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Kohut's Special Clinical Observations and Classifications

Psychology of the Self and the Treatment of Narcissism

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Kohut's Special Clinical Observations and Classifications

Special Clinical Phenomena

Let us first turn to certain specific special clinical phenomena identified by Kohut.

TRAUMATIC STATES

The new clinical concept of *traumatic states* (Kohut 1971, pp. 229-238) is explained as an intrapsychic flooding with narcissistic libido and sometimes oral sadistic rage due to the poorly internalized regulatory functions of the ego. Two clinical types are described. The first occurs as a nonspecific reaction to any variety of frustrations and narcissistic wounds, for example, a *faux pas* made at a party; the second paradoxically as a result of a correct interpretation which releases deep overwhelming yearnings for soothing and idealization.

Clinically, the patients feel uncomfortable, overburdened, and overtaxed. They may show a sexualization of everything, expressed by compulsive masturbation, sadistic controlling or masochistic or perverse fantasies to combat the sense of inner deadness, or by exhibitionistic and voyeuristic behavior. The patient may appear disheveled and even

temporarily "insane," in the manner of Hamlet. Further reactions are great irritability to sensory stimuli, such as noises, lights, children's hi-fi or TV sets; sarcasm and punning, followed by the tendency to get into dangerous activity or arguments in traffic, or to race people to stop lights; and a general rage and lashing out at the whole world that is experienced as strange, unsupportive, unempathic, and persecuting (for example Rockefeller's giving his widely publicized finger sign after he did not receive the 1976 Republican nomination for President).

Every request or demand made on the patient at this point is experienced as unwelcome and produces rage. The patient restores equilibrium by reassuming control of self-objects, by pseudo-obsessive compulsive behavior "to get all in order," or by various personal or religious rituals, an important function for religion.

Disintegration anxiety typically occurs due to the failure of a self-object to live up to demands, severe narcissistic wounding, or to the danger of uncontrolled regression in intensive psychotherapy. It is clinically different in dreams and experienced phenomena from the classical signal anxiety in Freud's structural theory which is based on castration fears or fear of separation. It is not related to the fear of the loss of love, but rather to the fear of disintegration of the sense of self, which would essentially result in a psychosis "in consequence of the loss of an intense archaic enmeshment with

the self-object." It is vague, cannot be pinned down by clinical questioning, cannot be expressed in detail, and is not attached to one situation such as a phobic object.

SELF-STATE DREAMS

In dreams which Kohut (1977, p. 109) calls "self-state dreams" that announce such anxiety, associations lead nowhere. One should not challenge the patient's "explanations" of this anxiety—a different approach from the approach to oedipal anxiety—as the self-produced "explanations" of the patient provide a tension-reducing intellectual structure, just like the paranoid patient's "explanations" of what is happening. Instead of fault-finding or arguing with the patient's explanations, it is best to concentrate on finding the narcissistic wound that touched off the anxiety and then explaining the sequence to the patient.

This type of dream, characterized as a "self-state dream" has been the target of strong disapproval by some critics of self-psychology. Kohut (Lichtenberg and Kaplan 1983) attempts to directly address this problem, which arose out of a misunderstanding of a short passage from *The Restoration of the Self* (Kohut 1977, pp. 109-110). It is not true that such dreams are interpreted only from the manifest contents. Associations are not ignored. Kohut points out that the clue to the self-state dream is that

associations lead nowhere; “at best they provide us with further imagery that remains on the same level as the manifest content of the dream” (Lichtenberg and Kaplan 1983, p. 402). It is most critical that the analyst’s understanding of the state of the patient’s self as depicted in the imagery of self-state dreams be accurate because, “only when an analysand feels that the state of his self has been accurately understood by the self-object analyst will he feel sufficiently secure to go further” (p. 406). To press the patient for further associations in order to emerge with dynamic-genetic conflict-based interpretations will be experienced by the patient as an empathic failure and will generate rage and “resistances.” Kohut does admit that most dreams are *not* self-state dreams (p. 404) and must be pursued in the traditional way.

Awareness of these types of dreams is important to the proper conduct of psychotherapy. For example, a woman patient who suffered from transient psychotic episodes gradually improved in psychotherapy to the point where severe stress manifested itself more in psychosomatic symptoms, such as premature ventricular contractions and bouts of nervous colitis and “indigestion.” With continued improvement and understanding of her states of temporary fragmentation, the danger of impending fragmentation in stress situations began to announce itself in self-state dreams. One week, when her husband was being particularly oblivious to her needs and the needs of her children, she had just started a new job and was under incredible pressure to manage everything alone. She dreamed, “I was coming to your office, walking

up the stairs, and someone stopped me and asked me to run an errand. I don't know what happened—I lost track of three hours of time and arrived at your office in a state of confusion." She woke up from this dream with great anxiety, because it was "very unlike me" to lose track of time and not know where she was for three hours, She was a very well organized and careful person, and recognized with alarm that this represented an abnormal state of herself. Associations led repeatedly to the current overburdened situation which she was in and her disappointment in her unempathic preoccupied husband for whom she ran many "errands." She was convinced that the dream was a warning that unless she reduced the stress, her psychosomatic fragmentation symptoms would return. In clinical practice such dreams often herald some form of disintegration; associations are vague and do not lead to any depth understanding of conflicts.

