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Some Tentative Clinical Applications

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The application of self-psychology seems to work consistently and helps us to understand certain clinical and group phenomena that were previously obscure or baffling. In this chapter and the next I will make some attempts to apply self-psychological concepts to some of my own clinical case material. I hope to stimulate therapist-readers to make self-psychology part of their therapeutic working armamentarium and conceptual system, and to try to apply it to their own special interests in individual and group phenomena. This is an effort to motivate readers to immerse themselves in self-psychology. as Kohut (1984) repeatedly asks us to do, "for protracted periods and with a variety of patients" (p. 90); then to see whether it actually produces a significant change in your examining and understanding various clinical phenomena.

Since I am now presenting my own material and ideas, self-psychologists may object that I have misunderstood or misapplied their concepts, and traditional analysts may raise the same criticisms that were applied to Basch's book. My purpose, however, is to encourage the reader to think in self-psychological terms at the

practical, everyday clinical level.

It would be a legitimate suspicion and expectable contention on part of traditional analysts that psychotherapists the psychoanalysts who shift to employing the psychology of the self are revealing an insufficiently analyzed Oedipus complex. Traditional analysts might claim that self-psychologists are attempting to defend themselves by adopting a psychological system which proclaims that the Oedipus complex is not at the nucleus of the various characterological disorders and narcissistic phenomena seen in our clinical work. Kohut's (1984) counterargument to this is that warm acceptance of self-psychology is found in "those who are more directly in touch with modern man's primary need" (pp. 61-62), and those who reject it cannot face the narcissistic blow in Kohut's discovery that the self's autonomy is always relative: the self "can never exist outside of a matrix of self-objects" (p. 61).

The Case of Dr. E. as an Introduction to Psychology of the Self

I usually introduce the psychology of the self to student therapists (who already have had a course in traditional

psychoanalytic therapy) by the following case presentation: E. was a psychiatrist who was born in a small town. His father was a minor businessman who was married twice. The second marriage of the father, who was in his forties at the time, produced E., the first son of this marriage. The father also had two sons from his first marriage at age 17. Father was one of those people who was always expecting something good to turn up; he was unsuccessful as a businessman.

By the time of his second marriage, father was already a grandfather because a son from his first marriage had had a son, and so E. was born an uncle. E.'s nephew, the son of his half-brother, was one year older than E. As children, the nephew was a close friend of E., but also a hated rival who was stronger because he was a year older. Yet he was still close enough in age for a continuing contest to take place.

E.'s mother was an attractive 21-year-old woman when E. was born, a year after she married his father. Their second child was a boy, born when E. was 11 months old. The child died 8 months later when E. was 19 months old. A sister was then born when E. was 2*Vs* years old; after that, four more girls were born, followed by a final child,

another son, born when E. was 10 years old. E.'s mother was described as a much respected but emotional lady.

An important figure in E.'s earliest years was a family maid, who was a strict Catholic, preoccupied with issues of paradise and the fires of hell, and who was discharged for stealing from the family when E. was 2V2 years old—at the same time his oldest sister was born.

E. was born in a caul, which was believed by the family to mean that he was destined for greatness, and there were several prophesies made in his childhood of his eventually becoming a great politician.

E. presented two early memories: at the age of 2 V2, when his sister was born and the maid was discharged, he saw his mother naked; and a memory at the age of 3 when he moved to a small city where the family lived for a year. (When E. was 4, the family moved again to a large city). The specific memory was during the move at the age of 3 to the small city; he saw gas jets from industrial plants which reminded him of souls burning in hell.

His early childhood was marked by the fact that he excelled in school and by an increasing disillusionment with his bumbling businessman father. He attached himself to older father figure teachers and formed an ambivalent relationship to his friends, often ending the friendship with competition and a quarrel. He became a physician, with his main interest being scientific research in the laboratory.

At the age of 41 he had his first psychoanalysis due to depressive symptoms, a "cardiac neurosis" with palpitations and hypochondria, and anxiety which became severe after the death of his father one year earlier. This first psychoanalysis dealt extensively with his Oedipus complex and took about three years. It produced a satisfactory result but still left him with two symptoms that interfered with his work.

Following his first analysis, Dr. E. experienced a gradually deepening pessimism and cynicism about people and loss of hope for the future of humanity, symptoms which became worse and more pervasive as he got older. He also continued to experience a strong aversion to receiving any awards, honors, or adulations, especially in public. These situations made him irritable and uncomfortable, and he even avoided celebrations of his birthday. Even before his psychoanalysis, he once wrote to his fiancée, "I am sure you will agree

to do without the presents, the congratulations, the being stared at and criticized; even the wedding dress that everyone gazes at and even the 'ah's' of admiration when you appear."

