Some Thoughts on Psychoanalytic Change:

A Self Psychological View

Analysts have been trying to define the curative factors in psychoanalysis for almost as long as psychoanalysis has been with us. Although consensus remains elusive, one thing at least that has become clear is the extent to which models of psychopathology inform models of cure. Even in the clinical thought of one single analyst, Freud himself, five separate theories of cure were necessary to account for the five different models that he embraced over his long and searching career (Frances, 1987). Further, there are those who maintain that the idea of cure, implying as it does illness, is in itself a distortion of the analytic process as they view it. Personal growth, self realization, increased psychological comfort in the conduct of one's life appear to them the more relevant concepts. In any case, as psychoanalysis broadens and shifts its boundaries, incorporating parts of new theories and discarding bits of old ones, the influence of theory on ideas about psychological change becomes an important factor as analysts search for a more universal vocabulary with which to communicate. In this paper I would like to use the framework of self psychology to indicate how ideas about theory can influence ideas about change and to look towards a common vantage point underlying the diversity that might make it easier for analysts of varying persuasions to compare their ideas with each other.

Self psychology, with its roots in the study of pathological narcissism, has, perhaps of necessity, a controversial view of successful outcome, one which has caused critics to raise the question of whether what self psychologists do is psychoanalysis at all. Kohut finds error in the value-laden goals of classical analysis saying, "Al-
though the attainment of genitality and the capacity for unambivalent object love have been features of many, perhaps most, satisfying and significant lives, there are many other good lives, including some of the greatest and most fulfilling lives recorded in history, that were not lived by individuals whose psychosexual organization was heterosexual-genital or whose major commitment was to unambivalent object love (1984, p. 7).

Be that as it may, in thinking about what self psychologists think may contribute to cure, I do not wish to imply that these factors are well-deliniated, complete, definitive, or even necessarily causal. Furthermore, I do not believe that one can exclude the contributions from other psychoanalytic models, as self issues and the more familiar questions of conflict are not likely to be mutually exclusive. Nor need they be ranged hierarchically, the so-called narcissistic problems disappearing before object-related oedipal wishes can come into view. The curative aspects of any psychoanalysis, whatever they may be, are likely to contribute to a self psychologist's successes as will the many principles of self psychological treatment that are employed, albeit often without acknowledgement, by analysts of other orientations.

I intend to focus here on the developmental perspective of self psychology and on the interrelated concepts of the analyst as self-object, selfobject interpretation, and transmuting internalization, hoping to show some of the ways in which Kohut's clinical insights have enriched all of psychoanalysis.

It is probably an uncontroversial contention that the notion of cure must imply some notion of what is wrong. Psychoanalytic self psychology rests on the belief that the human infant has an innate and peremptory need to develop and maintain a "steady and esteemed sense of self" (Pine, 1987), and that this need is and remains throughout life the primary force that motivates behavior. Failure to acquire the internal gyroscope of a cohesive self leaves one at the mercy of intense and often disintegrating anxiety and calls forth desperate and offputting defenses in an effort to maintain some semblance of emotional equilibrium. The resulting psychology of deficit is in sharp contrast to classical drive theory in which imperious biological urges, inevitably colliding with the requirements of family and society, eventuate in a psychology of conflict.
Therefore, the first concern of the self psychologist is not with the wishes of the oedipal child for certain sorts of forbidden relationships which are ambivalent and which must be renounced, but with the needs of the preoedipal child for a sense of private individuality and worth which are non-negotiable and must be met. Clinically, the development, understanding and working through of the transference remain fundamental goals (Kohut, 1984), but the change in perspective requires analysts to deal with certain preverbal dimensions of psychological experience that lie outside the classical arena of resistance and defense, and therefore make different demands on the analyst in establishing an analytic am-bience in which these new dimensions can be explored.

It is useful to remember that self psychology as we know it today grew out of Kohut's work over twenty-five years ago with narcissistically disturbed patients who at that time had been considered un-analyzable because of their dismissive or otherwise disappointing responses to object-oriented transference interpretation. Although these were often gifted and competent people objectively—many were candidates in psychoanalytic training themselves—they rarely consistently felt themselves so, and their problems were not limited to the way they handled their sexual and competitive needs. They also manifested pervasive problems in coping with many situations, and their apparent egocentrism, sensitivity to slights, and unreasonable demandingness, whether subtle or outrageously overt, frequently sabotaged their expressed wishes for relatedness and intimacy.

