AN ADAPTATION OF THE THEORIES OF HEINZ KOHUT'S PSYCHOANALYTIC PSYCHOLOGY OF THE SELF TO THE PRACTICE OF CLINICAL SOCIAL WORK

Elizabeth Eisenhuth

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by

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INSTITUTE FOR CLINICAL SOCIAL WORK

We hereby approve the Project Demonstrating Excellence

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ABSTRACT

This dissertation is an attempt to demonstrate a way to begin to adapt Heinz Kohut's psychoanalytic psychology of the self to clinical social work treatment.

In order to accomplish this, the major values, precepts, and practices have been traced in the social work literature written since 1889 when Hull-House opened in Chicago. The consonance of these principles with Kohut's most important contributions is detailed.

One of his earliest and most significant theoretical advances is his 1959 assertion that introspection and empathy are the essential psychoanalytic methods of observation, from which treatment proceeds. Explicated in this project, is the correspondence of this central concept with clinical social work's most intrinsic precept, which is, meeting the client where he or she is.

Clinical social work's primary concept is based on acceptance, which evolved out of a non-judgmental attitude. And, Kohut's use of introspection and empathy is closely related to clinical social work's cognizance of the pivotal value of the professional relationship, which

requires self-awareness and the professional use of the self.

Treatment based on diagnosis is a social work value borrowed from psychoanalysis, although social work has traditionally focussed more on strengths than pathology, and on helping a client cope rather than curing.

A concept unique to social work is the psychosocial approach. This practice has been developing since about 1917, with shifts at various times from more emphasis on the internal to greater attention to the external, and then back and forth. The term first appeared in print in a 1947 book by Gordon Hamilton, and since then, this concept has increasingly been recognized as basic and decisive.

Here again, consonance with Kohut's ideas is seen, as he has written a good deal about societal and familial matters showing his keen awareness of the social component of human development.

Another highly significant contribution of Kohut's is his redefinition of psychoanalytic neutrality, which has come to be conceived by many as primarily a cold, silent responsiveness. Kohut's view brings this construct more in line with Freud's original definition and practice, and certainly in greater accord with the more active, supportive

psychotherapy of many clinical social workers. Other areas of consistency are described.

Kohut extends theory in other ways useful to social workers. One is his postulating that narcissism is not just negative, since in normal development it leads to these worthy qualities: realistic ambitions and ideals, empathy, humor, creativity, and wisdom. This is of value to social workers who for many years have been treating clients more disturbed than those seen by psychoanalysts. In more recent years, these people have been appearing in the offices of analysts.

Four case examples are used, three of which I believe are more disturbed than a narcissistic personality or behavior disorder. These latter are the pathologies primarily considered by Kohut. Of my cases, two are of several years duration. The other two are shorter; one is less than six months, and the other, ten months. These cases demonstrate the clinical advantage of adapting Kohut's theories to once a week clinical social work treatment.

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INTRODUCTION

This dissertation is an attempt to demonstrate a way to begin to adapt Heinz Kohut's psychoanalytic psychology of the self to clinical social work treatment.

My absorption with the ideas of Kohut grew as I read and reread Restoration of the Self, then Analysis of the Self, followed by every published article I could locate. Later, Psychology of the Self: A Casebook and Search for the Self were added. As I deciphered Kohut's convoluted sentence structure, I began to glean his essential messages. And, what I discovered was so familiar. His ideas were very similar to theories and techniques I had been using or trying to use, but were formulated in a creatively new way giving deeper and broader scope. His methods were much like those of many social workers who, however, sometimes felt they were practicing an unorthodox or even heretical psychotherapy. Kohut pushed into the expanding frontier of his newly designated psychoanalytic psychology of the self, and provided a theoretical framework.

I find it of exciting interest that Kohut evolved his theories in Chicago, the city which spawned Hull-House, and a prestigious university in which one of the earliest professional schools of social work opened in 1900, and with which many influencial social workers have been associated. The significance of this coincidence is difficult to assess.*

Kohut was born in 1913 in Vienna, left that city in 1938 when he was 25, and came to this country. He first published in 1950 and has been actively advocating his theories on narcissism only since 1968.

Kohut believes the world has become more impersonal and dehumanized, and this has resulted in increasing numbers of people incurring pathologies of the self. He defines self-pathology as a breakup, weakness, or serious distortion of the core of the personality; and the condition may be permanent, long-term, or temporary. While indeed, these pathologies are increasing, social workers for many years have seen clients more disturbed than those treated by most psychoanalysts, and these clients have only

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* In 1969 (1978), Kohut raised a similar question about the decisive contribution of the environment to the fulfillment of human creative forces, and he referred to the Athens of Pericles.

more recently been appearing in the offices of analysts.

While many psychoanalysts are today seeing and writing about these more seriously disturbed people, the works of other analysts are not as consonant and compatible with the principles of clinical social work as are those of Kohut's.

His non-pejorative attitude is one crucial issue. This includes his view of narcissism, which in normal development primarily becomes positive qualities; as well as his conception of the symptoms presented by some individuals with self-pathology, such as sexual perversions, addictions, or criminal activities. Classical psychoanalysis has often focussed on pathology with an implicit insistence that the patient give up immature behavior and attitudes. Kohut takes a position closer to that of knowledgeable social workers, that symptoms--regardless of how severe, unusual, or offensive by conventional standards--are an attempt to cope. They serve a psychological purpose, often to prevent the fragmentation of the self. While the therapist will endeavor to help the client modify or replace some of these mechanisms, Kohut removes the judgmental aspect. This is more in accord with clinical social work's most basic value of the intrinsic

worth of the individual which gave rise to a non-judgmental attitude.

Another central matter is Kohut's use of introspection and empathy for clinical observation, and this is an essential element of all of his theories. This observational tool cogently defines the means which can be used to carry out the precept which is the very hallmark of clinical social work: meeting the client where he or she is.

In Chapter I, I review the social work literature and trace the evolution of the values, precepts, and practices which appear to me to most definitively characterize contemporary clinical social work.

Next, in Chapter II, an overview of Heinz Kohut's theories is presented, indicating ways in which they add to clinical knowledge and practice, as well as some examples of their incomplete nature, and some problems in their use.

Then, in Chapter III, I detail areas of consonance of Kohut's theories with the values, precepts, and practices of clinical social work.

Chapter IV briefly reviews some of the literature regarding the concepts of transference, the working alliance, the therapeutic alliance, countertransference, and psychotherapy. Included is a discussion of the distinction

between clinical social work psychotherapy, and Kohut's view of psychoanalysis. That section ends with my conception of the psychotherapy I practice, in once a week clinical social work treatment, of clients sometimes more disturbed than a narcissistic personality or behavior disorder.

Four case examples of once a week treatment are given in Chapter V. At least three of these four clients I believe were more disturbed than a narcissistic disorder. Two cases are of several years duration. The other two are shorter: one was seen less than six months; and the other, ten months.

All of these clients entered treatment, and two terminated, before I read Kohut. However, I use Kohut's theories to formulate the diagnosis and treatment. Ways in which Kohut's ideas add to the understanding of human personality and enrich treatment are enunciated, as well as are my differences with some of his constructs. And, finally, I delineate the benefits of this beginning to adapt Heinz Kohut's theories to clinical social work practice.

In the last section, Chapter VI, I attempt to indicate some of the many issues that need further study, experience, and conceptualization for clinical social work

to decisively define its methods and theoretical knowledge base. This is a task with which I expect to be intensely involved for much time ahead.

CHAPTER I

THE VALUES, PRECEPTS, AND PRACTICES OF CLINICAL SOCIAL WORK

Many fine histories have been written since social work's earliest roots in The English Poor Law. My focus is on identifying and tracing the evolution of the values, precepts, and practices of this field, which I arrived at by finding repeated references to them in the social work literature written since 1889.

I am defining "values" as the accepted enduring principles, beliefs, and standards that give direction and meaning to the profession. "Precepts" is used to signify the maxims or rules employed to carry out the values. "Practices" refers to the actions, techniques, or stance customarily engaged in.

Early social work evolved from philanthropic activities that developed after the eruption of the industrial revolution in the United States, and this followed the Civil War. While mechanization resulted in great wealth for the

country and a number of individuals, the toll of misery on many factory workers, immigrants, and others, was deplorable. Those poor wretches often lived in unbelievable squallor and crowded conditions, leading to destitution, poor health, and early death.

Various philanthropic endeavors emerged, two of the most notable were the Charity Organization Societies around 1870 and the Settlement House Movement in the late 1880's. People attracted to perform these activities were often independently wealthy, educated persons, usually women. While the Charity Organization Societies employed the case method, they emphasized a wealthy benefactor influencing a disadvantaged or "fallen" individual to better habits and improved ways of living (Kaslow and Associates, 1972).

The Settlement House Movement had a different perspective. Also staffed primarily with university graduated, financially prosperous women, these people lived with and among their clients, as equals. Stressed in this movement was that the reason for such widespread suffering was the social situation rather than the individual. Consequently, settlement workers sponsored and labored energetically for much reform legislation, some of which was passed (Levine

and Levine, 1970; Kaslow, 1972).

Levine and Levine (1970) make a thought provoking point:

> When the predominant ethos favors social change, people will be viewed as essentially good and the cause of problems seen in their living condition....When the predominant social ethos is essentially conservative, when the way of life is considered good and the institutions viable, the causes of problems will be located in the individual's personal weaknesses and deficiencies. (p. 279)

These two different persuasions seem to be reflected in the Charity Organization Societies and the Settlement House Movements, even though those philanthropies began operating not many years apart. But, it is significant that the two opposing views came together later in a central value and precept of social work, which is the psychosocial approach.

From its inception, social work has adopted ideas and theories from many disciplines--education, history, philosophy, sociology, medicine, psychiatry, and especially psychoanalysis. And, of course, through the years many social workers sought personal analysis, and began to apply theory and techniques acquired in this way.

At least three attributes are central and unique to social work. One: while borrowing a good deal, social

work has always had a broader vantage point, and it has adapted theories and methods to suit its own purposes. At times it has copied excessively, especially psychoanalytic concepts; for example, by attempting to become "junior analysts," by taking over the exaggerated stance of "psychoanalytic neutrality," and by excluding social qualities.

But mostly, social workers have included in their work an application of their unparalleled comprehension of the importance of environmental influences, by remaining keenly aware of the family, the socioeconomic situation, cultural, religious, ethnic, and racial factors. In addition, they have traditionally maintained an ability and willingness to utilize these social factors in treatment, where appropriate and helpful.

A second unique property is social work's focus on helping people cope rather than attempting to cure them, thus social workers have emphasized strengths rather than pathology.

A third identifying quality, which is fundamental in this profession, is social work's admonition and special ability to "meet the client where he or she is."

I am not addressing many of the often controversial issues that have engaged social workers through the years,

not because they are unimportant, but because they are outside my present scope. Some of these are: a specialty or a generic approach, the here-and-now as opposed to developmental psychology, the functional school versus the diagnostic school, whether social work is psychotherapy, social action in social work. There are surely others.

Wording of principles varies in different publications; several of these overlap; some could be subsumed under others; and, this may not be an all inclusive grouping. But, after considering various means of delineating and presenting them, I decided on the following values, precepts, and practices that have evolved through the years, and now in my opinion, characterize clinical social work.

1. The intrinsic worth of the individual; a non-judgmental attitude; acceptance

2. The professional relationship and its confidential nature

3. Self-determination

4. The psychosocial essence of clinical social work

5. Treatment based on diagnosis; helping rather than curing; focus on strengths rather than pathology

6. Meeting the client where he or she is

7. Self-awareness and the professional use of the

self

8. Education, experience, and supervision; the professionalization of social work

While I encountered recurring references to these principles in books, articles, and reports of addresses at social work proceedings, I have tried to select representative statements that most cogently reveal the essence of an idea, or that demonstrate the evolving nature of a concept.

My search of the literature started with Jane Addams and her establishment of Hull-House in Chicago in 1889. As specified by Henry Steele Commanger in his foreword to the 1961 reprint of Addams' 1910 book, the beginning of the settlement movement in America is regarded by many as the beginning of social work.

Helen Swick Perry (1964), in her introduction to The Fusion of Psychiatry and Social Science, spoke of the mosaic of Chicago social science from 1889 to 1930:

> ...the apparently dissimilar ideas, people, interests and experiences that grouped together in and around Chicago to form a patterned whole in the historical development of American social science. (p. xix)

She dated the start of this Chicago phenomenon with the opening of Hull-House. It was no accident, she thought,

that the University of Chicago became the center of sociological study in America, and that so many of its professors were intimately associated with Hull-House.

Influencial social workers such as Grace and Edith Abbott, and Professor Sophonisba Breckinridge, who was the first dean of the School of Social Service Administration at the University of Chicago, lived and worked together at Hull-House, the University of Chicago, and the West Side of Chicago (Abbott, 1942). Jessie Taft and Virginia Robinson met in 1908 while students at this university (Robinson, 1962). Charlotte Towle taught there from 1932 to 1962 and affected many later social workers. One was another University of Chicago teacher, Helen Harris Perlman, also that prestigious figure, Florence Hollis. Rudolph Ekstein (1979) readily acknowledged the significant contribution of Towle to his widely accepted classic, The Teaching and Learning of Psychotherapy, which he wrote with Robert Wallerstein in 1958, revised 1971.

Jane Addams evidenced many of the buds that grew and flowered into principles that have served as abiding guidelines for generations of social workers to this day. She fed the poor, nursed the sick, delivered illegitimate babies that no other "decent" woman would touch; she

provided a boy's club, music, art, theater, a museum; she kept her doors unlocked and open to all; she established Hull-House on Halsted Street, that 32 mile long "via dolorosa" of run-down buildings, dingy saloons, poor sanitation, with nearby houses of prostitution (Addams, 1961). In all of these pursuits, she clearly manifested that most fundamental value of the intrinsic worth of the individual and a non-judgmental attitude.

The Intrinsic Worth of the Individual
A Non-judgmental Attitude
Acceptance

This is generally regarded as the most basic social work value. Mary Richmond, credited by many as the first professional social worker, showed her own non-judgmental attitude in her 1922 statement that many disabilities, such as alcoholism and desertion, must be dealt with by pushing beyond these "presenting symptoms" (p. 158) to the underlying complex of causes.

Acceptance according to Hollis (1939) was a warmth, a liking, a wanting "to add something to the comfort and happiness of the other person" (pp. 6-7). She declared that the client always felt the presence or absence of this emotional tone.

In exquisitely simple terms, Annette Garrett gave expression to many of social work's most significant precepts and values in her 1942 book. Comments about this first value include: "It is essential for an interviewer to refrain from trying to impose his own judgments upon his clients" (p. 16), and, "Real acceptance involves positive and active understanding of...feelings [and behavior], and not merely a negative and passive refusal to pass judgment" (p. 23).

Hollis (1972) said that the emphasis upon the innate worth of the individual in casework gave rise to "acceptance" (p. 14). To her, this meant maintaining an attitude of good will toward the client whether or not his way of behaving was socially acceptable, or whether or not it was to the worker's liking.

Contemporary social work literature still acknowledges this basic concept. In 1978, Herbert Strean proposed that real acceptance involved accepting the many contradictory forces in the client's modes of relating, as well as the many dimensions of his personality.

The Professional Relationship And Its Confidential Nature

There is common agreement that good clinical social work takes place within a professional relationship which is confidential.

Already in 1910, Jane Addams had some presage of this precept when she asserted that "the social relation is essentially a reciprocal relation, it gives a form of expression that has peculiar value" (1961, p. 76). Her intuitive understanding preceded formal and intellectual knowledge of intrapsychic factors. These came into social work very little before World War 1 and were expanded later, especially in the decade of the 1920's, as Sigmund Freud's theories of psychoanalysis increasingly became accepted (Taft, 1926).

In Virginia Robinson's 1930 publication, considered by some a milestone in the growth of social work into a profession, she placed the dynamic of casework help in the relationship that developed between the client and the professional person.

That the relationship should be professional, not friendly, was advocated by Hollis (1939). But, she carefully emphasized that flexibility was essential so as to

adequately consider such important matters as the cultural background of the client.

That the purpose of a therapeutic relationship was healing, was declared by Gordon Hamilton (1947). Further, she thought that the healing element lay mostly in the relationship itself, which enabled the client to better use the resources within himself and his environment.

In 1948, Towle keenly discriminated the value of the professional relationship:

> All helping measures operate within this context.... The giving of advice, the timing and content of interpretation, and the limiting or the extending of the opportunity to unburden frequently are decided by the stage of development of the relationship. The professional relationship is in and of itself a treatment measure. Its characteristics are: its confidential nature, its respectful nature, its dispassionate quality. (1969, p. 136)

Somewhat later, Perlman (1957) added these important ingredients: that the therapeutic relationship sustained the client, provided the climate for growth of human personality, the nutriment for its development, and the stimulus for its subtle adaptations.

"The confidential nature of the relationship... brings beneficial results," simply stated Garrett (1942, p. 58). While usually not written about at length, confidentiality was mentioned over and over in the literature.

Self-Determination

Another valuable aspect of the professional relationship is client self-determination. As far as I could find, this precept was first hinted at in Mary Richmond's 1922 statement that the case worker must encourage the client's participation at the level of his capacity.

Jessie Taft, in 1933 (1962), considered the case-worker's function permissive not obligatory, and that the client could choose it or not.

A highly regarded treatise, Between Client and Community, by Bertha Reynolds (1934), argued the many facets of self-determination. She considered the recognition of this precept a radical departure from previous social work philosophy which considered the social case worker responsible for the solution of the client's problems. This concept recognized that the problem was the client's, and it was his right "to say when it was solved to his satisfaction" (p. 35).

She acknowledged the various abilities and disabilities of clients to do this. She also cautioned against traps for social workers in the name of self-determination, for example, refusing to give any advice because the supervisor said not to, or declining to console a family whose

baby had just died. Several case examples convincingly portray a meeting the client where he or she is," rather than rigidly adhering to a rule of self-determination (pp. 102-114).

The case worker was implored by Hollis (1939) to accept "that the client himself must be in control of the guidance of his own life" (p. 5), and noted that this principle was either stated or implied in all the writings of case workers listed in her 1939 bibliography.

With her incisive clarity, Towle in 1940 (1969), believed the caseworker should offer the client the opportunity to become self-determining, but noted that some clients have limited capacity for this.

"We must allow people a large measure of self-determination," said Garrett (1942, p. 47). Reynolds (1951) noted the central prominance and the interconnection between the client's worth and dignity and self-determination. Perlman (1957) set forth this principle as the democratic right of each individual. In a 1965 paper, she enlarged this by declaring that self-determination was nine-tenths illusion and one-tenth reality, but that the one-tenth was basic to human development, dignity, and freedom. She believed that self-determination was the

very essence of mature humanness, and that casework should help clients develop this quality.

I believe there is a value judgment in these assertions of Reynolds and Perlman, and that they do not accept the limitation of people's ability to be self-determining.

