Defects in the Self: Liberating Concept or Imprisoning Metaphor?

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The doctrine of defects in the self leads to a clinical focus on what is missing rather than on what is present in pathological organizations of self-experience. Felt deficiencies in the sense of self may be understood not as manifestations of an irreducible internal defect within the person, but rather as the consequence of various organizing principles established in early transactions with caregivers. An illustration of this idea is provided by a brief description of the life and treatment of a young woman who felt that she had no self and that she did not exist.

In this paper we briefly describe a young woman whose experiences and delusions bear interestingly on the doctrine of defects in the self. This woman, a 22 year-old hospitalized psychiatric patient, said that she had no self, was not real, did not exist, and was absent rather than present. The defect in her self, speaking phenomenologically, was not located in a preconscious “sense of the incomplete reality of the self” (Kohut, 1971, p. 210), which has been described as the core of narcissistic personality disorders; her experience was, rather, one involving a conscious sense of the complete unreality of herself.

The clinical context of her therapist's early encounters with this patient involved a struggle over a program of self-starvation she had undertaken. She had refused all food for a period of many days, and her weight, already low at the outset of this adventure, had begun to diminish to an alarming degree. In discussions she explained that she could not partake of food because anything she ate would necessarily be taken from someone else. It also concerned her greatly that animals and plants had to be sacrificed in order that she have something to eat. She said that she was made of “pure love” and thus could not do anything to deprive to bring harm to other living beings. The notion that she might die from her starvation seemed to have no meaning to her, and she was impervious to all rational argument concerning her diet.

Her therapist's initial approach to this patient was extremely concrete, emerging from a wish to stop her from killing herself rather than from any real understanding of what she was enacting. He told her that it was absolutely vital that she begin to eat again and that he had arrived at a solution he was sure she would find acceptable. He brought plastic bags of fresh fruit, nuts, and raisins to their daily sessions and told her that all the fruit and nuts had fallen spontaneously from trees into special baskets laid beneath the branches. Everything she was to eat would otherwise have simply gone into the ground and so she was free to partake of this nourishment without worrying about causing harm to others. He tried to show a sparkle of humor in his eyes as he presented this, in case the patient decided to focus on the total preposterousness of what he was telling her. Her reaction, however, was one of apparent acceptance, and she began to eat what he had brought. Her psychiatrist later joined in this intervention by taking cans of breakfast drink, denting them with a hammer, and presenting them to the patient with the explanation that they had been retrieved from the garbage. These too she began to accept. Over a period of weeks, again for reasons her therapist did not understand, the issue of self-starvation and the idea of being made purely of love receded from the patient's conversation and finally disappeared. In the meantime she continued to accept the things her therapist brought to her, the breakfast drinks, and a gradually increasing number of other foods from the hospital cafeteria.

Some months later, the patient and her therapist were walking across the hospital grounds to the canteen for coffee and doughnuts. She
turned to him and made the following statement: “There is this huge machine. Someone's inside it, hooked in. Wires come out of the machine and are hooked into another person. There is a switch on the machine and it has only two settings. When it is switched on one setting, it makes you forget all your memories and even your own name; when it is switched on the other one, it electrocutes the other person.”

This remarkable machine concretizes an organizing principle according to which the survival of other persons is contingent on the cancellation of the experience of her own authentic selfhood. If the patient retains her own memories, thoughts, and identity (symbolized by her name), someone else dies; if that other person lives, she loses all sense of herself. A partial isomorphism exists between this delusional machine and the starvation project described earlier. In the starvation enactment, if she ingested food and lived, others would have been harmed or made to die; if others were to be protected, her life would necessarily have been sacrificed. The embracing of love as her identity can be compared to the switch on the machine being set in the position that protects other persons at her expense. In a universe with these and only these possibilities—to live but to kill or to love but to die—she had opted for love.

Adopting the doctrine of defects in the self creates a clinical perspective from which our focus is on what is missing in the experiences we seek to understand, rather than on what is present. In exploring our patients' worlds, we are guided by an image of an optimally structuralized self, felt as cohesive in space, continuous in time, and with a stable sense of self-esteem. Disparities between this image and what is presented to us are then viewed as reflecting self-defects, results of various kinds of developmental deficits and arrests. Seeing the patient we have been describing from this viewpoint, as indeed her therapist did in their early work together, one's focus would tend to be on her sense of nonexistence, on the apparent absence of a cohesive and temporally continuous self, and one would be inclined to attribute this absence to an internal structural deficiency arising out of her developmental history. What such a view would fail to bring into focus, however, is that her experiences of nonbeing were themselves embedded in a well-consolidated structure of experience, an organizing principle according to which life affords only the mutually exclusive