HYPOCHONDRIASIS

Hypochondriasis is more important in Kohut's theory and better explained than by Freud's structural theory, as the latter is used, for example, by Arlow and Brenner (1964) to explain the bizarre somatic complaints of psychotics: "The symptoms of hypochondriasis are the expression in body language of a fantasy which is itself a compromise between an instinctual wish . . . and the defense" (p. 173). This ignores the vagueness and fleeting nature of such hypochondriasis and its stubborn persistence despite

interpretations in the treatment of narcissistic, borderline, and schizophrenic patients.

For Kohut, on the other hand, as disintegration anxiety appears, certain body parts become the carriers of the regressive development "from the patient's yearning for the absent self-object to states of self-fragmentation." These body parts become crystallization points for hypochondriacal worry. Anxiety and complaints become attached to a fragment of the body, indicating a desperate attempt to reconstitute and to explain the fragmentation of the self.

In the schizophrenic, a part of the self may become split off and utterly divested of libido in order to permit a shallow reconstitution of the rest; this may be represented by a part of the body which is then viewed as useless, unwanted, and may even be literally cut off by the patient.

The usual clinical sequence in the development of hypochondriasis is as follows: a narcissistic wound by, for example, the empathic failure or absence of a self-object; disintegration anxiety; hypochondriasis and traumatic states; insomnia; sexualization and an attempt to soothe the self in that fashion; deterioration of ego function, often accompanied by frantic compensatory increase of various physical and mental activities, e.g., "overwork," in an attempt to pull together by combating an inner deadness through self-

stimulation.

At this point judgment becomes poor, memory impaired, and even a disheveled confusion state may occur. Note how narcissistic wounding and fragmentation of the self precede the deterioration of ego function in contrast to Arlow and Brenner's theory, and how "overwork" is a symptom rather than a cause of fragmentation. Also some hints of concrete thinking may appear. The patient may become confused by interpreting figures of speech or instructions literally. One highly sophisticated patient thought that a bank cash dispenser that read "cash available only in multiples of five" meant that only five dollar bills were available.

NARCISSISTIC RAGE

We are now in a position to offer a clinical classification of rage as it appears in our work with preoedipal disorders. Narcissistic rage, from mild annoyance to catatonic furor, is seen over the disappointment in one's expectations from the self-object. It is typically accompanied by feelings of humiliation and may arise in an acute episode or with chronic unforgiving relentlessness and may or may not be expressed in acute or chronic somatic symptoms such as headaches or increased blood pressure. At worst it is projected and a fixed paranoid state may develop; such patients are sometimes very dangerous.

The sequence of depression followed by self-mutilation or even suicide is the world of the empty self; there is either a hopeless despair, where the individual is robbed of vigor and even muscle tone, or a state of unfocused agitation which is beyond the patient's control. This often also follows disappointment in the self-object, revealing a crucial weakness in the nuclear self, which can only sustain itself by a relationship to external self-objects for soothing or idealization. Patients who show this sequence are often labeled as borderline.

Sadomasochistic behavior combines the expression of rage with restitutive activity. In masochism there is self-soothing by repetitive activity and feeling alive through pain along with identification with the powerful, omnipotent torturer. In sadism the individual imagines or acts out reassuring fantasies of power and control which are very common in masturbation fantasies, usually central to pornographic movies, and acted out in rape. Because of the ever-present threat of fragmentation, these restitutive activities gain a compelling, repetitive, and all-pervasive quality.

In the normal individual a combination of selective assertiveness, achievement, and tolerance of disappointment must be balanced; there is not merely tension reduction. So assertiveness, says Kohut, also has a developmental line of its own which can be diverted into rage and aggression if there is sufficient narcissistic wounding or empathic failure from the self-

objects.

In therapy we focus not on the rage but on the state of the self that has produced the disintegration product: narcissistic rage. This is a critical difference in the psychotherapeutic approach of the psychology of the self from the more common conflict-based theories, and shifts our focus away from the sexual and aggressive "drives," a source of controversy.

A tantrum has no object. For Kohut, "drives" are secondary disintegration products due to empathic failures in the childhood self-object matrix. Thus the perspective is on the whole person and his or her achievements, not on viewing all human creations and activity as produced by the collision of drives and defenses. Kohut maintains that Freud's famous pessimism was an unavoidable consequence of his drive theory and that it followed from his metapsychology. Other authors blame the disasters of World War I and the death of Freud's daughter for his dark views expressed in *Beyond the Pleasure Principle* (1920) and *Civilization and Its Discontents* (1930).

