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Self and Object:

Fairbairn, Winnicott, Balint, and R. D. Laing

Psychology of the Self and the Treatment of Narcissism

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Three psychoanalytic theories that utilize the concept of the self have a resemblance to the work of Kohut and are often confused with his views. The theories of Fairbairn, Winnicott, and R. D. Laing use different conceptions of the self but all have in common with Kohut the assumption that the self is shaped and formed from its very beginning out of the interaction with the mother, or what Winnicott (1965) calls the facilitating environment. This is in sharp contrast especially to the views of Melanie Klein and other object relations theorists, who believe the psyche develops internally through cycles of introjection and projection. This development is seen to be relatively independent of environmental influences and more dependent on constitutional intensity or genetic unfolding of drive constellations.

The Views of Fairbairn

W. R. D. Fairbairn (1889-1964) formed his theories in reaction to Melanie Klein's work because he felt that the so-called biological or "id" basis of her theories should be eliminated. For Fairbairn, the

individual begins with a pristine ego that out of its inherent energy strives for self-development. His work gets into difficulty because he assumes that the ego becomes split in all development, normal as well as pathological. The precise metapsychological meaning of Fairbairn's split-up psychic self is not clear; for example, it employs the undefinable notion of "internalized object." Fairbairn uses "ego" in his theories to mean "the psychic self" (Guntrip 1974, p. 833). The struggle of this split-up psychic self to cope with the outer world is the problem, rather than the struggle of the ego with the id. In Fairbairn's view, there is no "id." Fairbairn thus differs fundamentally from Freud and presents an *entirely* different metapsychology, as discussed in detail by Rangell (1985, pp. 306-310).

Fairbairn, Winnicott, and Balint emphasize the primacy of the environment and the mother's influence. Unless "good enough mothering" (Winnicott 1958) occurs, the infant increasingly frequents the inner world of fantasy objects, but the ego always seeks and needs objects and always stands in some relationship to them. The ego is never regarded as an abstract set of functions or subsystems. Libido, for Fairbairn, in a totally non-Freudian definition, is always object-seeking rather than seeking discharge; "libido" is the energy of the

search for good objects, which makes ego differentiation and growth possible.

As in the subsequent work of Kohut, Fairbairn views aggression not as an instinct, but as a reaction to the frustration of libidinal drive. Fairbairn rejects Freud's oral-anal-phallic phases and substitutes three phases of development: immature dependency of infancy, a transitional phase, and a final mature dependence among equal adults. This last phase has some superficial resemblance to the later work of Kohut, who emphasizes the "empathic matrix" needed by all adults.

Fairbairn (Guntrip 1974) presents a three-fold split in the psychic self and an internal struggle that he calls "internal ego-object relations." The infantile libidinal ego (analogous to Freud's id) in a state of dissatisfaction is related to an internal bad object that Fairbairn calls the "exciting object" which excites but never satisfies the child's needs. This "libidinal ego-exciting object" is illustrated clinically in the dream of a male patient who follows a woman who constantly retreats from him.[1]

The next sector of the self is the infantile antilibidinal ego (the

sadistic part of Freud's superego) which represents the identification with rejecting objects; it is turned against the individual's own libidinal needs. A clinical example of this aspect of the self, "the antilibidinal ego-rejecting object," is presented in the dream of a female patient: "I was a little girl who saw you and thought 'If I get to him I will be safe.' And I began to run to you . . . but another little girl smacked my face and drove me away."

The third aspect of the self or the central ego (Freud's ego) is the conscious self of everyday living attempting to deal with reality, and in so doing idealizing the parents (the ideal object, the moral aspect of Freud's superego). Thus "the central ego-ideal object" struggles to preserve good relationships with the parents for the purposes of strength and adaptation.

Guntrip, the analysand and pupil of Fairbairn,[2] added an ultimate split in schizoid patients postulated to be in Fairbairn's infantile libidinal ego itself. This aspect splits into a clamoring, orally active hysteric libidinal ego and a deeply withdrawn, passive schizoid libidinal ego. This latter "regressed ego" is experienced by the patient as a compulsive need to sleep, exhaustion, feelings of being a

nonentity, a sense of having lost part of the self, of being out of touch—the commonly reported phenomena of schizoid states such as feeling that there is a sheet of plate glass between one's self and the world. Guntrip (1974) points out that the patient may protect against this sense of annihilation by remaining chronically angry and fighting in order to maintain one's energy level. This should be compared with Kohut's later theory in which the patient produces a pseudo-dramatization of everything in order to defend against the unbearable subjective sense of a depleted, empty self.