The Psychosocial Essence Of Clinical Social Work

Marcel Heiman (1953) provided some history for this inclusive quality: At the beginning of the mental hygiene movement, 1909 or 1910 until about 1920, the social worker helped lift the isolation of the mental patient by providing contact between the patient and the community. This allowed for a study of social forces that operated between the individual and his environment. Then, psychoanalysis added a description of those dynamic forces which took place within the individual and his family. In that way, Heiman said, psychoanalysis and social work respectively "fathered and mothered" (p. xi) psychiatry, out of which grew the mental hygiene movement.

By 1922, in her classic What Is Social Case Work? Richmond gave almost prophetic consideration of the now long standing discourse about the overlapping, confusing, and conflicting areas of practice of case work and psychiatry.

Her conclusion, now disputable, was that psychiatry was needed where the maladjustment proved to be predominantly individual and mental; and case work was required where it was predominantly environmental and social; "while both are probably indispensable where there is a disturbed personality in an unfavorable and complicated social situation" (p.133).

More in harmony with contemporary clinical social work thinking, is her statement that the broadest generalization she could make about social case work was that its theories, aims, and best intensive practice had been converging toward one central idea, the development of personality. She then defined that as "not only all that is native and individual to a man but all that comes to him by way of education, experience, and human intercourse" (p. 92).

This next anticipatory proposal of Richmond's must have been truly revolutionary in her day:

> How rapidly social case work will develop a private practice of its own cannot be predicted, but it should be evident from the examples given in this book that the skill here described can be used quite as well in the homes of the rich as in those of the poor. (1922, p. 221)

And, only four years later, in 1926, Jessie Taft

started treating a few private clients in Philadelphia, receiving referrals from psychiatrists as well as social agencies (Robinson, 1962).

Again, private practice was considered, as well as clients paying fees in agencies, by Bertha Reynolds in 1934. This early discussion, and actual occurrence, makes even more incomprehensible the long delay in full acceptance of private practice, especially within the profession.

By 1933 (1962), Taft thought that social work had swung too far away from the external, the physical, and the social; and too far toward the internal, the psychological, and the individualistic. She declared that either concentration ignored the reality that "lies only in the living relationship between the two" (p. 207).

"Work with the evnironment and work with the feelings are seen as going hand in hand, inextricably interwoven in most situations," held Hollis (1939, p. 307).

Hamilton (1947) ventured that the emotionally disturbed client cannot be assisted to a social adjustment without helping him to effect inner change. "This calls for a direct treatment approach through psychologically oriented interviews" (p. xiii).

Amounting to a tribute to social work, psychoanalyst

Jules V. Coleman (1940), indicated that casework had a potentially broader and more elastic field of usefulness than psychotherapy practiced by the psychiatrist. That was because social work took into account the patient's social environment and did not treat it as an unfortunate, if necessary, evil, as did some psychiatrists. Further, he thought that the casework process involved a much more far-reaching respect for the person than was found in psychiatry.

The term "psychosocial" seems to have originated in child guidance treatment. In her 1947 book, Gordon Hamilton wrote:

> The term psychosocial therapy, were it not so clumsy, would more precisely describe the purposes of child guidance. Psychoanalysis as a self-contained method is believed not to gain, especially for the adult, by having social services added; psychotherapy for children to a large extent derives its strength from a combination of psychological and social therapies. (p. 15)

Hamilton was to change her opinion about psychosocial treatment of adults by the time she revised her 1940 book in 1951.

A 1948 paperback publication of the Family Service Association of America was written by psychoanalyst Irene Josselyn for social workers treating children. In Psychosocial Development of Children, Josselyn stated:

> In attempting to evaluate the significance of human behavior, it is important to bear in mind the necessity for a dual approach. The temptation to lose oneself in the mechanisms of the individual, and to overlook the fact that he is a part of society must be resisted. (p. 7)

While Josselyn classified treatment as environmental therapy, relationship therapy, and interpretative therapy, she thought caseworkers capable of each of these, and especially espoused the value of environmental therapy. She deemed this the least artificial therapy, and referred to medicine which mostly provided support for the defense that the body had mustered against disease. Many cases in the psychological area, she declared, could be constructively treated only through the environment.

The 1951 revision of Himilton's 1940 Theory and Practice of Social Case Work was filled with the exposition of this precept. Central are these quotations:

> Advances in psychiatry and in the social sciences have steadily clarified the concept of the psychosocial case, the interaction of environmental and emotional forces and conflicts....Social work, always attuned to the concept of the psychosocial event, constantly finds new perspective and therapeutic opportunity for its traditional role of helping people in their living experience. (p. v)

Adelaide Johnson, a psychoanalyst, boldly denounced some of the proscriptions previously placed on social workers by psychiatrists, and unfortunately usually accepted

by social workers. She emphasized in 1953 that:

> The sharp demarcation between definitive uncovering therapy and supportive therapy, limited respectively to the psychiatrist and the social worker, seems obviously untenable. At present it is believed that good supportive therapy demands as thorough a knowledge of dynamics as does uncovering therapy. (pp. 80-81)

Johnson encouraged social workers to work with the transference and resistances as the case demanded and as the capacities of the workers made possible.

Succinctly summing up the central issue in regard to the social and emotional forces impacting on the individual, Bertha Reynolds (1951) specified that the question was not "what a person had packed away in his unconscious" (p. 131), but how he was using the interplay of forces in his mental life to cope with the objective world around him. Her case examples beautifully illustrate the unique ability of the social worker to see, understand, and respond to the complex of internal and external factors acting and reacting on each other.

An original and creative formulation by Perlman (1957) saw casework as essentially a problem-solving process. This position was, she thought, in congruence with the usual operations by which people adaptively moved from dilemma to resolution in their social as well as their

psychological activities.

Hollis (1972) took the position that the client or the situation or both, could be making a major contribution to a problem. The central thesis of her 1964 and revised 1972 publication, was that casework had always been a psychosocial treatment method. This approach recognized the interplay of internal psychological and external social causes of dysfunction, and endeavored to enable individuals to meet their needs more fully, and to function more adequately in social relationships.

I found few specific references to race or ethnic groups before Hollis (1972), except for her 1939 acknowledgment of the importance of cultural backgrounds. She commended social scientists for illuminating the way in which an individual's beliefs, values, and expectations are influenced by his ethnic background, class, and nationality. To Freud, she ascribed the long ago sketching of some of the mechanisms by which such influences take place--identification and superego and ego-ideal formation.

Omitting recognition of race and ethnic groups in social work literature is startling and incongruous, considering the strong emphasis on environmental factors in this profession. Such absence must reflect some conscious,

or probably unconscious, attitudes. Certainly, social workers always have been predominantly white, and often from the middle, and earlier, from the upper social classes. This exclusion, I have come to believe, indicates a strong need to deny differences. This probably connotes guilt about dealing with more disadvantaged people, as well as the great difficulty human beings have accepting distinctions of any kind.

To return to a fairly recent consideration of psychosocial issues, Strean (1978) saw the focus of the profession as intervention in precisely this area of the client's malfunctioning. He advocated modification of the situational variables as well as helping the client alter his own personal and interpersonal functioning.

Treatment Based on Diagnosis
Helping Rather than Curing
Focus on Strengths Rather than Pathology

Treatment and diagnosis are obviously terms borrowed from medicine, but, as with ideas from other disciplines, they have been adapted to social work use.

Mary Richmond (1915) first gave cognizance to this precept when she endorsed the need "to do different things for different people" (p. 367). By 1917, in her

precedent setting publication Social Diagnosis, she had incorporated understanding from psychiatry, and quoted particularly Dr. Adolph Meyer. To her, the essence of social diagnosis was "as exact a definition as possible of the social situation and personality of a given client" (p. 51). She advised arriving at this by gathering individual and family history, all relevant social and psychological evidence about the case, and then interpreting it. She said that in the past people had been treated all alike, but by that time it was realized people were different, and this difference should be taken into account in making a social diagnosis and devising a "differentiated treatment" (p. 368).

The changing concept of diagnosis was explicated by Herbert Aptekar (1936), as he noted that social work obtained this expression from medicine but had changed its meaning as social work philosophy had changed. Dynamic diagnosis, accordingly, involved the continuous and developing understanding, and was interwoven with treatment, not simply preceding it.

Hollis (1939) thought that "understanding" was a more satisfactory term than "diagnosis," which to her implied a disease entity (p. 279).

Another dimension was added by Jessie Taft in 1946 (1962): diagnosis as an attempt to discover whether client need and agency service could be brought into a working connection that was mutually acceptable. It will be recalled that Taft was already in private practice in 1926, and I believe this designation applies equally well to private practioners, then and now.

It is interesting that Taft, one of the leaders of the "functional school," proposed a psychology of helping as distinguished from a psychology of cure. The latter, she said, was inherent in the "diagnostic school." Despite her contention, case examples and specific statements in the writings of Towle, Hamilton, Hollis, and some of the other diagnostic school proponents, demonstrate their emphasis on looking for strengths, and on helping rather than curing.

Hamilton (1947) thought that social work was concerned with social adjustment. Later (1949), she submitted that this field lay midway between the healing and educational professions, drew on the insights of both, and offered both social treatment and psychological education.

With conviction Towle, in 1948 (1969), wrote of the urgency that social workers help clients affirm their

strengths, and also that they understand the purposes of defenses, which are often resources to be conserved.

> This implies an investigative focus which seeks to discover actual and potential strengths, rather than merely the pathology of the individual, one which, however, does not wishfully ignore pathology. (pp. 123-124)

The total process of diagnostic assessment, according to Hollis' 1972 thinking, consisted of trying to understand what the trouble was, what seemed to be contributing to it, and what could be changed or modified. She emphasized the consideration of strengths as well as weaknesses, in both the person and the situation.

Strean (1978) specified that social work included a myriad of items in its assessment of functioning and malfunctioning, in addition to individual symptoms and pathology. "Assessment" is the term he preferred to "diagnosis" (p. 86).

Meeting the Client Where He or She Is

In the literature, this has often been phrased as "beginning where the client is." I have deliberately extended this precept, as I believe such breadth is implicit in the theory and case examples discussed and published throughout the years. Further, it is a more accurate

designation.

While all the principles here delineated are significant, to me, the central, most essential definitive guide to clinical social work treatment is the precept of "meeting the client where he or she is." It follows logically the previous five precepts, and most decisively, that of "acceptance."

In Taft's usual direct and profound style, she presented this therapeutic function, in 1933 (1962), as the caseworker adjusting to the client's need and pattern by the most intense activity of attention, identification, and understanding.

In Hollis' (1939) sections on "What we need to know," "Gathering information," "How information is used in planning treatment," and "Treatment" (pp.278-295), she detailed attitudes and methods of "meeting the client where he or she is," without using that expression.

Garrett (1942) explained this principle as the interviewer adapting to the client rather than insisting the client meet the interviewer's expectations. She advised helping the interviewee relax and feel fairly comfortable, and then to listen carefully while he spoke of what was on the "top" (p. 36) of his mind. This, she said, enabled

the interviewer to see the situation and the client's problem from the client's point of view, to modulate his pace to that of the client, and to speak the language of the client.

That towering figure of social work, Charlotte Towle, wrote penetratingly about this most consequential social work value, in several articles and books spanning a number of years. In 1936 (1969), she observed that many cases had been closed with the notation "client untreatable" (p. 47), when the client may have been treatable if the caseworker was able to:

> meet the need which the client brings with understanding, . . . to grant him the reality of his feelings about his problem so that in the process of revealing his needs he may experience help, which may lead him to seek further assistance in other areas. (p. 49)

The skilled worker, she specified in 1941 (1969), then should endeavor "to meet the individual where he is" (p. 79) in terms of his capacity to carry responsibility in any area.

Here, she clarified any conflict between this concept and that of self-determination. The latter principle should be offered and encouraged, but could become an authoritative demand which the individual might not be able to meet.

Caseworkers should lay aside any rigid ideal as to the therapeutic role a social worker must play, and instead, flexibly meet the client's need at his particular level of personality organization. In many instances, this made a supportive relationship imperative.

Perlman (1969) editorially commented that by 1940 many caseworkers were heavily influenced by the psychoanalytic model of treatment in which the helper was neutral. Towle, she noted, had found this method worked better with more mature clients, and less well or not at all with many of those seen by social workers, clients who had extensive and deep anxiety.

It was crucial, Towle believed, in 1940 (1969), that social workers recognize basic limitations, and not impose their standards of how a client ought to react by expecting a growth response when the client was incapacitated for growth.

In 1948 (1969), she referred to the counseling component in social work, the giving of advice, which had been rejected somewhat earlier because of the stereotyped use of a number of prevailing concepts. These were: clients' right to self-determination; skepticism about an intellectual approach; the belief clients should struggle

to their own solutions even if they struggled in the dark; if there was anything wrong it must be a basic conflict which should be righted. "Treat the whole personality but tell it nothing was almost a creed social workers lived by a few years back" (p. 135).

By then, Towle went on, the principles of progressive education were operating within casework in the matter of counseling or advising a client, and casework was not as "blindly worshipful" (p. 135) of interpretation as a means to insight as it had been a few years earlier. She declared that casework was not so fearful of interpretation since it had become more discriminating in its use. Here, she expounded the now accepted tenets that insight is often gained spontaneously, and also, that change may come about by means other than interpretation.

In 1956 (1969), she simplified this entire precept of "meeting the client where he or she is":

> Modern casework strives to be client centered rather than procedure centered. It is guided by what the individual can and cannot do now and it moves in an ongoing way toward what he increasingly can do. (p. 57)

While I did not encounter a specific reference to this principle in Hollis' 1972 work, it was clearly indicated in her entire chapter on the client-worker relationship.

Self-Awareness and the Professional Use of the Self

"Meeting the client where he or she is" can be achieved more completely, if the clinical social worker has an elevated level of self-awareness, which leads to the professional use of the self.

The seed of this principle appeared in Mary Richmond's 1917 publication: "Full diagnosis--any correct diagnosis, in fact, is not always possible because we are dealing with human factors and we too are human" (p. 363). Self-awareness was thrust forward by her 1922 assertion that the growing mind of the client should be encouraged to find its own way out of difficulties, rather than dominated, or protected, or pitied. Dr. Felix Adler was quoted when she advised case workers "to act so as to elicit the unique personality in others, rather than indulging in egocentric self-sacrifice" (pp. 171-172).

Eloquently expressed by Jessie Taft in 1933 (1962):

> Therapy depends on the personal development of the therapist and his ability to use consciously for the benefit of his client, the insight and self-discipline which he has achieved in his own struggle to accept self, life and time as limited and to be experienced fully only at the cost of fear, pain and loss. (p. 175)

In my research, she was the first I discovered to advocate social agencies charging clients for treatment.

This was in 1933 (1962). She related caseworkers' ability to accept fees to their self-awareness. The value of fees, she saw as the client having a responsibility for his or her own health, not just the worker wanting the client's improvement. She observed that the majority of caseworkers had not at that time achieved the ability to accept payment.

That self-knowledge and self-acceptance were basic to knowing and accepting people, was reasoned by Charlotte Towle in 1935 (1969). She thought it imperative that the caseworker deal with his or her own needs and inclinations, and more, to be aware of the client's use of him or her, in order to be nonjudgmental and uninvolved emotionally. A caseworker might need psychiatric help, Towle remarked, to work through previous tangled or unfulfilled relationships, in order to be more effective in his or her professional efforts.

Hollis (1939) insisted that the worker must continually practice self-awareness so as to minimize the effects of his or her own needs, prejudices, blind spots, likes, and dislikes.

The possibility of unconscious processes operating non-therapeutically in the interviewer, was pointed out

by Garrett (1942). She cited the possibility of the interviewer reading into the client's problem, feelings the client did not have, and she proposed that the interviewer "recognize his own associations" (p. 50).

Countertransference was specified by Hamilton (1947), for example, in irrationally liking or disliking a client. She beseeched the social worker to control his or her emotional reactions in the interest of the client. She declared that a social worker would be better prepared to do therapy if he or she had been analyzed.

Delineated by Perlman (1957), the precept of self-awareness was seen as the management of "relationship reactions" (p. 81), which should be part of the caseworker's professional skill. She thought that a first step toward this was to honestly face the feelings, and that control could sometimes be aided by a supervisor.

That the helping situation in social work required a disciplined use of the self which no previous interpersonal situation demanded of the social worker, was advanced by Strean (1978).

Education, Experience, and Supervision
The Professionalization of Social Work

As early as 1897 (1930), Mary Richmond wrote about the need for a training school in "applied philanthropy" (p. 99), where the principles and skills learned in the preceding twenty years of charity organization work could be passed on. This was realized the following year. In 1917, Richmond insisted on the importance of detailed records, and the use of supervision to help students with their cases.

Robert W. Kelso (1922), in a presidential address before the National Conference of Social Work, endorsed the need for "a professional student of human relationships--the trained social worker" (p. 6).

Professionalization was already a concern of Edith Abbott's in 1927 (1942), when she asserted that social work could never become a true profession except through professional schools.

California, taking the lead in the promotion of standards and the development of the profession, in 1929 introduced a bill into the legislature providing for the registration of social workers. Although defeated, this was an epoch making event (Abbott, 1942).

The earliest use I found of the term "clinical social work" was in an address at the University of Chicago, in 1931 (1942), by Edith Abbott about social work education. She set forth three divisions of a good professional school in this field: the academic curriculum, the clinical social work (my emphasis) or field work, and social research (p. 12). She proposed that a university prepare people for scientific leadership, and thought that progress in the field had been lamentably slow because of the neglect of the scholar.

Cogently expressed by Robinson in 1936 (1978):

> Education for any profession aims not only to teach the specific knowledge and skills necessary in its practice, but it undertakes also to make over the personal self of the "lay" student into a professional self. This is particularly true in education for social casework whose helping function demands the most conscious and responsible use of a professional self. (p. 196)

That supervision should be able to help the case-worker become aware of prejudices, broaden outlook, and deepen understanding of the client, was the opinion of Hollis (1939). She thought that casework was only at the beginning of learning about treatment processes, and hoped the six cases she presented in her 1939 book would form a basis for further evaluation, discussion, and comparison. She, thus, contributed to the increasing knowledge base of

social work, and by so doing, to its professionalization.

Jessie Taft, in 1946 (1962), satisfied that supervision was a helping process not dependent upon psychiatry or psychoanalysis for form or content, said that the reverse was true. Psychiatry in this area had learned from social work, and some psychiatrists had freely so acknowledged. Frederick H. Allen (1946) did precisely this, recognizing social work's outstanding skill and use of supervision, and he maintained that these abilities had been neglected in the fields of psychiatry as well as in psychoanalysis.

Towle, in 1963 (1969), stressed nurture in supervision, which she stated was implicit in liberally meeting valid dependency, through teaching and helping the supervisee learn what he or she needed, in order to be competent. Nurture was also implicit in holding the supervisees accountable, and helping them hold themselves accountable. She declared that the supervisory relationship should be continuously related to the agency and the client. The worker's capacity to use the supervisor for client rather than for self-maximation, she believed, should become a dynamic factor in this use of help.

Clinical education fell into disrepute, as did

supervision, during the 1950's and 1960's, and this is certainly reflected in the literature. But, there was a change, and California again took the lead.

Robert L. Dean (1978) chronicled a moving and exciting account of the long, arduous, sometimes bitter California campaign to obtain licensure for clinical social work practice. This gave birth to the California Society for Clinical Social Work and the California Institute for Clinical Social Work. The experience caught the imagination of many social workers. It encouraged the formation of clinical social work societies across the country, as well as the National Federation of Societies for Clinical Social Work (p. 3).