For Kohut aggression is the response of a self threatened with fragmentation, not an instinctual discharge. The release of aggression in war does not subsequently reduce aggression in the world but increases aggression because it diminishes the cultural situation where parental self-

objects have sufficient security and comfort to be empathic with their children and each other.

All activities with a rage component, including exhibitionism, voyeurism, and oral and anal sadistic strivings, are secondary consolation or breakdown products due to the failure of the self-object matrix and represent for Kohut "a despair of the child in the depths of the adult." Thus the concept of the self-object is the pivotal point of organizing clinical data by self-psychologists.

PHOBIAS

Phobias are also understood differently by the psychology of the self. As an example, a case of agoraphobia is brought up by Kohut (Goldberg 1980, pp. 521-522). In this case, a female patient can only go out on the street if accompanied by someone, usually an older female. In contrast to Freud's explanation of this as representing a defense against an oedipal-based wish on the part of the woman to prostitute herself, Kohut asks, "What is it in the self-object matrix, not acquired yet, that requires the patient to have the company of an older woman when she goes out?" Notice the great change of focus and interest here as well as the way in which Freud's and Kohut's explanations of agoraphobia contrast with R. D. Laing's. The latter interprets agoraphobia in the Freudian fashion, but the sexual wish itself is seen as a

manifestation of ontological insecurity and not primarily of an oedipal drive. For both Kohut and Laing the emerging person is not essentially a bundle of untamed or barely tamed drives always striving for gratification.

Another example from work with preoedipally damaged patients is the spider phobia, in which the individual is terrified by spiders, feels helpless, and needs another person, a magical protector, to kill the spider. Again, a variety of interpretations are possible, for example Sullivan's (1953) use of the spider to symbolize the "not-me" or the anxious raging mother. In the psychology of the self, the patient is seen to be searching for a missing part of the self, for an omnipotent self-object; the idealized parent imago has not been integrated into the self.

For the psychology of the self, some depression is based on the inadequate idealization of the self and not on a predisposition to ambivalence due to fixation in the oral phase or the inability to neutralize aggression for various reasons.

Classification of Disorders of the Self

Kohut and Wolf (1978) present a nosology of the disorders of the self. I will borrow heavily from their important paper and from Kohut (1977, pp. 191-193) in the discussion which follows. Disorders of the self can be divided into secondary disturbances and primary disturbances. The secondary

disturbances of the self are reactions of a structurally undamaged self to the natural vicissitudes of life and health. Here is a critical area of understanding for crisis intervention and adolescent adjustment problems. The psychotherapy of secondary disturbances provides a mirroring and idealizable self-object so that the self automatically firms up. The patient's ego functions improve *pari passu* and the difficulties and vicissitudes can be handled in an optimal, relatively brief fashion, without much interpretation.

This approach is sometimes all that is possible in the psychotherapy of adolescents with profound disorders of the self that have temporarily undergone regressive fragmentation. I recall one famous case of an intuitively gifted psychoanalyst who successfully treated a transiently psychotic adolescent by debating the theological meaning of certain biblical passages. I had a similar case in which an adolescent made an excellent functional recovery after many hours of discussing motorcycles. No interpretations were offered; I could sense from his reactions that the patient was unwilling or unable to utilize them. Yet the patient was profoundly attached to the therapy.

Primary disturbances of the self may be divided into five categories. In *psychoses* there has been serious damage to the nuclear self and no substantial or reliable defensive structures to cover the defect, whether biological or not, have been formed.

In *borderline states,* there is the same defect as in psychoses, but it is masked by complex defenses with which it is unwise for the therapist to tamper except to improve their adaptability. This pessimistic outlook on borderline states has been challenged as stated above; I will discuss it in Chapter 13.

Schizoid and paranoid personalities wall off the self and keep themselves at an emotional distance from others in order to protect against "a permanent or protracted breakup, enfeeblement, or serious distortions of the self" (Kohut 1977, p. 192). Again, we are warned by Kohut (1971) not to be a "bull in a china shop" in trying to reach such patients. Here, too, I believe there is an excessive pessimism expressed. If the therapist is empathic and relatively patient, stable self-object transferences are sometimes formed by these patients and much improvement can occur.

In *narcissistic behavior disorders* there are symptoms of perversions, addictions, and delinquency, but the self is only temporarily distorted or enfeebled. These patients have a significantly more resilient self than patients in the first three categories and are more amenable to treatment. However they are not *easier* to treat than borderline or schizoid personality disorders.

In the *narcissistic personality disorders* the problem is the same as the previous category with one exception. Instead of predominantly behavior

symptoms, there are symptoms of hypochondria, malaise, boredom, depression, and hypersensitivity to slights. According to Kohut, only narcissistic behavior and personality disorders are analyzable, as the self in the first three categories cannot withstand the reactivation of narcissistic needs without fragmentation. This is a kind of reverse definition and depends on whether or not stable narcissistic transferences form.