E. became a successful man despite his residual difficulties, but he continued to have unpleasant interpersonal experiences with his friends, especially those who wished to compete with him, and he sometimes showed what certain observers considered to be a disavowed autocratic tendency; certainly, his attitude toward women could at least at times be arrogant.

It is a case such as this—where the successful psychoanalysis, because it did not go more deeply into the self-pathology behind the Oedipus complex, left residual narcissistic pathology—which led Kohut to turn to a deeper study of narcissistic structures to be seen as separate in their development and transformations from the usual oral-anal-phallic (oedipal) phases of the libido. I am sketching here the history of Sigmund Freud, who, in spite of his great genius, remained unable (Kohut 1977, pp. 292-297, Chessick 1980) to appreciate music, philosophy, or modern art, all of which were developing rapidly in *fin de siècle* Vienna (Janik and Toulmin 1973).

I will not attempt to "analyze" Freud's alleged unresolved narcissistic transformations, both out of respect for the extraordinary genius of Freud and because Kohut has discussed the subject at length (1984). When Kohut was asked by students what to read in the field of psychotherapy and psychoanalysis, he is alleged to have said, "Read Freud." When asked what to read after that, Kohut allegedly replied, "Read Freud again."

A study of Freud's biography and his writings gives us a hint of what self-psychologists are talking about when they argue that the psychoanalysis of certain psychoanalytic candidates has often floundered because insufficient attention was paid to disorders of the self. Kohut (1984, pp. 163-170) attempts to use this claimed common defect in training analyses to explain the remarkable history of the psychoanalytic movement, in which narcissistic injuries repeatedly produced serious inimical major schisms. Indeed, even a friendly observer of psychoanalysis would have to concede that, from its origins to the present day, it suffers from an extraordinary number of personally acrimonious disputes, beginning with those among Freud and his disciples (Roazen 1975). It does not follow from this, however, that Kohut's controversial explanation of this unfortunate historical

trend is correct.

While attending psychoanalytic meetings, Kohut listened to the various manifestations of quarrels and injured sensitivities among his putatively well-analyzed colleagues:

I was at that time president of our national association and had been puzzling about the dissensions within our group and particularly about the fact that now and then people who seemed to have been friends suddenly turned and became enemies. I learned to recognize that . . . one could always find some small but nevertheless important narcissistic injury at the pivotal moment that determined the later inimical attitude of such an individual. (Kohut 1978, p. 772)

The Case of Ms. X.: A Classic Clinical Error Corrected by Self Psychology

Here is a case vignette illustrating a classic error in psychotherapy as corrected by self-psychology. I erred in my focus on the patient's conflict over her eroticized longing experiences. This eroticized longing, however, in self-psychology does not represent a sexual "drive." Addressing it as such interpretively was perceived by the patient as an unempathic wounding assault and led to further

anger as a disintegration product. I also realized from this error that I must not miss the forward moves in psychotherapy and must consider confirming these! This is discussed by Kohut (1984, pp. 187-190) along with careful warnings that sometimes such confirmations can themselves represent empathic failure, for example, by not recognizing the anxiety that may accompany attempts at new achievements, and using the tone of a coach addressing his football team.

In supportive psychotherapy we naturally encourage and praise the patient. Even if the psychotherapy is primarily uncovering, the forward moves should be empathically acknowledged, unless there is good reason not to do so, because this confirming response increases the cohesion of the self and secondarily improves ego function. In contrast, focusing interpretations on conflicts and needs while essentially ignoring forward moves revives the memory of the parent who was always criticizing and never praising. Thus the tone of the way we do psychotherapy changes, as illustrated by Basch (1980) in the case of Ms. Banks, where he warmly congratulates her on a success in her work. Picking up and recognizing forward movement becomes more in the foreground of the therapist's interventions.

Ms. X. first presented herself in a way that DSM-III would immediately define as a borderline personality disorder; after considerable therapeutic work she now would be diagnosed as a narcissistic personality disorder. Following a session during intensive psychotherapy (twice weekly), when I had made an interpretation that she displaced certain erotic yearnings for me on to her new boyfriend Dan, she dreamed: "Dr. Chessick was taking care of a deaf child." Her association was, "Nobody is more deaf than those who will not hear." The patient did not want to hear the prior interpretation of displacement because she did not wish to be flooded with unacceptable and frustrating yearnings for me. This was a patient who had such an intense need for merger that as a young child she remembered lying in bed with her sleeping older sister and attempting to literally synchronize her breathing to exactly that of her sister while she lay in close physical contact with her.