Fairbairn (1963) published a one-page summary of his complex views. Guntrip (1974) attempts to explain this theory, which rests on an apparently metapsychologically untenable notion of internalized objects. Kernberg (1980) offers some stimulating ideas on the use made by Guntrip of Fairbairn's theory, and he criticizes them both from his own point of view. Klein and Tribich (1981) denounce Kernberg's criticism of Fairbairn severely; they seem to prefer Fairbairn's object-relations theory over that of Kernberg. The psychology of the self, although it has some resemblances to Fairbairn's object relations theory, is not an object relations theory as defined by the British school and Kernberg. However, it shares with

Fairbairn, Balint, and Winnicott their central emphasis on the mother-infant interaction ambience as crucial to the formation of the basic personality. In that sense it is a "modern" or neo-object relations theory.

Robbins (1980) reviews the current controversy in object relations theory, pointing out the striking resemblance between the views of Kohut and the ideas of Fairbairn. Robbins contrasts the views of Fairbairn and Kohut with those of Klein and Kernberg, which he feels are also closely related to each other.

According to Robbins, Fairbairn's terminology is confusing because Fairbairn uses the ego ambiguously to signify a primary self rather than simply an intrapsychic structure. Robbins criticizes Fairbairn because the latter's theory assumes capacities to differentiate among part-objects and affects, and to introject, segregate, and structure experience, all of which may be beyond the capacity of the infant. He adds:

> His core ideas are harbingers of Kohut, particularly his de-emphasis of libido, his conception of aggression as a disintegration product and his focus on the primary relationship between the self as a dynamic structure, and

> an empathic self-object. When such a relationship fails or disappoints, both Fairbairn and Kohut describe the expression of rage, the development of perverse, auto-erotic phenomena, and an overall picture of detachment and apathy, (p. 484)

The Views of Winnicott

D. W. Winnicott (1896-1971) was a magnificent, intuitive clinician who used questionable and confusing terminology, for example, "ego-orgasm." He emphasized the difference between oedipal patients who require psychoanalysis and preoedipal cases requiring "management" or what he called an ego-adaptive environment of holding. Among his most important concepts are those of the true and false self associated with his notions of "the transitional object" and "the facilitating environment" (Winnicott 1953, 1958, 1965).

The false self develops in response to early non-empathic mothering and has to do with learning to be compliant, never exploring one's own authentic self and its needs. Kohut (1984) mentions repeatedly that continued compliance on the part of the patient in psychoanalysis is one of the most difficult resistances with which to deal. The false self produces a certain inherent rigidity and

lack of autonomy or spontaneous feelings and it functions to keep the true self hidden. The patient is disengaged. For Winnicott this often has to be broken down through therapeutic regression, in order that the pathological false self-compliance can disappear and a real exchange of affect and feeling can emerge in the therapeutic situation. This is a time of regression to deep dependency when it occurs.

Winnicott (1958), before Kohut, writes that the patient makes use of the analyst's failures; these can be used therapeutically and treated as past failures about which the patient can be angry. This concept of the false and true self belongs to what Winnicott calls a schizoid subvariant rather than to borderline patients, who usually do not present compliance as a major problem in psychotherapy. But he describes patients who are split between a true self and a false self in terms very like Kohut's picture of certain narcissistic personality disorders. Winnicott (1965) writes: "Instead of cultural pursuits one observes in such persons extreme restlessness, an inability to concentrate, and a need to collect impingements from external reality so that the living-time of the individual can be filled by reactions to these impingements" (p. 150).

