Howard S. Baker

Shorter-Term Psychotherapy: A Self Psychological Approach

Handbook of Short-Term Dynamic Psychotherapy

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from
Handbook of Short-Term Dynamic Psychotherapy

e-Book 2015 International Psychotherapy Institute

From *Handbook of Short-Term Dynamic Psychotherapy* edited by Paul Crits-Christoph & Jacques P. Barber

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Our patients present us with an overwhelming amount of data that we must understand. Whether we know it or not, we have a theory, an organizational schema, that we use to make sense of the information. The theory, whatever one we choose, will clarify some things about our patients; but it will obscure other things. James Gustafson put the dilemma this way: "I say there is no universal method of brief psychotherapy. . .. Every observing position has its advantages, its successes, and its dangers. Every position has a periphery, where important phenomena will occur and be missed, because of the center of interest of that position" (1986, p. 7). This limitation holds as well for the contributions of self psychology. Nevertheless, I believe that the contributions of Heinz Kohut and his followers are particularly thought provoking and useful. The purpose of this chapter is to show how self psychology can provide a helpful organizational framework to guide brief therapy.

ORIGINS AND DEVELOPMENT OF SELF PSYCHOLOGY

The beginning of self psychology is generally given as 1971, when Heinz Kohut published his first book, *The Analysis of the Self*. Several of his earlier papers had anticipated what was to come (especially 1957,1966, and 1968), and he was to alter his thinking regularly and substantially until his untimely death in 1981. His colleagues and followers have continued this evolutionary

process, and there is every reason to believe that the discipline will continue to develop. This chapter continues previous efforts (Ornstein & Ornstein, 1972; Baker, 1979; Ornstein, Gropper, & Bogner, 1983; Deitz, 1988) to improve the effectiveness of brief psychotherapy by adding a self psychological perspective.

Although self psychology has been summarized elsewhere (Baker & Baker, 1987; Wolf, 1988), it is not widely understood. It is necessary, therefore, to offer a brief summary of central aspects of its theory. Four elements are essential: (1) the empathic perspective, (2) the concept of the selfobject, (3) the supraordinate position of the self in motivating behavior, and (4) the role of symptoms as the patient's best efforts to restore selfcohesion.

For self psychology, empathy is not being nice to someone. Nor is it putting oneself in another's shoes. Rather, empathy is an accurate cognitive and affective grasp of what others experience—what *they* feel in *their* shoes. Kohut thought that the empathic responsiveness of early caregivers was essential to the formation of a healthy personality, and that these responses indelibly colored normal sexual and aggressive drives and determined conflictual issues. He stated unequivocally that clinically significant Oedipus complexes occurred because the developing child's normal drives and conflicts were distorted and intensified by unattuned parental responses.

For self psychologists, the role of empathy is crucial to both the developmental and the therapeutic process. Kohut thought that change could occur only when the patient

> feels that the state of his self has been accurately understood. . . . It is one of the basic tenets of psychoanalytic self psychology as therapy . . . that understanding must precede explanation—indeed, that even completely accurate explanations may be useless if they have not been preceded by the establishment of a bond of accurate empathy between the analysand and the interpreting analyst. (Kohut, 1983, p. 406)

Kohut believed there were two elements in effective analysis: communicating understanding and then interpreting.

Kohut thought his main contribution to psychoanalytic thinking was the concept of the selfobject. At first, this concept routinely confuses people; but actually it is not very complicated. A selfobject is something or someone else that is experienced and used as if it were a part of one's own self. Metaphorically, it is as if the other is a part of one's own body. They become an "organ" that is responsible for sustaining certain vital psychological functions. Just as the lungs are necessary to maintain oxygenation, others function as necessary intrapsychic organs that help us to maintain self-esteem and to regulate tension and affect. For example, imagine an actor who looks to people in the audience for applause. Their positive response affirms the work he does. It is as though they are the organ that regulates his self-worth. In self psychological terminology, someone or something that we use

to regulate self-esteem is called a mirroring selfobject. The term draws the analogy that the "reflection" the actor saw in the "mirror" of the audience ruled his self-esteem. If the audience's response is sufficient, he is able to use the audience as a *mirroring selfobject*. If people were to hiss or boo, he could not use them as a selfobject, he could not use them to consolidate his experience of himself, and the narcissistic injury would probably create severe distress. He might feel that he was falling apart and be overwhelmed with fragmentation anxiety. Likewise he might fall into a depleted depression.

The extent to which our actor would rely on the audience may or may not be absolute. This would depend on (1) whether he has other sources of selfobject support and (2) his *intrapsychic* capabilities to maintain his self-esteem. If only some in the audience were bored, he might focus on the others. If his wife were there and nodded her approval, that too would help. These reassuring others could be used as mirroring selfobjects to stabilize the actor's self-esteem. He may also have internal dialogues with parents, friends, colleagues, and others. Sometimes those "conversations" with remembered others calm him and pull him back together. Then the intrapsychic construction, the memory of the other, can be used as a selfobject that encourages him and makes him feel better.

He would also have habitual patterns or theories to process information about the audience's response, and these patterns would be crucial in

determining his well-being. If, for example, he could not regard his performance as satisfactory unless the entire audience was highly enthusiastic, if one or two bored women fell asleep and he focused primarily on them, his organizational theory would lead to repeated insults. Even a good response could not be used to meet mirroring selfobject needs, and he would regularly feel humiliated and rarely gain support for his self-esteem. Likewise, all therapists can think of patients who "know" that we do not really care about them, that our positive regard is merely a part of our job. The result is that they cannot organize our responses to them in a way that consolidates their self-esteem. They cannot, in other words, use us as a mirroring selfobject.

In summary, what happens to any of us and what we think happens to us are not always the same. Michael Basch notes that "strange as it sounds at first blush, theory comes before facts. . . . Sensory input that finds no established ordering framework is just noise, not information; that is, it is not and cannot be organized" (1983, p. 223). The way we organize information is crucial in determining our well-being. Furthermore, our organizational theories or patterns have a way of confirming themselves. The way we construct reality tends to create the reality that we confront. For example, therapists also have patients who "know" that they will be angry at them for something they do. This may lead the patients essentially to pick a fight with the therapist. If they succeed, their theory is proven; and they will be unable

to use the therapist as a selfobject. They may also try to hide some provocative thing they did. Then they will never disconfirm that the therapist is angry, and their belief will persist.

It is important to note that a selfobject is not someone or something outside the self that is used as if it were an extension of the self. Rather, a selfobject is the intrapsychic representation of that person or thing that the self uses to maintain self-esteem and regulate affect. The internal construction of the other may or may not correspond to external reality. Constructivist (as opposed to realist) epistomology argues that external reality cannot be known. It holds that we always interpret data according to a framework or theory (recall Basch above). That theory determines what fraction of the theoretically available data is actually observed. Self psychologists are in general agreement that it is the intrapsychic construction of relationships that function as selfobjects, and they also agree that these constructions follow patterns that do not necessarily match generally (that is, consentually) accepted reality. External reality is certainly not irrelevant, but intrapsychic reality supersedes external reality in determining internal states and behavior.

Most of us, however, have a variety of ways of seeing things. Sometimes a slight will seem trivial, whereas at other times an essentially identical insult will feel devastating. Perhaps the most important contribution of self

psychology is that it has shown that the way we organize input, whether an affront feels denigrating or irrelevant, is largely determined by whether or not we feel securely enough held by the selfobject aspects of our environment. When we feel supported, we brush things off; when we feel isolated, minor problems become unbearable. Our intrapsychic structuring activities are determined partly by our past and partly by our ongoing relationships. This has crucial implications for the process of psychotherapy.