Kohut and Wolf (1978) review certain clinical syndromes in identifying disorders of the self. The *under-stimulated self* is due to a chronic lack of stimulating responsiveness from the self-object of childhood and the individual shows a lack of vitality, boredom, and apathy; such patients may have to use any excitement to ward off painful feelings of deadness.

The *fragmenting self* occurs when the patient reacts to narcissistic disappointments, such as the therapist's lack of empathy, by the loss of a sense of cohesive self. Here we must watch for disheveled dress, posture and gait disturbances, vague anxiety, time and space disorientation, and hypochondriacal concerns. In a minor way this occurs in all of us when our self-esteem has been taxed for long periods and no replenishing sustenance has presented itself, or after a series of failures which shake our self-esteem.

Kohut (1978, p. 738) points out that a narcissistic blow can lead to regression of the self in which there are archaic but cohesive forms and can

lead also to empty depletion or "enfeeblement," or temporary fragmentation. Such regression can manifest itself by a shift from normal assertiveness to narcissistic rage, voyeurism in the search for an idealized parent imago, or gross exhibitionism in the search for mirroring confirmation of the grandiose self.

The *overstimulated self* is caused by unempathic excessive responses from the childhood self-object, the intrusive over-concerned narcissistic excitement of neurotic parents. If the grandiose-exhibitionistic pole has been overstimulated, the patient is always in danger of being flooded by archaic greatness fantasies, which produce anxiety and spoil the joy of normal successes. Frightened by their intense ambition, these patients avoid normal creativity and productivity and avoid situations where they would attract attention.

If the ideals pole is overstimulated by parents displaying themselves to get admiration from the child, internalization cannot occur and an intense merger need remains. Loss of healthy enthusiasm for normal goals and ideals results.

In the closely related *overburdened self* the childhood self-object has not been calm. There has been neither merger with the calmness of an omnipotent self-object nor development of an internalized, self-soothing

capacity. A world that lacks soothing self-objects is experienced as inimical and dangerous. When the therapist fails in empathy, the patient dreams of living in a poisoned atmosphere surrounded by snakes and other creatures and complains of the noises, odors, and temperature in the therapist's office.

Certain behavioral syndromes in the realm of the disorders of the self are also presented by Kohut and Wolf (1978). *Mirror-hungry personalities* thirst for self-objects who will give them confirming and admiring responses. "They are impelled to display themselves and to evoke the attention of others, trying to counteract, however fleetingly, their inner sense of worthlessness and lack of self-esteem" (p. 421).

Ideal-hungry personalities are forever in search of others whom they can respect and admire for various idealized traits such as prestige, power, beauty, intelligence, or moral or philosophical stature. Such patients can only experience themselves as worthwhile when they are related in some way to these idealized self-objects. Perhaps the most pathological example of this comes from the autobiography of Albert Speer (1970) containing his own description of his idealizing transference to Hitler, which he apparently shared with a good many others.

Alter-ego personalities want others to experience and confirm their feelings, appearance, opinions, and values, and are capable of being nourished

longer than mirror-hungry personalities and even forming friendships of a sort. These three types of narcissistic personalities are not primarily pathological although, like Speer, they may be so if carried to an extreme.

Two other types of behavior represent psychopathology. These are the *merger-hungry personalities* who have a compelling need to control their self-objects, are very intolerant of the independence of the self-object, very sensitive to separations, and demand their continuous presence. A literary example of this is the relationship of Marcel to Albertine in Proust's (1981) *Remembrance of Things Past* in the section entitled, "The Captive" (see Chessick 1985a).

Contact-shunning personalities are the reverse of merger-hungry personalities in that they avoid social contact and become isolated. The intensity of their need is so great that they are excessively sensitive to the slightest sign of rejection, which they prevent by isolation and withdrawal from others.

DIAGNOSIS OF NARCISSISTIC PERSONALITY DISORDER

The diagnosis of narcissistic personality disorder for Kohut (1971, p. 23) is suspect if certain presumptive symptoms are observed clinically: in the sexual realm, perverse fantasies or lack of interest in sex; in the social realm, work inhibitions, an inability to form and maintain significant relationships,

and/or delinquent activities; in the realm of personality, a lack of humor, lack of empathy, distorted sense of proportion in life, and a tendency to attacks of rage, lying, and name-dropping; and in the psychosomatic realm, hypochondriasis and various autonomic nervous system function problems.

The diagnosis of narcissistic personality disorder is certain, says Kohut, if stable spontaneous self-object transferences develop. These consist of the amalgamation of unconscious narcissistic structures (the grandiose self, the idealized parent imago) with the psychic representation of the analyst in the service of the need to resume interrupted development. They should be compared with the transferences as defined by Freud in classical neuroses, which are the amalgamation of object-directed repressed infantile wishes and the analysand's preconscious wishes and attitudes toward the analyst. Whether the self-object transferences are true transferences is a "vexing question," but Kohut points out that the narcissistic or borderline ego seeks reassurance, not satisfaction, as in the neuroses.