These patients complained of feeling empty and emotionally isolated, of unpredictable shifts in mood, and were extraordinarily dependent upon the esteem of others however grandiose they might appear in assessing their own abilities. Many complained of troubling sexual inclinations. The common denominator among them was a state of inner tension so severe that it was felt as a threat to the very integrity of the subjectively experienced self. These patients are even today often pejoratively described as primitive, a consequence not only of their egocentrism and proclivity to tantrumlike outbursts but also because of the broad acceptance of Freudian theory which views narcissism as an early developmental stage, an obstacle, unless outgrown en route to object love.

Self psychology takes strong exception to this aspect of the
HELEN K. GOLDEN, Ph.D.

Freudian view, believing that the growth of the self has its own developmental history, fully on par, vicissitudes and all, with what is traditionally called psychosexual maturation. The fact that patients with what is now more broadly called a self disturbance are, as I've mentioned, quite frequently talented and socially adept people of significant accomplishment by external standards will be a point to remember when considering the question of what constitutes a desirable outcome of treatment—in other words, what is a cure.

Kohut was able to do useful analytic work with these apparently difficult and uncooperative patients, and to outline a more effective understanding of their problems than had previously been available once he recognized their psychopathology as having evolved out of a more or less continually unsatisfactory emotional connection with the caregiving person[s] during infancy and childhood and saw that much of their behavior was an attempt to ward off reexperiencing a similar misalliance with the analyst. Accordingly, he began to feel that the redress of the consequent developmental deficit or arrest was a more fundamental step in treating these patients than was the more familiar analytic task of uncovering unconscious wishes in the interest of conflict resolution. His discovery that if he simply avoided imposing a nonexistent object relationship upon his patient, that is, if he guarded rigorously against falsely intruding himself or others as objects into the patient's inner world, much of the patient's narcissistic furor abated, a new facet of the transference emerged, and a potentially curative analytic situation came into being.

The psychoanalytic exploration of preoedipal and often preverbal experience eventually gave rise to Kohut's concept of the selfobject and its treatment analog, the selfobject transference. These terms, ambiguous and often misunderstood, are, as So-carides and Stolorow (1984/85) have called them, the 'central, foundational construct[s] in the psychoanalytic psychology of the self'. Simply defined, a selfobject is an object, usually but not invariably a person, which the subject feels as not fully separated from himself, some aspect of which plays a vital role in sustaining his sense of psychological wellbeing, focus, and intactness. By contrast, its absence or unavailability is attended by a state of painful
and sometimes disorganizing emotional disequilibrium that is often spoken of as fragmentation or loss of self-cohesiveness.

Kohut speaks of these self phenomena in their developmental and transference sense as the 'archaic selfobject' and 'archaic self-object relations'. Thus he differentiates between the contemporary manifestations of these phenomena (which he came to believe continue in maturing form throughout life) and the archaic states and relations that are revived in the clinical selfobject transferences. Basch has captured the essence of the archaic self-selfobject relationship, in calling to mind the "wish-fulfilling fairy tale of Alladin . . . who could summon a genie to do his bidding, and, once his needs were gratified, send the all-powerful, obliging spirit back to its abode where it rested in suspended animation until he needed it once more" (1984, p. 24).

In a similar vein, let me present a very brief vignette to which I will return. A patient raised in a singularly sadistic family, and who was prone to destructive outbursts of rage that left her suicidally depressed, reported the following dysphoric dream after a session which she left in an indignant huff threatening not to return. She was orbiting around the earth wearing only a flimsy dress against the cold night and was feeling an indescribable dread when she saw her analyst drifting nearby. She had and intense need for body contact and the thought, “If I could press my heart against hers I would be all right.” With that, she was able to catch hold of the analyst and to press her chest against the other. Almost immediately her heartbeat equilibrated and her anxiety drained away. She was flooded with an encompassing sense of relief and safety.