With emphasis on the management of preoedipally damaged patients and his concept of good-enough mothering, Winnicott believes that the setting becomes equally or more important than the interpretations used in psychotherapy (Greenberg and Mitchell 1983). For Winnicott, maturation requires and depends upon the quality of the facilitating environment. The infant in this environment creates and recreates the object. According to Winnicott (1965), the object is at first a subjective phenomenon which he labels "the subjective object." Later it becomes an object objectively perceived; this is a function of the formation of an "objective subject," that is to say, "the idea of a self, and the feeling of being real that springs from having an identity." Notice that the self is not the same as the ego for Winnicott, who (1971) defines the self as "the person who is me, who is only me, who has a totality based on the operation of the maturation process." The key point here is that the quality of maternal holding has the crucial role in the shaping and developing of the self.

Cassimatis (1984) writes that Kohut has "expanded Winnicott's epigrammatic ideas and made a major contribution in showing that analysis *of* (and respect *for)* the self needs to precede classical analytic approaches and interpretations" (p. 69). With this issue of the true and

false self Winnicott (as does Kohut) introduces "existential" issues into clinical psychotherapy and psychoanalysis according to Cassimatis. He compares their work with that of Kierkegaard (1859) who writes of the desire to be a true self, by which Kierkegaard means an "authentic" individual, with theological overtones.

Primary Narcissism and Secondary Narcissism: Balint

We can distinguish two basic opposing views about primary narcissism. M. Balint (1896-1970) insisted there is no such thing. Following Fairbairn, he maintained (1953) that the individual is born with "primary object love." Initially, the infant seeks an object that will gratify the person without the person needing to communicate the need to the object first. It is the primal wish for the intuitive, totally empathic, all-loving maternal object. There is no room in the theory of Balint for primary narcissism and he believes development progresses strictly along the line of object relations, moving from primary object relations to mature object love. Eagle (1984) reviews the experimental evidence from work with infants and children that seems to support this view.

Basch (Stepansky and Goldberg 1984) addresses this issue, crediting Ferenczi with founding an approach to human development that culminates in Kohut's crucial assumption of maturation as based not on instinctual frustration and conflict, but on "harmonious interplay between instinctually potentiated genetic patterns and the releaser mechanisms for that potential embodied in the caregiver's empathic response to the infant's affective communications" (p. 12). This concept of human development, argues Basch, is consistent with scientific findings since Freud. Self-psychology has, therefore, "restored psychoanalytic theory to scientific respectability" (p. 37). Note, however, that the self of an infant for Kohut (1977) is a "*virtual*" self (p. 101). It must be described in terms of increase or decrease in tension and *not,* as in Klein, in terms of fantasies that are at least potentially verbalizable. This is a common source of confusion, and Kohut to some extent avoids the pitfall of attributing complex ego functions to the infant.

On the other hand, Freud believed that the infant passed from an initial state of autoerotism, in which there are simply body states prior to the development of any ego nuclei, to a phase of primary narcissism, which begins with the formation of ego nuclei and represents an

overwhelming cathexis of these ego nuclei with libido. Next, a gradual transition from the stage of primary narcissism to the state of object love occurs, as libido is divested from the ego (used interchangeably as self by Freud) and cathected to objects or object representations. Freud is not specific on this matter.

Secondary narcissism is also defined differently by different authors. Freud's secondary narcissism is a defensive withdrawal of libido from objects back to a cathexis of the ego or self, but all secondary narcissism is not just pathological. Some of this withdrawal is normal in terms of the vicissitudes of structure formation, which Mahler et al. (1975) call "sound secondary narcissism." On the other hand, Balint insists that *all* narcissism is secondary narcissism since there is no such thing as primary narcissism. Kohut argues that narcissism follows an independent line of development, entirely discarding the concept of secondary narcissism, and describing transformations of narcissism from primitive to mature forms.

According to Freud, the psychoanalytic treatment of narcissistic disorders is extremely difficult. Patients who have cathected most of their libido to the ego or self do not have libido available to cathect

objects and therefore no transference can form. These patients are consequently unsuitable for Freud's psychoanalysis, which requires that a transference neurosis develop and be resolved by interpretation. A pejorative gloomy connotation to narcissism is implied.

THE VIEWS OF BALINT

According to Balint (1968), psychotherapists treating patients who are not classical neurotics, but whose disorders have begun before the consolidation of the repression barrier, must supply a "new beginning" to the patient in order to correct a "basic fault." The therapist attempts to provide an atmosphere that is an emotional experience corrective to the early nonempathic mothering given to the patient. Those who follow Balint emphasize the patient's absolute need for empathy from the therapist and stress the danger of inappropriate verbal interpretations; the empathic interactions described by Balint, rather than interpretations of transference, are essential for the successful treatment of such patients.

