Heinz Kohut’s Self Psychology: An Overview

Howard S. Baker, M.D., and Margaret N. Baker, Ph.D.

In the 16 years since its inception, self psychology has provided a comprehensive theory of psychopathology and treatment. It has articulated a new group of developmental needs and transferences: mirroring, idealizing, and alter ego. The failure of parental empathy to meet those needs during childhood results in the inability to develop intrapsychic structures that can reliably regulate self-esteem and calm the self, leaving the person overly dependent on those in the surround to provide those functions. Treatment requires careful understanding of the early failures and provides an environment in which the intrapsychic structures may belatedly and effectively develop.

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In their recent review, “The Cutting Edge in Psychiatry,” Strauss et. al. (1) surveyed leading American psychiatrists for their views on the most important developments in their field in the last decade. Only 13 books and one journal article were listed by the respondents often enough to be considered the most important publications, and only one author was mentioned twice: Heinz Kohut, for The Analysis of the Self (2) and The Restoration of the Self (3).

These and other works by Kohut and his colleagues have formed the basis of self psychology. This substantive departure from traditional, psychoanalytically based thinking has precipitated a firestorm of controversy, challenging fundamental precepts about both the etiology and the treatment of psychopathology.

Central to traditional analytic thinking is Freud’s abandonment of the seduction theory, which he replaced with the conflicted and conflicting drives of the Oedipus complex. He came to believe that the parents of most patients do not actually abuse their children to fulfill their own needs. Rather, faulty resolution of the oedipal conflict results in the child’s projecting unwanted, repressed feelings onto the parents. The crucial issue in the pathogenesis of neurosis is the unsatisfactory resolution of the child’s conflicted drives, not the parents’ failure to properly respond to the child.

While Kohut has no doubt that conflicts, particularly oedipal conflicts, exist, he holds that they would be resolved without neurotic defenses were it not for the failure of parents to meet certain essential needs of the child. Kohut has gone so far as to state: “We could say that after an eighty-year-long detour, we are returning to Freud’s original seduction theory—though not in the form in which Freud had entertained it. The seduction that we have in mind related not to overt sexual activities of the adult... but to the fact that the [parents’ empathic responsiveness to their children] is distorted in a specific way” (4, p. 11).

These actual failures are unintended and beyond the parents’ control, having as their root cause the psychological limitations of the parents themselves.

Kohut has also challenged a fundamental assumption about what produces therapeutic change. He concluded that insight, while important, is not the crucial element. “Whereas traditional analysis has advanced interpretation as the psychoanalyst’s basic therapeutic action, Kohut emphasizes the analyst’s creation of a new kind of experience for the patient within the transference relationship, of which interpretation is only a facet” (5).

While these and other positions have seemed so controversial to many analysts, Palac (6), Basch (7), and others consider that these changes merely reflect the way that many good psychotherapists who have never read the self psychology literature have come to practice. It has repeatedly come to our attention that many of these clinicians would like to be better in-
It's Self Psychology

I have read the self psychology literature severely contradictory, even impenetrable.

Much of this confusion is a consequence of the evolution of thinking about psychopathology over the 16 years since the publication of Kohut's first book. Initially, he was concerned primarily with the narcissistic problems of patients with behavior and character disorders. More experience led him and his colleagues to realize that essential elements of self psychology were applicable to psychoses, borderline states, and the neuroses. While he did not adequately address the issues of biological predisposition, Kohut concluded that it was the earliness and extensiveness of the empathic failures of the parents and parental substitutes which differentiated patients in the diagnostic categories cited earlier. He thought that developmental arrests which inevitably resulted from parental shortcomings most comprehensively and helpfully explained psychopathology. This stands in opposition to the concept that psychopathology reflects inadequately resolved conflict (producing symptoms which are disguised attempts at gratification of drives) or developmental regressions to points where the conflicts could be more successfully resolved.