Dean believed it was the disparaging of clinical education in the 1950's and 1960's which witnessed the maturing of clinical social work, and needed "only a trigger to explode into productive self-assertion" (p. 5). That trigger was provided by the 1966 Attorney General's opinion, which denied California social workers the legal right to practice psychotherapy. This shock served as a rallying point that led to burgeoning creative activity by a small band of dedicated clinicians.

Verneice Thompson, a leader in this movement, held

an historic meeting in her Berkeley office on October 28, 1966. This was the first statewide organizational assemblage to consider the grave threat to social work of the Attorney General's opinion (Statewide Ad Hoc Committee, Minutes, 1966). At that meeting, decisions were made, and factors were set in motion which led to endless meetings across the state, fund raising, the gaining of expertise in the political process, and finally the retention of William Grimm as legislative advocate (Thompson, 1979). The hard won results were licensure in 1968, the formation of the Society for Clinical Social Work in 1969, privileged communication in 1970, and the National Federation of Societies for Clinical Social Work in 1971 (Dean, pp. 52-60).

Thompson became the first president-elect of the Society, in which capacity she chaired the first Scientific Conference of the California Society for Clinical Social Work, in San Francisco in 1971. Further, she went on to even more significant leadership, as the first president-elect of the National Federation of Clinical Social Work, in 1971.

In regard to the general uneasiness about supervision in the 1960's, Shirley Cooper (1974) declared that the word

"professional" had become almost pejorative. She believed this criticism helped "right an over-rigidified, hierarchical system" (p. 3), and led to consideration of modes of teaching other than the tutorial one. It also freed social workers to recognize the long overlooked fact that some competent workers were capable of functioning autonomously without the necessity of regular supervision.

While Cooper's entire address was a thoughtfully coherent treatise endorsing the necessity of supervision, her central statement was: "It is perhaps in the service of helping the student forge a professional identity that supervision in the field may make its most significant contribution" (p. 5).

But, social work is still reverberating from the fallow period of the 1950's and 1960's, as exemplified by this nostalgic recollection of Fritz Redl: "In social work we had a beautiful concept of the professional self, remember that?" (1977, p. 93). He thought the earlier strong emphasis on professional identity was still needed, and would be even more valuable in the future.

Ekstein (1979) expounded the greater merit of professional education over professional training, which has often been promoted in recent years. The synthesis of

all the learning needed by social work students, he saw as the task of the student and teacher to meet together in the school of social work, and through the fieldwork experience. He declared further that this was not simply the acquisition of didactic information, but a complex psychosocial process that touched the whole personality of the student. This proceedure helped him or her move toward developing a professional self.

While clinical practice has gained respect in some quarters, continued effort will be required. Certainly clinical education has advanced, as exemplified by a few schools which offer doctorates in clinical social work.

One such program is the California Institute for Clinical Social Work. Its conception and early development were fluently recounted by its first dean, Jean Sanville (1977): It was

> founded by clinicians, for clinicians, was created in October, 1974 as a legal entity separate from the Calirornia Society for Clinical Social Work, with tax-exempt status....In January of 1975, the Board of Trustees of the Institute began...to hammer out philosophy and direction for a school which would offer a doctorate in clinical social work. (p. 316)

The Institute formally began accepting students in May, 1977, and by the summer of 1979, had graduated 18 people with a Doctorate in Clinical Social Work. The degree was

changed later to a Doctor of Philosophy.

Having traced the values, precepts, and practices of clinical social work, I will now proceed to a presentation of an overview of Heinz Kohut's psychoanalytic psychology of the self.

CHAPTER II

AN OVERVIEW OF HEINZ KOHUT'S PSYCHOANALYTIC PSYCHOLOGY OF THE SELF

This overview has been derived from the publications of Heinz Kohut, unless otherwise referenced.

Kohut has come to believe that the classical psychoanalytic conceptualization of the nature of human beings does not fully explain a broad band in the spectrum of psychopathology. He is not attempting new theories that are more polished or consistent than the old. Rather, he is attempting to broaden and deepen our understanding of the psychological field, both inside and outside the clinical situation.

The theories of Kohut are still evolving. Some difficulty in understanding and using them is created by their incompleteness and certain unclarity. I will indicate these as I proceed. However, this is no different from adapting Freudian, or other psychoanalytic or psychological theories, as part of the knowledge base of social work. These models

also are incomplete and contain inconsistencies.

Kohut believes that human beings are changing, as the world they live in is changing. Expansion and change of theory are necessary if psychoanalysis is to remain alive, and is to remain the leading force in people's attempts to understand themselves.

The environment, which once was experienced as threateningly close, is now experienced more and more as threateningly distant. Kohut has written with some apprehension about the increased mechanization and depersonalization of modern life. Children were formerly overinvolved in the emotional and erotic lives of their parents, and he deems this overinvolvement the genetic determinant of structural neurosis. In this condition, internal psychological structures are intact, and psychoanalysis and resolution of the oedipus complex are advocated by Kohut as the necessary treatment. But, in another context, he conveys that even when treating structural neurosis, the use of the psychology of the self would be more effective.

Understimulated children, that is, children who are not responded to with adequate empathy by parents, develop defective internal psychological structures. These children, and the adults they become, thus have pathology

of the self. It is this self pathology that Kohut is attempting to understand, to describe, and to treat.

While he states that he is expanding Freudian theory, he often appears to be replacing it. It will be noted that in Restoration of the Self, 1977, and papers in 1978 and 1979, his ideas are presented entirely in self psychology language, in contrast with his earlier productions, which used psychoanalytic dual drive and structural model terminology.

Kohut holds that the theoretical conceptualizations of Freud are not sufficiently relevant, with regard to disorders of the self, and other psychological phenomena that lie within the domain of self psychology. This phenomena requires the introspective-empathic observation, and theoretical conceptualization of the participating analyst. Thus, Kohut is suggesting a move from investigation of larger psychological structures to more minute ones. And, this is to be accomplished by the introspection and empathy of the analyst, not by his or her external observation. First publishing his views on introspection and empathy in 1959, his current formulations reflect this long involvement.

His 1959 paper was a major departure from earlier

theory, and led in 1977 to his redefinition of the essence of psychoanalysis as "the scientific observer's protracted empathic emersion into the observed, for the purpose of data gathering and explanation" (p. 302).

In the past, Kohut could find no place in the psychoanalytic conceptual framework for choice, decision, and free will, even though he observed these activities. He can now see that determinism holds sway, as long as people's psychological activities are seen as being performed in the same way as processes explainable by classical physics. Some phenomena, including choice, decision, and free will, require the positing of a psychic configuration--the self--that has become the center of initiative, a unit that tries to follow its own course.

Meaning of the Self

Kohut places the self firmly at the core of the personality as a supraordinate constellation (Ornstein, 1978, p. 100). The self crystallizes in the interplay of environmental factors and innate qualities. "The patterns of ambitions, skills, and goals; the tension between them; the program of action they create; and the activities that strive toward realization of this program are all experienced

as continuous in space and time--they are the self, an independent center of initiative, an independent recipient of impressions" (Kohut and Wolf, 1978, p.414).

Selfobjects

Selfobjects are objects experienced as part of the self, and the original selfobjects of an individual are his or her parents. The psychology of the self differentiates selfobjects from true objects. The latter are felt and seen as independent from the self.

There are two selfobject functions: mirroring, which is approving and confirming the child's healthy exhibitionism; and idealization, which is allowing the young person to see the parent or parents as powerful and ideal. Traditionally, mirroring would be seen as a nurturing or maternal function, while idealization would be viewed as a paternal process. This may actually occur in some families in certain areas of the world, but this demarcation cannot be made in our varied culture.

In the treatment of narcissistic personality and behavior disorders, as well as neurotics, the therapist is seen as a selfobject. The patient feels the therapist is substituting for his or her psychic structure, is the supplier

of self-esteem, or the power which the patient can idealize. Treatment allows the patient to merge with the therapist and to internalize the needed psychic structure.

Throughout life, a variety of factors can become selfobjects which are experienced as part of the self, and which give the self purpose or meaning. These could be work, a cause, or an interest.

Selfobject relations occur on all developmental levels, and in psychological health as well as illness. In all mature love relationships, the love object is also a selfobject, and there is mutual mirroring and idealization which enhance self-esteem. This concept is somewhat unclear, and further experience will be necessary to clearly delineate it.

Kohut finds that defects in the self occur mainly as a result of empathy failures of the original selfobjects, the parents, due to narcissistic disturbances, and especially due to latent psychoses of these selfobjects. He clarifies that the child does not need perfect, continuous empathic response. The occasional failure of the selfobject is not pathogenic. It is the selfobject's chronic incapacity to respond appropriately, that is disasterous for the child's developing self.

Normal Development: Birth to The Achievement of a Cohesive Self

Since Kohut specifies that his theories derive from the analyses of adults, he does not give exact ages at which the developmental processes take place. He approximates them only, and these estimates have changed in different writings. But, he says that later observation will be necessary to confirm or disprove these early postulations.

The self is not considered to be present at birth, but arises out of the interchange between the neonate's innate qualities, and the selective responses of selfobjects. Certain potentialities in the infant are encouraged, while others are not encouraged or are actively discouraged. Sometime during the early years of life, a nuclear self emerges out of this selective process. This nuclear self changes somewhat throughout life, under the impact of new internal and external factors. The task of reforming the self is repeatedly imposed. A cohesive self describes a self that has achieved a state of strength, vitality, and integration.

Kohut asserts that only in late middle age can the success or failure of the achievement of the self be

decided, based on whether a person has been true to his or her innermost design.

The Bipolar Self

Another concept in Kohut's framework is that of the bipolar nature of the self. There are two basic psychological functions: healthy self-assertiveness vis-a-vis the mirroring selfobject, and healthy admiration for the idealized selfobject. These become the two poles of the bipolar self. Under favorable circumstances, an independent self arises out of the matrix of mirroring and idealized selfobjects. Thus, from its beginning, the nuclear self is a complex bipolar structure of nuclear ambitions and nuclear ideals.

If the mirroring selfobject fails to establish a cohesive nuclear self in the child, the idealized selfobject may be able to do so. Such a failure on the part of the mirroring selfobject, would be in the area of the child's self-esteem in regard to ambitions. This would prevent the grandiose-exhibitionistic component of the nuclear self from becoming consolidated. The area in which the idealized selfobject may help, is that of the child's self-esteem related to ideals and tension regulation.

Because of the bipolar nature of the self, the child has two chances to acquire a consolidated self. Pathological disturbances of the self, result only from the failure of both of these developmental opportunities.

It is puzzling that while Kohut is evolving a psychology of the self, in which the self is seen as partly innate, and further that he speaks of an innermost design, still he places an extraordinary amount of emphasis on the responsibility of parents for a child's mental health or pathology. Certainly, many studies show that the infant is not a "tabula rasa," but that even neonates often have an active part in influencing their environment (Benedek, 1949; Bruch, 1977; Huntington, 1978). Palombo (1979a) emphasized this in detailing the self-esteem problems of children with perceptual deficits.

Another concept of Kohut's is the "tension gradient" between the two poles of the bipolar self. This is an action-promoting condition that arises between a person's ambitions and ideals, and allows the development of the executive functions, the talents and skills, needed to realize the ambitions and ideals.

This conceptualization of the bipolar self and the tension gradient, makes understandable Kohut's portraying

the nuclear self as composed of three major constituents:

1. The grandiose-exhibitionistic self
2. The idealized parent imago
3. The executive functions, that is, the talents and skills

This now adds a third line of development, which needs further elucidation.

Kohut does not address the fate of children reared by one parent, or by a succession of babysitters, or with divided custody, or by some of the other child care arrangements fairly common in our contemporary culture. However, he does stress that several social factors have contributed to the increase of persons with disorders of the self. These are: smaller families, increased absence from home of parents, and lack of servants or change of servants to care for children.

Transmuting Internalization

This is the theory of the formation of internal psychological structure, and the following description of this process refers to normal development. Merger with the selfobject is a precursor of psychological structure. From birth, the child is responded to with adequate, but

less than perfect empathy, and it is this absence of perfection which causes aspects of the functions of an object to be gradually internalized. This takes place ideally in a step by step way, if the child is allowed to experience tolerable disappointments, that are not too intense nor too frequent. Transmuting internalization is prevented if a child is confronted with a continually unresponsive selfobject, or is suddenly faced with powerlessness in a selfobject. This is precluded, too, if the young person is required to merge with the selfobject past the child's need for it, due to the existence of a defective self in one or both parents.

When transmuting internalization is successful and psychic structure is formed, the internal structure then fulfills the functions that objects formerly accomplished for the child.

Transmuting internalization is not possible without another concept of Kohut's, which is "optimally increasing frustration" (1977, p. 9) of the child's needs. This, of course, is the appropriate response of empathic parents to a growing child, and is necessary in order for the young person to develop sufficient internal structure by way of transmuting internalization.

Gross identifications with selfobjects and their functions may temporarily and transitionally occur in childhood and in treatment, but the autonomous self is not a replica of the selfobject. The child takes in small particles of the functions of selfobjects, and transmutes them into its own self. Transmuting internalization is the process which takes place in the analysis of narcissistic personality disorders, which allows for the healing of self-pathology.

Disorders of the Self

Kohut (1977) discriminates primary and secondary disturbances of the self. Five primary disorders of the self are depicted.

1. The psychoses: "Permanent or protracted breakup, enfeeblement or serious distortion of the self" (p. 192)

2. Borderline states: "Permanent or protracted breakup, enfeeblement or serious distortion of the self covered by defensive structures which are more or less effective" (p. 192)

3. Schizoid and paranoid personalities: These are two defensive organizations that keep the person at a safe emotional distance from others by emotional coldness and

shallowness, and by hostility and suspiciousness.

These three disorders Kohut does not consider analyzable. He rarely discusses other forms of treatment. The fourth and fifth forms of primary self-disorders he believes are analyzable, because they are capable of limited selfobject transferences.

4. Narcissistic personality disorders: "Temporary breakup, enfeeblement or serious distortion of the self manifested in symptoms such as hypersensitivity to slights, hypochondria or depression" (p. 193)

5. Narcissistic behavior disorders: "Temporary breakup, enfeeblement or serious distortion of the self manifested in symptoms such as perversion, delinquency or addiction" (p. 193)

Freud (1914) considered characteristically narcissistic people to have disorders more serious than those now termed neurosis. And, Kohut earlier conceived of the psychoses and borderline states as narcissistic disturbances. By 1977, he expanded theory, and determined that people with psychoses and borderline conditions have disorders of the self, but these are not narcissistic disorders. Only after a person has achieved a cohesion of the nuclear self, can a narcissistic disorder occur. And, of

course, in these narcissistic disturbances, the nuclear self is subject to temporary breakups or distortion.

Secondary disturbances of the self, Kohut sees as the psychoneuroses, the acute and chronic reactions of a consolidated, firmly established cohesive self to the vicissitudes of life.

He differentiates the parenting experienced by patients with psychoses and borderline states, on the one hand, and narcissistic personality and behavior disturbances, on the other. In narcissistic disorders, the person had not given up all hope of the parents' response, as occurred in the more serious disturbances. The parents' empathy was not completely lacking; it was faulty, not flat. Occasionally, the parent had confirmed the child's sense of worthwhileness.

Narcissism

Kohut postulates that narcissism has its own line of development separate from that of object love. This is in contrast with classical theory which holds that narcissism normally becomes object love. The establishment of the grandiose self (which he earlier called the narcissistic self), as well as the idealized parent imago, he states are

maturationally determined, developmental achievements. He believes the grandiosity is phrase-appropriate and adaptive, just as is the overestimation of the power and perfection of the idealized object.

Further, he proposes that narcissism has two developmental lines. These were referred to earlier, in other contexts. One line, in normal growth, leads from the grandiose self to a person's lifelong realistic ambitions, and to self-esteem. The second line of narcissism leads to attainable ideals, and to self-regulatory mechanisms. Both lines develop into differentiated psychological configurations, which are transformations of narcissism, and become healthy, socially approved acquisitions. These are creativity, ability to be empathic, sense of humor, capacity to contemplate one's own death, and wisdom.

Anxiety

If the selfobject's response to the child is absent, non-empathic, or severely dulled, the child will be deprived of merger with the omnipotent selfobject. With regard to anxiety, this will prevent spreading anxiety from becoming signal anxiety, and then calmness. This does occur in merger with an empathic parent. Further,

absence of merger with the omnipotent selfobject prevents the building up of psychological structures that enable the child to deal effectively with its own anxiety.

On the other hand, if the selfobject reacts hypochondriacally to the child's mild anxiety, merger with the selfobject will produce the injurious experience of mild anxiety changing into panic.

Psychoanalytic Neutrality

Psychoanalytic neutrality, as an inactive, reserved responsiveness, has become an ironclad rule for many psychoanalysts, and adapted by many psychotherapists. This is based on Freud's famous 1912 dictum, that analysts should model themselves on the surgeon who puts aside all his feelings, even his human sympathy. However, Freud (1925) discussed his own cases in an involved, active way, with no evidence of silence, distance, and absence of response. In a 1927 letter, Freud said that some of his pupils took literally or exaggerated his precept about analytic passivity. He continued that a thorough analysis of the transference is important, and that what remains of the transference should have the character of a cordial human relationship (quoted in Kohut, 1977). Kohut says

that Freud's attitude as stated in this letter is in harmony with his own.

He then redefined psychoanalytic neutrality, as it has frequently come to be practiced, and this is a major contribution. His description of this concept is: the responsiveness to be expected from persons who have devoted their lives to helping others, with the aid of insights obtained through empathic immersion into patient's inner lives. Analytic neutrality is not, Kohut asserts, "an approximation of the functions of a psychologically programmed computer that restricts its activities to giving accurate interpretations"(1977, p. 252). When patients ask questions, he considers it correct to answer some, then to point out that the replies do not satisfy the patient. This is especially useful for narcissistic personality and behavior disorders. Even in classical transference neurosis, the patient's object-instinctual demands will become illuminated more sharply, if the needs of the patient are not rejected as defensive disguises, but are taken at face value and responded to.

He emphasizes that lack of emotional responsiveness does not supply the psychological milieu necessary for the delineation of the normal and abnormal features of a

person's psychological makeup. Such an attitude to patients with narcissistic disorders, will produce harmful results. The patient will feel rejected, and will react with a mixture of disappointed lethargy and rage.

Emotional reserve and muted responsiveness is often in tune with the needs of patients who suffer classical transference neuroses, says Kohut. This is based on the conclusion that as children, they were overstimulated and overinvolved in the emotional life of their parents. However, he modifies this statement. He continues that even in these patients, such a response would be experienced as unempathic, were it not frequently softened by emotional undertones from the therapist's psyche, in spite of conscious theoretical convictions.

The Oedipus Complex

According to Kohut, a firm self is a precondition for the experience of the oedipus complex. Unless children see themselves as independent centers of initiative, they are unable to withstand the conflicts and adaptations of the oedipal period.