Kohut thought that our embeddedness in a sufficiently empathic selfobject surround determined both our developmental and our ongoing ability to establish sufficient self-sustaining capacities. It is the early caretakers' delight in the child (metaphorically, the gleam in the mother's eye) that provides the foundation for the development of healthy self-esteem. Their happy response facilitated our enjoyment, and their encouragement authorized our appropriate self-assertion and ambition. We can recruit memories (consciously or unconsciously) of those responses, and the intrapsychic construction of those experiences can be used to shore up our self-esteem throughout our life. Additionally, early experiences are organized by the infant (Stern, 1985) into patterns of expectation. As noted above, these patterns will determine future interactions with others in ways that are likely to be self-confirming. The infant who is treated with empathic respect and understanding is likely to grow into an adult who likes himself or herself, enjoys human interaction, and will be able to find an abundance of selfobject

support. By contrast, the abused or developmentally deprived child will understand relationships in unhelpful ways, often behaving in a manner that garners continued painful responses (Lichtenberg, 1983, 1989).

Parents, of course, are never perfect; and perfection is not necessary. At least with children who do not have biological vulnerabilities, all that is required is reasonable consistency—in Donald Winnicott's (1965) term, the "good enough mother." But if parents are regularly critical, disappointed, or inhibiting, the developing child cannot create satisfactory intrapsychic self-sustaining capabilities to maintain self-esteem, enjoyment, or ambitions. There will be deficits and distortions in intrapsychic structure. Shane and Shane (1989) have recently summarized the developmental research that substantiates the self psychological developmental theory.

When a sufficiently empathic environment is not present, the child is not able to develop capacities to maintain self-esteem. He or she cannot organize information about relationships in ways that grant support; the necessary conditions are simply not present. You cannot breathe in a room with no oxygen, and a person cannot develop self-esteem in an environment that denies the mirroring needs of the developing child. Rather, the deprived child will formulate enduring patterns of understanding that lead him or her (1) to find the negative elements in most interactions and (2) to ignore the positive as if it were transparent.

These deficits and distortions will inevitably lead to both intrapsychic and interpersonal conflicts, but self psychology believes that these are not the normal stuff of life. Instead, clinically relevant conflicts are the product of empathic failure. When the developmentally deprived child grows up, he will be unable to sufficiently maintain his self-esteem internally. Consequently he is forced to turn to others excessively. His dependence may terrify him, leading him to flee from relationships. But his inability to care for himself draws him back in a way that some would consider greedy. Thus we see an intrapsychic conflict, and we can predict that his needs will provoke interpersonal conflicts. No amount of clarification of the rapaciousness of his needs or the false nature of his independence will help because he simply does not have the intrapsychic capability to care for himself. This is why self psychologists focus on deficit rather than conflict.

There are other opportunities for developmental success and failure. In addition to mirroring selfobject needs, we all have what Kohut called idealizing selfobject needs. We all require others to function as selfobjects to help us regulate or contain our affects. The developmental paradigm for this is the child who stumbles and scrapes her knee. She returns home to mommy and *then* bursts into tears. As if by magic, mother's kiss calms and soothes her, teaching that others are available for help and that she, too, will eventually be able to manage her own upsets. If the mother's response is regularly nonempathic, either agitation or disinterested neglect, the

developing child will have difficulty forming intrapsychic capacities to contain affect and channel and regulate sexual and aggressive tensions.

We also have so-called alter-ego or twinship selfobject needs. It is necessary to feel like others, to maintain a sense of connectedness. Kohut believed that this aspect of relationships facilitates our ability to turn latent talents into usable skills.

In summary, we use selfobjects to maintain or restore an internal experience of consolidation and organization and to promote psychological growth. For self psychology, object relations do not merely activate the feeling tone of past conflicted relationships (the traditional view of transference). Object relations also activate the endopsychic experiences of wholeness, vigor, self-esteem, tension regulation, ambitions, goals, and skills by providing selfobject experiences.

The intricate interactions between the child's biological endowment and the responsiveness of the selfobject milieu leads to a variety of skills, memories, and perceptual patterns (which self psychologists call self-sustaining structures). These structures tend to impact each other; and they, in turn, are organized into a supraordinate organization or scheme. This suprastructure is what self psychologists call the self.

Figure 1 provides a schematic representation of the self. Depending on

the flexibility and usefulness of the constituent parts, and depending on how the parts impact one another, the structure of the self may be effective and harmonious—or it may be weak and vulnerable and contain elements that are incompatible. Under stress, one structure may fail to function. Sometimes a breakdown in function will be relatively circumscribed. For example, if loop A remains intact, if memories of maternal love and comfort are securely available, then self-organization may be preserved relatively easily. But if several structures are vulnerable and loop A is barren, if it contains no happy memories because of serious deprivation, the unraveling of self-structure may progress.

Figure 1: Interlocking Self-Sustaining Systems (The Self)
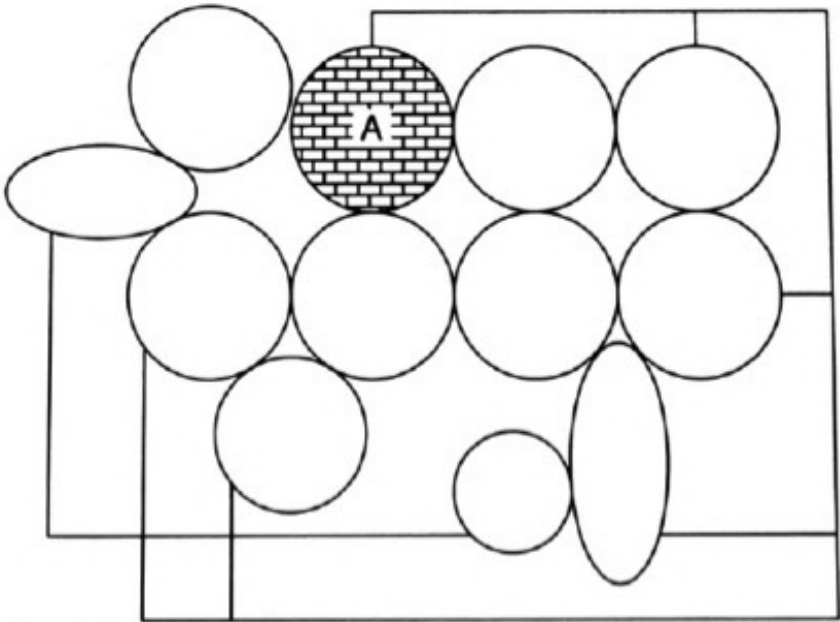
1. *The various structures interact with each other.*

2. *One structure may impact some or all of the other structures.*

3. *One structure may impact another directly, or it may impact another only through another, or it may do both.*

4. *Loop A is particularly important and impacts nearly all loops. It might be thought of as either (a) the way that the person organizes information that concerns crucial, core relationships, ambitions, and goals or (b) memories of parental love and reassurance that can be retrieved (consciously or unconsciously) under stress.*

If there is sufficient disintegration of self-structure, the internal experience can be one of severe depressed depletion, or what Kohut called fragmentation anxiety. That anxiety is considered to be the most powerful

terror known to humans, and people will do almost anything to avoid it. A patient once illustrated fragmentation in a terrifying dream he had after he finished studying organic chemistry. The dream consisted of nothing but organic compounds that were being twisted and torn. As they ruptured, blood gushed from the broken molecules. This was precisely the way that he experienced his life at the time of the dream: his life and his inner experience were disintegrating and he was filled with profound and disorganizing anxiety and dread. He turned to his therapist and felt that his predicament was understood. The interaction enabled him to use the therapist as a selfobject, and the patient was able to repair his selfstructure, at least temporarily.

Although this patient's needs were extreme, Kohut was certain that we all have needs for selfobject support to maintain and sustain the self throughout the entire life cycle. This is true for healthy individuals as well as for the severely troubled. Depending on the success of our self-sustaining capabilities (our relative degree of health), the way we understand our relationships, and the amount of stress that we are experiencing, selfobject needs may be (1) intense (or archaic) and difficult to meet or (2) relatively benign (mature) and easily met. The ability to find and effectively use relationships that meet our selfobject needs is essential to the psychological health of us all, although the extent of the need varies. Selfobject failures and successes, then, occur not only in infancy and early childhood but throughout

life. For the healthy self, selfobject needs are modest, techniques to meet them are well established, and there are only occasional times when the environment fails to meet the needs. For those with weakened self-structure, the needs are intense, techniques to meet them are strident and ineffective. Failure to sustain the self is frequent and symptomatic efforts to restore the self are often necessary.