While self psychology has never denied the existence of the drives or of conflict, it has now placed them in an entirely different context. It proposes such a substantially different view of these issues that it offers a virtually new, comprehensive view of psychological life—one that its practitioners obviously consider offers important therapeutic advantages.

Empathy

Self psychology holds that parents' inability to appropriately empathize with their children causes the parenting failures noted earlier. Although parents are usually not purposely unresponsive, children must adapt—or maladapt—to parental treatment. Repeated empathic failures by the parents, and the child's responses to them, are at the root of almost all psychopathology.

Kohut and other psychoanalysts have long emphasized the importance of empathy, but it was in the case of Miss F. (2) that Kohut initially emphasized the crucial role of empathy in healthy and pathologic development as well as in the facilitation of psychotherapeutic cure. Miss F. greeted Kohut's carefully thought-out traditional interpretations with fury and the repeated comment, "You are ruining my analysis with these interpretations." For a considerable time he understood her protestations as resistance and confident about the accuracy of his understand. Eventually he realized that he had failed to put himself empathically in her position—imposing his theory on her situation.

The American Heritage Dictionary defines empathy as "understanding so intimate that the feelings, thoughts and motives of one are readily comprehended by another." It is not to be confused with being nice to someone. Empathy is to intrinsically comprehend the experience of others from their own unique perspective, which is often very different from "what I would feel if I were actually in their place." Empathy has the potential to enable someone to respond in a helpful, responsible way or in a destructive way. It has both affective and cognitive elements—one feels what the other feels and then, through a complex, not necessarily conscious process, becomes aware what the other is feeling.

Self-Objects and Self-Object Relationships

These crucial empathic failures occur as a normal aspect of human interaction that Kohut called self-object relationships. He realized that Miss F. did not experience him as a separate person. Rather, she seemed to need him to be an extension of herself, someone over whom she had a degree of control normally reserved for a part of one's body like one's hand. She demanded that his responses instantly and totally fulfill certain needs (see following discussion) which she genuinely could not meet herself. Kohut labeled these "internal needs," which must be at least partially met by another person, self-object needs.

Kohut tried to distinguish self-object needs from object needs. In the latter, the other person functions as an autonomous object, an independent center of initiative. Objects are valued for who they are. Self-objects are valued for the internal functions and the emotional stability they provide. The self-object need's being met is more important than who meets it.

The essential element of Miss F.'s psychopathology was her absolute reliance on the responses of others (both the analyst and the people in her surround) to maintain her self-esteem. That is, for her, people primarily had to function not as objects but as self-objects. She needed others to reassure her or she would experience catastrophic loss of self-esteem.

An old slogan of the American Dairy Association proclaims: "You never outgrow your need for milk." The same is true of empathically accurate self-objects. We always need them, although they undergo developmental maturing. Kohut strongly held that, in addition to the generally accepted line of object development, there is a parallel line of self-object development. In infancy, self-object needs are absolute and intense and must be externally met, primarily by the mother. Throughout childhood, increasing distance from the mother is tolerated. The father's role becomes more important, and parental substitutes (like grandparents, teachers, friends, and neighbors) are willingly accepted. During adolescence, the peer group is a crucial self-object. In adulthood, the spouse, friends, and careers may be self-objects. In addition to broadening who or what may serve as self-objects, the healthy individual develops reliable, consistent, and endopsychic.,.structures which assume many of the functions.
that were previously required of external self-objects. The person becomes more internally competent, less externally needy, and more flexible in meeting the remaining self-object needs.

SELF-OBJECT TRANSFERENCE AND NEEDS: MIRRING

Miss F. and other patients led Kohut to formulate a new group of transferences that reflect unmet self-object needs. Initially, he formulated two major types of self-object transferences, mirroring and idealizing. Eventually he added a third, the alter ego, or twinship, transference.

Miss F. primarily demonstrated the mirroring transference. Just as she looked into the mirror to see how she appeared as she rebuffed her, she constantly and intensely turned to Kohut’s responses to determine how valuable, good, and worthy she was. Any response that did not seem totally approving was intolerable and shattered her self-esteem.