From the point of view of self psychology, the healthy oedipal phase may be described as follows. The

child enters the oedipal period with a firm, cohesive self. He or she experiences assertive, affectionate, sexual desires for the heterogenital parent; and assertive, self-confident, competitive feelings for the parent of the same sex. If the heterogenital parent is empathic, response to the child's advances will be aim-inhibited. The homogenital parent, if empathic, will react with aim-inhibited counteraggression to the child.

These parental responses are important in aiding the child's growing capacity to integrate libidinal and aggressive strivings, and to acquire psychic structures that modulate drive expression. It is clearly harmful for parents to respond with gross sexual or counteraggressive actions. The essence of the classical position is that the result of a successfully completed oedipal phase is a firm mental apparatus. This formulation remains unchanged in self psychology.

In treatment, Kohut has sometimes seen patients go through an oedipal phase after years of work on a self defect. He now believes these were not transference repetitions, but were new experiences, the positive result of a consolidation of the self never before achieved.

He raises the question whether the dramatic, conflict

ridden oedipus complex of classical theory is the result of failures of narcissistically disturbed parents, rather than a normal phase of development.

Diagnosis and Transference

Kohut derived his theories largely from work with patients he designates "narcissistic personality and behavior disorders." Loosely, these are people who have been referred to as character disorders. However, diagnosis, in Kohut's scheme, is based not on symptoms or history, but on the kind of transference activated in treatment. He believes that narcissistic personality and behavior disorders are analyzable because they are capable of limited selfobject transferences. This differs from the classical opinion.

The selfobject transferences are 1) merger (the most archaic), 2) twinship or alterego, 3) mirror, (these three are called the mirroring transferences in the broad sense, and are related to the mirroring selfobject function); and 4) the idealizing transference, (pertaining to the idealized selfobject function).

Kohut proclaims that empathy failure, rather than trauma, is the major cause of disorders of the self. Also,

he observes that patients are often quite conscious of genetic material that leads to their pathology, but that they do not realize its importance because of the chronicity of the lack of empathic response.

Resistance

Kohut speaks of two phases of interpretations: the "understanding" phase, in which the therapist empathically echoes or merges with the patient, and the "explaining" phase. He says that patients with narcissistic personality and behavior disorders sometimes need the understanding phase for long periods.

The therapist may be quite active in the understanding phase, and does not simply passively listen while echoing and merging. Kohut emphasizes also that the patient's perception of the analyst's understanding must precede each genetic reconstruction, during the explaining phase.

Some of the persistent resistances in treatment are not defenses activated by fear that some repressed ideation will be made conscious. Instead, these resistances are frequently mobilized because the phase of understanding has been skipped over.

If the patient becomes enraged when the therapist attacks a resistance or makes an interpretation, the person is experiencing the therapist as non-empathic and as damaging his or her self. Some lack of empathy on the part of the therapist is inevitable and is, in fact, necessary in order for the patient to form a firm, independent self. Notice the correlation here with the earlier described "optimal frustration of needs," which is required for transmuting internalization to bring about internal structure, in treatment as well as in childhood.

Aggression

Kohut has come to see human destructiveness as a product of the disintegration of the self, rather than as a primary drive. Aggression in the form of destructive rage is always motivated by an injury to the self. The primary psychological configuration is assertiveness. Aggressions of the assertive baby indicate the security with which the infant makes its demands, based on confidence, which Kohut believes is innate. He recognizes that a young baby's assertiveness may be short lived, if the milieu is not empathic and responsive.

Treatment of Narcissistic Personality Disorders

In narcissistic disorders, internal psychological structures are defective. Secondary structures of two types are built on top of these defective self structures. These are: 1) defensive structures that cover over the defect of the self, and 2) compensatory structures that compensate for the defect of the self. Compensatory structures bring about a functional rehabilitation of the self, by making up for the weakness in one pole of the bipolar self, through strengthening the other pole. An example is, weakness in the area of ambitions may be compensated for by self-esteem gained through the pursuit of ideals. The reverse may also occur.

Treatment of a narcissistic personality or behavior disorder does not consist of making the unconscious conscious, of taming the drives, nor of resolving the oedipal complex. Treatment consists of healing the defect of the self, and this can be done in two ways. One is by analyzing the defensive structures, exposing the primary defect of the self, then with working through and transmuting internalizations, sufficiently filling out the defective structures. The second manner of treating a self-defect

is by making compensatory structures functionally reliable, by cognitive and affective mastery of the defenses and compensatory structures.

In treatment, one of the selfobject transferences becomes mobilized, and its nature indicates to the therapist the defect of the self. If a mirroring transference is established, the function of the therapist will be to mirror the patient. This will permit the transformation of the patient's grandiose-exhibitionistic qualities into self-esteem, and into realizable ambitions. If an idealizing transference emerges, the therapist's correct procedure is to allow the patient to idealize him or her, as long as necessary. This enables the patient to acquire self-soothing, self-protecting, and self-regulating psychic structures, as well as attainable idealized goals.

Countertransference helps the therapist recognize the nature of the emerging transference. If the therapist feels a need to protect the patient or to give advice or suggestions, an idealizing transference is probably being established. If the therapist feels an "inner smile" at the exhibitionistic antics of the patient, a mirroring transference is perhaps developing (Palombo, 1979b).

If the pathogenic narcissistic frustrations of

childhood are worked through in the transference, the characteristic rage and guilt gradually subside. Patients will come to view shortcomings of parents with mature tolerance. Further, they will learn to cope with the unavoidable frustrations of their need for empathic responsiveness, by developing increasingly varied and nuanced behaviors.

The central weak spot in certain narcissistic disorders cannot be reached in treatment, because healthy instincts in the patient would prevent regression to such archaic experiences. Regression to those depths might bring about disintegration of the self that would be irremedial. Treatment need not deal with these weak spots, if solid compensatory sectors are secured.

Treatment is complete when the patient's self has become firm, when it has ceased to react to the loss of selfobjects with fragmentation, weakness, or uncontrollable rage. Selfobjects and their functions, when treatment is completed, have been transformed into psychological structures, and these function relative independently, in conformity with ambitions and ideals.

Comments

Kohut is writing about the psychoanalysis of patients with narcissistic personality and behavior disorders. One of my theses is that his theories are useful and adaptable, to once or twice a week psychotherapy of clients with disturbances sometimes greater than those he is considering. I expand on this later.

One problem that occurs in attempting to understand Kohut's ideas, is in relation to his proposing that self psychology exists side by side with structural model psychology. His frequently qualifying this leads to speculation that perhaps self psychology alone is preferable.

Ornstein, in his introduction to Search for the Self, 1978, attempts to solve this theoretical problem. He explains that Kohut postulates separate lines of development for single, isolated body parts and single physical and mental functions, on the one hand; and for the experience of a cohesive, continuous whole self on the other. Continuing this exposition, Ornstein states that "cohesion" of the self refers to experiencing unity and coherence of the self in space, and its continuity in time. "Fragmentation" means the loss of this unity and coherence, and the experiencing instead, of single, isolated bodily and mental

functions. Such fragmentation often leads to "disintegration products," which can have oral, anal, phallic, or genital qualities. These could be, for example, addictive eating or drug ingestion, sexual perversions, or hypochondriacal symptoms. These are all attempts to solve the problem of fragmentation, and to bring about "reintegration," which is a regaining of the lost unity of the self.

In spite of some difficulties, Kohut's creative and original ideas add depth and breadth to the understanding of human personality, and can be of considerable value to clinical social work treatment.

His major contributions, I believe, are:

First, the psychoanalytic psychology of the self eliminates a decided value judgment in psychoanalysis. This is the implication that the highest achievement possible for a person is to be able "to work and to love"--"to love" meaning heterosexual object love leading to marriage and a family. Kohut's formulation is that the development of the self is as valuable as the attainment of object love. This, together with his asserting healthy transformations of narcissism, creates a less judgmental, more humanistic psychology, certainly more in accord with social work values.

A second important advance is his redefinition of psychoanalytic neutrality, and his emphasis on natural warmth and responsiveness.

A further addition is his concept of the two phases of interpretations, the "understanding" phase, and the "explaining" phase, and his assertion that narcissistic disorders sometimes need a long understanding phase. I think this is often of even greater importance with more disturbed clients.

And yet another significant contribution, is his admonition to accept the patient at face value, and not assume resistance if a patient becomes angry or rejects an interpretation.

Kohut's viewing destructive rage as the result of an injury to the self, rather than as a primary configuration, can have enormous implications for treatment.

His use of the transference in making a diagnosis, instead of symptoms or history, has to be modified in adapting his theories to once a week treatment of clients sometimes more primitive than narcissistic personality or behavior disorders. This is because the transference, under these conditions, is not as consistent, and may not regress to the degree it does in psychoanalysis.

One of the difficulties of working with Kohut's model, is that the narcissistic personality and behavior disorders span such a wide range of pathology, and character structure is not considered. Ornstein, in his introduction to Search for the Self, 1978, recognized the need for a new and extended psychoanalytic characterology and psychopathology. He anticipated that the psychology of the self was ready to give rise to these, and that they would develop directly from the clinical situation.

Malerstein and Ahern (1979) used psychoanalytic and Piagetian findings to discriminate three distinct character types, which correspond to Piaget's phases of cognitive development. And, in a 1978 paper, Kohut and Wolf began to differentiate various character structures. The 1978 extension, however, included people who previously might have been diagnosed as psychotic or borderline. The "merger-hungry personalities" are a notable example. "The fluidity of the boundaries between them and others interferes with their ability to discriminate their own thoughts, wishes and intentions from those of the self-object" (p. 422). The "contact shunning personalities" are probably Kohut's earlier paranoid and schizoid personalities. Their intense need for objects leads to great fear of rejection, also, on

a deeper level, to "apprehension that the remnants of their nuclear self will be swallowed up and destroyed by the yearned-for all encompassing union" (p. 422). So, Kohut's ideas are still evolving.

Now, I want to proceed to detail ways in which Kohut's theories are consistent with, and in no way contradict, principles of clinical social work.

CHAPTER III

CONSONANCE OF HEINZ KOHUT'S THEORIES WITH CLINICAL SOCIAL WORK'S VALUES, PRECEPTS, AND PRACTICES

Several of the values, precepts, and practices of clinical social work have been simply assumed as givens in psychoanalysis. For example, "the intrinsic worth of the individual, a non-judgmental attitude, and acceptance" were inherent in the doctor-patient relationship. It is recognized that psychoanalysis, as a science, has been considered value-free. However, as already noted, a judgmental attitude is implicit in one of the primary goals of analysis which is heterosexual object love, and this is valued over self development. Also, narcissism has been a decidedly pejorative term.

The "confidential" nature of the doctor-patient relationship was taken for granted. In regard to "professionalization," medicine began struggling with its own education and standards only fifty or so years before social

work started this process. "Self-determination" was not an issue in psychoanalysis, since physicians did not assume responsibility for the people they treated, as did social workers. But, psychoanalysis and Kohut would certainly not quarrel with this precept. "Treatment based on diagnosis" was obviously derived from medicine. And, the concepts of "self-awareness and the professional use of the self" were learned directly from psychoanalysis. The "psychosocial" nature of clinical social work is entirely its own. However, Kohut makes many statements revealing his clear comprehension of the impact of social reality, even though his treatment focus is narrower. And, "meeting the client where he or she is," has been social work's greatest theoretical and practice achievement. Here, I perceive a pronounced correspondence in Kohut's theories.

Introspection and Empathy

In 1959, Kohut introduced a concept new to psychoanalysis:

> ...that introspection and empathy are essential ingredients of psychoanalytic observation....Psychoanalytic theory...is derived from the field of inner experiences observed through introspection and empathy. (p. 482)

Explaining his understanding of these terms, he said:

> The inner world,...our thoughts, wishes, feelings, and

> fantasies cannot be seen, smelled, heard or touched. They have no existence in physical space, and yet they are real, and we can observe them as they occur in time: through introspection in ourselves, and through empathy, (i.e., vicarious introspection) in others. (p. 459)

He agreed with Freud who considered empathy that mechanism "by means of which we are enabled to take up any attitude at all towards another mental life" (1921, p. 110). Kohut further clarified his own meaning of empathy. He asserted that when we thought ourselves into the place of another, and by vicarious introspection began to feel what the other felt, as if it were our own, we revived inner experiences in which we had felt similarly. Only then, did we begin to have an appreciation of the meaning of an event to another person.

This was almost a quarter of a century after Charlotte Towle wrote in 1935 (1969):

> Because we have all experienced defeat, frustration, deprivation, despair, pain, unhappiness, hunger--at least to some degree--we are thus enabled to put ourselves in the place of [others] and to feel with them and for them. (pp. 31-32)

And, she called this quality "identification," as did a number of other social workers.

Even earlier, Jessie Taft in 1933 (1962), described the casework function as adapting to the clients' needs

and patterns by the most intense activity of attention, identification, and understanding, which she thought could be accomplished only by personal discipline and responsibility for self.

And, before that, Virginia Robinson (1930) declared that a worker should have sufficient security to enter into the reality of another individual's feelings. This participation, which she entitled "identification" (p. 170), should not be merely intellectual or verbal. It should be a genuine feeling experience, a living through of the other's attitudes and experiences in their essential meaning to the other.

Social workers have sometimes been charged with using intuition primarily, or even exclusively. Irene Josselyn (1948) helped elucidate this construct:

> What is often erroneously called intuition is the capacity of an individual to evaluate objectively the emotional experiences resulting from identification with another individual. (p. 126)

With most admirable candor, Kohut (1968) described the case in which he was able to put aside previously held theory, as well as to acknowledge certain human qualities in himself, such as boredom and irritation with this patient. He was then able to listen to his patient's high-

pitched voice, which expressed such utter conviction of being right, that it led him to new theoretical formulations about narcissistic disorders. He did not give the date of that analytic session. But, his publication was 28 years after Towle, in 1940 (1969), admonished social workers to guard against becoming possessed by their theories, and to unwittingly serve them rather than their clients.

How similarly did Kohut express his belief, in a 1977 (1978) letter, that theory had achieved somewhat exaggerated significance in modern psychoanalysis. He went on that he loved theory, and believed psychoanalysis should continue its pursuit of framing relevant general statements. "But theory must not become our master; it must be our servant" (p. 928).

Palombo, who has devoted considerable effort to adapting Kohut's theories to clinical social work practice, in 1976 advised shedding "the old textbook rules in order to respond with empathy to a patient's needs" (p. 157).

Rather outspoken in a 1973 (1978) article, Kohut termed the abilities and skills of psychoanalysts, their "tools and methods" (p. 677). He believed that the relinquishment of the idealization of these would lead to the

ascendance of an exhilarating expansion of the self, to a new kind of humanitarianism in the form of scientific empathy. Here, he was attempting to broaden psychoanalytic empathy, which he thought could have wide usefulness in a world rampant with strife.

Kohut was able to "listen" to his patient and develop new theory, 26 years after Annette Garrett (1942) advised caseworkers to "listen carefully" (p. 36) to clients; to become acquainted with them; to learn what language they spoke, literally and figuratively; to see the situation and the client's problem from the client's point of view.

In his introduction to Search for the Self (1978), Ornstein repeatedly emphasized that it was clinical necessity, Kohut's experiences with patients in the analytic process, that demanded his reconceptualization of theory and technique.

Cogently summing up his attitude toward diagnosis and treatment, is this 1973 (1978) letter of Kohut's replying to a request for help in diagnosing a patient:

> All in all, I would as his therapist be inclined to worry neither about the diagnosis nor about the name of the treatment, but would try to be attentive, perceptive and empathic in order to understand what he wants and what he needs. (p. 873)

Clearly, this statement describes clinical social work's

primary precept of "meeting the client where he or she is."

Psychoanalytic Neutrality

Knowledgeable social workers, even those markedly affected by psychoanalysis, have long known that inactive, unresponsive "neutrality" has limited use. In the psychotherapy of many, if not most, clients seen by social workers, it is nontherapeutic. Here, Kohut's views are very close to those of many social workers. He elaborates the critical importance of a therapist's empathic responsiveness to a patient, including natural warmth, and appropriate activity. He decries the concept that therapeutic neutrality means minimal responsiveness and inactivity.

Social worker's comments on this subject include the following: Towle, in 1940 (1969), noted that when the helper used the psychoanalytic model of neutrality, of being a screen on which clients projected and then discovered themselves, many clients became confused, anxious, and frustrated. They might become demandingly dependent, or they could withdraw.

Absence of response, Garrett (1942) said, could easily seem to the client to reflect absence of interest.

Hollis (1972) quoted a 1964 study by Ripple, Alexander and Polemis. This research found that "a bland, seemingly uninvolved eliciting and appraisal of the client's situation, in which the worker appeared neutral in affect" (p. 236), was usually associated with discontinuance or unfavorable outcome of treatment.

In a 1975 (1978) letter, Kohut phrased this emphatically:

> It is...my view that the normal, neutral atmosphere--from the beginning of life--is empathic acceptance.... Silence, nonresponsiveness, is a crass deviation from the basic axis of psychological neutrality....Spontaneous warm reactions of the analyst are the "neutral" environment for an analysis,...everything else is a strained artifact. (p. 899)

Psychosocial Issues

Kohut has written much about societal influences and their effect upon the individual. Indeed, it will be recalled that one of his basic tenets is that psychoanalysis required modification because the world was changing. Life was becoming more impersonal and dehumanized, and this caused more people to develop disorders of the self.

Commenting on Professor Alexander Mitscherlich's book, Society Without the Father, Kohut in 1963 (1978), contended that the basic problem Mitscherlich illuminated

was that influences, which could not be attributed to individuals, had altered society. We no longer had the security of an authoritarian state, he said, but lived in a society of anonymous equals. He urged everyone to ponder the profound sociopsychological problem posed by Mitscherlich: the need to "preserve the father-mother-oriented family structure within this broad, sibling-oriented society" (p. 567).

A significant aspect of Kohut's interest in the arts conveys his appreciation of societal factors. He has published several articles, and devoted a substantial and rewarding section of Restoration of the Self (1977), to artistic endeavors. Great artists, he believes, are ahead of their time in focusing on the central psychopathological problems of their era.

> The musician of disordered sound, the poet of decomposed language, the painter and sculptor of the fragmented visual and tactile world: they all portray the breakup of the self and through the reassemblance and rearrangement of the fragments, try to create new structures that possess wholeness, perfection, new meaning. (p. 286)

At least one prominant social worker shares his acute perception. Perlman (1971) wrote that the sweep and magnitude of the forces of technological, industrial, and social organization had dizzied and dwarfed human beings.

Art, she observed, reflected this--fragmented and distorted and machinized.

The social component is heeded by Kohut in even such a basic psychoanalytic concept as "penis envy." This construct has long been a controversial one, with which many social workers have wrestled. Freud saw the "female's striving to possess a male genital" (1937, p. 250), as an inevitable theme in every woman. But, Kohut in 1975 (1978), demonstrated his awareness of the weight of familial and cultural attitudes in this matter. He declared that if a little girl is as accepted and admired as a little boy, she will grow up to become a woman with the same degree of security and idealizability as a man.

One of his most brilliant insights gives recognition to the psychosocial nature of humankind. Narcissism, he discovered, does not have to be destroyed (as some analysts hope to bring about), but it can be transformed into qualities that have biological and sociocultural value.