Stress imposed by disruptions in self-selfobject relationships, narcissistic injuries, or traumas are the precipitant causes of loss of self-cohesion. The extent to which self-cohesion is lost may run the spectrum from mild upset through to profound fragmentation anxiety and depleted depression. The ultimate motivation for most symptomatic behavior and psychopathology is either (1) to avoid or terminate those unbearable affective states or (2) to gain some modicum expression of core needs of the self. For example, a schizoid adjustment may be an effort to avoid the threat of lost selfobject support. What isn't present can't be lost, and the danger is avoided. Such a person might be devoted excessively to a dog, because the pet responds with greater consistency and fewer demands than any human. The patient gains some expression of the self in the relationship to the dog. His devotion might expand to fervent vegetarianism and caustic antivivisectionist activism (I do not mean to imply that all vegetarians or antivivisectionists are so motivated). Likewise, a young woman may indulge in a binge-purge cycle in an effort to invigorate a self depleted by a disruption in her relationship

with her mother (who had been functioning as a centrally organizing selfobject).

Symptomatic behavior follows this sequence: (1) disruption of a selfselfobject relationship, trauma, and/or narcissistic insult, leading to (2) loss of self-cohesion, leading to (3) fragmentation anxiety, rage, and/or depleted depression, leading to (4) efforts at self-restoration. These efforts may be healthy, such as turning to a loved one for support or performing a task one does well, or they may be symptomatic, such as addictive behavior. The goal usually is not mere gratification of a conflicted drive need (although such needs may indeed be met). It is restoration of selfcohesion.

Symptoms fall into three general categories: (1) direct affective expression of the loss of self-cohesion, such as panic disorder, rage reactions, or depression; (2) intrapsychic defenses, such as splitting or obsessional thoughts; and (3) symbolic or manipulative behaviors designed to restore the self, such as addictive sexuality, drug abuse, and suicidal gestures that are a call for help. The symptoms may be shortsighted, but they are the patient's best effort to restore self-cohesion. If loss of self-cohesion is severe, it feels like an absolute emergency. If something with long-term negative consequences will function to restore the self temporarily, it may be used despite its long-term consequences. The current state must change.

Even under severe stress, most people do not undergo such a complete loss of self-cohesion that they resort to such thoughtless actions as drug abuse. Self psychology postulates a spectrum of self pathology that runs from adjustment reactions through to psychosis. In adjustment reactions, there is a transient and relatively limited disorganization of the patient's self-structure. Generally, this is precipitated by either a serious narcissistic insult, a traumatic event, or a disruption in a relationship that is meeting important, but circumscribed, selfobject needs. Returning to figure 1, a breech in a self-selfobject relationship has disrupted the functioning of an intrapsychic self-sustaining structure (one of the loops in the figure) that is peripheral and not intricately interconnected to the deepest layers of the core self. The effects of this breakdown do not expand rapidly and weaken other areas. We might suspect that for most of these patients, development had proceeded well and that problematic failures in important selfselfobject relationships were relatively circumscribed. As a child, the patient was able to find needed selfobject support in most areas; and failures that did occur happened at a relatively late phase, perhaps even in adolescence. Consequently, the patient is vulnerable in only a few aspects of personality, and most of the self-sustaining structures have been sufficient to meet the demands imposed by normal stress. Because the patient is able to recruit memories of positive self-selfobject interactions from the past, he or she is able form new object and self-selfobject relationships with relative ease—and he or she can also

establish a good therapeutic relationship quickly.

When the loss of self-cohesion is of longer duration and is more pervasive (eventually moving from disorganization to fragmentation), the diagnosis moves through neurotic disorders to narcissistic character and behavior disorders, to borderline conditions (Kohut & Wolf, 1978). In the more severe disorders, the organization of the self is more vulnerable and prone to fragmentation. Again referring to figure 1, the number of loops that fail is greater, and the entire self-structure is more likely to collapse under less stress. Kohut and Wolf believed that schizophrenics were still worse off and had failed to construct any reliably integrated self at all.

SELECTION OF PATIENTS

In theory, following a careful evaluation of a patient, indications and contraindications for treatment are assessed on the basis of the diagnosis, and the best treatment is prescribed and provided. Economic realities, however, add another dimension. Brief interventions may be the only possible treatment even when more extended treatment might be optimal. Happily, many people get some relief from their symptoms, some through an appropriate series of several time-limited interventions over a period of several years (see, for example, Siddall, Haffey & Feinman, 1988).

For many patients, however, short-term psychotherapy is either the

treatment of choice or at least a very good option. There is surprising agreement on the positive indications for brief psychotherapy. In general, self psychologists concur with the indications voiced by Davanloo, Malan, Sifneos, and Strupp at the 1975 and 1976 International Symposia on Short-Term Dynamic Psychotherapy (Davanloo, 1978). Self psychologists are encouraged when a patient has a genuine motivation to change and shows a relatively effective self-structure, with significant strengths that are handicapped by weakness in only some areas (in figure 1, only a few loops). If the patient has a history that includes positive self-self object interchanges with early caregivers, it is likely that memories of those past interactions can be recruited and built upon in the therapeutic setting, allowing him or her to establish an effective therapeutic alliance rapidly (Charles Jaffe, personal communication, October 1990). Reasonably good intelligence and an interest in self-understanding also help. Jeffrey Deitz may have summarized the thinking of many with his opinion that "time-limited psychotherapy is an especially useful approach . . . [when] both patient and therapist agree that the goal of treatment is reconstitution to a previous state of psychic equilibrium" (1986, p. 295).

By contrast, brief interventions are unlikely to do more than palliate the difficulties of those with major self pathology. Because they have undergone severe deprivation or trauma, they are limited by a paucity of memories that they can recruit to gain selfobject support. Protracted psychotherapeutic

work is generally required for them to risk opening themselves to the sort of human interactions that are necessary for them to make genuine changes in the structure of their personality. For them, prolonged, intensive psychotherapy or a self psychological psychoanalysis is the treatment of choice.

In addition to assessing the extent of the patient's personal self pathology, it is also important to determine the actual quality of his or her interpersonal relationships. Because one goal of treatment is to enhance the patient's ability to use his or her ongoing relationships to meet selfobject needs, patients who have a circle of reasonably positive relationships are likely to profit most from brief therapy. By contrast, some people are locked into unhealthy relationships. A spouse may have more pervasive psychopathology than the index patient. A marital interaction may have developed that meets absolutely vital selfobject needs for that spouse; and when the patient begins to change, the partner is threatened and must undermine treatment. Sometimes this problem can be overcome by punctuating an individual treatment with occasional marital or family counseling.

Finally, careful assessment of possible biological factors is essential. Combined psychopharmacological and psychotherapeutic interventions may be ideal.

There are some contraindications to brief therapy. Of course, patients with bipolar disorders or other psychoses, addictions, severe character disorders, and the like are not appropriate candidates for brief treatment. For some, setting a time limit may encourage magical hopes for major life changes that will certainly be thwarted; this may leave them even more demoralized and unwilling to seek further treatment. Brief techniques may also enhance pathological defenses, creating a more brittle self-structure that is increasingly vulnerable to fragmentation. This requires that the patient try to maintain ever more ironclad control over relationships or that he or she self-protectively withdraw from all human interaction.

Serious damage may also befall patients who develop regressed selfobject transferences if the therapist's personal, technical, or financial limitations prevent him or her from sustaining the therapeutic relationship through to its necessary and time-consuming resolution. Borderline patients and those with serious narcissistic disorders are most vulnerable to rapidly establishing regressed selfobject transferences. Fortunately, their defenses (particularly their tendency to provocatively test limits) generally protect them from stumbling into this unwanted situation. If a patient develops such a transference in brief treatment, and if more intensive treatment is not possible, every effort should be made to direct attention to ongoing outside relationships and away from therapist-patient interactions.

In summary, except for the danger created by the development of a selfobject transference that cannot be resolved, self psychological brief treatment indications and contraindications are essentially similar to the guidelines that others use. We do, however, have a different explanation why these guidelines hold.