The next day Dan took in a male roommate. The patient reported being enraged at Dan because the new roommate invaded their privacy; she felt humiliated getting up in the morning after sleeping with Dan and finding his roommate there. Dan, on the other hand, argued that he needed the money. The patient reported the following

dream:

A biplane is landing. A flap falls and it crashes. It touches off a series of explosions and we must all run. I climb some hills trying to reach and cling to safety, but the scene is scattered with garbage and tin cans, and I must climb from one hill to the other, like Sisyphus. As I climb up, I note that if I slip the fall down will be very steep.

In the next scene Dr. Chessick is driving a car and puts a hand on my breast. I say to myself, "What is this?" Then I realize it is part of a physical examination—after all he is a doctor. He feels my stomach and says it is bloated and I should not eat so much. Then in the next scene I find myself squeezed into a very small space, but this is not painful or frightening.

It should be noted that the narcissistic patient who dreams of climbing reminds us of Kohut's (1971, p. 87) comment that such dreams often are harbingers of the impending formation of an idealizing transference and that the narcissistic patient who dreams of falling may be about to develop a merger transference.

The associations to this dream were as follows: "I am proud of myself because in contrast to previous episodes when Dan disappointed me I did not explode at him. This is the first dream in

three years I have had where Dr. Chessick appears interested in me (in contrast to many dreams where various parental transference figures utterly ignored her) and it is an exciting dream! The squeeze in the last scene of the dream is associated with chest pain—perhaps I am having a heart attack and then I could be nursed in the intensive care unit."

My first interpretation of this dream was rather traditional in which I suggested that Dan's taking a roommate reminded her of the (to her unwelcome) birth of one of her siblings and therefore produced an increase of narcissistic rage fueled by both the past and present situation. This was followed by the search for an idealized parent to help her to restore narcissistic equilibrium, but it did not work because she remembers that her parents were too disappointing —garbage and tin cans. The patient then reaches to me but is frightened of this and must reverse the situation so in the dream I reached to her. That is to say, she must defend against the temptation to reach out to me. Since she can't make the reach due to her fear of loss of autonomy, anxiety about impending fragmentation manifested by hypochondria and strange body sensations develops. Thus I interpreted the "defense"—her fear of loss of autonomy—before the content, which is technically correct, although I used self-psychology rather than a traditional conflict interpretation, which eventually would be based on oedipal strivings, the primal scene, and pregnancy wishes involving father.

The patient's response was to feel great rage at me while I was making the interpretation because, she said, I missed the step forward! The dream, although it represented only a small step, regardless of the prevalent defenses, she insisted, "the point is that it was not an unpleasant dream, it was hopeful." The patient said, "You are like my mother, who was always efficient, driving for performance, and missed the little accomplishments I did make as a child; I viewed this dream as a gift that would make you happy as a response to my reaching out for contact to you as with my sister, and I was pleased when I awoke and remembered it."

After thinking it over I agreed with her comment, feeling that I had made an empathic lapse (probably based on the typical countertransference frustration in the slow and frequently disrupted work with such difficult patients); she calmed down immediately and relaxed. When I asked her about the stomach bloating in the dream, she related it to the wish to be pregnant. This step would give her

control over the problem of physical merger, for the baby would need her, even be inside of her, and depend on her. I saw this as a possible incipient withdrawal into the grandiose self out of disappointment in the idealization attempts with the parents; when this, too, fails one gets fragmentation, manifested by hypochondria, and the wish for nursing care.

If the reader does not attempt to interpret and reinterpret the incomplete clinical data, the reader will notice how different this approach is from the standard oedipal interpretations that might easily be made from this dream material. The therapist, says Kohut, must make a judgment about what predominates. This particular patient performed the same function for me in a minor way that Miss F. performed for Kohut (1971). My patient was an unusually brilliant and exquisitely sensitive individual with very serious pathology who raged severely whenever I lost attunement with her; at the time I was beginning to investigate the psychology of the self and I found, as did the analysts in the casebook (Goldberg 1978), that I began listening more carefully to the patient's complaints about where I was experienced by her as a self-object that was failing her. It was here that I dimly began to recognize that the notions of self-psychology had a

genuine clinical validity. I started to listen to the patient in a new way, letting her guide me to a better understanding of her current self-object needs and so tolerating these more easily in the psychotherapy.