Comparison of Kohut's and Kernberg's Views

To clarify Kohut's clinical views on the narcissistic personality disorder, let us briefly compare them with those of Kernberg (1974, 1974a, 1975, 1975a, 1980; Schwartz 1973). For Kohut the central pathology of narcissism comes from a developmental arrest, whereas for Kernberg narcissism

represents “a defense against paranoid traits related to projected oral rage” (1975, p. 228). Kernberg (Schwartz 1973, Kernberg 1974a) agrees with Kohut on the clinical characteristics displayed by these patients.

Such patients for Kernberg (1975, p. 229) cannot be depressed but experience rage, resentment, and massive devaluation of the other person with a wish for revenge when a loss occurs; Kohut recognizes this but sees the patient’s early self-object experience as the key explanation of the clinical phenomena (Ornstein 1974).

For Kernberg (1974a, 1975), the defenses of the narcissistic patient are similar to borderlines. There is a predominance of splitting, denial, projective identification, and primitive idealization with a sense of omnipotence. Kernberg says (1975, p. 234) that narcissistic and borderline patients have the same intense oral aggression either constitutionally determined or due to frustration as infants and this is the key to the etiology. The grandiose self of narcissistic patients allows better superficial social and work functioning, but over a long period we observe the “emptiness beneath the glitter” (1975, p. 230).

For Kernberg (1974, 1974a), in psychotherapy we must focus on the positive and negative transferences since the patient has the need to devalue the therapy and the therapist, and to avoid dependency. Devaluation and

treating of the analyst as an appendage gives a typical countertransference reaction of impotence, boredom, worthlessness of the therapy, and rage (1975, pp. 245-248). For the patient, the therapist as a source of envy and projected rage must be devalued, controlled, or destroyed. The grandiose self is a defensive pathological structure and must be broken down. Kohut’s idealizing and mirror transferences are alternative activations of components of the fused pathological grandiose self (Schwartz 1973, p. 621; Kernberg 1974, p. 260; 1974a, p. 223), and an early idealizing transference in psychotherapy is a defense against envy and devaluation of the feared external object or therapist. Rage is at the core of the disorder.

For Kernberg, Kohut’s reluctant compliance with idealization hides what is underneath and avoids facing the patient’s hatred and envy. The idealizing transference gives less countertransference problems than the devaluation and it is therefore tempting to leave it alone. However, Kohut’s acceptance of the transference allows the patient to make a better adaptive use of the grandiose self. It constitutes a reeducation but does not lead to basic structural change (Kernberg 1974a) and so Kohut’s method is by implication not psychoanalysis (which Kernberg recommends for these patients [Schwartz 1973, p. 622; Kernberg 1974, p. 265]), except for those functioning on a borderline level (Kernberg 1974, p. 257, 1974a, p. 217).

The “self’ for Kernberg is part of the ego and contains multiple self-

representations and affects. Unlike Kohut, for Kernberg (1974, 1974a) the grandiose self is formed from the pathological vicissitudes of structural development of the ego. For Kohut the grandiose self is a replication of an archaic normal primitive self-image and not a pathological structure. Kernberg (1974, 1974a) argues that the grandiose self of the adult differs significantly from that of the child: the adult grandiose self is more extreme and distorted in its demands; there is a warm quality to the child's self-centeredness; there is less abnormal destructiveness and ruthlessness in the normal child's self-centeredness. Kohut (1971, pp. 124-125), however, notes that the grandiose self is a "regressively altered edition" of the child's grandiose self mixed with sadistic drive elements that are fragmentation products, so this is not an irreconcilable difference.

For Kohut, narcissism follows a separate line of development, but for Kernberg (1974a) we cannot separate it from libido and aggression and the vicissitudes of internalized object relations. There is no separate line of development. Kernberg (1975a) argues that Kohut's method leads to better adaptive use of the grandiose self but is not accompanied by much change in pathological object relations because the grandiose self is not analyzed. Kernberg states the process of improvement does *not* occur simply because lines of development of narcissism and other libido are separate. These views are basically irreconcilable and cannot be synthesized.

Kohut’s Other Clinical Contributions

Another late clinical concept of Kohut (1984) is what he calls “the principle of the relativity of diagnostic classification and the specific prognosis” (p. 183). A clinical vignette is presented (p. 178) in which the critical task of the analyst was based on self-scrutiny in order to prevent the tendency to attack the analysand’s transference distortions. Such an attack “only confirms the analysand’s conviction that the analyst is as dogmatic, as utterly sure of himself, as walled off in the self-righteousness of a distorted view, as the pathogenic parents (or other self-object) had been” (p. 182). Kohut recommends continuing sincere acceptance of the patient’s reproaches as psychologically realistic, followed by a prolonged attempt to look at the analyst and remove barriers that stand in the way of the empathic grasp of the patient. If successful, this process may produce the reward of a borderline case becoming a narcissistic personality disorder; in Kohut’s terms an unanalyzable patient becomes an analyzable patient. In a way, this could be considered the answer of Kohut to the approach of Kernberg in the treatment of narcissistic personality disorders.