GOALS OF THERAPY

The process of framing the therapeutic situation begins when the patient calls for an appointment, but this becomes more specific at the beginning of the first appointment. It is usually best to clarify that the first visits are to evaluate the patient's problems and determine what is likely to help him or her.

Generally within the first two appointments a standard psychiatric examination should be completed. It is particularly useful to assess the patient's ability to relate. Is there a potential for her to use interactions in her life to meet selfobject needs? Does the interaction with me predict whether a positive therapeutic alliance will develop? If not, does this say something about our particular interaction? If it does, then referral elsewhere is mandatory. If our interaction reflects her problems in relating, can the reasons be addressed in brief therapy?

If it is possible to offer a suggestion about why the patient is

experiencing her symptoms, this should be offered very early on. For example, I might suggest, "When you sit down to study, you often encounter material that you don't understand. This makes you feel stupid, and you avoid that feeling by doing something else. Maybe you have some ideas about the kinds of things you use to avoid that stupid feeling." Notice that I suggested she avoids feeling stupid—*an affect*—not studying—*a behavior*. A comment like this serves partly to assess the accuracy of the interpretation. But a more important use is that it may give an idea of the extent to which she is interested in self-understanding and how well she can put such information to use.

Following the evaluation, the patient deserves an explanation about the duration and cost of treatment, the nature of the symptoms, what psychotherapy is like, and what can reasonably be hoped for.

Duration of Treatment

A generally agreed upon time framework should be established. Sometimes, external realities such as graduation from college or an anticipated move to another city create an absolute time limit. In general, we plan twenty to thirty weekly appointments, with the understanding that treatment may be a little shorter or a little longer. If there is a crisis, frequency may need to be increased.

Jeffrey Binder (1979) reported the successful treatment of a patient with serious narcissistic problems that suggests a disadvantage of a firm time limit. He had set (imposed?) a firm twelve-visit limit. Following standard procedure, he related much of the patient's material to the termination. At a follow-up interview several months after termination, the patient believed that he got the majority of his benefits during the first six visits. After that he felt that the therapist's focus on termination prevented him from doing more work. Perhaps the selfobject bond to the therapist was needlessly disrupted and further reorganization of the self stopped. I do not, therefore, make termination such a central focus of brief therapy.

Nature of the Symptoms

What the patient wants to change is, of course, a central goal for therapy. If his wishes are impossible, then we must try to restructure them into something relatively discrete and attainable. I might well explain something like: "I think that you would like to change the way you do your schoolwork. It seems you are a champion procrastinator and that, even if you do sit down to study, you are often distracted and quit. We may discover some other problems, but I think that is the major thing you would like to change. Does this make sense to you?"

What Therapy Is Like

Many patients really have no idea what to expect in psychotherapy. I think Martin Orne (1968) is correct when he states that it is important to explain the process to them. I will often suggest something along these lines:

> Therapist: You have ways of understanding your relationships and what happens to you that aren't very helpful. Since it's pretty hard to change something you don't know is happening, I'll try to help you understand those patterns. That means I won't give you much advice. Instead I'll try to help you understand what interferes with your making up your own mind. We'll want to look again and again at what happened at the moment you decided to eat three bags of cookies. That may be just before you do it, or it may be ten hours before you could find the opportunity. What is important is the thing that precipitated the decision. Sometimes it may even be something I did. If that happens, you probably won't want to tell me; but that sort of thing will be especially helpful to talk about. Any feeling you have toward me—whether it makes you feel better or worse—is important, because I think you'll find it is similar to what gets you in and out of trouble out there. Is that fairly clear?

The Therapist's View of the Goals

From a theoretical perspective the goal of therapy is to help patients change their intrapsychic patterns so that they are less vulnerable to either the loss of selfobject support or narcissistic insults. This means they (1) expand their repertoire of sustaining selfobject memories (perhaps including thoughts of the therapist) and (2) change the way they process information about what is happening to them. We therapists try to help them more usefully organize input about their relationships, affects, drives, cognitions, and motivations. For example, they may realize that every time they are

ignored the other person is not trying to deliberately humiliate them, or that all of their mistakes are not serious. When troubled, they may have an imaginary conversation with the therapist that calms or encourages them. All of this would be expected to help them maintain their selfesteem more effectively. Additionally, they may come to develop new skills at managing relationships, affects, drives, cognitions, and motivations. Perhaps they will turn to a friend or to practicing an instrument to calm themselves when they are upset rather than going out and getting drunk. These two aspects work synergistically—affects that spring from a slight that is understood as accidental are easier to learn to manage than the pain of what is perceived as a deliberate insult.

THEORY OF CHANGE

Self psychologists agree that success in therapy requires that dysfunctional intrapsychic structures be changed or compensating new structures be added. (I suspect that most therapists, whatever their orientation, would agree with this, although some would change the language). Although there are differences among self psychologists about what causes change, there is general agreement on essential points. All agree with Kohut's (1984) position that change occurs via a two-step process: understanding and then interpretation.

Understanding is fundamental to developing an effective selfobject transference. This transference serves numerous functions: (1) It restores a sense of self-cohesion, and this alone reduces pain and suffering. (2) The therapeutic selfobject relationship also functions to sustain the self while old structures are reorganized and new structures are built. This happens in two ways: it helps the patient contain intense affects so that they can be worked through; and it sustains the overall integration and coherence of the self while various elements are being reorganized and reintegrated into a new, perhaps considerably different, overall self-organization. It is as though the therapist's accurately empathic responses were reliable, strong hands that support the self system (recall figure 1) during the reorganization. (3) Because the therapist's response is empathic, it is in fact different from previously traumatizing interactions. As such, the relationship provides a corrective emotional experience (Alexander & French, 1946). It confronts patients with a new reality that demonstrates that the present and future need not be endless repetitions of the past.

Understanding is accomplished through careful empathic immersion in the patient's experience. Kohut regularly referred to empathy as "vicarious introspection," intending to emphasize that the therapist must grasp the patient's life both affectively and cognitively from the patient's own particular perspective. This understanding is then communicated to the patient. In essence, the therapist clarifies how the patient constructs the cognitive,

affective, and interpersonal elements of his life. Until a selfobject relationship is firmly in place, the therapist does not try to correct what seems to be distortions or inconsistencies in the patient's views. That is to say, the therapist does not try to deconstruct their view of reality, because to do so might prevent the development of the selfobject transference.

Self psychologists believe that genuine change occurs only in the context of a relationship that sufficiently sustains the self-organization (the selfobject transference). Without that relationship, the patients may appear to alter behavior and thinking; but, all too frequently, this change proves to be mere compliance with what they believe are the therapist's wishes. Furthermore, in the context of a sustaining selfobject transference, patients routinely change their own minds about how they are thinking. Interpretations then solidify the changes—after the fact. When patients are unable to change dysfunctional patterns in the presence of a selfobject relationship, interpretations are offered. At that point, interpretations are less likely to fall on deaf ears. This helps explain why timing is so important.

The content of most interpretation would not be directed toward correcting "reality distortions" of dysfunctional thinking or the irrationality or shortsightedness of symptomatic behavior. Instead, attention would be directed to the context in which problematic thinking or behavior occurs. We usually find that difficulties occur when the patient feels dropped from a

needed self-selfobject relationship, narcissistically wounded, or otherwise traumatized.

Although this technique contains elements that are similar to Alexander's (1946) corrective emotional experience, Kohut insisted that what was corrective was the therapist's accepting and tolerant stand, that is, remaining empathically immersed in the patient's experience no matter how painful that experience might be. He eschewed Alexander's recommendation to deliberately respond to the patient in a way that is opposite to childhood traumatic experiences. It seems obvious that if we hope to help our patients find new ways of understanding themselves and others, they cannot do so unless they actually have experiences that are affectively intense and different than what they believe to be "just the way things are." Whether it is acknowledged or not, I believe that some sort of corrective emotional experience is a part of every effective therapeutic experience.