Miss F. and other people with problems in this area have experienced repeated and significant mirroring failures from their parents or parental substitutes. While these failures often continue into the present, the crucial ones occurred during childhood. Early, pervasive self-object failures produce the most severe developmental arrests, greater reliance on archaic self-object relationships, and a predisposition to more severe psychopathology.

The delighted response of the parents to the child—the gleam in the mother’s eye—is essential to the child’s development. This response mirrors back to the child a sense of self-worth and value, creating internal self-esteem. Parental responses of indifference, hostility, or excessive criticism reflect back low worth and consequently inhibit the child’s assertiveness. The mirroring responses of the parent are concerned with the maintenance and development of self-esteem and self-assertive ambitions.

Any parent knows that all of the child’s needs cannot be met and that all of the child’s wishes should not be met. It is an accomplishment for a 2-year-old to throw a ball regardless of where it lands. An aspiring response for the same feat accomplished by an 8-year-old is inaccurate and therefore destructive. To be fully empathic, the mirroring response must be developmentally appropriate and genuine.

Children may seek interaction with an exhausted parent who is simply too tired to respond. They will sometimes be rebuffed by the reality of the parent’s fatigue. Should these inevitable “failures” in parental self-object responses become overwhelming, the child may try to compensate for a lack by trying to be perfect, cute, bright, or wonderful. This attempt to “fix” the insult reflects the child’s perception that something is wrong with him or her; the child believes that the lack of mirroring responses, which would have affirmed the child’s sense of self, is caused by his or her inadequacy. Self psychology refers to the effort to be perfect as the “grandiose, exhibitionistic self.” In the context of a generally responsive environment (the “good enough” parents), the intensity of the grandiose self is diminished but not destroyed. “In other words, given reasonable care, humans are so constituted that they preserve a ‘pincushion of the old grandiose delusion’ . . . in spite of the fact, and even because of the fact, that from the beginning of life a countless number of inevitable in phase (‘optimal’) frustrations and injuries begin to modulate and transform these delusions by teaching us the limits of our own and other’s power” (8). It is these optimal failures which require the child to develop or invent internal means to maintain self-esteem, tolerate unavoidable failure, and pursue appropriate ambitions with vigor. The developing child’s self-object needs can then mature from archaic demands for perfection and constant attention to self-confidence and the healthy self-object need for occasional, thoughtful appreciation and praise.

Clinically, we do not see the results of the “failures” of good enough parents. Instead, we see people for whom the parent-child interaction seriously failed to meet the child’s self-object needs. This occurs for some combination of these three reasons: 1) the child has exquisite needs due to such factors as genetic predispositions, physical handicaps, or learning disabilities; 2) there is an unfortunate mismatch between the temperaments of the parent and the child (9); and 3) the parent has serious limitations in his or her ability to respond adequately for various reasons, including the parent’s own psychopathology and externally imposed circumstances (e.g., death of another child, job loss, illness). There is a complex interaction, a feedback process between parent and child that results in a “continuous modification of both. The relationship, therefore, is gradually changed over time” (10). A deteriorating process may ensue, and whatever the reason, there may be repeated, actual failure in meeting the child’s legitimate self-object needs. Consequently, the child is impeded in developing internal structures to regulate self-esteem.

Several examples will clarify the concepts of good enough and pathogenic mirroring. Marion Tolpin (11) has described an incident with a friend’s 5-year-old child: he was learning to skate with his parents’ help and delighted encouragement. On a school outing, he tried to skate when his parents were not present and failed miserably. His parents’ approving presence was necessary for him to be able to function adequately—they almost literally firmed up his ankles. When an expectable, unavoidable disruption in the needed self-object relationship occurred in the context of this reasonably empathically responsive family, this minor failure to meet the child’s needs probably resulted in a small bit of growth. The child’s grandiosity was both preserved and tempered.