With understanding of the enormous implications, Kohut (1977) proclaimed that each change in the social surroundings confronted people with new adaptational tasks.

> In order to ensure...survival...certain psychological functions will have to achieve a position of predominance. It is human beings' ability or inability to

> create new adaptational structures that will determine their psychological survival or death. (p. 280)

Having traced the values, precepts, and practices of clinical social work, giving an overview of Kohut's theories, and now detailing the consonance of these two sets of ideas, I want at this point, to discuss various issues involved in treatment. That will be followed by case material, to demonstrate the value of Kohut's theories to the practice of clinical social work.

CHAPTER IV

CLINICAL SOCIAL WORK PSYCHOTHERAPY OF CLIENTS WHO HAVE PATHOLOGY OF THE SELF

Kohut developed his theories practicing, supervising, and teaching psychoanalysis. Much of his creative understanding is adaptable to the psychotherapy carried out by clinical social workers. The following are some of the characteristics of clinical social work which distinguish it from psychoanalysis: 1) the clients are sometimes more disturbed than narcissistic personality or behavior disorders, that is, these people often have borderline or psychotic disturbances, 2) they are usually seen once or twice a week, rather than four or five times, 3) clients sit up facing the therapist, 4) it is not unusual for two or more clients to be seen together--a couple, a family, or a group, and 5) some, although certainly not all, of the techniques used, are referred to as supportive.

An understanding of the nature of transference is necessary in psychotherapy as well as psychoanalysis, although the methods of handling the transference are often different.

Whether or not a patient is capable of transference is a crucial question to many psychoanalysts, who believe that true analysis is possible only with those in whom it is possible for a transference to emerge. For psychotherapists who are not analysts, the matter is perhaps less central. Nevertheless, it is still significant in that its understanding furthers comprehension and conceptualization of what does and does not help, and with whom. I will now summarize some of the many and varying ways the following concepts have been used: transference, working alliance, therapeutic alliance, the real relationship, and countertransference.

Transference

Transference, as conceived by Freud (1912, 1915, 1916), occurred in people who had a completely structured psychic apparatus. It was the revival and repetition with the psychotherapist of the patient's early childhood libidinal and aggressive strivings.

Both Greenacre (1954) and Greenson (1967) specified that the matrix of the transference was the early mother-infant union.

Patients with psychoneuroses possess fully completed mental structures, and develop discrete symptoms attributable to intrapsychic conflict, which can be treated by psychoanalysis. Kohut has demonstrated that narcissistic personality and behavior disorders are capable of limited selfobject transferences, and therefore are analyzable.

The pathology of individuals with borderline and psychotic disturbances is mainly structural, that is, their psychic structure is severely deficient. Psychoanalysts and psychotherapists who have extensively treated these patients, differ widely about the nature of the transference they develop, or whether in fact, one can exist.

Sullivan (1953) and Searles (1965) thought that the schizophrenic patient had an excessive transference, rather than a lack of it. Searles submitted that psychoanalysis made possible a deep feeling involvement with these patients, which was of necessity in their treatment. Winnicott (1965) appeared unconcerned about the name of the treatment, but stressed the reliability of the setting as the primary therapeutic measure, rather than the

analyst's insightful interpretation.

Jacobson (1971) found she could successfully analyze depressed psychotic patients. She endorsed the value of maintaining a positive transference with such patients, by which she seemed to mean some continuing relationship after termination of treatment. She corresponded with one such patient for 35 years, and she permitted periodic contacts with other formerly psychotic patients after the successful completion of their analyses.

The appropriate treatment for most borderline patients, concluded Kernberg (1975), was expressive psychoanalytic psychotherapy rather than classical psychoanalysis. Narcissistic personalities, he considered a specific group within the broader classification of borderline organizations. For most of these narcissistic patients, he advocated unmodified psychoanalysis as the treatment of choice. These people, he asserted, were extremely hard, if not impossible to treat, and the only help conceivable for them was psychoanalysis.

Volkan (1976) proposed that primitive internalized object relations were reactivated in the transference situation with borderline and schizophrenic patients, which rendered many of them psychoanalyzable.

Psychotic patients could form transferences, Arieti (1978) claimed, and he believed it essential for their treatment that the countertransference be equal in importance and intensity to the transference. The treatment he advised was psychotherapy, in which the therapist and patient retained each other as object, not classical psychoanalysis, "in which the analyst rejects the patient as object and teaches the patient to reject the analyst as object" (p. 57).

Giovacchini (1979) saw the basic mechanism of all transference as primitive, with different levels of ego integration. He, therefore, declared that people with severe disturbances, including psychotics, did form transferences and could be analyzed.

Blanck and Blanck (1974) summed up the view of ego psychologists: "In psychoanalytically oriented psychotherapy, transference is used--if it exists" (p. 132). They asserted that people who had established object representations, could and did transfer to the therapist. Those whose object representations were undifferentiated from self representations, the Blancks thought, were less capable of transference.

Kohut (1977) declared that borderline and psychotic

people were not capable of even limited transference, and therefore could not be managed by interpretation and working through. He did think a rapport might be established between such patients and a therapist. I agree that borderline and psychotic clients cannot be managed by interpretation and working through, but they can be helped by other methods which I go into later.

The Working Alliance and The Therpeutic Alliance

Some authors regard the development of a working alliance or a therapeutic alliance, indispensable for successful treatment of any disorder, primitive or well structured. And, some distinguish this condition from transference.

Zetzel (1956) introduced the term "therapeutic alliance," and considered it one aspect of transference, but a decisive one. Greenson (1965) preferred the phrase "working alliance," and designated it the relatively non-neurotic, rational, conscious motivation of the patient to overcome illness. He differentiated this quality from transference, which he portrayed as more regressive, Both, he believed, were essential for successful analysis.

The Real Relationship

The reliable core of the working alliance, Gumbel (1970) stressed, was the real object relationship between the patient and the psychoanalyst.

According to Guntrip (1977), all relationships have a subtly dual nature, as a transference experience and as a real life experience. He continued that all through life, people took into themselves both good and bad figures, who either strengthened or disturbed them, and it was the same in psychoanalytic therapy.

In a surprisingly similar vein, Anna Freud (1954) wrote that as far as patients had healthy parts of their personalities, their real relationship to the analyst was never wholly submerged. She respected the strictest handling of the transference, but felt room should be left for the realization that analyst and patient were also two real people. She wondered whether the almost complete neglect of this matter was not responsible for some of the hostile reactions of patients, which were apt to be ascribed to "true transference" only.

Blanck and Blanck (1974) endorsed the therapist using himself or herself as a real object to the patient, when treating psychosis proper. The therapist acquired

value in those situations, not from the past nor from being appreciated as a real person, but because the patient was is such desperate need for an object world.

Kernberg (1975) questioned the advisability of the therapist appearing a "real person" to the borderline patient. He thought it was probably not possible for the patient to use the therapist as an object of identification and superego introject, as some authors had suggested. He particularly disagreed with the therapist giving inordinately to these patients, in response to their so-called excessive dependency needs. He also deplored self-disclosures to patients which, he emphasized, repeatedly had been shown to be of little, if any, clinical value.

A different tact was taken by Gerald Adler (1979), who also had questions about the "real relationship." He thought that primitive patients needed a relationship in which they were partially fused or merged with another person. Otherwise, they felt empty, fragmented, alone, and uncertain about who they were and who the other person was. He went on that when these patients were sustained in a self-object relationship, they felt complete, and did not question the reality of the other person, since that person was part of themselves.

Adler noted that in clinical work with borderline patients, there was frequently a rapid breakdown of what had seemed to be a tenuous, or sometimes more solid, alliance. Borderline aloneness could emerge, he submitted, when unbearable affects appeared, or when the therapist made a response that was unempathic, or perhaps incorrect.

I am in accord with his description of a sequence which occurs in the successful therapy of primitive patients:

> 1) the establishment of stable self-object transferences that sustain them, 2) the increasing capacity to appreciate the therapist as a real and separate person, and 3) their gradual ability to ally themselves with their therapist in the service of accomplishing work. (p. 645)

So, these issues of transference, therapeutic and working alliance, and the real relationship are still being debated, and will require further experience before differences can be resolved.

Countertransference

Frank (1977), quoting others' reviews of the literature, succinctly summarized the opinions about countertransference. He identified two groups of authors: the classicists and the totalists, or modernists. In general, the classicists viewed countertransference as a problem which

originated in the unconscious responses of the analyst to the patient's transference. The totalists' broader view saw countertransference as the analyst's total emotional response to the patient, including conscious as well as unconscious reactions. It also provided for responses to the reality of the patient, as well as to the transference, including responses emanating from the analyst's realistic, as well as neurotic needs. The totalists believe the countertransference aids in understanding the patient.

My own comprehension of this process is similar to that of the totalists, as here described by Frank.

Once a Week Psychotherapy

As I am defining psychotherapy, it may consist of supportive measures, interpretation of resistances or the transference, as well as relating early childhood experiences to current life patterns or problems.

"Supportive psychotherapy" has often been maligned, and its meaning and the usefulness of the methods attributed to it, have led to much dispute. Supportive therapy has often denoted ego-supportive treatment. Although Kohut has largely abandoned reference to the tripartite structure in his theoretical formulations, there is merit in employing

this widely used term, to discuss the adapting of Kohut's theories.

Many authors have proclaimed that supportive psychotherapeutic methods do not require less technical and therapeutic preparation than psychoanalysis (Josselyn, 1948; Johnson, 1953; Alexander, 1954; Dewald, 1978).

Alexander (1954) described five procedures which he said constituted the essence of supportive measures: 1) gratifying dependency needs, 2) giving opportunity for emotional abreaction, 3) objectively reviewing the patient's stress and assisting his judgment, 4) aiding the ego's neurotic defenses, and 5) manipulation of the life situation.

The concept of ego-support was extended by Bernard Bandler (1963) to embrace parental, progressive, educational, and life functions. He suggested that the model for psychotherapy should be life itself: its processes of growth, development, and decline; its methods of problem-solving and need-satisfaction. Psychoanalysis, he stressed, continued to be needed for understanding clients, their treatment, and the processes of the life span.

A number of analysts have attested to the value and long-lasting quality of much supportive psychotherapy.

For example, Alexander (1954) wrote that, "Many so-called transference cures which in the therapist's judgment are not based on real changes in the personality often persist in spite of the theory" (p. 727). A Menninger Clinic study discussed by Wallerstein (1978), found that supportive psychotherapy could be surprisingly thorough and lasting.

That structural change could be greater in the psychotherapy of primitive clients than in psychoanalysis, was advanced by Blanck and Blanck (1974). This was because, in psychotherapy, structure building was the very purpose of treatment. Such cases can become very long-term, but I have found that is not always necessary.

In his introduction to Aichhorn's Wayward Youth, Freud amplified that in certain cases "something other than analysis must be employed, though something which will be at one with analysis in its purpose" (quoted in Gill, 1954, p. 774). Gill recognized that psychotherapy could result in a quantitative shift which might not be so completely different from what often happened in psychoanalysis.

All psychological forms of therapy, including psychoanalysis, can be considered ego-supportive, and Wallerstein pronounced psychoanalysis the most supportive therapy of

all. He was referring to the effect, of course, not the method.

Discussion

In my experience, the psychotic and borderline clients who remain in treatment, sooner or later enter into a relationship with the therapist in which mirroring or idealizing aspects, or usually both, emerge. At that point, the therapist becomes a selfobject. Because this relationship has elements of the emotional reactions the client had to the important figures of his or her early childhood, I consider this transference.

These clients desperately need the therapist to relate to their pain or other condition which brought them to treatment, and to communicate this so that they feel heard and responded to. This is the critical element that determines whether clients will continue in treatment or not, and whether they will be enabled to receive help. Such psychotherapy often involves grueling effort by the therapist, when a client is vague, tangential, or barely able to speak because of confusion or anxiety. It also requires a careful attention to maintaining the distance needed by the client. More disturbed people frequently

have difficulty with closeness, often yearning for it, but fearful of engulfment. Alternate moving in and moving away may occur, and this must be respected by the therapist. This empathic response, meeting the client where he or she is, can lead to a selfobject relationship where the client feels sustained and supported, and can grow developmentally.

The patients Kohut writes about, enter and maintain either a mirroring or an idealizing transference. Or, after a period in one transference, a patient may activate another transference. Kohut, of course, is referring to patients with narcissistic personality or behavior disorders, in psychoanalysis. My experience with once a week treatment of clients who are sometimes more disturbed, is that the transference is less durable, varies from session to session, and several different transferences are often evidenced in the same interview. The fact a transference is chaotic or variable, is a diagnostic clue that the underlying personality is confused, very needy, or disintegrating. When the transference is this disorganized, I find that the self-defect occurred very early, and that neither parent was sufficiently empathic to allow much of a nuclear self to evolve. Self-pathology, then, is in the borderline or

psychotic sphere.

In dealing with more primitive clients, Kohut's "understanding" phase of treatment may be long. Supportive measures are often used during this phase, in the psychotherapy I provide. They may be used also in the "explaining" phase. Of such methods, I suggest that gratification and abreaction serve a mirroring function; limit setting and manipulation of the environment can have an idealizing function; while parenting, advice giving, and education can serve both lines of development.

Kohut, and many of his colleagues, believe that any intervention except interpretation of the transference and dynamic genetic reconstructions, can produce gross identification with the therapist. This does not allow minute transmuting internalizations that enable the patient to internalize the function of the analyst, and thus develop psychic structure.

I am postulating that such gross identifications are often therapeutic in themselves, and sometimes lead to later internal modifications that become a part of the client's psychic structure, rather than remaining a large chunk of introject. These may, however, remain unintegrated (non-transmutingly internalized), and in that form

they may allow clients to go on drawing from them for years. For example, when troubled, the client may think, "What would my therapist say now?" This can be a useful and therapeutic mechanism.

The principles advocated by knowledgeable social workers through the years are adhered to in the psychotherapy I am defining. The therapeutic methods I propose are determined by the strengths and needs of the client. This is meeting the client where he or she is, and can well be accomplished by use of Kohut's introspective-empathic mode of observation.

In the next chapter, four cases are presented of clients seen in once a week treatment. Two are long term cases, and the other two are shorter. One was treated for ten months; and the other, less than six months. At least three of these clients have disturbances I consider greater than narcissistic personality or behavior disorders. There is a question in my mind about the diagnosis of the fourth.

In this discussion, Kohut's framework is used to formulate the pathology and the treatment.

CHAPTER V

FOUR CASE EXAMPLES

The Case of Mrs. B.

This is an ongoing case, a woman I have seen weekly for 8 years over an 11 year period. The first series of sessions lasted 4-1/2 years. She was away from treatment 3 years, and has been back now for 3-1/2 years.

When she first applied at the family service agency, Mrs. B. was 28 years old, a Caucasian, Protestant housewife, with 5 children, aged 5 to 10. Her husband, also 28, was a skilled machinist. She was an attractive, well-groomed, slender woman, with a wide-eyed, breathless, little girl demeanor. In the first interview, she was composed. In later sessions, she sometimes broke into long body-engulfing sobs, as she talked of her troubles. Occasionally, her eyes looked vacant, and she seemed to be out of contact. We were never able to determine the cause of this in interviews, nor when it happened not infrequently in her everyday life. It has not occurred in our sessions

for about the past two years.

Her initial complaint was her desperation that her husband had not spoken to her except for necessities, for five months, because she refused anal intercourse, and because, even though she took pleasure in oral-genital contact, she refused to swallow his ejaculations. She had no objection to these practices, she simply did not enjoy them. In the past, her husband had often controlled her by "the silent treatment." Now, she did not want to give in, but was no longer confident she could or should hold out.

She was experiencing a lot of anxiety and depression: crying a good deal, losing weight, having trouble sleeping, and difficulty functioning. The distress was increasing as the weeks went by.

From treatment, she seemed to want somehow to make her husband different. I saw him twice for evaluation, and found him a deprived, depressed man with low self-esteem. He was passive-aggressive with wife and children, and took little home or child-care responsibility. Since he became interested in treatment, I referred him to a co-therapist.

Only in the second contact, did I learn of Mrs. B.'s multiple hypochondriacal and other fears, of sometimes

crippling proportions. Later, when she was able to talk of these in depth, they often had a delusional quality. The fears were of cancer, leprosy, and other diseases, also of natural disasters, predominantly earthquakes, and of the world coming to an end. The disease fears culminated in her dying and being buried, which meant to her she would cease to exist. Sometime later, she revealed that the earthquake and natural disaster fears were of her being swallowed by the earth, and associations were to group picnics or group sex. Thus, many of her fears had an oral or sexual character.

These symptoms had existed since early in her marriage, were worse during her pregnancies, were better on occasion, but never entirely absent.

When hypochondriasis was intolerable, she saw her internist who reassured her. To protect herself from her other terrors, she avoided any news coverage which might report the death of a famous person, natural disasters, or predictions about the end of the world. When engulfed in the fright, she sought solace from a woman friend, or sometimes from her husband. Unfortunately, the consolation was short lived, as Mrs. B. had difficulty convincing herself that her fears were unrealistic, thus the delusional

appearance.

She returned for the second treatment period because of panic about her children's safety, especially her 13 year old daughter being sexually attacked. Choking back a sob, she professed that she was barely able to keep herself from going crazy. Again, she could not always persuade herself her feelings about her children were not based on reality. When talking about her fears, she usually trembled, became light headed, and often was slightly disoriented.

The symptoms had become severe nine months earlier, when she lost several of her environmental supports, although she did not make this connection. A leaderless women's group in which she felt liked and supported, had disbanded. A close woman friend moved to a distant city. Feelings of abandonment, due to one of her sisters leaving the area two years earlier, were still strong. At the time she returned to treatment, she was soon to complete a nursery school teaching program begun four years earlier, the fulfillment of a lifelong dream. Further, she had concluded her husband would never become what she wanted, and this discouraged and depressed her.

Life Situation When First Seen

Mrs. B. was an intelligent, capable, overly responsible woman. Severely moralistic, she allowed herself few pleasures, and drove herself to long hours of drudgery. Although generally frugal, she could spend almost nothing on herself, and usually wore hand-me-downs, although this was not financially necessary.

She had two or three women friends she related to in a distant, little girl way. Her interests were almost entirely centered on her home and children. There were occasional outbreaks of impulsive sexual behavior, when a wealthy older woman friend took her on expensive trips to Hawaii or the Bahamas.

She was aware of much of her unconscious, and of her rich and active fantasy life. Oral fantasies predominated. Dreading the loss of control of her sexual impulses, she often longed to melt into an attractive man, lick him all over, and literally eat him up. For years, she spent odd moments in an enjoyable and comforting reverie, revolving around an unexplainable ache in her teeth. She was quite critical of her husband, although she seldom expressed this. Several of his "low-brow" interests she scorned, such as TV, rock music, handball. His lack of

need to overwork, and his relatively greater ability to relax and enjoy himself, both fascinated and disgusted her. One of her most persistent complaints was about his unwillingness to repair household items and to care for the yard. As treatment went on, she became concerned about his having little contact with the children, except to be critical or sarcastic.