For Kohut, there exist two types of dreams, those expressing latent contents that involve drives, conflicts, and attempted solutions, and those attempting “to bind the nonverbal tensions of traumatic states (the dread of overstimulation, or of the disintegration of the self [psychosis]). Dreams of

this second type portray the dreamer's dread vis-a-vis some uncontrollable tension-increase or his dread of the dissolution of the self" (1977, p. 109). These are the self-state dreams discussed above. It follows from what has been said that the so-called bedrock beyond which analysis cannot penetrate is not the castration threat in the male or the lack of the penis in the female and is more serious than a threat to physical survival itself. Kohut (1977, p. 117) says it is the threat of the destruction of the nuclear self. Any price will be paid to prevent this.

Thus Kohut (1977, p. 121, p. 124) points out the failure of the Kleinian emphasis on the manifestations of rage as a bestial drive that has to be tamed: for Kohut, rage is a specific regressive phenomenon arising from a deficiency in empathy on the part of the self-object. In hypochondriasis certain body parts become the carrier of the regressive development "from the patient's yearning for the absent self-object to states of self-fragmentation and will, therefore, especially lend themselves to becoming crystallization points for hypochondriacal worry" (Kohut 1977, p. 156).

Kohut (1977) introduces the clinical concept of "action-thought" which is not the same as acting out in the usual sense (Chessick 1974). It represents steps made by the patient who is healing a disorder of the self on the path to psychological equilibrium. It consists of action patterns, creatively initiated by the patient on the basis of actual talents, ambitions, and ideals but to be

further modified and perfected in order to provide a reliable means of establishing the postanalytic maintenance of a stable psychoeconomic equilibrium in the narcissistic sector of the personality. Such activities should not be expected to dissolve as a consequence of correct interpretation and do not represent regressive steps but rather constitute a forward movement. Lack of recognition of the forward nature of this movement is experienced by the patient as an empathic lapse.

The sequence described in the case of Mr. M. (Kohut 1977) of movement from playing the violin, to befriending an adolescent boy, to opening a writing school, is an excellent description of action-thought as clinically observed. A similar form of action-thought has to take place as the patient gradually develops a more effective empathic matrix of self-objects that reflects the improvement in the cohesion of the self and the integration of the archaic narcissistic structures internally.

Another important clinical psychiatric phenomenon examined by Kohut is his emphasis on middle age. Late middle age for Kohut is the pivotal point in the life curve of the self that forms the final crucial test of whether previous development failed or succeeded. Patients presenting with hopelessness, lethargy, empty depression, without predominant guilt, but with self-directed aggression are strong candidates for the diagnosis of a disorder of the self and are common in clinical practice.

Another important clinical contribution results from Kohut's reflections on patients who continually seem to make the wrong choices which result in suffering attributed to "unfortunate circumstances." Such patients often have pathology of the self which makes it difficult for them to make realistic choices, defined as "choices in complete harmony with the innate abilities he possesses and with the external opportunities open to him, choices that serve his principles or fully support the pursuit of obtainable goals" (Kohut 1977, p. 283). Another clinical marker of recovery from self-pathology is the patient's manifest improved capacity to find a productive and creative existence that is actually realistic in the sense defined above, as well as the gradual accretion of a consistent self-object matrix.

This brings us again to the "Zeigarnik phenomenon," from which Kohut postulates that the self-object transferences will develop as a result of the need to complete unfinished developmental tasks. These tasks, if completed in childhood, would have produced a cohesive self. The Zeigarnik (1927) effect in experimental psychology generated the theory that interruption of any task leads to tension, and that the tendency to resume that task at the earliest opportunity relieves the tension. Transference in the narcissistic disorders develops out of the need to complete the development and form structure, not as a result of striving for instinctual gratification via objects as in classical metapsychology (Kohut 1977, p. 217). This notion of the reactivation in the treatment situation of the "developmental potential of the

defective self" is what Kohut (1984, p. 4) calls the "central hypothesis" of self-psychology.

One of the biggest arguments against Kohut's theory involves the vagueness of this conception. How does an individual know that a part of the structure is missing? What are the nature and origin of the developmental forces that drive the patient to replace or form missing structures? The assumption is that the forces of development will resume, in a properly conducted treatment, in order to continue a development that was interrupted at the age of two. These spontaneously arising self-object transferences lead to what Kohut (1984) calls a basic therapeutic unit common to both forms of patients: those with oedipal conflict neuroses and those with narcissistic personality disorders and narcissistic behavior disturbances.

The first phase of the treatment is understanding. This begins with the inevitable need activation in the treatment and its optimal frustration, nonfulfillment of the need or "abstinence." The therapeutic process provides the substitution for direct need fulfillment by reestablishing the bond of empathy between the self and self-object, which is threatened by nonfulfillment of the need directly, through the communication of empathically based recognition that the patient is suffering. Sometimes this occurs even through a "wild interpretation," regardless of the psychoanalytic

"school" from which it arises. This substitution provides limited structural accretion and might be thought of as a form of psychotherapy with ephemeral results, a form which is incomplete because it is not broad or deep and takes place in the presence of a weaker empathic bond.