alternatives of others being murdered or of undergoing psychic death oneself. This structure, as it was reconstructed in the course of the patient's treatment, appeared to have arisen out of a mergerlike closeness with her father that provided the only consistent tie during most of her developmental years, a closeness that protected the father from otherwise devastating feelings of worthlessness and suicidal depression. As the treatment proceeded, she expressed intimations of a developing sense of existing in her own right in a transitory delusion of having been attacked and stung by a swarm of bees. Her therapist came to understand these stinging bees as concretized symbols of sporadic moments of painfully felt being (“be’s”) interrupting the deathlike emotional numbness that had previously pervaded all her experiences. The delusion of the bees may also have carried a continuing trace of the machine, in that her increasing shift from selflessness toward a disemmeshed position honoring her own spontaneous desire in the new attachment to her therapist would inevitably be accompanied by a sense of deep foreboding and endangerment. Perhaps the painful sting of the bees corresponds to the “zap” of the machine that obliterates all of one's memories and identity. The steps of growing authenticity were also associated at every stage with consuming anxiety for the well-being of her therapist, expressing again the close link in her world between existing as her own person and endangering emotionally important others.

This case highlights the very different conceptions of psychic structure that appear in self psychology and intersubjectivity theory. In the original formulations of self psychology, Kohut (1971) envisioned psychic structure in terms of a reified conception of the self. The self, instead of being seen solely as a content of experience, was viewed as a mental entity in its own right, achieving through processes of (transmuting) internalization varying degrees of its own internal structuralization. The concept of structure within intersubjectivity theory, by contrast, refers to broad patterns within which experience repeatedly takes form, prereflective organizing principles manifest as recurring themes in the flow of subjective life (Stolorow, 1978). If we dispense with the reifications inhering in traditional self-psychological formulations and rely instead on the idea of organizing principles, then we can see that the experiences of nonbeing and of unreality present in our clinical case are not the result of any deficiency or lack of structure. These

experiences arise as the product of a quite specific psychological structure, namely, the organizing principle according to which the survival of the other is contingent on the cancellation of the sense of one's own authentic existence.
In some earlier writings critiquing classical metapsychology (Atwood and Stolorow, 1980, 1993), we argued that many of the reified constructs in psychoanalytic theory can be profitably understood as condensed symbols of various classes of experiences and can therefore be retranslated into phenomenological terms. Applying this translation project to the topic of the present discussion, the question arises: What are the experiences reified in the notion of defects in the self? We believe that there are two groups of such experiences, each associated with a distinctive intersubjective context of origin. In one of these, self-experience is dominated by a sense of defectiveness, of being inherently flawed, perhaps of lacking something essential that a complete person should certainly have. An intersubjective context producing this theme is one in which bonds to caregivers are repeatedly disrupted but the child maintains a tenuous sense of connection by shamefully ascribing the disruptions—and the child's painful emotional reactions to them—to a weakness, flaw, or defect within himself or herself. The second group of experiences are ones in which the individual feels a diminished sense of existing at all. This felt deficiency in the experience of one's very being is illustrated in the extreme by the case presented earlier. A common intersubjective context of origin for this pattern of self-experience involves very profound invalidation and the association of authenticity with the danger of the total loss or obliteration of emotionally important others.

The vision of the self as a reified structure needing nutriment from selfobjects, as noted earlier, establishes a clinical focus on what is missing rather than on what is present in self-experience. This focus seriously circumscribes our observational range as it leads to the homogenization and reduction of the multiple dimensions of transference to an over-inflated selfobject aspect (Stolorow, 1995). It has become apparent to us, for example, that the term selfobject transference is being used to refer to two types of relational experiences that have distinctly different origins and meanings. In one, the patient longs for the bond with the analyst to supply missing developmental experiences—what Kohut originally meant by selfobject transferences. In the other, the patient seeks responses from the analyst that would counteract invariant organizing principles that are manifestations of what we (Stolorow, Brandchaft, and Atwood, 1987) call the repetitive dimension of the transference. In the former, the patient longs for something missing; in the latter, the patient seeks an antidote to something crushingly present. Making this distinction has profound implications for the framing of transference interpretations, whereas merging the two types of relational experience into an overinclusive selfobject concept obscures Kohut's clinical contribution. One's interpretive approach to a patient's wishes for mirroring, for example, will be radically different, depending on whether the patient seeks mirroring of an emerging, long-sequestered expansiveness or of a defensive grandiosity serving as an antidote to an underlying sense of defectiveness or deficiency (Morrison and Stolorow, 1997). In the case of the former, mirroring experiences foster integration and developmental transformation; in the latter, addiction to the analyst's “responsiveness.” It is the search for antidotes to crushing organizing principles, not for archaic selfobject functions, that leads to such clinical phenomena as addictions, sexual perversions, and aggressive, grandiose enactments.

References

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