Before treatment, she tolerated then resented his self-indulgent impulsive spending. In the first series of sessions, she gradually assumed more of the management of their finances. Her thrift and orderliness enabled them to live better and to acquire some income property.

They enjoyed an active and imaginative six life, she usually climaxed. When her husband was not speaking to her, he chose to masturbate instead.

Their social life was exchanging dinners with a few couples, usually friends of hers, as her husband was pretty much a social isolate.

Her relationships with all five children were, to a large extent, mergers. This was evident in the content and manner in which she discussed them. For example, when putting the youngest to bed, she took a good deal of time, lay down, held and sang to him, totally engrossed

in the process. She described this in a dreamy, ecstatic way, as if the two of them were one. She indulged in excessive physical contact, especially with the boys. The children were catered to by her, and kept near her as much as possible. Mergers with the two boys were more complete than with the three girls.

The children were showing signs of damage from this parenting, which allowed little autonomy. This was especially true of the oldest girl and the two boys. As each daughter became thirteen, Mrs. B. developed strong fears that the girl would start engaging in sexual activity. Eventually, I did see the oldest boy weekly for nine months, with good results. Also, the oldest daughter came to me for a few intermittent sessions.

Relevant Past History

Mrs. B's mother and her sisters, three and five years younger, have similar fears. In addition to her sisters, she has a brother fifteen years younger.

Her relationship with her parents in childhood was characterized by her feeling responsible to make them happy, and to take care of them. She felt superior to her mother, criticized her messy inefficiency, and took over

much of the housework and cooking. They bickered and competed. Later, she nagged her mother about her manner of dressing, personal cleanliness, and medical care.

She adored her father. When alone in the house, she would get his pillow, hold it against her face, and rock herself while rubbing the pillow and drinking in her father's odor. This brought on a trance like state (a merger with father in fantasy), which gave her pleasure and comfort.

Apparently, father was a frustrated, distant, but kindly man, who subtly encouraged his daughter's catering attention. Mrs. B. received little nurturance, guidance, or support in this home.

She recalls little of her relationship with her sisters, and she was in mid-adolescence when her brother was born. It is perhaps significant that she met her husband the same year, both were 15, and they began a sexual relationship. Ignoring birth control, she became pregnant, and they married when they were 16. Both graduated from high school two months before the birth of the baby.

Mrs. B. wanted many children, but only one was planned, with husband's reluctant agreement. She blamed

her "careless use of her diaphragm" for the last three children. Mr. B. was particularly unhappy about the last two, did not talk to his wife during these pregnancies, and obtained a vasectomy shortly after the birth of the fifth.

Transference

Mrs. B. developed a quick idealizing transference, and related to me in an eager, girlish, adoring way, as she had to her father. Our contacts soon became a central factor in her life.

She wanted my opinions, enthusiastically tried anything I suggested, was grateful and complimentary. Supportive statements I made were likely to evoke quick, deep sobs, as from a wounded, forgiven child. Thus, the transference soon became a bipolar one: the suggestions and support served the idealizing line, while my being willing to listen and attend to her was affirming, and performed a mirroring function.

Diagnostic Considerations

This woman had a disorder of the self, of serious proportions. Her self was incomplete and underdeveloped, and subject to grave fragmentation. She had a diffusion of boundaries, was not clear where she ended and others

began, what was inside and what was outside. Also, a number of times she appeared delusional. Along the psychotic--borderline--narcissistic personality disorder continuum, I place her pathology in the borderline state, closer to psychosis than to narcissistic personality disorder.

The most central element of this woman's life was her need to merge. She longed for fusion with an all-loving, all-giving, omnipotent person.

During the entire first treatment period, Mrs. B. was unable to remember details of her interactions with her husband, even though she complained bitterly about him. Her inability to remember was a function of merger. She described going into a dream-like state in his presence, feeling the two were blended.

She wanted many children in order to be surrounded by objects with whom she could merge. Her "careless use of her diaphragm" was Mrs. B.'s way to get what she compellingly needed, without directly going against her husband's wishes.

Her countering his demands in regard to their sex life prior to entering treatment, indicated a healthy strength in her, a move toward being a separate, independent person.

Her early history of taking responsibility for her parent's happiness was repeated with her husband and children. The critical, superior attitude toward Mr. B. was reminiscent of her earlier relationship with her mother.

The oral and sexual fantasies, as well as the hypochondriasis, are seen as her retreat to isolated body parts when the poorly developed self was threatened with disintegration. Her occasional impulsive sexual behavior was an attempt at merger when away from her family, as well as serving a temporary self-esteem enhancing function.

The intense, perhaps delusional, quality of her fears and hypochondriasis, are viewed as last ditch stands to prevent complete fragmentation of the self.

Treatment Plan

In terms of Kohut's framework, my job in treatment was twofold. One was to affirm her, to aid the development of self-esteem, and the transformation of the grandiose-exhibitionistic elements of her personality into ambitions. The second was to allow her to idealize me in order for her to acquire self-soothing, self-protecting, self-regulating functions, as well as attainable ideals.

I started seeing her before I read Kohut, and thought

my treatment should be primarily a parenting function, in order to help her grow developmentally. I found Kohut's framework especially useful and clarifying, and in no way contradictory to the work I was already doing.

An essential part of our efforts was to help her differentiate what was outside from what was inside herself. She needed to determine where her responsibility ended and that of others began, to separate herself as much as possible from her husband and her children, since this merging was destructive. Because merger was essential to her, I wanted to help her find more appropriate objects to attach herself to, such as me during treatment, good role models, work, or a cause. After reading Kohut, I saw these as selfobjects which she would experience as part of herself, and as sustaining in a healthier way.

In her treatment, I wanted also to serve as the interpreter of reality, to enable her to better understand and make sense of the world.

My approach to her was to be active, make suggestions, educate, and give a lot of feedback. This made me into a real person, even though she might not have seen me that way, especially in the beginning.

Treatment

Our work of helping her separate has been a slow, step by step process. It involved our going over her interactions with her husband and children in detail, with my pointing out what she was doing, and helping her learn alternate attitudes and behaviors.

Regarding her children, we discussed specific incidents with my being direct and specific about the child's needs, rights, also about what constituted appropriate parenting behavior. In addition to her need to merge, she also had a healthy interest in her children's well-being.

As for her fears and hypochondriasis, I endeavored to bring the global terrors more under her control by breaking them down into their parts so she could see them in linear fashion. This made them less frightening. I asked for minute details of the feeling, how it started, how it developed, how she thought it would end. We did this over and over, each time she brought up a fear. I also encouraged associated fantasies, and sometimes asked her to draw the fantasies with colored pencils.

To teach her problem solving approaches, as well as to provide relief while the intrapsychic work was taking place, I advised her to do everything she could to protect

herself from her fright about her children, without unduly restricting them. She particularly worried when they were walking to and from school or a friend's, so I suggested she drive them; also that she continue to ascertain where they were and when they would be home, since she became frantic when she did not know.

As earlier described, when discussing her fears, she usually trembled, became light headed, and somewhat out of contact. About 2-1/2 years ago in an interview, she grew so frightened, she became totally disoriented. She screamed, gasped, was dazed, visibly shook, and flailed her arms about. I went over near her, and when I thought she could hear me, I told her calmly that she was alright, that everything was fine. I repeated this several times until she regained control. This lasted perhaps four minutes.

Later in the session, she became aware of a fantasy or hallucination of her mother as a witch flying though the air, then swooping down to snatch her children and eat them. She managed to stay calm for the remainder of the hour, although alone later these thoughts seemed so real to her, she had to expend great effort to put them out of her mind. In subsequent sessions, we reviewed the fantasy or hallucination until she could tolerate it. Several weeks

elapsed before her terrified reaction subsided.

Results of Treatment

She has moved along developmentally and has separated a good deal, both from her husband, and from her sons and daughters. The clinging and overcontrol has disappeared.

When the oldest girl became 13, Mrs. B.'s fears led to such nagging accusations about possible sexual activity, that she very likely could have pushed the daughter into precisely that conduct. Fortunately, she became able to talk to me about the worry, instead of acting on it. Later, she gained awareness she had projected her feelings from her own adolescent behavior. Although the concern recurred as each girl became 13, she was better able each time to handle the fears in such a way as to minimize damage.

The results of her enormous efforts in regard to her children are apparent. These young people are in quite good mental health and have a keen interest in life.

There have been decided shifts in her actions with her parents and her siblings, a gradual loosening of her involvement and feelings of responsibility for them.

An important new therapeutic support Mrs. B. has acquired is in the form of a close friendship with a woman who is spontaneous, warm, and accepting. This woman and her husband enjoy many interests, and Mrs. B. receives a good deal from this contact. She feels nourished, uses them as role models, as well as to test reality.

Her fears and hypochondriasis became quite mild for months at a time during our first contact, but increased in strength at periods of stress. In the present contact, the fears gradually receded during the first year, and since then are rarely in evidence.

She is able to give to herself and to allow rest and pleasure. As finances are now comfortable, she takes trips, buys clothes and household items as she wishes. This reflects her increase in self-esteem.

A valuable gain was her fulfilling a long held dream of becoming a nursery school teacher. She enrolled in a community college program which took four years, and completed that a few months after returning to treatment. Her present part time work affords her profound gratification. She is engaged in further courses with the goal of directing a nursery school. This indicates an advancement in the grandiose-exhibitionistic line of the self, in which

realistic ambition has been achieved and is proceeding.

There has been no recurrence of the impulsive sexual behavior for several years. Awhile back, she did enter into quite an involved relationship with a man. This was a deliberate decision, not an impulsive act. As she came to see her husband more realistically, she found they had little in common, and worse, that her respect and love for him had disappeared. All that remained was a feeling of responsibility for him. When her husband learned of the relationship with the other man, he reacted violently, threatened to kill the man or himself, and watched and followed her for weeks. She terminated the relationship in order to placate her husband, although she became more and more convinced she wanted a marital separation. Concerned about the effect this might have on her husband, she persuaded him to resume psychotherapy, and hoped that would sustain him through a divorce if she did make that decision.

Her relationship with her husband has been a primary focus of our work for the past two years. Fairly early in our first contact, she became comfortable resisting his controlling her by "the silent treatment," and has not be subjected to this for several years. Very gradually, she has

moved in the direction of seeing him as a separate person responsible for himself. However, she is still not completely free from feeling it is her job to make him happy, and to assure that he is not hurt or uncomfortable. The depth and tenacity of this need has frustrated and depressed her. We continue to chip away at it.

She has made a few comments about her growing sense of separation from me. Laughingly, she noted the difficulty she had contemplating buying a sports car, quite different from my more conventional model.

The amount of psychic structure she has been able to acquire by transmuting internalization is considerable, along both the grandiose-exhibitionistic and the idealizing lines. Her self-esteem has markedly increased. She has recognized and then achieved certain ambitions, and this line continues forward. Along the idealizing line, she has acquired self-soothing, self-regulating, and self-protecting mechanisms in all areas, and her ideals have expanded. Her self is no longer constantly in danger of fragmentation, so she does not have to resort to isolated body parts. She is clearer about what is inside and what is outside, where she stops and others start. Her self is more cohesive and more of a complete structure.

The Case of Howard

Big, soft, and rounded, 20 year old Howard had a babyish look as he sat uneasily in the chair across from me. His hands jerked awkwardly before alighting in his lap. His lips pressed primly into a slight smile. His eyes blinked a lot and moved nervously here and there, never fully meeting mine, and they finally came to rest momentarily on the floor.

To ease the tension I started, "Well, Howard, it's been a long time." He mumbled and nodded in agreement. I asked about his family. His mother had seen me for a period several years earlier. I found her an isolated, somewhat schizoid woman. She came in around marital problems, and stayed until she gained the courage to divorce her second husband, stepfather of Howard and his sisters. This man physically mistreated the boy, and verbally abused him and his mother. Howard had three sisters. One was two years older, and the other two were two and four years younger. Two had been clients of mine for awhile. The mother brought Howard to me once after her divorce when he was 13. At that time, he was almost immobilized, spent most of his time in his room reading. Apparently quite intelligent, his IQ was reported by the school as 160. In

spite of that, he had missed much school from kindergarten on, with one excuse or another, usually some minor illness. When he did attend, he was often cruelly teased by the other children because of his ungainly appearance and rather strange behavior. His mother had separated from Howard's father when she discovered she was pregnant with Howard, and there had been no contact since.

When I saw Howard at age 13, I referred him to a male therapist who treated him a few months with no noticeable gains. At the time he came to me at age 20, his mother had been on total disability for several years due to a degenerative physical condition, although she was able to take care of her basic needs. His maternal grandmother, who frequently visited this family, had been hospitalized several times through the years, diagnosed schizophrenic.

Howard completely dropped out of high school early in his junior year and did almost nothing but eat, read, and sleep for about three years. Then he got himself together somehow, and enrolled in a community college. He called me for an appointment a few months after entering college.

In our first interview, he was painfully apprehensive,

and during the early part responded minimally to my questions and comments. Finally, he was able to let me know he was in college. Then came a number of seemingly endless minutes in which his speech was halting and hesitant. He would manage a word or two, then sigh and fall silent. I tried to help him by making guesses about what he was struggling to get out. At last, he revealed that he was discouraged about his relationships with other students in general. More particularly, he felt he had been rejected by the only girl he ever let himself get close to. He had never dated her or anyone else, but he had been able to talk with her.

Only during the next several sessions was I able to piece together some semblance of this rejection. Apparently the relationship was more in his mind than in reality, but probably was the most intimate he had had with anyone outside his family. On his bicycle, he several times tried to follow this girl in her car. One night, he either followed her or accidentally spotted her in a coffee shop having a snack with some friends. Daringly, he left a note in her car. Later, she informed him she was displeased with his action, and Howard was demolished.

In that interview, he dispairingly inquired what he

could do to repair the damage. I felt I was being asked to construct a map of unknown territory. Nevertheless, I did make tentative suggestions, such as his initiating a casual conversation with her about some occurrence in the class they both attended. I asked him to think about a specific happening he might comment on. Timorously, he practiced this with me, and later he did approach the girl. He subsequently told me that this worked fairly well, she was not unfriendly, but he was convinced he had "blown it" with her, and they could not return to the philosophical kind of discussions they earlier held. By then, he seemed sadly accepting of this finality.

As the weeks proceeded, he became more comfortable in sessions which allowed me to work less hard. He was learning a little of the art of casual conversation by my example and questions. I inquired about the events of the day at school and at home, about any amusing things that had happened, any unusual occurrence, about the pets in his home. Surprisingly, he could describe in sensitive detail many charming and amusing antics of these animals.

His oil painting and essay writing were consuming more and more of his free time. He had begun thinking about getting out on his own, and realistically recognized

that painting or writing were unlikely to financially support him. However, he was enrolled in TV courses, and thought some kind of job in a TV studio was feasible.

We had 37 contacts over a 10 month period. Several months before we terminated, he began to consider attending a state university which offered a good TV course of study. If he went there, the distance would necessitate his living away from home. About then, he obtained a part time job and bought a motorcycle for transportation. He applied to the university for admission and for financial aid, and was successful in both endeavors.

He terminated with me three weeks before school began, as he planned a solo motorcycle excursion. This was to be his first trip away from his mother--he was truly venturing out into the world.

Discussion

I do not know if Howard actively hallucinated, but he apparently spent a lot of time in intense fantasies, although he did not report these, and I did not ask for them. Sometimes in sessions during silences, he seemed to drift off to some faraway place and appeared slightly startled when I interrupted. For this reason, I did not

allow many long silences. I titrated them just enough, I hoped, to enable him to learn to tolerate them, and to initiate conversation himself.

This young man had a severe disorder of the self, and was probably psychotic. Nevertheless, his getting himself together and to school for several months before starting therapy with me, is indicative of strength.

My efforts with him were to help him develop compensatory mechanisms, and no attempt was made to touch the underlying defect. The work was along both lines of the self. I mirrored by my close attention to any production of his, from his first halting verbal attempts, to his later bringing in pictures to show me. They were abstracts, truly beautiful. My response was in regard to the emotional reaction they aroused in me, and these comments obviously pleased him. He evidenced a quiet dignified pride. My actively teaching him conversation and relationship skills by suggestion as well as the practice of our sessions, served both lines of the self. They showed an interest in him, which is in the mirroring line, and they helped him learn to live in the world, which served the idealizing line. Suggestions and advice about school, jobs, school loans, and living arrangements also served the idealizing

line.

While I did not discourage relationships with either sex, I did not show any particular interest in these, as I thought he was deficient in this area and would do better to strengthen compensatory structures in the area of the self. Thus, I was more active and supportive in regard to his painting, writing, taking a motorcycle trip alone, and other solitary activities.

His self-esteem improved as demonstrated by greater confidence and his gradually increasing advance into the world.

I believe he was able to come in for treatment because I was the "family therapist," thus he already had an idealizing tie to me. Only slowly and hesitatingly did he allow me to become a selfobject. By the time we terminated, this relationship was fairly solidly established. Confirmation was provided by his "checking in" with me twice following termination.

The first was for one session shortly after he successfully completed two years at the state university. He had lived there in a dorm with a roommate, acquired several acquaintances with whom he socialized, and held a part time job. All in all, he appeared much more a part of the

world than the immobilized 13 year old, and the rather awkward 20 year old, I had earlier seen. While he still spoke with some hesitation, on the whole he appeared quite confident. With him, he brought three of his recent paintings to show me. He had decided he wanted a break from school, to work full time, and he wanted my ideas about a job. We discussed this.

The second time he came back for one session was almost a year later. During this time, he had held a couple of full time jobs and was living at home. Now, he wanted to get away, and was contemplating a move to another state to live with mother's brother and his wife, with whom he had spent some time during a couple of recent summers. His aunt and uncle were acquainted with a successful artist who was willing to help Howard with his painting. Howard wanted to work enough to support himself while learning more about painting pictures. I was in favor of his plan which seemed well thought through. That was a few months ago, and I have not heard from him since, but will not be surprised to have him pop in again one of these days.

While the bulk of the work in this case was completed prior to my acquaintance with Kohut's ideas, I

found his theories valuable in understanding the treatment of this young man. Social workers have for years recognized the importance of meeting people where they are, but Kohut's discovery of the development and transformation of narcissism added a new dimension. His framework made more comprehensible the correct treatment for an isolated, sometimes immobilized, person such as Howard, which was to help him primarily in the development of the self. This enabled him to develop compensatory structures which endured, and which allowed him to begin to function reasonably well and comfortably.

The Case of Harve

This is an ongoing case, a divorced man, now 38, whom I have seen weekly in individual sessions for 4-1/2 years in a family service agency. He was, in addition, in a group of mine for five months at the beginning of treatment, and in a co-worker's group for seven months during his second year of treatment.

Before starting with me, he saw another therapist at the agency for two months when she left and transferred the case to me. She gave me the following information: Harve was Caucasian, divorced two years after four years of marriage, had three children who lived with their mother in another state, claimed no religion. He was a door-to-door salesman who had difficulty functioning, and was often unable to get himself to work even a few hours a week. A severe dog phobia further curtailed his activities. He was still sometimes the top salesman of his district. These periods were followed by a long slump until he was almost penniless. Thus, he was living a hand-to-mouth existence and was $1500 in debt. He was well-read and intelligent, a talented jazz musician, but abruptly stopped that activity several years earlier. Also, he quit college within a few months of graduation. He complained about

financial problems and vague "weird" sexual difficulties.