This contrasts with the case of a young man who was flunking out of college. His father was not pleased about his son’s getting into a prestigious school, and
As his final words to him, as he left home for the first time, were: “Just don’t come around here acting fancy and driving some big car” (12). That comment is an obvious example of a continuous and destructive mirroring pattern: the father’s own narcissistic vulnerability and competitiveness prevented him from enjoying and encouraging his son’s success. The distortions in the father’s personality made him like a fun-house mirror. Whatever the son did, the reflection was negative. As a result, the son had serious problems maintaining self-esteem and acting assertively.

While the preceding is a blatant example, destructive interchanges more frequently occur in subtle ways. A female patient remembers that her mother was delighted at what a “good child” she was. She never made any demands on her mother, who used to let her spend hours every day playing alone in the fenced-in yard while she herself pursued her personal interests. This benign neglect provided a mirror that said, “You are not a source of joy and pleasure.” In adulthood, it was not natural for this patient to value or enjoy her many substantial accomplishments, nor could she accept real affection as genuine.

There are three basic personality types that result from consistent shortcomings in mirroring self-object relationships. Individuals with merger-hungry personalities must continuously attach themselves to self-objects in such an entangled way that they are often unable to “discriminate their own thoughts, wishes and intentions from those of the self-objects” (13). Those with contact-shunning personalities avoid social interaction and become isolated because they fear that they will be swallowed up or that further nonempathic mirroring will destroy the remnants of their already vulnerable nuclear self. Finally, and generally suffering from less profound self pathology, are individuals with mirror-hungry personalities. They are compelled to insistently display themselves in such a way as to obtain continuous confirming and admiring responses, without which they feel worthless. Because of the intensity of their needs, their conviction that the needs will not be met, and the shame they feel, all of these people often alternate between depressed, hopeless withdrawal and outbursts of enraged acting out.

IDEALIZING NEEDS AND TRANSFERENCES

In addition to mirroring needs and transferences, people have what Kohut called “idealizing” requirements. These deal with our need to merge with, or be close to, someone who we believe will make us safe, comfortable, and calm. The child who falls and who is a knee runs to a parent for a kiss, which, through no known medical process, has profound healing powers—the pain disappears! Again, an external object serves as internal function—calming and comforting—and so functions as a self-object for the child. Basch (14) has likened this to the genie in Aladdin’s lamp, who could always be counted on to provide help, protection, and comfort. Kohut referred to this all powerful self-object as the “idealized parental imago.”

As with other self-object needs, there is a developmental process of maturation of the idealizing needs. Initially there is a wish to merge with the idealized parental imago; then there is a wish to be very near a source of such power; eventually the mature person is satisfied knowing that friends and family are available in times of stress. The intensity of the self-object needs decreases as the internal capacities increase—as the child creates ways first to calm the self when upset or overstimulated. Later the idealized self-objects facilitate the endopsychic abilities to control and channel libidinal and aggressive drives, and during the oedipal period contacts with the parents help the child set the beginnings of meaningful goals for (10).

As with mirroring, a good enough parental environment is necessary for the idealizing developmental line to mature successfully. Minor failures create the need for internal structures, while basic success creates a secure enough environment to permit growth. Internal structures develop like muscles—some resistance adds power and bulk. No challenge yields atrophy, and excess exhausts, or can even tear, the muscle.

Willie Loman in Arthur Miller’s Death of a Salesman seems to the younger son Biff to be the perfect hero. But when Biff suddenly and dramatically discovers his father’s weakness and infidelity, he collapses and loses all sense of direction. There have always been problems between Biff and Willie: with machine-gunnlike insistence, Willie demands that Biff do things his way; Willie does not encourage gradual, increasing independence; finally, and most dramatically, Willie’s failures emerge in a traumatic way, rather than in a phase-appropriate, nontraumatic fashion. It is not lack of love but the personal limitations of the parents that caused the symptomatic son.