In the proper regression in psychoanalysis that Balint (1968)

calls benign regression—to distinguish it from malignant regression for the sake of gratification, which has the unworkable qualities of despair and passion—the patient reaches what Balint calls the “arglos” state. In this state, the analyst must recognize the patient’s needs and longings for satisfaction which are the essence of a “new beginning” and the patient’s recovery from the basic fault. The arglos state, which Balint considers to be an absolutely necessary precondition for the new beginning, is explained by the patient’s craving for primary love.

The special atmosphere provided during this state has much more to do with recognition than massive gratification. Only token satisfaction of need is provided, and there was a slow evolution of Balint’s views so that the tokens of direct gratification were fewer; the recognition of the patient’s need and the unobtrusiveness of the therapist are the essential ingredients. Even in this relatively crude precursor to the theories of Kohut, there is a move away from the more unsophisticated views of Balint’s teacher Ferenczi, who (1955) advocated that an actual effort be made to gratify the needs of the patient on a massive basis, a procedure that always leads to chaos and destruction, often for the therapist as well as for the patient (Chessick 1974).

In his earliest cases, Balint allowed patients to jump rope or do somersaults before him, with Balint functioning as what Kohut would call a mirroring self-object. He soon realized that even this sort of "corrective emotional experience" was futile except on a temporary basis. Yet, his intuitive recognition and interpretation of the patient's exhibitionistic need was an early step toward the concepts of the psychology of the self.

There are two clinically valuable ways in which the therapist can communicate recognition of the patient's needs and longings in order to enable the patient to make a new beginning. Balint communicates this recognition to the patient by, for example, an explanation or interpretation or perhaps by some token satisfaction of the need. Kohut's way is more subtle: the patient experiences the therapist's empathic recognition of his needs by the ambience of the therapy and the tone, phrasing, and timing of the interpretations. Both Balint and Kohut have been unreasonably criticized and accused of attempting to provide some kind of direct gratification to the patient on a massive basis. Therapists who attempt this are not psychoanalysts or psychoanalytic psychotherapists—such behavior is always an acting out on the part of an insufficiently analyzed therapist.

Balint and Winnicott introduced the concept of archaic transferences into the treatment of preoedipal disorders. The transference that forms in the regressions of patients with preoedipal disorders does not represent the crossing of a repression barrier of wishes for infantile libidinal need discharges. Instead, certain archaic transference like states develop, which respond not to interpretation at first—interpretations may even interfere—but to the quality of the therapist-patient relationship. The longings involved are more "archaic" and Modell, Little, Kohut, Gedo, and numerous others have attempted to describe these longings. It is difficult to discuss these archaic transferences in terms of classical psychoanalytic theory, and they require a sensitive therapist to understand and treat them. Prior to the work of Kohut, gifted clinicians usually responded to them intuitively.

Little (1981) presents an example of archaic transference in discussing "basic unity": a primary total undifferentiatedness, before symbiosis, before Klein's paranoid-schizoid position, occurring at birth. Premature disruption of basic unity is accompanied by annihilation anxiety; according to Little, basic unity becomes a crucial issue in borderline patients who cannot relegate it only to fantasy.

They must regress to it with the therapist and rework repeatedly the separation from this basic unity in psychoanalytic psychotherapy. Needless to say, a heavy countertransference strain is placed on the therapist in dealing with this sort of archaic transference.

Unfortunately, theoretical formulations such as those of Balint or Little are based on adultomorphic errors and have a mystical aspect to them. Deliberate attempts to provide a special atmosphere for certain patients are manipulative, overly dramatic, and mystical. All patients (Stone 1961) should be presented with the physicianly vocation and the authentic self of the therapist. It is not clear what special techniques are involved in trying to provide the patient with empathic mothering. This vagueness about the notion of good enough holding pervades the therapeutic suggestions of intuitive clinicians such as Winnicott, Balint, and Little.