The second phase of the therapy is explaining, which also depends on empathy. Here the dynamics are interpreted to the patient with respect to the transference experience. The genetic precursors of the patient's vulnerabilities and conflicts are discussed and explained. This leads to a more powerful empathic bond and a broadening and deepening of the patient's self-understanding and acceptance. Basically, however, the cure does not rest on an expansion of cognition but on an accretion of psychic structure. In this approach to psychotherapy the use of confrontations is discouraged (1984, p. 173) and should be replaced by consistent interpretation of self-object transferences. Kohut concludes that the patient

> must be able to mobilize . . . the maturation-directed needs for structure building via transmuting internalization of the revived self-objects of childhood. As precursors of the child's psychological structure, these self-objects perform the functions . . . which the psyche of the adult will later be able to perform with the aid of a self-object milieu composed of his family, his friends, his work situation, and-. . . the cultural resources of the group to which he belongs. (1984, p. 71)

AMBIENCE OF THE TREATMENT

Contrary to many misconceptions about self-psychology, Goldberg (1978) states:

> The analyst does not actively soothe; he interprets the analysand's yearning to be soothed. The analyst does not actively mirror; he interprets the need for confirming responses. The analyst does not actively admire or approve grandiose expectations; he explains their role in the psychic economy. The analyst does not fall into passive silence; he explains why his interventions are felt to be intrusive, (pp. 447-448)

The analytic ambience, based on the therapist's reasonable, humane, tactful, non-humiliating attitude, facilitates the process of psychoanalysis and psychoanalytic psychotherapy and has a soothing effect that can also be interpreted. Interpretation rather than gratification is the rule. But at times a certain "reluctant compliance" is necessary to avoid a cold, critical, unaccepting ambience, which will certainly disrupt the treatment of, especially, preoedipal disorders.

An average expectable environment is necessary (Wolf 1976). If the patient in a hot room, "half rising off the couch, half turning back toward the analyst" (p. 108), asks if he may remove his suit jacket and the response of the analyst is an icy silence or poker-faced stare, there will result "transference artifacts" which often may be mistakenly interpreted as aggression arising from the transference. Why might the hypothetical "classical" analyst respond with an icy silence or poker-faced stare to such a request? The therapist may have thought he was following the "rule of abstinence" and did not want to

gratify the patient's erotic or exhibitionistic wish, assumed to underlie the request. Although this may be technically correct, it loses sight of the narcissistic wounding involved when an average expectable environment is not provided, and the psychology of the self tends to help us keep our perspective on this important factor.

The patient must adjust to whatever ambience the therapist insists on providing, regardless of the theoretical grounds given by the therapist for this ambience. For example, Kohut (1984) mentions (without naming) the practice of Langs (1981) who criticizes (pp. 162ff) making available a box of tissues for the patient, out of the wish to avoid any "intervention" which would give gratification to the patient. Patients will adjust to such extreme aridity, but, according to the psychology of the self, a price will be paid for it in the development of an iatrogenic narcissistic withdrawal and a reactive grandiosity.

The importance of such iatrogenic regressions, which harden into "resistances" that are extremely difficult to resolve by interpretation, is discussed at length by Stone (1961, 1981). Both he and Lipton (1977, 1979) discuss this as an erroneous understanding and application of Freud's views. Leider (1983, 1984) reviews the controversial subject of "analytic neutrality" and the arguments for and against the role of empathy and non-interpretive interventions which basically arise "from differing views of the essential

functions of the analyst in the psychoanalytic process" (1983, p. 673) in detail. Kohut's work has fueled much new controversy on this subject, as we shall explore in the clinical examples from self-psychology to be reviewed in subsequent chapters. The argument is over whether the "classical" (or "neoclassical") analytic stance is or is not sometimes so nonresponsive as to interfere with the analytic process, or whether the "empathic" stance of Kohut and his followers does or does not contaminate the transference and interfere with analysis.

Kohut's View of Psychoanalytic Cure

I will now turn to Kohut's final version of psychoanalytic treatment. As stated above, empathy does not require any sort of deliberate attempt to mirror or gratify the patient. At its base it requires that the therapist first accept the prevailing self-object transference without interpretation. Empathy must always pervade both of the crucial steps that constitute the ultimately curative interventions of the analyst.

First, through empathy the analyst must understand what the patient is experiencing at any given time, and why; then the therapist must explain "over and over again" (Kohut 1984, p. 206) that which has led to temporary interruptions of the self-object transferences by empathic failures and connect this historically with the childhood milieu provided by the significant

self-objects. This requires that the empathic therapist not interfere with the developing self-object transferences by interpretation, for example, in an effort to reach a postulated underlying aggression that is thought to be hidden by an idealizing transference.