These selfobject transferences, originally called the narcissistic transferences, fell into two classes. The wishes of the grandiose or mirror transference were seen as analogous to the young child’s need for approval of his age-appropriate unbridled and exhibitionistic attempts at self-definition, significance and active mastery which are the forerunners of pride, self-confidence and the capacity for pleasure. The idealizing transference, analogous to the developmental need for merger with an idealized and powerful source of comfort and contentedness can, when necessary, restore a sense of narcissistic perfection, and provides the foundation for the later capacities of self-soothing and anxiety tolerance.

In the course of analyzing, working through, and finally re-
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solving these selfobject transferences, Kohut and his patients were able to reconstruct the defective empathic communication and the selfobject failures that they together came to feel were germinal in each patient's psychopathology.

Since these first investigations, other critical selfobject functions, particularly that of affect differentiation, modulation and integration (Socarides & Stolorow, 1984/85) have been elucidated in the transference and continue to have significant consequences for the emotional ambience of the analytic situation, and for the better understanding that we now have of the factors that contribute to improvement and change.

Let me now turn to interpretation which is, as in all psychoanalysis, the bridge between the analyst and the patient, or more exactly the bridge between the analyst's understanding of the patient and the patient's understanding of himself. As I have tried to show, the empathic listening perspective, the analyst as selfobject, and the reactivation of one or another of the archaic selfobject relationships in the transference taken together provide the analyst with a testable model of what the patient's experience has been. However, the analyst's empathic and cognitive understanding does not guarantee his being understood by his patient, and by itself, is rarely enough to bring about change. As in any psychoanalytic treatment, the analyst must be able to convey to the patient what he has understood in such terms as to confirm the existence of a helpful relationship between them as well as in terms that make it emotionally relevant and assimilable. Further, a useful interpretation should carry just enough additional meaning as to enlarge the patient's perspective on his own response and to give him a somewhat broader picture of himself than the one he generally entertains (Lachmann, 1985).

But how does one convey this understanding to patients who were initially defined by their very inability to accept traditional interpretation, who were not enlightened by descriptions of their alleged feelings towards the analyst, who often reacted to the idea of the analyst having any significant role in their psychological life as if it were preposterous, and who seemed to experience the analyst's imputed role as an unwelcome intrusion that reflected gross misunderstanding, lack of skill or simply intolerable conceit. Kohut's great contribution was his recognition that these responses
were not necessarily manifestations of resistance. They usually meant that the interpretation was wrong. Furthermore, as all incorrect interpretations do, they inhibited the progress of the work, in these cases by distracting the patient from a vitally necessary and exclusive focus on himself, a focus that was interfered with during the crucial formative years when his needs were more than likely coerced into serving the pathological narcissistic demands of his emotional surround. Once again, as the outraged tirades of the now legendary Miss F eventually made clear to Kohut, she experienced herself as selfobject of the analyst's narcissism.

I hope I have suggested by now that the interpretation must come from within the "contextual unit" (Schwaber, 1981), the self-selfobject unity. It must address the feelings that have for the moment interrupted the free flow of the patient's communication, and it must address itself to the patient's immediate affective and cognitive state. The question of exact interpretation is not so much at issue here as is the attempt by the analyst to fine-tune, with the patient's reciprocally reverberating response, the meaning of the current feeling. When an interpretation is good, an unmistakable resonance takes place between the analyst and the patient. Wolf (1981) has said "At the moment that I really understand what is going on in the analysand, I also know that he really understands what I am doing. The accuracy of the analyst's empathic insight is confirmed by the patient's expression of his own empathic grasp of the analyst's activity at that moment. A process of transmutation of the analyst's functions into the patient has begun" (Bacal, 1985, p. 211). This is quite different, in my experience, to the "ah ha" of sudden insight when an interpretation reveals a heretofore hidden meaning, the recognition of which makes sense out of otherwise inexplicable feelings and behaviors.

