the imposition of preconceived concepts slanted toward problems of the self and toward preoedipal issues" (p. 627), and the patient's

achievement of full genital object love as interrupted by powerful unresolved oedipal issues is neglected.

This again illustrates the continuing criticism by traditional psychoanalysts that self-psychologists may be leading psychotherapists and analysts into a collusion with patients to avoid confronting lust and aggression arising from unresolved Oedipus complexes. Basch implies that the cases he presents are primarily preoedipal disorders of the self and that their oedipal difficulties are secondary. Self-psychologists believe that most patients seen in psychotherapy in clinics are such patients, and differ from the traditional cases in classical psychoanalysis who have an Oedipus complex at the core of a psychoneurosis. However, Kohut in his last work (1984) places pathology of the self underneath even the traditional Oedipus complex.

The reader must judge from studying the case histories reported by Basch whether Basch is justified in treating his patients as representing disorders of the self or whether their pathology represents regression from an unresolved Oedipus complex. It is a difficult judgment to make since we do not have the data of a full-scale

psychoanalysis on which to base our thinking. I agree with Basch that the specific cases presented by him are typical of those which the average trainee confronts. Basch's cases are not well approached as neuroses based on an unresolved Oedipus complex.

Let us take for example the case criticized by Waldron (1983) of Ms. Banks, who presents herself to a therapist who is going into private practice in eight months. Her previous therapist worked with her for three years on her "unresolved Oedipus complex" until he finished his training in psychotherapy and went into private practice. The patient could not afford to continue with him and presents herself in an extremely injured and antagonistic state, which the therapist handles with superb skill. This case illustrates how easily such a patient could be labeled borderline if there were not a correct understanding of what she had experienced. Basch explains that when patients with poor impulse control are called "borderline":

> Often this is simply a pejorative attesting to the fact that the therapist is angry at and unsatisfied by a patient who will not play the game by the rules and leaves the therapist at a loss as to what to do next to make therapy effective. If a patient is "borderline" the implication is that he is essentially a psychotic individual who manages to adapt

> marginally to the demands of life but is in ever-present danger of disintegrating if his brittle defenses become strained, (p. 60)

Basch feels that Ms. Banks is not a borderline case but represents a narcissistic personality disorder, a developmental arrest. He explains her tantrums in therapy as based on a child's unrealistic expectation "that he will have a smooth passage through the world, and that if such a passage is not forthcoming, there is someone to blame—and that someone must then be forced to set matters right again" (p. 61).

In treating such patients, says Basch, rather than "working toward getting the patient to like him, the therapist needs to work toward being able to like himself as he is functioning with the particular patient in the particular session. . . . Failure to be satisfied with himself is a clear signal that something is amiss" (p. 75).

As the case of Ms. Banks unfolds, the ambience and acceptance offered by the therapist lead to the establishment of a vital self-object transference, which was not essentially interpreted or resolved in the therapy. As termination was being considered, Ms. Banks decided to become a physician like her father and devote herself to this goal; a

year later she called the therapist to tell him she had been accepted at a medical school and felt content with her life at that point.

The point of contention about whether self-psychology avoids oedipal strivings of patients manifests itself in Basch's report:

> When for a brief time the patient sexualized the transference and became frightened by her thoughts, the therapist pointed out to her she was mistakenly attributing genital motives to the love and affection she felt for him who was, through his work, giving her a chance to achieve satisfactions heretofore closed to her. She was helped to understand that her emotions were appropriate to the child who stands in awe of and wants to unite with the powerful, giving parent, and were not those of a sexually excited woman, (p. 86)

Basch insists that her decision to become a physician does not represent an unresolved transference—an identification with both her physician-father and the physician-therapist—or "an attempt to resolve a neurotic conflict through action rather than through psychological insight," because she proceeded with her plans in a thoughtful fashion, was not "driven," and achieved genuine satisfaction from the process.

Trying to understand what happened and whether or not Basch offered an "inexact interpretation" that led to the termination of the therapy is a controversial issue, fraught with the difficulty of varying interpretations of reported psychoanalytic data. I do not think such an argument can be resolved, and it tends to obscure Basch's point: if the patient is judged to be suffering from a disorder of the self or a narcissistic disorder, the therapeutic work ought to focus on threatened fragmentations, disruptions, and temper tantrums that occur upon disappointment in the self-object, phenomena which restrain the patient from having any successful interpersonal experiences or ever being able to form an affective, empathic self-object matrix.

The appearance of sexualization is muted in this approach and not interpreted as a representation of infantile lust or aggression; the focus is on the patient's need for mirroring or idealizing self-objects. If the therapist has judged wrongly, or if the narcissistic phenomena are predominantly defensive regressions from an unresolved Oedipus complex, therapy according to the approach of self-psychology will represent a collusion between patient and therapist to avoid the emergence of infantile aggressive and sexual issues (both homosexual

and heterosexual). Clinical judgment is involved.

A similar dilemma is presented by Basch in his report of a patient with a depression. Basch "explains" in part to the patient that

> The hallmark of depression is the sense or the attitude that life is meaningless—an indication that the perception of the self is no longer a unifying focus for ambitions and ideals . . . the myriad symptoms of depression are an attempt to circumvent helplessness and to enlist assistance in restoring some meaning to life—that is, to recapture a sense of direction for the self. (p. 136)

Again, this approach may be viewed as a collusion with the patient in order to avoid the issues of infantile lust, aggression, and oral ambivalence that are often postulated to lie behind depression. However, Kohut distinguishes the depression of Tragic Man, which is based on the depleted empty self that has failed to achieve its nuclear aims, from the problems of Guilty Man described by Freud (1917). Clearly Basch believes that the patient he refers to belongs in the "Tragic Man" category of Kohut, which explains his "explanation." The assessment of Basch's book depends on an acceptance of the underlying premise in the cases presented: they represent primarily disorders of the self and not regressions from an unresolved Oedipus

complex. These are presented as cases in psychotherapy, not traditional psychoanalytic treatment reports. Basch illustrates the activity of the therapist in explaining repeatedly to the patient in psychotherapy what has occurred in terms of the patient's expectations and disappointments. This increased activity of the therapist is also a consequence of the concept of cure presented by self-psychology and again exposes the procedure to the accusation of representing suggestion, education, and persuasion.

But one might question whether the particular cases presented by Basch would have responded better to a silent, solely interpretive approach such as that of Langs (1982), or even a more moderate traditional approach such as that of Kernberg. Would the patients have exploded with rage and disappointment, which then might have been interpreted to them as manifestations of a projection of their all bad self- and object-representations onto the therapist? It is left to the reader to ponder which approach would be correct, and for what reasons.

Notes

1 I am criticizing the terminology here, not the concepts expressed by these geometric metaphors. My

interpretation of Kohut's metaphor given here is supported by his contrast in another place (Kohut 1977, p. 251) between a "sector" of the psyche and a "layer" of the psyche. Later (1984, p. 49), he refers to "sectorial" as "experience in depth."

2 But *not* those of Freud. See Lipton (1977, 1979) and Chessick (1980, 1982).

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