TWINSHIP/ALTER EGO NEEDS AND TRANSFERENCES

In his last book, Kohut thought it useful to consider a third area of self-object needs, twinnship or alter ego. Here he was concerned with the need to feel a degree of alikeness with other people. The small boy may stand by his father when he shaves. The son also “shaves,” using a bladeless razor. These sorts of experiences lead to a feeling of being like others, of being a part of and connected to the human community.

Initially, the closeness sought may have a merged quality, but with development, greater tolerance for being different is accepted. In the adolescent peer group, with its often strict dress codes, the T-shirts with the names of rock groups, and so forth, difference is often threatening. In mature adulthood, we enjoy a feeling of collegial closeness with professional organizations, take pride in a winning sports team, and so forth, but at the same time we respect and can be respected for having differences.
As with mirroring and idealizing needs, trust and closeness to the parents are essential, as is gradually increasing autonomy. If parents cannot provide activities to participate in with their children, the result is often that the child reacts defensively by being aloof and rejecting or by becoming an insistent clone.

A female patient was struggling with her relationships with other women. She could not understand why she permitted sexual contact with a particular friend and stated, “What I really want is just a sister.” It emerged that she actually longed for a clone-like sense of twinship with this woman. Throughout her childhood she felt isolated and different. She was a tomboy, enjoyed playing with boys, and hated to play girls’ games. Her father was cold and distant, and her more available mother was obsessed with trying to get her to behave like a girl. Being a girl meant wearing pretty dresses and not playing baseball. The absence of satisfactory twinship self-objects in childhood produced a distorted and intensified need for a twin in adulthood, and (as is often the case with these and other unmet self-object needs) the longing became sexualized.

**NATURE AND DEFINITION OF THE SELF**

“The concept of the self was derived from empirical data as a clinical matter of necessity; it was not invoked as an abstract scientific concept” (6, p. 323). Therefore, we must come to some useful understanding of “self” as it is used in self psychology.

The self in the broad sense of the term is “the center of the individual’s psychological universe” (3, p. 311). It is what “I” refers to when we say, “I feel such and such, and I do so and so.” We may describe the nature of what the self experiences and the actions that the self undertakes as a consequence of those experiences. Kohut did not believe it was possible (or necessary) to go further in defining the essence of the self.

Stolorow (15) has underscored the dual nature of the self: 1) a psychological structure which organizes the way we experience ourselves and 2) an existential entity which initiates and undertakes actions based on how we are experiencing ourselves—the “I” that experiences itself and the “I” that takes action. Not separating them can confuse an already complicated concept.

If the self is healthy, if during the course of the child’s development there was a sufficient self-object environment, internal structures develop and there is consistency and clarity of patterns of experience and behavior even in the face of considerable stress. The healthy self can internally regulate self-love, calm and soothe the self, and so forth. As a consequence of these effective internal structures, others serve as self-objects in a mature, limited way. The unhealthy self is to varying degrees dependent on self-objects to do what those underdeveloped intrapsychic structures cannot do. The self-object relationships remain archaic and generally interfere with interpersonal functioning: e.g., a husband’s archaic demands on his wife for continuous, selfless attention often will disrupt the relationship, preventing or interfering with both object love and the development of mature self-object relations (normal support).

When the unhealthy self experiences a disruption of a self-object relationship or a narcissistic insult, even though it may seem very minor to the outsider, the self may experience depleted depression or disintegration anxiety. Kohut was unambiguous in his assertion that disintegration anxiety “is the deepest anxiety man can experience” (4, p. 16). It is similar to the fear of death, except that what is feared is not physical annihilation but loss of humanness: psychological death. Patients describe this in a variety of ways. Some feel they are falling apart, some that they are lost in space without any supply of oxygen, others that they are treading water in the middle of the ocean with nothing solid to touch, no one nearby, and the ever-present danger of sharks; still others feel dead. In its more minor forms or when the anxiety is well defended, the experience may be just one of boredom or sleepiness.