Where controversy arises in self psychology may be summarized by Kohut's description of the therapeutic relationship as optimally frustrating and Bacal's (1985) term, optimally responsive. It is clear that, even in formal analysis, the analyst's focus on the selfobject transference creates an atmosphere that is more gratifying than what is generally understood under the rubric of the rule of abstinence. In the context of psychotherapy, especially relatively short-term psychotherapy, most practitioners probably

deviate even further from the rule of abstinence and occasionally allow quite direct expressions of support, pleasure, and concern.

The following vignette of a twenty-nine-year-old executive in intensive psychotherapy may provide clarification of the gratification versus abstinence controversy as well as demonstrating other principles of how change occurs. At one point in the hour, I said: "During our last hour, you very much wanted me to express my delight about your promotion. If I had, you would have felt proud and motivated to work extra hard; and when my response seemed insufficient, you felt hurt, frustrated, and angry; and you got drunk in an effort to calm yourself down." At least in an analytic setting, I do not know whether Kohut would have thought it appropriate to add, "But, of course, I was pleased as punch about it." He might have thought that comment would prevent optimal frustration. Indeed, if I had made that comment during the previous hour, the material in this hour might not have emerged. As the hour continued, I added, "It seems now that you particularly wanted me to do that because Sam [a friend] seemed to ignore it or even seemed angry at you." And later I added, "This all fits with the way you sensed so little pride from your parents for your accomplishments." By relating the transference interaction to the patient's current life situation and developmental experiences, the triad of an ideal interpretation was completed. Over time I tried to help this patient understand that thwarted mirroring needs precipitated feelings of narcissistic rage (Kohut, 1972), that this fury led directly to assessing his

friend's response to be competitive or hostile, and that these affects overwhelmed his ability to calm himself without the use of alcohol.

The point is that the patient longed for someone outside of himself (his therapist) to perform the self-sustaining functions of maintaining selfesteem and motivation. He was unable to accomplish this for himself because he did not have the intrapsychic structures to sustain himself any more than he had the ability to fly. The patient's inability to gain sufficient mirroring responses precipitated some loss of self-esteem and selfcohesion, which resulted in anxiety and rage. These precipitated affects are the stuff of pathogenic conflict and are what Kohut called breakdown products. They are normal affects intensified by the absence of a needed selfobject response. Moreover, this combination of selfobject failure and affect (a breakdown product of the disruption he had experienced in our relationship) led the patient to intensify habitual and dysfunctional patterns of understanding relationships. He saw the hostile and competitive aspects of his friend's response, and he probably failed to recognize his friend's pleasure at his promotion. He turned to alcohol because it provided temporary, albeit illusory, wind that made him believe he could fly.

This patient had three intrapsychic problems. First, he could not experience pleasure at his promotion unless another also delighted in him (a deficit in the intrapsychic ability to maintain self-esteem). Second, because of

the way the patient organized his understanding of the responses of those around him (both therapist and friend), he was unable to internalize the normal mirroring responses that were available—he actually experienced less mirroring than was within reach (a developmentally based distortion of information processing). Third, he wanted more mirroring than he would be likely to obtain from a typical environment (an unmeetable need). To reduce that demand would require that he become more capable of independently enjoying himself. But he could not do that because he had an intrapsychic deficit. He simply could not regulate his motivation and self-esteem at that time. It would only have added insult to his deficit to point out his neediness, and he eventually came to the realization on his own as his intrapsychic limitation subsided.

My combined understanding without either criticism or specific gratification of his wish would have provided Kohut's optimal frustration. Again going back to figure 1, the understanding would have allowed the patient to use the therapist as a selfobject—to have the therapist function in place of a self-sustaining loop. Without gratification of the wish for praise, the patient still needed to create his own intrapsychic capabilities to perform the function of that loop. He would need to work out a way to maintain healthy pride and motivation intrapsychically, and not rely on the presence of the therapist to function as a selfobject that maintained self-esteem. But because of the therapist's presence, the task would be one of manageable proportions,

not one that was entirely beyond his capabilities.

For Kohut, change consisted of building or reorganizing intrapsychic self-sustaining capabilities through "transmuting internalization." He thought of this as a process by which the patient (or developing child) took aspects of the way he or she was sustained by a variety of others and combined these aspects into his or her own endopsychic capabilities to maintain a vigorous experience of self-cohesion. Kohut compared this process to the way the body builds protein by digesting other proteins into amino acids, absorbing them, and then rebuilding new proteins from the amino acids. Transmuting internalization works best in circumstances of optimal—not traumatic or excessive—frustration.

As noted above, some in the self psychological arena (Bacal, 1985; Terman, 1988) have questioned whether change occurs because it is propelled by optimal frustration. Instead, they believe that transmuting internalization is part of a person's normal developmental thrust. They realize that the frustrations in the therapeutic work are unavoidable, that these disjunctions clarify what goes wrong for the patient; but they think that growth occurs principally during the times in therapy when the patient feels enclosed in a secure selfobject milieu. Particularly in briefer psychotherapy, they might have congratulated the patient described above for his promotion and have assumed that the essential material would have arisen in some

other way.

Self psychologists agree that the treatment focus is on the following sequence: (1) a disruption in a salient self-selfobject relationship or a narcissistic insult (whether this occurs in the transference or in the patient's outside life), leading to (2) a diminution in self-cohesion, leading to (3) affect that the patient very much wants to terminate (such as anxiety, depression, or rage), leading to (4) an effort to reduce affect and restore self-cohesion. Just as in analysis, the brief therapist clarifies this sequence through interpretation given in a context of an understanding and kindly relationship. The relationship catches the patient as he or she falls, providing a needed selfobject bond that prevents (or at least minimizes) further loss of self-cohesion. In that circumstance of improved self-cohesion, reorganization of the events that precipitated the symptomatic outburst can occur. The differences between analysis and brief approaches are that the shorter methods concentrate more attention on discrete areas of the patient's personality and behavior (that is to say, the treatment is more focused on particular issues) and on self-selfobject interactions in the patient's outside life as much as interchanges within the transference. The result is that there is far less regression in the therapeutic relationship.

In figure 1, the self was represented by a number of interlocking loops. In patients for whom brief therapy is the treatment of choice, one might

conceive of problems in only one or two of the loops. Those loops, moreover, are not so interconnected to the core of the patient's being that general disorganization occurs when they are disrupted. The patient is afforded an opportunity in the transference for the therapist to function temporarily as one of the loops.

For example, although she functioned well in most areas, a college student sought treatment for studying difficulties that affected her grades. She felt stupid when she didn't understand the difficult course material almost immediately. This was especially obvious when she did her calculus homework. A loop involved with maintaining self-esteem was regularly broken when she studied. In most other aspects of her life, she maintained her self-esteem in a healthy, reasonable way. When the following interchange occurred, she was able to use the therapist as a substitute loop. This happened because he was interested, remained nonjudgmental, and stayed relatively close to her viewpoint. In other words, he was empathic and tactfully suggested that she organized her experience in a nonhelpful way, even using some lighthearted humor.

> Therapist: You didn't get those problems, and you decided you were stupid—not that the problems were really hard.

> Patient: They weren't hard. It's just that I never get how to do them. Therapist: Then you felt stupid and hopeless and quit trying.

> Patient: Yeah, there's no use. Well, no, I didn't get up and go to Marge's room. I kept

trying.

Therapist: You kept sitting there with the books. Did everyone else get the problems?

Patient: All the smart ones.

Therapist: Just the dummies like you messed it up.

Patient: . . . Well, maybe a few kids who weren't dumb didn't get it. Therapist: How did that happen?

Patient: . . . Well, I guess they didn't study.

Therapist: They studied a lot less than you did.

Patient: That's right—I studied three and a half hours!

Therapist: Gee, most people can't study that long without a break. How'd you do that?

Patient: I always do it.

Therapist: You can concentrate for three and a half hours! I'm impressed.

Patient: And look at all the good it does.

Therapist: Doesn't your mind wander?

Patient: Well, sure, a little.

Therapist: You mean you daydream some.

Patient: Yeah.

Therapist: I wonder, could you think back? Did you daydream for a few minutes, or

did your mind wander off quite a bit?

Patient: Well, I'm not sure. I don't remember. . . .

Therapist: What are you thinking?