I have found that the analyst is rarely so far off the mark as to invoke a narcissistically defensive response from the patient so long as he rigorously avoids imposing an object relationship into a psychological field where it is unwarranted. But because we are all more used to being ourselves than otherwise, and because countertransference reactions against feeling like a non-person, or feeling merely used, are always ready to ambush us, it is all too easy to fall into the trap of setting ourselves up without justification as the target of the patient's feelings rather than as an inseparable part of them. Let me turn to the dream of the patient in
orbit to provide an example. An interpretation made from the narcissistic, or self perspective might be something like this: "When you get angry you feel so disconnected and so unable to help yourself that you get terribly frightened and sometimes feel that you are coming apart." An object-focused interpretation, which could be equally pertinent to the patient's history, might be something like, "You feel frightened when you get angry because you are afraid I'll throw you out in the dark and the cold." The first interpretation, which I'm also assuming is more or less correct, addresses the increased and painful sense of fragmentation that a patient may suffer when an empathic failure temporarily interrupts the tension-reducing relatedness that flows between himself and the selfobject. The object-focused interpretation, unless there really are active but unconscious aggressive oedipal wishes or fears at play, is not helpful because it is, for the moment, beside the point.

The question now remains; how does the patient internalize the new and powerful experiences of his psychoanalytic treatment and make them his own, so to speak? Central to Kohut's idea of the process of analytic change is his concept of transmuting internalization. He believed that repeated experiences of 'optimal frustration' act as stepping stones in the formation of psychic structure. In its developmental sense, optimal frustration can be thought of as that state of affective tension in the infant or young child which is neither so traumatically intense as to cause a giving up or a turning away from reality, nor so quickly relieved by external (self-object) intervention as to bypass the natural developmental thrust towards mastery, but which, by being perceivable, prompts some kind of effort towards the independent reestablishment of narcissistic comfort.

Under these conditions, the caregiver's behavior, by virtue of its timeliness and emotional attunement takes on the characteristics of a selfobject, that is, becomes experienced as part of the infant's own being. From this there follows a gradual internalization of the selfobject's psychological functioning, its soothing, affirming, admiring, and validating qualities being transmitted via the essentially nonverbal communication which we call empathy.

Transposing this concept to the clinical setting, one sees, in the tension that motivates the patient for treatment and in the inevi-
table disruptions and restorations of the empathic connection a similar process. In various forms of identification with the analyst, quite broad at first, but ever more refined, and ultimately depersonalized completely, a reactivation of the process is noted, the train of events that Kohut believed to be the *sine qua non* of analytic cure.

Little by little as a result of innumerable processes of micro-internalization, the anxiety-assuaging, delay-tolerating, and other realistic aspects of the analyst's image become part of the analysand's psychological equipment, *pari-passu* with the micro-frustration of the analysand's need for the analyst's permanent presence and perfect functioning in this respect. In brief, through the process of transmuting internalization new psychological structure is built (Kohut, 1977, p. 32).

One can argue over the details of this view of internalization, and many have, but it has emphasized for clinical practice the crucial importance of the empathic selfobject perspective when the analyst's concern is to develop and maintain the kind of psychoanalytic ambience in which the narcissistically injured patient can resume his arrested or distorted psychic development.

Consider for a moment the other side of the coin, the consequences of an unempathic early milieu. A mother described her adolescent son as having been aggressive from the day he was born. This judgment was formed the first time he was put to the breast when he clamped down on her tender nipple and vigorously began to suck, an act that she perceived as biting. From that moment, the infant's innocent behavior was perceived as a motivated act and the mother-infant dyad was converted by her into a hostile object relationship in which she was the victim of the baby's aggression. This is a clear example of the inappropriate attribution of object relatedness where none exists and one that distorted the boy's personality development in many ways throughout his growing up. Not only was he was held responsible for aggressive object directed wishes that were not there, at least initially, but equally important, he missed completely the developmental opportunities whose foundations are laid in the narcissistic stage of preambivalent sucking in a secure and containing selfobject relationship. What does this imply for self development? Since this boy was so quickly coerced into his mother's view, how could he ever get a sense of who he was separate from her? He dared not see himself as a hungry baby because his mother forbade it, and yet to
see himself as the hostile and biting baby she claimed he was, had little connection with other aspects of his confused self experience. Translating this not unusual story into the clinical sphere it becomes more easily apparent why an unwarranted object interpretation by the analyst can, in fact, recapitulate the childhood trauma, and additionally, why these patients need time to get to know themselves privately, apart from the object-populated world of classical psychoanalysis. It is for these reasons that the self psychological analyst must make an uncompromised effort to fully apprehend the patient's subjective experience and the ways in which his own subjective state impacts upon and reverberates with that experience. This endeavor has given new meaning to the therapeutic aspect of the analytic relationship and is a radical departure from the more prevalent idea that the psychic apparatus, except in its infantile or anaclitic state, is an autonomous organization, a closed system in which the well-functioning, fully internalized superego bears primary responsibility for the maintenance of self-esteem.