He was a tall, gaunt, soft-spoken man looking younger than his age. When I first saw him, he was shabbily dressed and wore a coat much too large. He hunched his shoulders and seemed to pull himself into the smallest possible space, as if to hide, kept his head somewhat lowered, and eye contact was in a darting, evasive manner. All this reflected his characteristic shame and low self-esteem.

Toward the end of our first hour, he broke into fast, breathless sobs as he revealed he had come for treatment because he was caught in a bar masturbating under his coat, and was kicked out with a warning not to return. With disgust, he claimed he was perverted and a freak, and he had been unable to tell the previous therapist about his perversion. Because I was able to listen to this and not reject him, but instead show concern about his humiliation and desperation, he thanked me profusely. This grateful attitude has been much in evidence during our entire contact. (Kohut's idealizing transference.)

Paranoid trends were perceived during early hours in his closely watching my every move, and in the cautious way he presented material.

The previous therapist encouraged him to keep a journal. He relished this, and in the second and a couple of later sessions he read parts to me. I enjoyed listening to his beautifully sensitive writing, and he basked in my reaction. (Kohut's mirroring transference in the narrow sense.)

Most of the themes we have followed in the 4-1/2 years of treatment were introduced within the first few months. But, one of the difficulties of working with this man was the vague, tangential way he brought up issues with few if any specifics. I recognized that because of his paranoid thinking, attempts to get details would drive him from treatment. Later, he revealed more, but there are still gaps.

These principal themes have been: his sexual deficiencies; his "freakish" qualities and sexual practices; his problem getting himself to work; his reaction to a good sale which was either depression, or overexcitement with grandiose fantasies of million dollar sales and worldwide renown; his fear of possible homosexuality; his longing for his father's love; and his dog phobia.

He most frequently verbalized his conviction he was a weird, angry, friendless, "nothing," but sometimes acted

as if he were a vastly superior individual. He also alternated between feeling he was a victim or a predator. There were suicidal thoughts and occasional paranoid delusions.

Early Diagnostic Thinking

Before reading Kohut, I thought Harve had a paranoid character disorder, with a lot of shame, low self-esteem, and depression. In Kohut's frame, he was a paranoid personality. He had difficulty functioning on a day-to-day basis, and my first goal was to help him get through the day and then the week until I saw him again. With his paranoid ideas, I should not get too close and had to let him determine the distance as well as the pace. In addition, I knew he would be extremely perceptive, and I needed to be open about my feelings as well as willing to answer questions about my ideas or personal life, that I might not with other clients.

I anticipated that talking about his initial symptom would lessen the need to turn the impulse into action. Further, I hoped he could slowly accept the fact he needed to keep a distance between himself and others, and not feel so uncomfortable about it. Essentially, I saw my job

as a parenting one, of teaching him modified ways of looking at himself and at life by identifying with my attitudes.

Sexual Deficiencies

Except for the four years of his marriage, his contact with women had been mostly with prostitutes or ghetto women, for sex only. There was a period when he was involved in jazz, that he had successful sex with a number of women. Otherwise, he was often impotent, and there had been only one woman with whom he had been able to sustain an erection. She was a kind black prostitute who was able to contract her vagina for long periods.

It was months before he was able to inform me that masturbating under his coat in a bar was a frequent practice of several years duration, and occurred during his heavy drinking bouts. He got as close to a woman as possible, and carefully hid his activities. Later, it became clear that this practice was a reaction to depression or overstimulation following a good sale, or to some decrease in self-esteem. It was not until I read Kohut that I saw the full meaning of this behavior. It served to achieve some cohesion of his self when the self was in danger of fragmenting; also, the action provided a

short-term self-soothing mechanism. However, for two or three days following one of these episodes, he felt so weird and remorseful, as well as hungover, that he was unable to work.

Work Inhibition

Fairly early, he described aimlessly driving around for hours in dread of going up to a door to face a potential customer. Later, he deplored "prostituting" himself to make a sale by acting pleasant and self-assured when he felt angry and inferior. Still later, he expressed his dilemma that if a sale was easy, he thought he was not working hard enough, if it was difficult, he believed he had manipulated the customer. Until a change in employer and sales area two years ago, he preferred approaching young ghetto women with suggestive sexual remarks until he inveigled them into a "yes mood," then he switched the subject to his product and completed the sale. From time to time, he afterwards contacted these women for sex.

History

Slowly, some details of his early life came out, many he still does not remember or has not decided to disclose. (See Freud, 1925, p. 387, regarding the

difficulty of working with paranoids who say only what they want to say.)

He was reared in a middle western city, and is the oldest of three children. He recalls almost nothing of a sister 10 years younger and a brother 12 years younger. He and his mother spent almost every waking and sleeping moment alone together for his first five or six years, while his father was away in World War II. He remembers no details of this period.

He felt cast out when his father was discharged from military service. Nevertheless, he tried desperately to win his father's love, but received only cold rejection or belittling criticism. The one thing he remembers his father approving was Harve snickering at love scenes on TV. Later, he recalled his father occasionally inviting Harve to fix something with him. Then, his father did all the work accompanied by lots of grunts and excessive body movements, apparently contrived to obtain Harve's admiration.

After the war, father worked as a foreman in a factory. He had a hearty manner and espoused middle class values. Also, he frequented bars, used prostitutes, and when mother found out, she stopped sleeping and

talking with father. Harve was then 13. They divorced after he left home.

Much of his feeling of being a freak he has associated to an incident when he was 13, although this emotion must have been engendered much earlier. He found a calendar with a picture of a girl which he took to bed with him, then forgot it the next day. He was horrified when his mother found it and told him he was too young for "it." Although unable to describe the details, he sobbed about this incident several times. I have referred to it when he reported feeling weird, and he agreed the feeling was the same. I think somehow his mother communicated that his normal sexual feelings meant he was weird.

As for masturbation, he said there was none until he entered the service at 19, then for awhile he masturbated almost continually, and since, gradually less often.

Many times he complained bitterly of his mother wanting him to remain a "boy." He associated that also to the period when he returned from the Army and thought he should find a job. His mother repeatedly assured him he had plenty of time.

Harve described himself as a loner in high school. He was attracted to girls, but was too uncomfortable to

talk to them. He had three male friends who were considered peculiar, although two are now quite successful. Harve preferred to spend most of his time alone, playing his clarinet or reading.

After high school he bummed around for awhile, then enlisted in the Army for four years as a musician. Following that, he attended college a little more than 3-1/2 years. Then, there was more wandering around during which he played jazz off and on, mostly with black musicians. At times, he gave away everything he owned and was often without food for two or three days. Then, he remembered wistfully, people would sometimes buy him coffee and donuts. He depicted this period as a very gratifying one.

Following his second bumming around internal, he obtained an office job where he met his wife. He cannot understand why she married him, as she was good looking, middle class, and a nice person. This is the only woman with whom he has had any emotional involvement. Of his marriage, he has divulged little except the sexual problems. His wife was dissatisfied with his premature ejaculation and impotence. Several times he hit her, she threatened to leave, and when he hit her again, she left. In other

ways, he treated her in a derogatory manner and believes he drove her away. Following the divorce, he was arrested and jailed three or four times for drunk and reckless driving during which he took serious chances with his life.

Before his marriage and after the breakup, he preferred to spend his time in a black ghetto, as he felt an affinity for poor black people because of his identity with what he considered outcasts in society, and because of his interest in jazz.

Transference and Countertransference

Already indicated is the bipolar nature of the transference that started in the first and second interviews. In early sessions, he tried to erotize our relationship. For example, he looked at me appealingly and professed that he could spend the rest of his life talking to me. My countertransference was of concern, I was touched, I also had some sexual feelings. I try to handle countertransference that might interfere with treatment by fantasy or by talking with a colleague or consultant.

He displayed a belittling, attacking attitude toward me for the first time in the fourth month of treatment.

This continued periodically for about two years, until I came to look at rage as a reaction to an injury to the self, as Kohut proposes, and the attacks gradually diminished. More about that later.

Because of his paranoid perceptiveness, he knew when he "got" me, and sometimes picked up feelings I was unaware of. When this happened, I admitted my feelings, but would not argue about them or discuss them at length as he pushed for. Harve's rage with me alternated with an overidealization, as well as a fear I would terminate his treatment following an attack.

Somewhat enviously and at times disparagingly, he has referred to me off and on as the "sorority" type, middle class, rich, and successful.

He sometimes complained I did not understand how desperate his situation was, that I acted like his mother who thought he had plenty of time. There were veiled references to my wanting to keep him a "boy" like his mother. This complaint was an infrequent but recurring one which I did not understand until later.

He proclaimed he exaggerated everything to me as he had to his father. Frequently, he giggled as he started sessions saying he felt mushy with me. He related this to

the way father was with him, mushy and sentimental after harsh criticism.

Occasionally, he speaks of something assuming I feel or see it exactly the way he does. (An example of Kohut's more regressed alterego or twinship transference.)

Over a year ago, I noticed that for several sessions Harve appeared more distant and constrained. He revealed that, "I've been seeing you as part of myself." He went on that I seemed to care as much about what he was saying as he did, if I was talking he could cut me off and say what he wanted, and I didn't seem to mind. He clearly felt discouraged, as if he were doing something wrong. I assured him his reaction to me was quite alright, as it enabled him to speak freely which he needed to do in our sessions. (This is an example of Kohut's merger transference, the most archaic mirroring transference.)

Participation in My Group

At the beginning of treatment, I thought Harve needed to be seen more than once a week and that was not possible because of agency policy at that time, so I offered him a group I conducted in addition to his individual sessions. I question whether this was helpful. He

attended regularly for five months, often felt left out, and sometimes played therapist with perceptive comments. Quite critical of the women to me alone, he finally verbally attacked two of them who reacted with anger. This went on for two group meetings, then he dropped out feeling he had been "stoned." (This referred to a short story, The Lottery, by Shirley Jackson.)

His Legal Arrest

After a year of treatment, following Christmas, and while I was on vacation, Harve was arrested for indecent exposure. He spent a night in jail, was devastated, and saw no alternative to pleading guilty and "being hung." He resisted, then gave in to my persuasion to retain an attorney. Later, I talked with the lawyer two or three times, and to the probation officer assigned to the pre-trial investigation. When requested, I wrote a letter. I helped Harve plan the strategy of his approach to the various officials and to the court. He did fairly well, considering the deputy district attorney was insisting on a guilty plea and a court order that he register as a sex offender. Harve was finally allowed to plead guilty to disturbing the peace, and he had to register for that,

which involved one appearance at a police department. He was also fined $200 and placed on four years probation. All the court proceedings took about seven months, during which he was in an agony of suspense.

A review was held a year later. I again wrote a letter as requested, and I recommended that probation be terminated. That did happen, and Harve no longer had to register.

Co-worker's Group

Following his arrest, he asked for a second weekly appointment. As I was unable to provide that, I referred him to the group of a male co-worker in addition to his weekly individual sessions with me. He attended that group irregularly for seven months.

During those last few months, I was going through a crisis in his treatment. Harve had become increasingly critical and attacking of me: I wasn't helping, I asked dumb questions, I didn't remember things we discussed. His attacks aroused strong countertransference of anger and hate, helplessness and stupidity. Then, he sadistically enjoyed pointing out my discomfort and accusing me of being unprofessional. I admitted my anger and my dislike

of being attacked, and he thought it unfortunate I couldn't be more objective. I began to dread the days of his appointments.

Although I did not recognize it then, I now think Harve was reacting to what he perceived as a rejection when I referred him to someone else. Further, I think he was responding to a difference of opinion that was going on between my co-worker and me about Harve's treatment. Harve aroused strong countertransference in my co-worker. He urged me to actively encourage Harve to complete college and to become sexually involved with women, as he was wasting his life. I thought this approach was incorrect, and our disagreement was never resolved.

Harve sometimes complained about me to the group, then my co-worker more forcefully criticized, and also pressed me to transfer Harve's individual treatment to him. I was about to capitulate when I decided I needed consultation. Fortunately, this helped me see that a transfer was not appropriate. Soon thereafter, Harve stopped attending that group.

Several months later I discovered Kohut, and in the pages of Restoration of the Self, I encountered Harve a number of times. Of greatest benefit, was seeing hostile

rage as a reaction to an injury to the self. When Harve became angry, I began to look for such a hurt. This changed my whole stance. I started asking him if I had done anything that bothered him. On one occasion, he stopped short, and after a pause said I hadn't seemed very glad to see him. At times, he has thought I was distracted or bored or not listening. Usually my asking and admitting my true feelings has reestablished the selfobject tie.

Development of Original Symptom

A couple of months after the court proceedings, Harve let me know he had again masturbated in a public place. I became quite directive and told him it was important he discuss this with me any time it occurred as he was taking serious chances. If caught again, he most likely would be convicted and have to register as a sex offender. There were one or two more incidents which he did talk about, but none now for over 2-1/2 years.

Two questions might be raised here: one, how do I know he did stop and was not just telling me that to pacify me; the second is a matter of correct technique. As for the first issue, I believe he did stop because from time to time he has referred to thoughts about engaging in public

masturbation again, and then discussed the activity he substituted. More recently, he has noted incidents which formerly aroused in him the need to do his "bar thing."

As for technique, my intervention was directive and could have stopped his activity only if it permitted him to grossly identify with me. This is what I think happened, there was no transmuting internalization. Because of the primitive nature of Harve's self, I believe this intervention was appropriate.

About the time he discontinued this sexual practice, he decided to stop smoking and drinking, he started jogging and other body building activities, and he began eating nutritious meals after living on junk food for years. At times of low self-esteem, he has resumed some drinking and smoking, but less than in the past. When depressed or overstimulated following a good sale, he more often used jogging, swimming, long showers, or masturbation in private for relaxation.

Paranoid Thinking

In the third month of treatment, he became able to take his coat off for the first time in my presence. He did it slowly and deliberately, with great caution. And, when

he accomplished this act, he looked relieved and slightly pleased. I smiled and nodded. My response was a mirroring function, appreciation that he was able to complete a difficult task he had set for himself.

A couple of months later, he was able to take his coat off outside my office. He had literally been hiding within that shabby, shapeless coat. His being able to take it off indicates some slight decrease in his paranoid suspiciousness, and some modicum of increase in self-esteem.

In the seventh month of treatment, he talked in a confused, delusional way about "having to move again." Something had happened where he lived in an unfurnished room, and someone was trying to hurt him. I encouraged him to check it out. He did that, reported next session, again obscurely, that things were alright.

He did move in the eighth month to nicer quarters, a furnished apartment where he could swim every day, although still in the ghetto. This was a deliberate move upward, not an impulsive running away.

He became delusional a couple of times after I wrote the letter following his arrest, even though he read it before it was mailed. He wondered if I were tied in with the power structure, asked if I might show him one letter

and send another. He even questioned whether he had participated in "nailing" himself by allowing me to send the letter.

Occasionally, Harve reported people looking at him threateningly which caused him to "slink away." Or, people peered at him strangely on the street. Once in awhile, he had a tire slashed or a window in his car broken, and usually thought someone had "done it to him," then gave an unclear, jumbled account of the reason.

After almost two years of treatment, he noticed he no longer had to watch me all the time. Thereafter, he discussed with me his feeling someone was out to kill or do him in. By examining it with me, the fear diminished.

Homosexual Fears

In an early session, he revealed that after a good sale he had gone looking for a male prostitute for fallatio. Later in the hour, he sobbed as he recalled a clarinet solo he performed in a high school program which his father attended but showed no interest in. His sobs increased in intensity as he yearned for his father's love. The connection between this and his wish for contact with a man was obvious.

In the next session, he insisted his penis was too small, expressed concern he was homosexual and worry I had him so diagnosed. Later, he specified four incidents in which men gave him money to let them fellate him. Other than these occurrences, and in early adolescence he and a male friend once mutually masturbating each other, he has had no homosexual contact. His fantasies during masturbation were always of a woman's "soft flesh."

A number of times, he disparagingly claimed weak, girlish qualities such as "no guts," crying, physical powerlessness. Thus, he fears a feminine orientation and depreciates femininity.

Longing for Father's Love

He amplified this with intense emotion. His father wanted him to be a "man," he boasted with pride, contrasting that with his mother preferring he remain a "boy." Father encouraged him to be successful and make a lot of money. In a much later interview, he thoughtfully decided father would be downcast if Harve outdid him. He claimed he despised his father's superficial middle class values, but that he identified with father's belittling attitude toward women, roaming bars, and using prostitutes.

A number of times he admitted looking for "daddies," and referred to several bosses. He scorned his phony subservient attitude toward them, his strong wish for their admiration, then his fury this was not forthcoming.

He once dreamed of a man kissing him; also of a man hitting him then putting his arms around him; later, he had two dreams of a man wanting to be near him and Harve pushing him away.

In a session beginning our fourth year, he depicted his individually visiting three old bosses and presenting himself as a "boy," like a dog rolled over on its back to show its vulnerable side. The bosses were not responsive, and he went away feeling sorry for himself and wanting to smoke a cigarette, like desiring to suck a breast, he said.

Dog Phobia

He is afraid a dog will attack him, so he avoids any dwelling a dog is near. A tiny dog is as great a threat as a large one.

He had a devoted male collie in adolescence which he loved but also sometimes hit, and he showed off to a friend he could punch the pet which would then lick his hand. He described his first sexual experience as having

this dog lick his testicles, then he struck the dog.

He related his mushy sentimentality with the dog after hitting it, to the way father was with him after being harsh and critical.

Later Developments

During the second year of treatment, Harve could admit he was often vague, and that he gave me few details. He was afraid I might have him arrested or committed if I knew more about him. Later, he acknowledged the relief he would feel sitting and reading in jail or a mental hospital, with no responsibilities.

He began revealing occasional thefts of small sums of money from work, or signing a sales contract fraudulantly, or lying on a sales agreement, once of stealing some sunglasses. After each of these events, he slept intermittently, and tortured himself for several days with obsessive worry about being arrested.

Two years and nine months into treatment, he made a major change by going to work for a company which took him out of the ghetto. This eliminated his exploiting lonely women on welfare, and gave him the possibility of earning more and living better. Unfortunately, my

vacation coincided with this change, and he was able to complain for the first time about my being away. Earlier, he jeered that he had heard about the transference, and he could stop coming in anytime he wanted without feeling a thing.

The holiday season is the worst time of year for him, it is then his self-esteem is lowest and his slumps are deepest. Towards the end of the third year of treatment, shortly before Christmas, Harve came in giggling and acting coy. With glee, he reported consuming a lot of alcohol, then having an urge to rob cars. He roamed a parking lot, exposed his penis, dissolutely explored several unlocked cars, but found nothing he wanted. In a teasing way, he referred to himself as a robber baron, as a creepy crawly creature, he compared himself with the Manson family.