When this happened the patient transformed gradually from an individual that would clearly be diagnosed as a borderline personality to an individual who formed a stable self-object transference and would be diagnosed as a narcissistic personality, and who could at least tolerate a traditional psychoanalytic approach. I regarded this as an important step in my own sense of conviction that there was something legitimate about the self-psychological approach.

Above all, it caused me to hear material that I previously would have regarded as either defensive or not very relevant or important. Here, again, is the crucial argument regarding the two analyses of Mr. Z. Would a properly trained traditional analyst without the self-psychological approach still hear this material? If not, the self-psychological approach has validity because it opens up new orientations toward clinical data and leads to significant new understanding of difficult patients. Traditional psychoanalysts might reply that they would hear this material, and failure to do so simply

represents a countertransference problem.

The Case of Ms. Y.: An Alternative Perspective on Patient Material

Another deeply disturbed patient of mine dreamed that she was at a dance with a minister. She reported, "When he smiled at me I felt really pretty and glowing and beautiful and very feminine." The patient's associations dealt with the possibility that I might be the minister in the dream, which she found "ridiculous," and she claimed that she certainly did not want such a response to me. From the point of view of self-psychology, the dream is important because it shows the formation of an idealizing transference or an archaic merger transference. The emphasis is on the paternal figure whose smile pulls together the self of this patient and gives the little girl the sense of being pretty, glowing, beautiful, and feminine. This is an illustration of Kohut's idea of a phase-appropriate response by a parent to the oedipal strivings of the little girl. A more traditional interpretation would concentrate on the falling in love, the sexual aspects, and the minister as a relatively untouchable parent figure. Rather than seeing this as a self-state dream which occurs during the formation of a selfobject transference, the more traditional approach would emphasize hidden incestuous wishes in the dream.

This was a stormy patient who already had four years of traditional psychoanalysis with a graduate analyst; the analysis ended in a failure. At one point she became overwhelmed with sexual desires for the analyst and functionally collapsed. This was regarded as a transference neurosis and was so interpreted, but the analysis had to be stopped temporarily and supportive psychotherapeutic measures instituted by the analyst. When the analysis was resumed after the patient had pulled herself together in a few months, the affect was less intense and the material was very intellectual and shallow; soon the patient began to notice that the analyst was repeatedly falling asleep and snoring in the sessions. After several such instances the patient took the initiative and stopped the treatment.

In her second psychoanalytic treatment, the patient revealed a profoundly empty and depleted self with an overwhelming need for mirroring and idealization accompanied by a terrified defense against the formation of self-object transferences. At same time she formed a spectacular merger transference with her infant in which she regarded

herself and the infant as the perfect mother-child couple, akin to the blissful Madonna-and-Child paintings of Leonardo da Vinci.

If her child fell down and suffered even a minor bruise, the patient became fragmented, suffered from overwhelming anxiety and fear, insomnia, and the various other symptoms that have been described earlier as clinical manifestations of the fragmented self. These responded relatively rapidly to interpretations based on self-psychology and the treatment was able to proceed smoothly with disruptions kept to a minimum.

At this writing the patient remains one of those patients "with fragmented selves who apparently never find sufficient inner tranquility to let themselves settle into a reliable self-object transference" (Wolf, in Stepansky and Goldberg 1984, p. 153). Thus the patient presented with compliance—which Kohut (1984) recognized as the most profound and difficult resistance of all—but defends with vigor against forming a meaningful, consciously experienced self-object transference, for which at the same time she yearns. The case is hopeful, however, and I believe that underneath all of this a silent merger transference (Kohut 1971, p. 251) is forming.\frac{1}{2}

It appeared that the first analysis represented compliance with the analyst. The self-psychological explanation of the formation of an intensely eroticized and disruptive transference—as has been described in work with borderline patients (Chessick 1977)—helps us to understand the collapse of the first analysis as a phenomenon which represented fragmentation or disintegration products of a disappointed self which had again been failed in its expectations from the self-object analyst.

I fully recognize that numerous counterarguments are possible. One could even argue that the patient's report of her first analysis may be unreliable, but in this case I have reason, both from the nature of the patient's perceptive abilities and her general reliability, to believe that she was presenting an honest report of her first analysis. There is no implication here that traditional analysts commonly carry out their treatment in this fashion. However traditional psychoanalysis with these difficult patients carries an increased danger of frustration, disruption, and countertransference.