The idea that the psychological function-serving aspect of the analyst, gradually internalized, becomes part of the patient's own capacity for self regulation, while raised to new heights in self psychology, is inherent, more or less explicitly, in classical psychoanalytic theory as well. Despite its theoretical insistence on the analyst as objectively positioned outside of the 'closed system' of the patient's psychic apparatus, Strachey (1943) describes the patient's use of the analyst as an 'auxiliary superego' whose benign qualities are introjected by the patient, gradually 'infiltrating' the patient's harsher and more rigid superego with beneficial consequences, molding it, as Schafer (1960) has felicitously said, in the direction of a more "loving and beloved superego", a concept that has enormous implications for the maintenance of a steady and esteemed sense of self.

Gitelson (1962) sees the mother-child relationship of infancy and early childhood as the appropriate model for the first phase of classical psychoanalysis, referring to the mother's function as an 'auxiliary ego' that supports the development, integration, and maturation of 'partial functions' in the child's rudimentary ego. The achievement of 'rapport', the phenomenological expression of the primitive mechanisms of projection and introjection, is the essence of the beginning of successful analytic work. 'Rapport', the
patient's regressed wish that he and the analyst will be 'tuned in' reflects the hypothesized feeling state that exists before primary narcissism is resolved.

To the analytic self psychologist however, the need for selfobjects is not a regressive phenomenon. This conviction underlies the still very controversial assertion that the empathic understanding of archaic selfobject needs as they become reactivated in the transference, while surely gratifying to the patient, is not anti-therapeutic. The wish for empathic understanding need not be co-opted into the service of resistance, nor must it grant license for exhibitionistic or self-indulgent behavior. On the contrary, the empathic comprehension of the egocentrism, and the communication of this understanding to the patient in an empathic milieu, to help him reorganize his responses to affective stress is intrinsic to the process of internalization and to analytic change.

In summary, I have tried to address two aspects of 'cure' that seem to be most considered when psychoanalysis is discussed; first, what effects the cure, and second, what counts as cured. In spite of the endless quarrels about what is and what is not psychoanalysis, and what does and what does not count as a healthy adult, I think in fact most self psychologists would assert that the curative factor in their work is the eliciting and subsequent interpretation of a transference situation. This is seen, paradoxically perhaps, as externalizing and objectifying, in a controlled and useable way, the characteristic cognitive and affective processes that a person brings to bear on his own experience, makes them apparent in their strengths and weaknesses, and thereby allows them to be understood, and if necessary, modified.

Fundamentally this is not so different from the classical analyst's dependence on interpretation of the transference as the ultimate instrument of 'cure'. What is distinctly different however, is the nature of the transference being interpreted, and therefore the ways that elicit it best, and the focus of the words that will be offered to a patient to illuminate and describe his experience. The distinguishing features of a self psychoanalytic therapy—the analyst's greater attention to nonobject related affect, his preoccupation with aspects of psychic development that are irrelevant in more conventional analysis, and his willingness to let his patient inhabit his world alone, as it were, are not curative in themselves.
They are not even meaningful by themselves. They are only means to an end and not a very surprising end, the correct interpretation. As to the post-treatment aspects of 'cure'—what a person makes of his life once he feels less thwarted and helpless in the face of it—self psychological analysis is less prescriptive than classical analysis about what it considers healthy. But here too, I think that the differences are more apparent than real: That adults should be comfortable enough with their own inner experiences to use them as sources of strength in dealing with an admittedly difficult outside world, that they should know themselves well enough to make flexible and appropriate choices for their lives, and that they should not be unnecessarily limited in this flexibility by the archaic needs and fears that beset them when they were, in fact, more vulnerable creatures—these are the ultimate ends at which self psychological interpretations, and I believe all interpretations, are ultimately aimed.

REFERENCES


19 Mayhew Avenue
Larchmont, New York 10538