The self-experience of fragmentation or enfeebled depression causes the self-as-initiator-of-action to do something to end (or to develop some defense mechanism against) those intolerable states: to restore to the self-experience a sense of coherence, wholeness, or vigor. Even if the behavior employed to ward off disintegration anxiety is self-defeating or self-destructive, it is experienced by the individual as preferable to disintegration anxiety or depleted depression. From a self psychological point of view, then, most symptomatic behavior is viewed as an emergency attempt to maintain and/or restore internal cohesion and harmony to a vulnerable, unhealthy self.

**THE TRIPOLAR SELF AND ITS DEVELOPMENT**

Self psychology holds that as a result of accurate mirroring, a child develops a sense of ambition and enthusiasm for life. As a result of being able to idealize parents and draw strength and comfort from that idealization, a child develops self-direction and an ability to set challenging but realistic goals. The ambitions and goals represent the two poles of what Kohut called the “bipolar self” (3). Connecting these poles is the particular pattern of talents and skills that to a greater or lesser extent enable the ambitions to turn into achieved goals. More recently, Kohut (4) considered that the pattern of talents and skills should be considered a pole more or less equal with the ambitions and goals. It is thus more reasonable to think of a “tripolar self.” This third pole develops from the twinship or alter ego self-object relationships described earlier.

For psychopathology to develop, the child must experience a fairly repeated pattern of difficulty in at
least two of the three poles of the self—mirroring, idealizing, and alter ego (4). If, for example, the parenting environment is extremely defective in providing satisfactory mirroring, the child may turn to satisfactorily available sources of idealizing and alter ego supplies. In such a case, while development might not be entirely normal statistically, the person may be able to lead a symptom-free, happy, and effective life.

The intrapsychic structures that maintain self-esteem, calm the self, and so forth are developed through a process which Kohut called “transmuting internalization.” He coined this term to differentiate it from identification, which often refers to a wholesale, or total, internalization of another person (16). In transmuting internalization, bits and pieces of the important self-object are internalized. They may be altered by the child’s inventions and are then reassembled in a unique way by the child to meet his or her psychological needs. Kohut compared the process to the body’s digestion of proteins: proteins, after ingestion, are broken down into amino acids, then absorbed and reintegrated into new or similar proteins.

DRIVES, CONFLICTS, AND THE OEDIPUS COMPLEX

It is obvious to most observers of human nature that people have what are called sexual and aggressive drives and that these drives are often both in conflict and unconscious. Self psychology has no disagreement with this. However, conflict that results in psychopathology is different from the inevitable stuff of life. The problematic drives, fears, and conflicts that our patients experience have been intensified and distorted in their childhood as a consequence of parental and environmental self-object failure (17). Kohut considered such intensified drives and conflicts to be breakdown products of self-object failure (3, 4).

There is, for example, a difference between anger or aggression and rage. Whereas aggression and anger are considered normal, healthy aspects of the self, rage is a breakdown product of self-object failure (4, 18). Aggression is directed against objects that are not self-objects, that is, against people or things we are experienced as autonomous centers of initiative, not against people or things serving internal self-object functions. Aggression seeks to remove whatever obstruction may exist to meeting and gratifying object-related drives. It subsides when the need is met, when the goal is achieved. We may get angry at a recalcitrant nail that will not go into a wall when we try to hang a picture. However, when the nail finally yields and the picture is hung, the anger subsides.

On the other hand, if the nail presents what is experienced as narcissistic injury, if it makes us feel incompetent, we might slam the nail, damage the wall with the hammer, and feel terrible for hours. Narcissistic rage seeks revenge for the disruption of a vital self-object tie or redress against a narcissistic insult even though the outside observer, or the person himself, may consider the insult trivial. Rage is not satisfied with reestablishing the self-object tie or ending the insult. It pushes us to get even, to destroy the source of frustration, often without caring about the damage that may result to the self or others. In literature, Captain Ahab’s uncontrollable urge to destroy Moby Dick provides a clear example of the lengths to which a person driven by narcissistic rage may go. Ahab lost his life and the lives of most of his crew and destroyed his vessel as well.