Patient: I was remembering. I was thinking about going to law school, and then I thought about having this wonderful apartment. I think about that place a lot.

Therapist: What's it like?

Patient: *(Proceeds with a long description of an attractive, spacious apartment.)*

Therapist: It sounds wonderful. It must have made you feel better to think about it rather than to frustrate yourself with the calculus.

Patient: Boy, that's for sure.

Therapist: But, you know, if you were thinking about that, you must have spent a lot of that time with the books not studying.

Patient: Yeah, I guess so.

Therapist: I call that the librarian theory of study.

Patient: Huh?

Therapist: Well, you know, librarians spend all day around books. If being near books was all that was necessary, they'd know more than anyone in the world. *(Patient laughs.)* In other words, did you spend all that time near the books or studying?

Patient: I guess I spent a lot of time near the books.

Therapist: You said that the other kids who didn't get the problems didn't study. I

wonder if you were really one of the other ones who didn't study?

Patient: . . . You know what else—I was thinking about Joe [a boyfriend at a distant school]. He didn't call me.

Therapist: Why?

Patient: I don't know.

Therapist: Were you thinking it's because he's losing interest in you?

Patient: No. . . . Well, I don't know. I worry about that.

Therapist: And when he doesn't call, does that make you worry more?

Patient: Sure.

Therapist: Well, let's look back. You were worried when Joe didn't call. You tried to study, but instead you spent a lot of time daydreaming; and, surprise, you didn't learn very much, but the daydreams made you feel a lot better—at least for a little while.

In this interchange we see a relatively complete sequence. The patient felt dropped from an important relationship that served selfobject functions. In addition, she felt narcissistically injured when she didn't understand the problems. She wandered off into a self-reparative fantasy, which worked for the moment but prevented her from doing any real work. Because the therapeutic relationship could grant her a temporary selfcohesiveness, she was able to reorganize the narcissistic insult. She went on to think that it was possible that the problems were really quite difficult and that only the smartest students got them all. Eventually, she could see that she had an

established habit of processing all studying difficulties as evidence for her stupidity. She also came to see that she tended to do this most when she felt lonely or rejected. In metapsychological terms, when she felt a disruption in a mirroring self-selfobject relationship, a relatively circumscribed weakness in her self-esteem-regulating structures became evident. Because the therapist's attitude helped restore her self-esteem and self-cohesion, she was able to reorganize her routine perceptions about her intellect. She also began to realize when she was particularly vulnerable to trying to restore self-esteem through ineffective means like withdrawing into daydreaming. She began to take alternative steps (for example, calling Joe rather than sulking if he forgot to call her). The result was better study habits, which yielded better grades, which further consolidated her reorganization of her attitudes about her intelligence.

Because the developmental process normally occurs throughout life, if a patient improves the quality of her self-selfobject relationships outside the therapeutic setting, she can use those relationships to enhance growth. The patient just described had a basically good relationship with Joe; but her tendency to sulk nearly ruined it. As she came to understand this, she changed and the relationship improved. Perhaps this could further sustain her so that, if they should break up, she would not collapse.

In summary, the theory of change stresses the establishment of,

disruptions of, and repairs of self-selfobject relationships both in the transference and in the patient's outside world. Disruptions clarify what precipitates symptomatic behavior, and the effective functioning of the relationships meets the patient's selfobject needs. The selfobject experience (1) restores self-cohesion, thereby alleviating pain and suffering; (2) provides a corrective emotional experience that allows the patient to realize new potentials for his or her life; and (3) supplies an environment that allows the patient both to reorganize dysfunctional self-structures and to develop and integrate new structures.

TECHNIQUES

People are very complicated amalgams of affects, needs, conflicts, deficits, cognitions, motivations, and relationships. Although the basic theory of self psychology is quite straightforward (I like to think parsimoniously elegant), its application is anything but simplistic. There is always a very intricate interaction between a multitude of variables that regularly test the psychological integrity and strength of therapists. Even this relatively austere theory is best learned with careful supervision and after a considerable amount of personal self psychological analysis.

Although both brief and intensive self psychological treatment techniques flow from the same theoretical groundwork, there are important

differences in what the therapist does and does not do. For intensive work, the development of robust, often highly regressed selfobject transferences is an essential part of the change process. These will unfold best—or perhaps only—if the therapist is able to remain within the empathic perspective, eschewing correcting the patient's cognitive distortions and following the patient's thoughts and associations wherever they lead. Because of their personal histories, patients dread the risk involved in opening themselves to such powerful transferences, and deviations from analytic technique tend to intensify rather than resolve these resistances. Once such a relationship is allowed to develop, careful attention is paid to disruptions in the transference, the patient's reactions to these breaches, and the ways that the relationship is repaired.

In short-term approaches, it is necessary to focus attention on one or two areas that are particularly problematic for the patient. Greater attention is directed toward breaks in the self-selfobject relationships in the patient's outside life. The therapist must attend to the patient's immediate problems, but this sacrifices the potential for developing full selfobject transferences. For practitioners who do both brief and intensive therapy, it can be very difficult to shift between these two very different therapeutic stances.

Both approaches focus attention on the four-step symptomatic sequence that I have stated above. This concentration on the intricate

interaction between the degree of self-cohesion and the self-selfobject relationship surround is what differentiates self psychological approaches from other systems. Keeping clear attention on one or two themes in the patient's life is essential and differentiates brief work from intensive psychotherapy.

To clarify how self psychologists work, I will briefly contrast self psychology to several other methodologies. Although comparing what I might have said to what others report they said is risky, I think it is important to do.

Although self psychologists help patients alter cognitive distortions and build more useful ways of understanding what is happening to them, the technique is extremely different from the procedures of cognitive therapists (Beck, Rush, Shaw, & Emery, 1979). Their very logical interventions attempt to alter the patient's problematic thinking patterns directly. By contrast, because so much attention is paid to the interpersonal context in which the cognitive distortions occurred, self psychologists find the almost obsessional cognitive techniques unnecessary. In fact, patients regularly correct their own distortions when they feel genuinely contained in a sustaining relationship.

The technique is also very different than that recommended by neo-Freudians such as Peter Sifneos (1979) or Habib Davanloo (1978), who seem to almost hammer the patient into awareness of their drive-related (generally

oedipal) conflicts. Because self psychologists would focus on how patients deal with disruptions in self-selfobject relationships, the content of the interpretations obviously would be different. There would also be a more gentle quality to the interactions, because confrontational techniques often lead to serious ruptures in the selfobject aspects of the relationship. It seems, however, that Davanloo and Sifneos personally are able to sustain the relationship through these confrontations. I would suggest, therefore, that they are able to sustain a rather effective self-selfobject relationship through what many others would find impossibly assaultive techniques. Self psychologists might attempt to understand how confrontational techniques work for these two talented therapists.

Likewise, there is considerable difference with the procedures recommended by post-Kleinians such as Michael Balint (Balint, Ornstein & Balint, 1972) or Malan (1976). Gustafson (1986) provides a transcript of much of an appointment with a young woman whom he treated using the Balint/Malan model. He tried to help her confront her "true feelings" rather than bury them in order to maintain a so-called necessary relationship. A self psychologist might understand the same pattern of behavior using different terms. The patient may suppress feelings to maintain a self-selfobject relationship that is necessary to avoid fragmentation. Thus far, the difference might seem to be a trivial variation in terminology. However, from a self psychological perspective, the feeling is sacrificed to maintain a relationship;

and this is done because the patient simply does not have the intrapsychic capabilities to manage the feeling if the relationship is disrupted. Consequently, what would happen in therapy is different.