In the 1930s, Balint already noted an important theoretical change in the classical conception of psychotherapeutic technique. This change was determined by the increasing importance given to the actual experience or "education" (Freud called it "after-education") that the patient in a benign regression has with the therapist. Such a

treatment is more crucial when dealing with preoedipal borderline or narcissistic disorders than when dealing with the so-called classical neuroses. Balint attempted to divide types of treatment into those for patients at the oedipal level and those for patients at the level of the "basic fault." Whether this is psychoanalysis, intensive psychoanalytic psychotherapy, or psychoanalysis with parameters remains highly controversial even today. As Winnicott states (1965), "Analysts who are not prepared to meet the heavy needs of patients who become dependent in this way must be careful to choose their cases that they do not include False Self types" (p. 151).

Laings "Divided Self'

To conclude this chapter I wish to review *The Divided Self* by R. D. Laing (1960), in which Laing fuses the work of Winnicott, Fairbairn, and Balint of the so-called British school of psychoanalytic clinicians with existentialist authors such as Sartre and Kierkegaard. For my purposes here I will discuss only Laing's notion of "the divided self' and not his later conceptions of schizophrenia, family and group interaction, or his radical political and antipsychiatry views.

As in the work of Sartre, the individual's self as agent is at the center of Laing's conceptions. However, Laing believes splitting of the self is induced in childhood by forces outside the agent's control, whereas Sartre recognizes only the self as a conscious agent with conscious intent and no pre-intentional causal origins (Hunter 1977). Laing (1960) states that organic, biological, and genetic factors influence the formation and splitting of the self along with the politics of the family or family pressures. In Laing's later work he drops this aspect of his conception of schizophrenia, which I believe isolated Laing from the mainstream of psychiatric thinking about schizophrenia.

Laing never explains why some patients develop schizophrenia from a divided self and some do not. Later he does not see schizophrenia as a clinical entity, and believes that "illness" is an unsatisfactory model for mental disorders. Psychotic phenomena are intelligible, says Laing, and he believes that there are no criteria for the term schizophrenia and that it is a scientifically unsound concept. To understand "madness," one must study the family and not only the individual. People who are dissident members of a family or political group are often incorrectly classified as mad, and statistical normality

is not necessarily preferable to madness. Thus, concepts of sanity and madness are socially relative, and he came to believe that madness can even be naturally curative (Collier 1977).

In his early work Laing presents what he calls the existential-phenomenological foundation of a science of persons. The schizoid individual has experiences split in two ways: with respect to the world, the individual is not at home in the world, is alone; and with respect to the self, the individual feels divided with only a tenuous link to the body, prompting the individual to speak of parts of the body in the third person. This leads to what Laing calls "human tragedy," which is not far removed from Kohut's concept of Tragic Man and is rooted in a double alienation of the person from the world, and from the false self and the body. This is the patient's way of being in the world, which we must understand by Laing's existential-phenomenological method; it resembles Kohut's effort through empathy or vicarious introspection to grasp what the other's world is and the other's way of being in it, although their methods rest on totally different epistemological foundations (Chessick 1980b). Laing, in contrast to Sartre, does not reject the unconscious, but uses it only in an adjectival sense and not as a realm with special laws of "primary

process." Kohut's use of the unconscious is much closer to that of Freud.

Laing introduces the theoretically untenable term "ontological insecurity" to characterize an important clinical phenomenon, the individual who is unable to maintain a sense of continuity and cohesion of self. The patient with Kohut's cohesive self closely resembles the patient with Laing's ontological security. The patient with Kohut's fragmenting self resembles the patient with Laing's ontological insecurity. This coincidence continues in Laing's statement that patients with ontological security wish primarily for gratification of themselves. Thus, such patients are ready to enter libidinal and oedipal phases of development. In Kohut's terms (1978, p. 163) patients with a cohesive self seek satisfaction; those with self-pathology seek reassurance.

The patient with ontological insecurity wishes to preserve the self and suffers from three forms of anxiety: *engulfment,* the fear of being overwhelmed, which requires strenuous desperate activity to preserve the self and uses isolation as the main defense; *implosion,* the fear that reality will crash in and obliterate the empty self (thus reality

becomes the persecutor); and *petrifaction,* the fear of becoming an automaton or object, in Sartre's terms. The latter often is accompanied by *depersonalization,* which occurs when another individual becomes tiresome or disturbing, and the patient stops responding.