This vignette illustrates the way in which self-psychology offers an alternative way of looking at patient material which might otherwise be ignored or thought of as irrelevant. It also presents an antidote to the danger coming from the traditional psychoanalytic outlook being applied too rigidly, as reported by Malcolm (1981). Here an unidentified and perhaps partly fictitious traditional New York analyst seeks repeated reanalysis from analysts with a traditional orientation as a solution to unyielding narcissistic personality difficulties. Would there not have been some value, in proceeding with a third or fourth analysis, for this analyst to have chosen someone with a self-psychological approach?

LITERARY CASE EXAMPLE: JUDITH ROSSNER'S AUGUST

A provocative modern novel which has been generally praised for its clinical veracity presents a case study that lends itself to a discussion of the difference in the ambience of treatment between traditional psychoanalytic psychotherapy and self-psychology oriented psychotherapy. In *August*, Judith Rossner (1983) presents a vivid description of a borderline suicidal adolescent girl in treatment with a Ph.D. psychotherapist who herself suffers from a core depression and an empty depleted self. The therapist required two psychoanalyses of unspecified type to be able to accept a public

compliment about her attractiveness, an indicator of an unintegrated repressed archaic grandiose self as depicted in Kohut's "horizontal split." Because of early disillusionment with her alcoholic father and depressed mother who commits suicide, the therapist is unable to form mature male attachments free of her narcissistic self-pathology.

The story line of the book is a pseudo-dramatic search by both patient and "doctor" to provide for themselves an empathic self-object matrix. The therapist fails and remains, in her forties, essentially alone; the future of the patient, as she graduates college in her early twenties, is more hopeful. The book is also a commentary on the transitional status and genuinely tormenting social problems of modern women from two generations. One dramatic line sums up the therapist's attitude: "Women looked at a gray-haired man and saw father; men looked at a gray-haired woman and ran from death" (p. 36). Rossner indulges in a common defense in my clinical experience —she blames the therapist's inability to successfully relate to men on the pathology of the men in our culture.

The therapist carried out an intuitive mixture in the treatment that led to substantial improvement, a treatment that was allegedly a psychoanalysis but certainly not a traditional form of it. It remains unclear what the therapeutic convictions of the therapist are. What makes the story ring true is the ambience of the therapy, which illustrates what Kohut believed to be essential in firming cohesion of the self in psychotherapy.

August is convincing as a treatment report of a borderline patient and is a worthwhile illustration of how an intuitive therapist can apply self-psychology with favorable results, even in the absence of any theoretical understanding. It was Kohut's goal to transform this intuitive expertise into a craft with theoretical underpinnings that could be taught and methodically practiced.

The title of the book refers to the traditional vacation time of psychoanalysts, and the unavoidable disruption of self-object transferences by this and other absences. The entire drama of the book revolves around these vacation disruptions in a remarkable literary portrayal of Kohut's (1971, p. 91) emphasis on such vacations as typical of the inevitable failures in empathy that must occur in every treatment!

A TRADITIONAL COUNTEREXAMPLE

Searles' (1985) discussion of the borderline patient is an example of how the object-relations approach differs from that of the psychology of the self. He notes the tendency of the borderline patient to "regard all his subjectively good, healthy aspects as having been created by himself, and all his psychopathology as being attributable to interactions with, and identifications with, the warped, hurtful, neglectful (and so forth) aspects of his parent figures" (p. 21). According to Searles, therapists tend to share this orientation and even come to believe that they are "the first good person, or potentially good person, whom the patient has ever encountered" (p. 10). His explanation, based on mechanisms of splitting, introjection, and projection, is diametrically opposed to that of Kohut.

When Searles is caught "semi-dozing" behind the couch and the patient, after a silence, remarks, "I don't know whether you're really here" (p. 14), he responds by connecting the patient's silence and remark with her early experiences of an emotionally detached mother (p. 14). A self-psychologist would approach this incident differently, stressing the here-and-now failure of the self-object therapist, and taking the patient's comment literally, as a communication of current disappointment. Searles notes that the silence and comment were

preceded by a period during which the patient appeared not to notice his "semi-dozing." On this basis, he interprets the silence and comment as an identification with "the more detached components of the therapist's personality" (p. 14).

Notes

1 A year later, the patient had indeed formed such a stable transference with a remarkable concomitant improvement in ego functioning.

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