The patient Gustafson described was a college student who had a panic attack when she thought about her boyfriend, Sam. During the hour, she realized that she panicked because she was "mad as hell" at him because he had left her and gone on an extended trip. The goal of therapy was to help her uncover her tendency to become enraged and then to help her try to contain it by redefining it as mere anger. Gustafson emphasizes this by italicizing three places in the transcript (I have deleted the italics):

> Therapist: But being mad and being in a fight are not the same thing.
>
> Patient: I know they're not. They're different.
>
> Therapist: But you tend to run them together.
>
> Patient: Yeah. . . .
>
> Therapist: [The anger] either wrecks you or wrecks him. . . .
>
> Therapist: And what you're dealing with is not only anger. You want to punish him, until he says uncle. (Gustafson, 1986, pp. 143-150)

From the rest of the transcript, there seems no question that his assessment of what the patient does is correct—she does fall into rages that she cannot control. His therapeutic intent is to get her to understand that the

rages happen, and it also seems that if she stops denying the rage she will be able to contain the intensity of her affect and convert rage to manageable anger. However, she has avoided the rage precisely because she neither understands its origins nor possesses established intrapsychic capacities to govern it.

Why can't she manage it? We learn that she can—if she is with Sam. When she gets angry at him, he does not become defensive. Rather, he accepts that she has some justification for her feelings, and he says he'll try to be more responsive to her needs. Gustafson does not, however, comment on this or explain to her that her anger might not escalate to unmanageable rage if she were able to express it in a way that the other person could comprehend; nor does he wonder what keeps her in relationships with other people who respond defensively and push her from anger into rages. In other words, he does not examine the contexts, the drops from selfobject relationships, that precipitate the rage. Nor does he help her see how some relationships can help her contain and usefully express her anger.

Why does she have this particular vulnerability? We also learn that her mother regularly flies off the handle. The patient says that she does not like losing her temper because it makes her "feel like my mother." His response is that she is "tempted to be like [your mother]" and that "children identify with their parents," and then he switches the subject to his belief that she enjoys

"sock[ing] it to" Sam. The problem is that she hates to sock it to him; but she is unable to stop herself because she apparently doesn't really know why she's mad at him, and because she simply has never been able to establish intrapsychic structures that would help her contain her rage. Her family could not help her develop techniques to manage anger; they could not help her because they themselves were unable to direct their own rage. She was not motivated to be as out of control as her mother—she could not help herself because of an intrapsychic deficit.

A self psychologist would have, first, commented on her contained response when Sam responded thoughtfully; second, wondered what it meant that she could sometimes control herself; and, third, sympathized with her frustration about her inability to control herself when she got angry. The therapist might have added that it was fairly clear why she was never able to develop the capacity to contain her anger, and he or she would certainly have tried to get a better grasp of precisely what about Sam's trip made her so angry. For example, did she feel insulted that he didn't stay with her? Did she feel that she couldn't keep herself together without him? Did she just miss him? I would also have wondered what Sam would have thought about her anger, perhaps suggesting that he might see that at least a part of it was understandable. She had, after all, been left behind.

In summary, it is not a sufficient goal of therapy to open up the patient's

"true feelings." Doing that may only leave the patient overwhelmed with affect that cannot be managed. Rather, it is more useful to examine the origins of the feelings. This tends to reduce their intensity to a level at which the patient can begin to develop defenses to manage them. As the defenses gradually build up, greater levels of affect can be experienced safely.

Finally, I think there is a significant parallel between the self psychological approach and Lester Luborsky's (1984) Core Conflictual Relationship Theme (CCRT) method (see Short-Term Supportive-Expressive Psychoanalytic Psychotherapy). The wish expresses what the patient wants from the relationship. I would simply add that this is one way to explain what selfobject need the patient obtains when the relationship succeeds. The expectation of the other expresses how the patient expects the other to fail to meet selfobject needs. The expectation also organizes the relationship in a way that tends to be self-fulfilling and self-defeating. The response of the self expresses what happens to the patient when he or she feels dropped from the relationship.

CASE EXAMPLE

Mike was a twenty-two-year-old, single, white, Roman Catholic man who was completing his last year of undergraduate studies before going on to professional school. He presented complaining of depression and anxiety that

would occasionally escalate to moderate panic attacks. He was terrified that he would be unable to perform satisfactorily in his graduate education, although he understood that his undergraduate average of 3.9 and his admission examination scores indicated that he would do well.

Several months earlier, he had responded to a newspaper ad and participated in a no-fee psychopharmacology study at a nearby medical center. He had gotten little help during the course of the study, and on follow-up he was diagnosed as having an atypical depression and given a monoamine oxidase inhibitor. The treating physician relied on the medication as the sole treatment mode. Mike did feel better, but he had stopped the drug because he feared (with some justification) that taking a medication would reduce his chances for getting the scholarship he needed.

On further examination, he showed a considerable amount of obsessional thinking with some ritualization. There were no signs of overt psychosis. Although he had enough friends, he was concerned about his heterosexual relationships. Several months previously, he experienced his only sustained relationship, but he and the girl had mutually agreed to break up after several months. His only sexual experience had been with her. It was successful but not very satisfying because he felt extremely guilty about it and believed that God would surely punish him for his transgression.

Mike's family life was troubled. His father, an engineer in his midforties, had been laid off from his job and had moved the family from the area in search of a better job. He remained unemployed for several months and had gotten a satisfactory job only weeks before the patient began treatment with me. Although the father had moderated his drinking, there was a history of alcoholism that led to frequent verbal and occasional physical abuse of most members of the family, including the patient.

Mike's mother was a deeply religious woman who worried incessantly. When confronted with problems, her solution was to pray or undertake some unrelated good deed in hopes that God would intercede on behalf of her or her family. Proof that her methods worked included that the father had indeed gotten a job before the family finances collapsed.

The patient had two younger siblings toward whom he directed the sort of contemptuous hate that is normally relinquished by college age.

He needed treatment for his depression, anxiety, and obsessional and narcissistic character problems. Not being an ideal candidate for brief therapy, he could, I thought, benefit from long-term psychotherapy; but this was not possible. With massive educational bills to come, there were no financial resources to support it. He planned to leave college in three months, live with his family for several more months, and then begin professional

school in a distant city. We agreed on twelve weekly appointments, after which he would leave town.

Mike was eager to understand himself and rapidly formed a strong positive therapeutic alliance. His depression lifted almost immediately, and his anxiety decreased substantially. An unusual focus emerged from his first appointments: his relationship to God. I pointed out that he thought of this relationship the same way that he understood his relationship to most people. God was not a source of comfort and help, someone to turn to in times of trouble. Rather He was a critic to be placated in hopes of avoiding punishment. It also seemed to Mike that if he pleased God, He might grant some special favor. From my perspective, Mike could not use God, me, or anyone else as an idealizing selfobject to help calm and soothe him when he was upset. This, in turn, necessitated a need for absolute control lest his emotions gain the best of him. He also could not enjoy any accomplishment because he was unsure whether he had earned it or whether it was the result of some special dispensation from God. My point in addressing these matters was not spiritual. Rather, we used Mike's relationship to God as a metaphor that showed how he organized his understanding of all of his interactions: no help was gladly given and only supplication could possibly gain a favorable response. This omnipresent judgment left him chronically enraged, frightened, and depressed.

After Mike's God metaphor was clarified, he rapidly realized that interactions with me did not conform to those organizing principles. When we discussed his fears that he would fail in his future education, he saw that he expected the faculty to be like his avenging God. I took some pains to point out that most of them would be helpful, but that he shouldn't use the genuinely nasty ones as proof of his fears. We succeeded in Kohut's two-step recommendation: Mike felt understood, and then I was able to interpret the unhelpful way that he organized most interactions.

During his fifth appointment, he talked about a young woman whom he had met. He liked her and she seemed to like him, but he couldn't understand why.

> Patient: You know, I'm covered with hair. Women think it's disgusting.
>
> Therapist: All women think that?
>
> Patient: Yes. Even my friends make fun of me. They call me "bear man."
>
> Therapist: I have to tell you that some women like vanilla ice cream and some like chocolate. I don't think all women hate body hair.
>
> Patient: Yeah, well none of them like hairy ice cream, and you'll never convince me of that.
>
> Therapist: I don't think that's really the point, anyway. You think Sarah will take one look at your hair and be disgusted. That makes
>
> her kind of like God—looking for a flaw. And when she finds it, she'll throw you

away because of it.

Patient: But my hair is really gross.

There were several rounds on this subject; when the hour ended, Mike left convinced that his hair was revolting but perhaps, maybe, possibly, some woman could like him in spite of it.