That night he had a dream. He was in a room with two other people, an ex-boss and a vague man or woman who was like a child. Each had his or her own snake, and they must kill their snakes before going to bed. He killed his by hitting it with a shoe. The other two did not slay theirs. Harve was in charge, and he sternly demanded, "Now, why don't you kill your snakes?" A dog appeared, it looked up at him smiling and friendly, but it was badly

beaten up, one eye was out and bloody, and its tail had been cut off and was bleeding. He ordered his ex-boss to murder the dog to put it out of its misery. The man hit it several times with a shoe, but Harve realized this was just torturing it. He saw a baseball bat and was going to finish the dog with that. But, he just couldn't, and awoke.

He associated: the ex-boss was like Harve, like a snake, hiding things. There were no associations to the other person, except that he or she was childlike, needing to be told what to do. The dog was one he had when married, that his wife left with him when they separated. It became "neurotic" in his care, and he found a family for it to live with. The dog's bloody eye reminded him of his mouth, he had an abscess and was often in pain because of a lot of needed dental repair. He could think of no other associations.

I commented on his being strong and in charge in the dream. He did away with his snake, the creepy crawly, weird, hidden part of himself he didn't like, I noted. The dog was a part of him too, I thought, the part he tortured and didn't take care of. He expressed relief, claimed I always saw the most positive things.

Gradually, he recovered from the 1977 holiday

slump and during the past 1-1/2 years has demonstrated increased self-esteem. He has been able to make sales calls on more men as he does not feel quite so inferior; the depression and overexcitement following a good sale have somewhat decreased; by last summer he had $1300 saved, more than ever before; he had his teeth repaired; he dresses much better; he dealt with a noisy, threatening neighbor in a confident manner; he began thinking he might like to have some "middle class" possessions; he started a Spanish class he enjoyed; he even fantasied visiting his family from whom he had almost completely cut himself off, due to shame about his life circumstances.

His complaints about my not recognizing how desperate his situation was, became clear after I learned he always had to act happy for his mother and to pretend he had many friends. When I looked at some action of his in a positive way, he thought I did not want to hear how miserable he felt, that I wanted only to see him happy as his mother had. His desperation was often in relation to his inability to work. When I have not pushed him, and have not been upset myself about his inactivity, he thought I wanted him to remain a "boy." We have worked to clarify this.

Again, the 1978 holiday season brought on a slump, and again he returned to some drinking in bars, but there was less, and he did not feel as low as in the past. During that period, he mentioned that several people had recently addressed him as "sir," and slightly smugly asked if I thought he looked older. I observed that "sir" was also a title of respect, and kidded him that if he wasn't careful he might join the middle class. He responded with a pleased grin.

For the first time, he "exposed his poverty" to his family. He sent them Christmas cards with a note that he hadn't been able to invite them to visit because he was not in a position to offer them the hospitality he would like. This was a large step for Harve, and he took it with serious misgivings, but later felt some pride he was not hiding as much as before.

For several months now, there has been no mention by Harve of worry about homosexuality, longing for his father's love, fear of dogs, and there has been no evidence of paranoid thinking. He has made a number of tentative excursions into himself and his childhood, attempting to ferret out how he became the way he is. Here, he is hesitant and uncomfortable. But, I believe he is beginning to

be able to make the effort to look at himself and to take some charge of his life. His work inhibition continues, and so we go on.

Discussion

Harve's symptom of masturbating in a public place is seen as a self-regulating mechanism. It was the way he handled feelings of overstimulation or depression following a good sale, unusually low self-esteem, as well as feelings of incompleteness or fragmentation. It also occurred when there was a break in the selfobject tie with me.

His overexcitement was due to insufficient mirroring of his archaic exhibitionism and grandiosity by his mother, so that he was not able to transform those qualities into realizable ambitions. When such a person has some success, his unmodified grandiosity gets activated, and the tension can become unbearable. Here, we see a difficulty with the theory. Unmodified grandiosity is in the mirroring line, tension regulation is in the idealizing line. This symptom is due to a breakdown in both lines of the self. The interaction between the two lines has not yet been clearly delineated.

Fragmentation of the self was the cause of the

original symptom as well as the actions which led to his legal arrest, also the erratic spree in which he robbed cars with his penis exposed. He used sexual exposure and criminal activities to achieve some cohesion of the self, also some self-soothing. He could relax and go to sleep after these occurrences.

Neither of Harve's parents responded empathically to him. His mother used Harve as an extension of herself by keeping him near her for those first five or six years, and later as well. Her expecting him to be happy and have friends, rather than accepting him as he was, met her own needs. She did not mirror him sufficiently. Therefore, not only was he unable to transform his exhibitionism and grandiosity into ambitions, but also he was not able to achieve adequate self-esteem. This latter is reflected in his characteristic depression.

Since his father was away during his first few years, the father was unable to merge with Harve and then allow himself to be idealized. Even when he returned, he was not responsive, but rejecting and critical. At times, he presented himself to be mirrored by Harve, demonstrating his own pathology of the self. Thus, Harve was not able to develop healthy ideals.

Because of the lack of empathic response from either parent, Harve was prevented from acquiring self-soothing, self-protecting, and self-regulating functions. This accounts for his neglect of himself and his health, and his inability to handle anxiety adequately. The absence of healthy ideals as well as the lack of self-regulatory mechanisms, is the cause of the lying, stealing, manipulating, and predatory activities.

His low self-esteem and the underdevelopment of ambitions and ideals is evident in Harve's inability to work more than a few hours a week. It is also shown in his being unable to achieve beyond a certain point, such as discontinuing jazz music and dropping out of college within a few months of graduation; also, his difficulty rising above a marginal level of existence.

Because both parents were insufficiently responsive, Harve has severe deficits in both lines of development of the self, the grandiose-exhibitionistic line and the idealized parent imago line. Thus, it is questionable that he will be able to achieve a fully completed self.

In treatment, Harve has taken in some of my values and attitudes by gross identification, but there is doubt about how much he will be able to transmutingly internalize

these qualities into his own self. He has, by identification, acquired some self-esteem and has learned better self-soothing, self-protecting, and self-regulating mechanisms.

My cautious expectation is that with enough mirroring from me, as well as allowing him to idealize me, he can gradually let himself work more, and live more comfortably, with increased self-esteem. I also hope he can develop some of his considerable talents and skills, which he can then use as selfobjects, to make himself feel more alive and complete, to give him personal satisfaction, and perhaps to bring some mirroring from others.

His ability to acquire meaningful object relatedness is questionable. It is possible he can learn to permit himself the distance from others he needs without feeling so weird.

The Case of Susan and Mike

This is a young Caucasian, Catholic couple, Susan, 21, and Mike, 24. I saw them a total of 20 sessions over a 5-1/2 month period. The primary focus of the work was on Susan. After the initial interviews, Mike was seen from time to time with her.

In the first conjoint session, Mike, a big husky man, presented himself as the head of the family, gruff, concerned, subtly hostile. The hostility was a defense against his feelings of impotence about needing help. In his culture, men were supposed to be strong and to handle their own and their families' problems. Susan appeared fragile, helpless, confused, and at times, terribly alone and starkly frightened.

Mike introduced the reason they were there. He and Susan had been married only five months. Both were from large families, they had had a traditional church wedding preceded by extended religious preparation, and they were baffled by the problems they came in with. Susan could barely fight back tears at work and elsewhere, at home she cried continually. While she managed her necessary duties, she was finding it increasingly difficult, and wanted to sleep all the time. Mike suffered stomach

distress, from mild discomfort to intense pain.

This couple stated they got along well, seldom became angry, and just wanted to be happy. They grew up in large, working class families, and both had completed high school. Susan was employed as a stock room clerk, and Mike was training to be a machinist in a metal shop. Susan had no friends, former acquaintances had all moved away, and Mike spent little time with the guys he used to hang around with. They talked little about their sex life, although both conveyed that it was quite satisfactory.

In this first session, every time Susan spoke she hesitated, looked at Mike and proceeded only when she received some nonverbal cue that it was alright with him. At first, I thought she was immature and had an excessive need for approval. Later, I realized her need was more profound. Her object relations were primitive. Objests served as selfobjects affirming her right to exist, and perhaps even the fact she existed. Susan expressed this as expecting Mike and marriage to meet all of her needs which she acknowledged was unrealistic.

Mike was an uncomplicated person who primarily wanted the conventional comforts and simple pleasures of

life. He was willing to work to obtain these, but was not particularly ambitious. When seen alone, he revealed his concern he had made a mistake by marrying. The change in his life from a year earlier was staggering. He must now earn $900 a month just to meet expenses. He could not spend time with friends because Susan did not like to be left alone. Also, he always had to be correcting her, like her mother, he said, because she made such dumb mistakes.

While he could verbalize it only vaguely, Mike saw Susan's need for him and her bids for his attantion as excessive. Because he was "nice," he could not refuse or show anger, so his method of expression had become psychosomatic, his stomach discomfort.

Thoughtfully and with some remorse, he insisted he did not like to consider that his marrying was an error. I encouraged him to think about it and to talk with me about it. He worried if he thought about it he might leave Susan, and I assured him that did not have to happen. He experienced relief in frankly complaining about the responsibilities and the disappointments of married life.

In the next two split sessions, Mike's stomach was better and he focussed on Susan, especially her concern

she might become like her mother who slept all day, neglecting her children. His primary message here was that Susan was the client, and I accepted this.

Susan was much more troubled than Mike, and when she found me willing to listen and try to help her, she made a quick idealizing transference. My countertransference was a strong desire to help and protect her, but further, a keen awareness of her intense fear and feeling close to fragmentation.

Early, she asked how she could go about making new friends, and other things she could do to help herself. I responded in an educational way, with concrete suggestions. She listened carefully and the next hour, with quiet pride, told me what she had accomplished. She enrolled in a crafts class, and also contacted a young woman she previously knew and arranged a visit. Seeking and receiving guidance characterized much of our work together.

By the fourth interview, I was fairly well established as an idealized selfobject. Susan then softly professed that she spent all her time each week thinking about our sessions. After that, I saw Susan individually for six full sessions. Mike was quite agreeable and accepted an

appointment for a later conjoint interview.

I thought Susan had an almost complete absence of purpose in her life, was nearly overwhelmed by feelings of aloneness, depression, and hypersensitivity to slights. While I had not yet read Kohut, I now think her self at that time was a rudimentary, precarious structure. Early in these sessions, she talked about various current problems which centered around powerful feelings of aloneness and a marked need for selfobjects to affirm her. As a result, she allowed people to denigrate and take advantage of her.

At her place of employment, her boss arbitrarily and inconsistently performed some of her tasks, then blamed her when mistakes were discovered. She had been threatened with termination if there was another error. Often she arrived home sobbing. Tearfully she portrayed another issue. Her husband's and her own family frequently questioned her, to the point of harrassment, about the reason she had not become pregnant. We contemplated her inability to protect herself from these barbed comments, and then, how she might do so. In essence, I gave her permission to take care of herself.

As we went along, the relationship between her and Mike improved. But, in one hour she contended she had to

discontinue one of her crafts classes as she had designed a wooden bathroom and Mike "sort of took over the project." She described them as "becoming competitive," and declared she could not let that happen. Again, her intense need for Mike's presence made her avoid any situation that might anger or disturb him.

She started to talk about events two years earlier. A boyfriend and she had begun to think of living together. One night, he drove off after heavy drinking, had an automobile accident, and was instantaneously killed. She was overcome with what appeared to be feelings of abandonment. In addition, she faulted herself for letting him drive while drunk. After his death, visual hallucinations haunted and terrified her for several disorganized, now hazy weeks. These were usually of snakes on the windshield of her car. She saw a therapist about eight times until she felt better.

Susan began to allude to childhood events, then hastily changed the subject. One hour, she resolutely declared that she must now get into talking about her family. She sobbed as she recalled her mother sleeping all the time, giving her no nurturance, or even the rudiments of child care. She had a number of siblings, and

an older sister occasionally comforted her. Quite early, she was pushed by her mother to take care of still younger children. Her father was away most of the time.

Especially painful was an incident at age 16, which probably encapsulated many earlier occurrences. She had a severe case of poison oak and was not taken to a doctor by her mother until seriously infected. As she spoke of this, she cried unconsolably for several minutes.

Susan continued to bring up various incidents of her childhood in which she felt alone and uncared for. From time to time, I related these to more recent and current similar feelings, and especially to her now looking to Mike for the confirmation and care which were lacking in her early life. She found it reassuring there was an explanation for her behavior.

In another session, she expressed alarm that Mike might become infatuated with a young woman they knew who was sexually seductive. She worried about being abandoned and helpless as she had felt when her boyfriend died, and then when two other young men rejected her. I noted the correspondence of this current fear with childhood experiences when mother absented herself by sleeping. She responded with a depressed nod.

Mike and Susan were seen together the 11th hour. He was feeling left out, his stomach was bothering him again, and he complained they had no social life. With Susan's agreement, I explained to him that she and I had been mostly looking at what she had missed as a child, that she now wanted Mike to provide this, and she was trying to learn other ways to meet her needs. He was glad to get this report, but wanted to be included more in the sessions, so we agreed on conjoint sessions every other week. Mike's attitude is indicative of the importance of his need for Susan as a selfobject, over whom he had a good deal of control. I made no interpretation. Their marital relationship seemed to be the kind both of them wanted and needed.

Susan was surprisingly pleased at my comments to Mike. She apparently heard them as validating and clarifying. They were, of course, explaining her to him and asking him to understand her.

In a later session, Susan sadly recognized she asked Mike's permission for everything. She scornfully berated "the big lack" in herself, asked how large it was and how it had happened. I responded that as a child she had not learned that she deserved some things she wanted. She

mused, "Another mother thing, huh." She quoted Mike as commenting that since they had been coming in, they had learned that when they faced something, it went away. I agreed that often happened, and encouraged her to watch herself asking for permission, and I hoped she could learn to be compassionate about it.

In our last two individual sessions, Susan reported several gains. She finished a craft item which the instructor wanted for a show, and she spoke of the calming and fulfilling satisfaction of her craft work; she enrolled in a health spa for body toning; she had started looking for another job as she decided she would no longer tolerate her intrusive, inconsiderate employer; also, she stopped a relative from teasing her about having a baby.

She was particularly pleased she had been able to assert herself with Mike, and she gave the example of directly asking him to build a table he had promised. In this instance, she was speaking to Mike as an equal, rather than coaxing or pleading or asking permission like a child. We both took pleasure in her progress. Here, my response was a mirroring function.

She and Mike wanted to come in one more time together to review what had happened in their therapy, and

to determine how to prevent trouble in the future. The last conjoint session was spent mostly in going over their plans for the months ahead. Mike had some ideas of starting a small business, also they might buy a boat now that they would not have their therapy to pay for. Both grinned. Mike wanted any direct suggestions, and I thought they were doing fine.

About five months later, Susan called concerned about her mother. They came in together for one session. Susan hoped to get her mother into therapy to work on her many problems which she would not admit nor do anything about. I addressed the frustration of seeing people we care about refusing to get help for themselves, but the impossibility of obtaining treatment for individuals against their will.

The marriage, they warmly proclaimed, was better than ever. Susan had a new job which was satisfying, and Mike had had no recurrence of his stomach distress. They looked relaxed and comfortable with themselves and each other. Susan was disappointed nothing could be done for her mother, but seemed relieved she had at least made the effort.

The situation with her mother appeared no different

then than it had been earlier. I was unable to determine any particular reason for the contact at that time. At least in part, it was a renewal of the selfobject tie with me, in which they both wanted to participate.

A little over a year later, Susan called to ask me to recommend a speaker for a public service organization in which she was then active. We talked briefly on the telephone, and she let me know the marriage continued to go well, her job was still fulfilling, and her participation in the public service work was quite rewarding.

Discussion

Because of the intensity of Susan's feelings of aloneness, and my perception of her distress as near complete fragmentation, I believe she had a borderline disturbance. However, she rather closely fits the description of a new category Kohut and Wolf (1978) have designated a merger-hungry personality. Susan's need for merger, however, appeared at times to be to affirm her very existence, which may indicate she was more disturbed.

She urgently needed constant merger, and Mike did not want to merge as much as she. I offered myself as a transitional merger object, and helped her find crafts and

and other activities to use as selfobjects. The speed with which she accepted these, I think, was due to her gross identification with me. She introjected my permission to assert herself and protect herself, and was able to continue to use this after termination.

Did her self become more structured and more cohesive? That is difficult to answer. I believe she continues to use me as a selfobject, evidenced by the two contacts after termination, and this may be the reason Susan has been able to retain the progress she made. It may also account for her appearing to have made advances in both lines of the self: increased self-esteem allowing assertive behavior; and development in the idealizing line permitting the acquisition of self-soothing and self-protecting mechanisms. The contact 1-1/2 years after termination indicates the improvements are enduring.

CHAPTER VI

CONCLUSIONS

In this dissertation, I have attempted to demonstrate an adaptation of Heinz Kohut's psychoanalytic psychology of the self to the practice of clinical social work. Certainly, these elaborations are far from complete. The consonance of Kohut's ideas with the values, precepts, and practices of clinical social work is shown by noting the striking similarity of many statements and constructs of Kohut's with those of a number of clinical social workers. This consistency is further illustrated by four case examples. The case material details a manner in which Kohut's theories can be adapted to once a week clinical social work treatment of clients who may be more disturbed than narcissistic personality or behavior disorders. Some difficulties in the use of these concepts are indicated. And, finally, ways in which Kohut's ideas add significantly to the understanding of human personality and markedly benefit clinical practice are delineated.

One of the usually unspoken conspiracies among many clinical social workers is something like this: "Let's continue to be the helpful clinicians we are, but let's not talk about what we do." An important goal of the students in the doctoral program of the California Institute For Clinical Social Work is to define methods, to be as clear as possible about the concepts underlying clinical work, and to describe openly what is being done in practice, why, and what the results are.

Here, Heinz Kohut provides an invaluable bulwark for many clinical social workers. Because of his prestige as a highly respected member of the psychoanalytic community, because of his brilliance as a scholar, because of the original creativity of his discoveries about the self and self-pathology, and because a number of his methods are similar to those of many clinical social workers, he is enabling some of them to have the courage to reveal themselves and their work.

While advantages have been indicated in regard to adapting Kohut's framework for use as a theoretical base of knowledge, much remains to be done to find an answer to a central question. That is, what stance, concepts, and techniques are helpful in the clinical social work situation,

with which clients, and why?

Many factors need to be addressed. The entire matter of supportive techniques requires even further study. Definitions are still not agreed upon. For example, exactly what in the clinical situation constitutes gratification, clarification, limit setting, environmental manipulation, education, parenting, support--to name a few techniques sometimes used in clinical social work treatment.

An instance of a difference in the understanding of terms is this. Kohut (1977) equated "education" with urging self-control or insisting that a patient give up an offensive symptom. And, I certainly agree with his contention that this is not helpful. However, by "education," some clinical social workers are conveying the technique of teaching clients methods of functioning, and I believe this practice is helpful to many clients.

Ornstein and Ornstein (1975) helped elucidate this whole area in an article about the interpretive process in psychoanalysis. It is the patient's perception, they stated, rather than the analyst's intent, which is decisive. I endorse this view as accurate and applicable to all interventions. But, it raises the critical issue of the means by which to determine how a patient will preceive an

intervention.

There are many more questions. Much further thinking and framing of relevant concepts derived directly from clinical experience needs to be accomplished for clinical social work to clearly and correctly define its theory and methods.

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