Kohut also reformulated the nature of the oedipal phase. In the traditional view, the central issue is the appearance of phase-specific, unconscious fantasies that are related to the maturation of the sexual and aggressive drives. “As was true with regard to earlier phases of development, what happens to these drives becomes understandable only when they are considered within the matrix of the empathic, partially empathic, or unempathic responses from the side of the self-object aspects of the environment during the oedipal period” (3, p. 230). Kohut considered the oedipal phase, marked by the normal, not necessarily problematic, sexual attachment to the heterogender parent and aggressive and competitive feelings toward the homogender parent, to be inevitable during the oedipal period. However, for an oedipal complex to develop, for those drives to produce substantially unresolved conflict, parents must fail, in a significant manner, to provide a satisfactory self-object environment.

Such failures transform the normal upsurge of affectionateness and assertiveness—essential attributes of the proud and joyful oedipal self—into the pathological and pathogenic drives, which we traditionally view as the manifestations of the final stage of normal infantile sexuality. As with “pre-oedipal” infantile sexuality and destructive aggression, we consider the infantile sexuality and hostile-destructive aggression of the oedipal phase (i.e., the Oedipus complex) to be disintegration products. As such, they supervene only after the selfobjects [usually the parents] have failed to respond to the primary affectionateness and assertiveness of the oedipal-phase self with fondness and pride because they [the parents] have, on the basis of their own psychopathology, experienced [preconsciously] these emotions of their oedipal child as sexually stimulating and aggressively threatening (26, p. 390).

If, on the other hand, the parents are able to provide a good self-object milieu, the child is “able to assimilate the oedipal lesson, i.e., change his goals and with that his self-concept ... [and he becomes] able to accept without a sense of permanent loss the fact that his selfobjects are selves in their own right and have needs that at any given time may displace even be in opposition to his own.... He may come to recognize and understand that the selfobject needs of others are as significant and as worthy of respect as are his own” (14, p. 27).

Many patients have experienced serious pre-oedipal self-object difficulties. They, too, must go through the oedipal phase, but they must do so insufficiently pre-
pared. Failure is virtually inevitable, and oedipal material will overlie—and perhaps mask—serious preoedipal pathology (19, 20). Clinically, we believe that this describes the majority of today's narcissistically vulnerable patients. For them “it is not the unconscious fear of forbidden erotic love that generates anxiety, but the anticipation of reexperiencing the devastating, potentially disintegrating disappointment of early empathic failures if they dare once again to reach for emotional fulfillment” (21). To try again, either in the outside world or in the therapeutic setting, to obtain in a later relationship what one did not get and needed as a child seems foolhardy on the one hand but essential for continued growth on the other.

TREATMENT CONSIDERATIONS

The self psychology literature grew out of classical psychoanalysis. However, its theory and practice can be directly applied to psychotherapy. From a self psychological perspective, there is a continuum from psychoanalysis, through psychoanalytically oriented psychotherapy, to focal therapy. The major difference is that “psychoanalysis places the transference neurosis into the center of the therapeutic activity, whereas psychoanalytic psychotherapy focuses upon intra- and extratherapeutic [italics added] transferences within the broader context of the therapist-patient relationship” (22). This continuum is valid so long as “the therapist's interventions are not manipulative (supportive [educative, advice giving] or reassuring) but, rather, are fairly consistently interpretive (23).