During the sixth appointment he said that he had asked Sarah out and that she had accepted. The expected date was to come before our next meeting. He began the seventh appointment by saying there was good news and bad news. The good news related to his future education, the bad to Sarah canceling the date. She had left a message on his answering machine that she needed to go home, but that there was a possibility that she might be back early enough on Sunday for the date and would call him. She never called, and Mike was furious.

Patient: There was some way she could have called.

Therapist: So what do you make of her not calling?

Patient: I don't care. She's written off. If she wanted to, she would have called.

Therapist: Sounds like you feel put down.

Patient: You bet. The dumb could damn well have called.

Therapist: Little angry, huh?

Patient: You bet.

Therapist: So what are you going to do?

Patient: Nothing. She can call me.

Therapist: And if she does?

Patient: (Snarling) I'll tell her, "Thanks for calling Sunday."

Therapist: And how will she take that?

Patient: I don't care. Don't you think she could have called?

Therapist: I don't know, but you sure do. (This leads to several interchanges about what could have excused her failure to call, all of which he had considered and dismissed.) So you want to get even with her for humiliating you like that.

Patient: You bet. She deserves it. . . . Well, don't you think so?

Therapist: That's up to you, but I think what you really hope will happen is that she'll say she's sorry and almost plead with you to go out.

Patient: Sure, I guess so.

Therapist: Well, if that is what you want, I mean if you want to find out if she likes you, then it seems to me that if you sort of snarl "Thanks for calling," it might screw things up.

Patient: Yeah, but she deserves it. She didn't call and there's no excuse.

Therapist: I understand what you're saying, that if she put you down she deserves to get it and you deserve to get even. But if you talk to her like that, that doesn't come for free. You'll have an effect on her—and that effect will screw up finding the answer to the Does she really like you? question.

Patient: I don't understand. She deserves it.

Therapist: That may be, but if you snarl at her when you're trying to find out if she likes you, you're changing things. Look, it's sort of like doing an experiment. The experiment has two parts. One is to find out if she likes you and the other is to get even. But the get even part is sort of like spitting into a petri dish when you're doing a microbiology experiment. If bugs grow there, you don't have any idea why because you spit in the dish. Your experimental technique fouled up the experiment.

Patient: You mean, if I say, "Thanks for calling," she takes offense?

Therapist: (laughs) Well, yes, wouldn't you?

Patient: Yes, I suppose. But she deserves it and I wouldn't.

Therapist: (Both chuckling) Of course, you'd never make a mistake. But the point is that when you do that, you'll probably make her want to say, "Screw him." And then you'll never find out why she didn't call, and you'll never find out if she likes you.

Patient: Well, I suppose.

Therapist: And it's kind of like with God. You don't trust Him, and you approach Him in a way that makes it hard to find out about Him.

Patient: Well, what should I do? I mean, what should I say to her?

Therapist: I think you could figure that out if you realize that you're angry because you feel rejected. That makes you want to get even, and then you're likely to treat her in a sort of nasty way. If you do that, it has an effect that is likely to screw up your ability to find out why she didn't call or if she really would like to go out with you.

Patient: You mean I'm not supposed to get angry.

The exchange led to a discussion of how he could express some anger without getting so angry that he spoiled his chances to find out what he wanted to know. We also thought more about the source of the anger—his feeling rejected—and how what he did next would either clarify or obscure his finding out if he was, indeed, rejected. I told him: "This is a tough message. You want to get even and to find out if she likes you. There may

not be a way to do both, so you have to make a choice." It was important not to contradict his belief that he was wronged, sticking instead to the idea that there might be another explanation or that he might, in fact, be right.

When he left, he was determined to ask Sarah what happened and to say that he felt bad about her not calling. He returned the next week saying that I would be angry at him. He had spoken to Sarah, she had come over to his apartment, and they had ended up in bed. This led to another opportunity to explore his expectation that my opinions would be the same as God's. We began to relate this expectation to other relationships, making particular reference to what he might anticipate when he went to professional school in the fall. He thought that he had learned a general principle from the interaction with Sarah.

The goal had been to help Mike understand that when he felt dropped from a relationship that met mirroring selfobject needs, he felt a narcissistic

insult that precipitated rage. This fury led him to want to get even, but he realized that he needed to exercise some caution about how he expressed anger lest he create a self-fulfilling prophecy that proved no one liked him or would help him. These and the other main themes of his treatment were explicitly reviewed during his last appointment. At that time we also agreed that he should continue to think about these concepts.

When he terminated he felt better, and, more important, he had some understanding of how he dealt with relationships. A consistent focus and a supportive relationship that acted as a splint for his self-esteem combined to enable him to reorganize much of his thinking in a remarkably short time.

EMPIRICAL SUPPORT

There have been scores of excellent case studies on self psychology, and self psychologists are generally agreed that this theory has yielded superior results. We have found that we are able to help most patients more effectively and that we can treat patients previously considered unreachable. However, there are no experimental outcome studies, and all descriptions of the therapeutic process are merely anecdotal. There are several reasons for this serious shortcoming. Self psychology is a relatively young area, and most of its practitioners have been engaged in psychoanalytic or other intensive treatment approaches. Research on long-term therapy is, of course, fiendishly

difficult. There has been little systematic work applying the theory to brief models of treatment, and there is no manual that defines the method.

Despite this regrettable situation, several facts derived from existing research beg for a self psychological analysis. Many researchers (for example, Strupp, 1989; Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988) find that a positive therapeutic alliance correlates with a good outcome. Does the concept of the selfobject transference help clarify this most consistent and robust finding of existing research? Robert Wallerstein (1986) comprehensively studied the intensive psychoanalytic individual treatment of forty-two seriously troubled patients. He found that some of those who gained great insight did well, but others with good insight did not do at all well. Still others with superior outcomes had gained little insight. These data raise the serious question whether traditional psychoanalytic insight (insight related to drive-based conflict) produces therapeutic gain.

Crits-Christoph, Cooper, and Luborsky (1988) have found that there is a good correlation between positive outcome and Core Conflictual Relationship Theme (CCRT) interpretations that are accurate. The content of CCRT interpretations is at least similar to what self psychologists might say. Did their patients gain insight from these interpretations? If so, one could also speculate that CCRT insight is, in fact, useful. At the least, accurate CCRT interpretations help create a sense of being understood that enhances the

empathic bond; and the empathic bond is central to all self psychological theory. Does the self psychology help explain why the CCRT works, and might the modest alterations that self psychologists could add yield still better outcomes?

These questions are pregnant with research promise, but the best that can be said is that the answers remain a gleam in the eyes of some self psychologists.

CONCLUSION

The great German physicist Werner Heisenberg (1958) realized that it was possible to locate an electron in space or to determine the amount of energy it contained—but that the process of establishing one destroyed the possibility of finding the other. Both procedures uncover elements of the "truth" while simultaneously obliterating other "facts." Whatever procedure we undertake to examine anything, even an atom, irreparably alters it. We destroy one aspect of reality as we clarify another.

The same holds for psychotherapeutic interventions and theories. Although some hypotheses (such as phrenology) uncover very little useful information, others (such as traditional Freudian and self psychological metapsychologies) hold considerable explanatory power. Whatever theory we use to understand our patients clarifies some elements of their lives and

renders other facets opaque.

In this chapter, I have provided a description of how self psychological principles can guide brief psychotherapy. I have found this perspective useful —I think more useful than alternate approaches. Yet I am convinced that others have helped their patients with entirely different techniques. Robert Wallerstein (1986) demonstrated that psychoanalysis does not exist in a pure form in clinical practice. Likewise, I suspect conceptual purity is routinely abandoned in brief psychotherapy and that we all should and do borrow from other methods in order to meet the particular needs of individual patients.

Nonetheless, the Heisenberg principle applies: whatever approach we use inevitably alters the course of therapy. Patients may obtain positive outcomes from many different approaches. But these are different outcomes with different benefits and different shortcomings. It remains for future research to determine whether one approach is always best or is best for particular patients. Perhaps we will also discover that therapists have inherent styles that determine which methods they can use and which they do well to avoid.

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