

What Is Valuable in Self Psychology and What Isn't?

One Analyst's Opinions

by

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A contributor to the "Psychoanalytic Studies" listserv (University of Sheffield, England) posted a series of questions regarding self psychology. As a psychoanalyst who has studied self psychology and who accepts some aspects of it while rejecting others, I responded as follows.

What do you agree with or disagree with in self-psychology?

I agree with its critique of Freudian drive theory in its literalistic form which holds that human beings are primarily motivated by somatically-based sexual and aggressive impulses that, although differing from animal instincts in being redirectable in terms of their aims and objects, are nevertheless innate, biologically hard-wired (though aims and objects are soldered on later), essentially ineradicable and, in their primitive forms, asocial and antisocial in that the sexual drive is incestuous and polymorphous perverse and the aggressive drive is utterly amoral and egocentric.

Self psychology does not deny asocial and antisocial impulses in human beings, but it sees these not as natural (expressing our original nature) but as "disintegration products" of more fundamental wishes for positive responses to our intrinsic selfobject needs (for mirroring, for merger with idealized objects, for alter-ego relatedness, for adversarial relatedness, and so on).

The problem I have with this framework is that in correctly rejecting Freudian biologism, like Guntrip, it swings all the way over into an extreme environmentalism, missing existentialism on the way. To bring existentialism (by which I do not mean Sartre's or Schafer's radical voluntarism but Heidegger's "Dasein") back onto the scene entails recognizing that while our asocial and antisocial impulses are not

biologically given, neither are they simple reactions to environmental (parental) failure. Although intensified by the latter, these impulses are essentially reactions to anxiety, a good deal of which has nothing to do with environmental failure but rather with psychological birth as a human subject who, as self-conscious "being-unto-death," must live with a degree of existential anxiety and guilt.

Should the focus of therapy be on psychological deficiency, intrapsychic conflict, or something else?

Both "deficiency" and "conflict" are concepts reified in contemporary psychoanalysis. The essence of pathology--in both analysands and analysts--is reification. Therefore the focus of therapy, in both the transference and countertransference, should be on reification or concretization. Concretized thinking involves regression from Klein's D (depressive position) to PS (paranoid-schizoid position). Whether a person is lived by a phantasy that she is deficient, or a phantasy that she is evil for wanting to eliminate one parent and possess the other, or a phantasy that she is multiple, or that she has a suffering child within, such phantasies need to be *analyzed*--i.e., deconstructed, dereified, deliteralized. But this project encounters "resistance" because leaving PS for D means separating and individuating, exchanging depression for sadness, guilt and remorse, surrendering the splitting defense, accepting responsibility, mourning.

Do you disagree with Kohut that the goal of treatment should be the internalization of the structure and function of a cohesive self?

Most definitely. This is merely to confirm the patient's core pathology: misidentification with a mirror image (Lacan). What should be happening instead is analysis of the anxieties driving the defensive need for identification.

Do you disagree that psychic structure is acquired in the context of a self-selfobject relationship? Do you disagree with the following statement: "As the client's internal world and deficits are understood and explained by another, new compensatory structures are built and the client slowly over time replaces his or her former enfeebled self-structure with a stronger, more cohesive, self-structure"?

Psychic structure based on identification with images is the problem not the solution. Yes, such (mis)identifications are acquired in the context of what

Kohutians call a self-selfobject relationship through what Kohut called "transmuting internalization". Yes, such compensatory structures are built up this way. But all this adds up to what Winnicott called a "false self" and what Lacan called the "ego". These are defensive structures that may reduce anxiety--so does Paxil, religious conversion, etc. This is therapy through inspiration, identification, suggestion, reparenting, soothing, merging with a good object, or with a good community of selfobjects. This is good, non-analytic, supportive psychotherapy. It is not psychoanalysis--at least not if this term of Freud's is to retain any recognizable connection to what he himself meant by it.

Do you agree that if the needs of the child are met this helps to build a grandiose, idealizing and twinship part of the self-structure?

If the child's needs are met it has little need to build up a grandiose self because it's too busy "going-on-being" (Winnicott) and it doesn't need this false self--although given the existential disruption that will occur no matter how well its needs are met, some such defensive false self, grandiosity, need to cling to idealized objects, etc., will inevitably arise. What Kohut saw as normal grandiosity, etc., is already a disintegration product--not of Freudian drives--but of the "going-on-being" that has been disrupted due to normal psychological birth as a human subject (being-into-death) and, in addition, to whatever surplus disruption arises from parental failure.

Do you think extended periods of mirroring are a prerequisite for helping the client risk self-examination?