The primary content of self psychology's interpretive focus has shifted from unconscious conflicts and disavowed wishes. Instead, it focuses on how patients try to restore a sense of vitality, cohesion, or harmony to the self when it is 1) threatened by the disruption of an important self-object tie or 2) injured by some narcissistic assault. While symptomatic behavior has obviously negative elements and may express profound narcissistic rage, it is primarily understood as an attempt at restoration of a fragmenting or depressed self and therefore contains an important element of health. Symptoms are not primarily understood as efforts to seek symbolic gratification of unresolved conflicts. Interpretations focus on the nature of self-object disruptions and narcissistic insults, what the self experiences in the face of these, the rage that may be provoked, and what the patient does to restore to the threatened self a feeling of vitality. For example, with patients who shoplift, interpretations do not focus on symbolic gratification of object-instrumental drive conflicts. Rather, events in the patient's that were experienced as disruptions of vital self-object ties or narcissistic assaults are sought. Then an attempt is made to understand how the symptoms restore the cohesion and harmony of the self, perhaps by reducing intolerable rage or by giving a sense of power (24).

The therapist serves as a self-object in the therapeu-
Both object and self-object transferences are seen in all patients. The former include castration anxiety secondary to competitive feelings toward the therapist, and so forth. There are five primary self-object transferences: merger, contact shunning, mirroring, idealizing, and alter ego. One may see, for example, a patient who is attentive to the slightest nuances of our responses, reading them as fierce criticism or extravagant praise. The smallest perceived insult will result in a disruption in this mirror transference and may cause the patient to fly into a rage, collapse into depression, or indulge in acting out.

Kohut believed that patients with character and behavior disorders formed self-object transferences throughout most of their therapy but that they formed object transferences toward the end of treatment. With neurotic patients, the sequence is reversed. They are struggling primarily with the consequences of oedipal conflicts and have developed a reasonably secure nuclear self. As the neurotic conflicts resolve, these people discover underlying disappointment, grief, and rage that their parents were unable to sufficiently meet legitimate self-object needs during the oedipal period. These feelings are then worked out in the transference. Wolf (23) did not find such clear sequences of transferences in his patients. Rather, he considered that the transferences alternate throughout treatment, with self-object transferences clearly predominating in patients with character and behavior disorders. With neurotic patients, Terman acknowledged the obvious and important presence of conflicted object transferences. However, he cautioned, "with respect to technique, in patients with injury to the oedipal...self, attention must be directed to the parental responses—as perceived by the patient—and their role in the genesis of the injury. Attributing the self-injurious attitudes to the strength of underlying impulses re-creates the original narcissistic injury" (26).

We may summarize the therapeutic process using Wolf's guidelines (27). He described five steps in the analytic process, which apply directly to psychotherapy.

1. Analysis of defenses against therapy, the fears of further self-object failure, and the painful injury the failures exact. Condition: ambience of acceptance and understanding, which is necessary for and encourages regression and mobilization of transference.

2. Unfolding of the self-object transference. Condition: noninterference with this process by fragmental interpretations, such as educative comments as to the nature of the patient's oversensitivity, but the boss really meant, and so forth.


4. Appropriate interpretation of the observed disruption, restoring mutual understanding by explanation. Condition: an honest and plausible explanation of the experienced disruption as blamelessly unintentional and probably unavoidable.

5. The patient's self, now strengthened, continues the deeper unfolding of more archaic self-object needs in the transference. The therapist then points out the patient's failures and successes in strengthening the self and attempting to integrate into the surround in a way that establishes healthy, mature (rather than archaic) self-object and object relationships.

Extended descriptions of self psychologically informed analysis have been offered by Kohut (28), Tolpin (29), and Goldberg (30).

CONCLUSIONS

We can perhaps best conclude by quoting Kohut. He was referring to analysis per se, but the comment also applies to effective psychotherapy in general.

A well-conducted analysis...which has been brought to a proper conclusion, provides the analysand with more than the diminution or disappearance of his painful and disturbing symptoms—existing in him now is a certain psychological openness, perhaps even a spark of that playful creativeness which turns toward new situations with joyful interest and responds to them with life-affirming initiative. Such a person may yet continue to be more easily traumatized than one who has learned to maintain a reliable yet restricting psychic equilibrium. But he will also be more perceptive and responsive than the rigidly normal. (31)

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