A coincidence of thought runs from Sartre in Part 3 of *Being and Nothingness* through Laing, through Kohut, in the concept that another individual can either enliven one's self or deaden an already impoverished self. When there is "ontological dependency" (Laing 1960) on the other person instead of genuine mutuality, there is an oscillation between isolation and merger with that other person. In normal mutuality, the oscillation is between separation and relatedness. In pre-Kohutian terms, Laing points out that if there is no mirroring there will be no "ontological autonomy" and the patient will not have a problem in the traditional sense of conflicts—Freud's unconscious pressing for expression and defended against by the ego—but the patient will need to seek ontological security. This disorder cannot be described by conflicts and drives in the Freudian sense but is "beyond the pleasure principle" as Laing puts it.

In the case of Mrs. R., described by Laing, the symptomatic

difficulty was agoraphobia. Her parents were always too engrossed in each other for either of them to take notice of her; she longed to be important and significant to someone else.

In a manner similar to Kohut, Laing points out that Mrs. R.'s incestuous fantasies were a defense against the dread of being alone. He concludes, "Her sexual life and fantasies were efforts, not primarily to gain gratification, but to seek first ontological security. In lovemaking an illusion of this security was achieved, and on the basis of this illusion gratification was possible" (p. 61).

Laing distinguishes between the normal "embodied self' and cases manifesting the pathologically split off "unembodied self." In these pathological cases, a true unembodied self is split off from a defensively formed compliant false self which is attached to the body. Thus a detached, disembodied, inner true self looks on with tenderness, amusement, but usually hatred at the false self attached to the body. Laing explains how the unembodied self becomes hyperconscious, attempts to posit its own imagos, and develops a possibly complex relationship with itself and with the body.

Laing (1960, pp. 101-102) distinguishes between three false self-systems:

In the normal false self-system, some of our behavior is mechanical, but it does not encroach on spontaneity and has no subjective feel of an autonomous foreign body forcing itself on the individual, no sense of compulsivity; nor do we have a sense of being lived by something within us.

1. The hysteric false self-system is a way of life aimed at gratification and characterized by pretending consciously or preconsciously—a form of disavowal related to Sartre's concept of bad faith.

2. The schizoid false self-system is starved and ungratified, a system that aims at preservation, not gratification.

3. The compulsive compliance or "being good" of the schizoid patient involves hatred and a sense of persecution. The self-consciousness of the schizoid patient gives the assurance that the patient exists and represents an apprehensive awareness in the face of danger which is felt to be everywhere in the world.

Laing points out:

> The mother, however, is not simply a *thing* which the child can see, but a *person* who sees the child. Therefore, we suggest that a necessary component in the development of the self is the experience of oneself as a person under the loving eye of the mother. . . . It may be that *a. failure of responsiveness* on the mother's part to one or other aspect of the infant's being will have important consequences, (p. 125)

Laing's theories are highly metaphorical, but his explanation of the schizoid personality is the first to attempt to employ the concept of the subjective sense of self that allows us to place ourselves empathically within the experiences of the individual that we diagnostically label schizoid. This method, even in Laing's poetic form, allows us to better understand the bizarre behavior of schizoid individuals, and the self-defeating nature of schizoid defenses.

Laing had an intuitive genius for understanding schizoid and schizophrenic communications. In a dramatic passage (pp. 29-31) he reviews Kraepelin's classic 1905 lecture describing a patient with catatonic excitement, in which Kraepelin finds the patient inaccessible and impossible to understand, thus diagnosing the patient as psychotic. Yet Laing's review of the patient's actual material demonstrates that the patient is presenting a dialogue between a

parodied version of Kraepelin and the patient's defiant, rebelling self. The rise in popularity of the psychology of the self is based on its analogous potential to make behavior, symptoms, and communications, previously labeled as those of a "bad" patient, intelligible and amenable to the process of intensive psychotherapy or psychoanalysis.

NOtes

1 The use of manifest dream content to illustrate intrapsychic or self states by Fairbairn, Guntrip, and later allegedly by Kohut has been much criticized by traditional psychoanalysts. This is discussed in Chapters 11 and 19.

2 The currently unresolved issue of to what extent and why Guntrip distorted the theories of Fairbairn is beyond the scope of this book.

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