If the understanding and explaining of the therapist is experienced repeatedly by the patient, and if empathy generally pervades both of these interventions, structure building via transmuting internalizations will occur. This is how analysis cures disorders of the self, and Kohut (1984) describes some degree of such self-disorders as universal in psychopathology. The “proof” of cure is not abstract but lies within the patient’s capacity to develop a secure empathic matrix with others, a matrix that Kohut considers to be vital to self-cohesion throughout life (p. 77).

Kohut insists a psychoanalysis grounded in self-psychology does not lead to any change in basic psychoanalytic technique. Psychoanalysis and intensive psychotherapy share the “understanding” step (or phase) of treatment, which entails a sequence of three substeps “of the therapeutic mini processes that lead to the laying down of psychic structure and thereby prepare the soil for the analytic cure” (p. 103). These three substeps are the reactivation of a need by the therapeutic situation, “abstinence” or nonresponse by the self-object analyst, and the reestablishment of a bond of empathy between the self and self-object by the analyst’s communication to

the patient of his more or less correct understanding of the patient's inner experience.

Despite the analyst's understanding of what the patient feels and the acknowledgment that the patient's upset is legitimate from the patient's experience in the self-object transference, the analyst still does not directly act in accordance with the patient's archaic need. However, through the understanding and communication of it, an empathic bond is established or reestablished between the analyst and the patient. This substitutes for the fulfillment of the patient's need, allowing structure to be built by transmuting internalization. Whether these are new structures that fill in defects or compensatory structures is not the main point. Some patients will require long periods of understanding alone before the second step (or phase) of analytic cure can be usefully undertaken.

The second step (or phase) of analytic cure constitutes psychoanalytic explanation via well-designed interpretations. Not only does it increase the impact of the first or understanding step, but, by referring to the genetic precursors of the patient's vulnerabilities and conflicts, it broadens and deepens the sense of being understood for the patient. It also allows the patient to face experiences similar to those that have previously led to the interpretation of a transference disruption, such as the analysand's reaction to the analyst's canceling a session, which produce what Kohut (1984) calls

"undulations" (p. 67) in the flow of empathy between analyst and analysand that has been established in the understanding step.

There are two substeps of this second or "explanatory" step or phase (Kohut 1984, p. 106). The first constitutes interpretations which explain the undulations in dynamic terms, and the second refers to exploring and explaining the genetic precursors of the patient's vulnerabilities and conflicts. Thus genetic reconstructions for their knowledge value alone are not as important as they are for deepening the patient's sense of being understood. Through these two substeps a truly psychoanalytic therapeutic effect can be achieved, an effect which is "qualitatively different from the effect that resulted from the understanding phase alone" (p. 105).

The critical point of methodological difference between Kohut and traditional psychoanalysis is in his (1984) statement that, "the basic therapeutic unit of the psychoanalytic cure does not rest on the expansion of cognition. (It does not rest, for example, on the analysand's becoming aware of the difference between his fantasy and reality, especially with reference to transference distortions involving projected drives)" (p. 108). The essence of the cure is the accretion of psychic structure based on an optimal frustration of the analysand's needs or wishes. The accretion of psychic structure is provided first by understanding and then by explanation and interpretation involving the genetic precursors of the patient's vulnerabilities, which

establish a basic change in a sector of the self. This leads to cure of the disorder of the self by transmuting internalization.

This emphasis on the structure-building aspect of understanding, explanation, and interpretation, as well as on “the self and survival of its nuclear program” (Kohut 1984, p. 147), separates the psychology of the self from traditional psychoanalysis. To emphasize the difference, Kohut points out that he cannot accept the notion that psychoanalysts primarily are engaged in a battle to increase knowledge and that everything that impedes progress toward becoming conscious and sharing liberated cognitive content with the analyst is a “resistance.” On the deepest level, the patient’s motivations are “an expression of his enduring wish to complete his development and thereby realize the nuclear program of his self” (p. 148).

The difference between psychotherapy and psychoanalysis is as follows: the results of the analyst’s more or less accurate empathic understanding of the condition of the patient’s self, when communicated, promotes the movement toward health and leads to the laying down of new psychological structure, but the results of this tend to be “ephemeral” (p. 106). The second step (or phase) of dynamic genetic explanations or interpretations “not only broadens and deepens the patient’s own empathic-accepting grasp of himself, but strengthens the patient’s trust in the reality and reliability of the empathic bond that is being established between himself and his analyst by

putting him in touch with the full depth and breadth of the analyst’s understanding of him” (p. 105). For Kohut, a rise in self-esteem occurs as the direct consequence of optimal new self-structures acquired in treatment as well as from the firming of existing structures. The proof this has occurred is provided by the patient’s increasing success in finding a stable empathic self-object matrix and developing at least one area of joyful activity between the poles of the self that harnesses genuine preexisting talents in the service of realistic long-term goals.

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