For some clients no amount of mirroring will ever be enough to enable them to risk self-examination. They are anti-analysands, essentially psychotic and unanalyzable. For others no extraordinary mirroring is necessary at all. They arrive having decided to undertake a process of radical self-doubt and self-scrutiny; they have decided to radically call themselves into question with another's help. After some initial testing of this other as to his/her reliability, empathy, integrity and so on, they get on with it. These are the two poles of a continuum upon which people occupy every other point. The less basic trust, the more paranoid anxiety, the more testing and the more resistance. With paranoid and highly resistant patients long periods of non-interpretive "holding" (Winnicott), "containing" (Bion) and "mirroring" (Kohut, Spitz) are often necessary. I consider such work essentially "pre-analytic" in that sometimes it makes an analysis possible. In some cases it cannot accomplish this and serves

instead as a supportive psychotherapy.

Do you disagree that pathology develops from the absence of empathically responsive selfobjects in the child's inner and outer world?

Pathology results from: (1) the maddening human condition, the condition of a self-aware subject moving toward death having to make irrevocable choices and burdened with unavoidable existential guilt and anxiety; and (2) the surplus anxiety, rage and guilt due to parental (selfobject) failure.

Do you disagree that the elements of any interpretation should be acceptance, understanding, explanation? Do you disagree that without these three components interpretations are often experienced as narcissistic injuries?

Where does "acceptance" come from? That is not Kohut who spoke of understanding through empathy as necessary prior to explaining. I agree with Kohut about this, and with Stolorow, Atwood and Branchaft's notion of "sustained empathic inquiry" into the patient's experiential world. This is crucial. I must always have the capacity to set my theories and hunches, etc., aside and open myself to understanding the patient's way of processing and experiencing what goes on between us. This emphasis on the analyst "de-centering" from his own perspective and immersing himself in the patient's is a major contribution of self psychology that I have found very helpful, especially in situations of crisis or impasse.

But, of course, empathy is not enough. Having thoroughly understood my patient, I may decide that, all things considered, his reality-testing is off and I will confront him with my view. He may feel mine is off. Out of our dialogue one or both of us may shift ground.

I don't like the sound of that word "acceptance". It sounds dangerously patronizing to me. I'm not the patient's father, mother or priest; just his hired professional therapist. It's not up to me to accept or reject, only to analyze--to understand and explain.

Do you agree that narcissistic issues are found in all age groups and in every diagnosis?

Definitely.

If not empathy...what do you think is curative in therapy?

I don't think empathy cures, but I think it is a necessary element in a complex process that (sometimes) cures--if the patient comes to want to be cured. Lots of patients are in therapy without really wanting to be cured or wanting to really be in therapy. Part of the therapeutic work in such cases is to clarify this fact and invite the (pseudo) patient to consider becoming a real patient.

I think being accurately understood by a non-judgmental person who helps clarify the truth of one's situation and one's stance toward it, its roots in the past, its effects in the present, its various functions, etc., can be very helpful. There is a sense in which a therapeutic relationship with a responsible, reliable, empathic professional constitutes a good object relationship and a "corrective emotional experience" above and beyond the self-understanding that accrues from the analytic work as such.

Do you disagree with Kohut's idea of optimal frustration that helps the child move from archaic manifestations of mirroring needs (i.e., exhibitionism) and archaic manifestations of idealizing needs (i.e., omnipotence) to mature levels of self-development?

Although I have problems with both Kohut's idea of optimal frustration and Bacal's idea of optimal responsiveness, I prefer the former in that the latter encourages a move beyond the sense in which a good therapeutic process is legitimately viewed as a "corrective emotional experience" to the notion of therapy as a kind of reparenting. This conception has swept the field in contemporary psychoanalysis, not just in self psychology. It contrasts markedly with what I consider to be the genuine analytic task: neither to optimally frustrate nor to optimally respond to the patient's "child within," but rather to help the patient realize there is no child within and that the analyst is neither an optimally frustrating nor an optimally responding parent or parent substitute, but simply a good-willed, well-trained, caring professional working together with the patient to enhance the latter's self-understanding and self-acceptance and to realize his or her (the patient's, not the analyst's) goals.

Do you disagree that the type of transference that develops depends on the area of self-structure with the most deficit?

I don't accept the "deficit" metaphor. It harms patients who think they're defective when their analysts agree with them. The point is to see how the *phantasy* of deficit produces particular transferences and to *analyze* the deficit phantasy, not attempt to "fill in" an Imaginary hole.

It is a type of "folie-a-deux" for an analyst to join a patient in the filling-in of imaginary holes.

Have you in your practice seen the emergence of the idealizing transferences and mirroring transferences Kohut speaks of?

I've seen plenty of what Kohut would describe in these terms, yes. I have found his identification of the selfobject transferences descriptively useful. While some selfobject transferences do seem to stem from unmet developmental needs remobilized and directed toward the analyst, I think many self psychologists are not alert to the defensive quality of these transferences and to the conflicts, rage and paranoid anxiety they often cover over.

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