Commentary on Trop and Stolorow's "Defense Analysis in Self Psychology"

Stephen A. Mitchell, Ph.D.

I want to begin by thanking Drs. Trop and Stolorow for a very interesting paper. I am in basic sympathy with many features of the clinical approach they recommend and describe so clearly and persuasively. I see their perspective as similar and in many respects compatible with other major theoretical traditions, such as interpersonal psychoanalysis and some versions of object relations theories. Taken together, these various relational theories have provided a compelling and comprehensive alternative to the classical model of orthodox psychoanalysis. In my view, the battle against orthodoxy has been largely won; the real vitality and creativity in the field have shifted to efforts, like the present one, to develop postclassical, broadly relational approaches to mind, development, and the analytic situation. Because the battle has been won, it is now less interesting to recount the deficiencies of the classical model than to explore the subtle but quite important differences among postclassical perspectives, and that is what I intend to do in this discussion.

Trop and Stolorow's paper on defense analysis in self psychology is largely a set of commentaries and conclusions drawn from a very interesting and elegantly presented case description. In what might be considered an opening transference/countertransference gambit, Alan in some sense elicits and then becomes very sensitive to, and angry about, the analyst's enthusiasm about his heterosexual activity. The analyst skillfully acknowledges his participation and then backs off; the patient's homosexual behavior and his critical rejection of women must both be accepted and not questioned by the analyst if the patient is to remain in treatment.

What lesson is to be drawn from this initial interaction? The authors conclude that Alan is incapable of hearing any perspective different from his own because of the fragility of his self-cohesion; only prolonged immersion in the analyst's selfobject confirmation of the patient's perceptions will make this possible. They use this clinical lesson to establish a more general principle: the activity of interpreting defenses can feel very different and can have very different transferential meanings to the patient, depending upon where he or she is developmentally; they argue that to have attempted such interpretation of defenses earlier could have been experienced only as an attack and would have been intolerable and disastrous to the treatment.

Before we explore this argument more closely, I would like you to consider briefly the general nature of case reports such as this one. Psychoanalysts used to think of psychoanalysis as operating like a natural science (19th-century natural science), and case presentations could claim evidential value. The data of psychoanalysis, like a "rock" at a geological society or a "bettle" at a biological society, were viewed as "out there" to be examined. Now most of us assume that any analysis and therefore any case description have embedded in them the theoretical perspective of the analyst. The analyst himself cocreates and is embedded within the data, which cannot be examined by others in the same privileged way. Thus, I believe we approach case reports now less as evidential than as illustrative and inspirational.

Each tradition has its own variety of inspirational tale. Donald Spence has pointed out the close similarity between Freud's cases and Conan Doyle's Sherlock Holmes stories. The clever analyst/detective finds the singular solution to a bizarre and totally confusing quagmire of apparently unrelated details. If classical cases read like intricate mysteries, case illustrations in the interpersonal tradition, particularly those most influenced by Fromm, draw more on adventure story genres. The analyst, mustering great personal courage, takes a risk and generally does or says something unconventional and self-revealing, and this act of courage provides the breakthrough. I do not have time to develop descriptions of these different genres, but I would suggest that Kleinian cases, with their spooky internal presences, are rather like ghost stories and that the
predominant feature in self psychology clinical tales is the emotional steadfastness of the analyst as a benign and caring presence.

In redefining the purpose of case presentations as largely inspirational rather than evidential, I do not mean at all to minimize their importance. Psychoanalysis is extremely difficult, intellectually demanding, ethically harrowing, lonely work. I, for one, can use all the inspiration I can get. Further, the kinds of qualities inspired by case studies—intellectual acuity, moral courage, an openness to spooky resonances and presences, and emotional steadfastness—are all qualities that I find very valuable in doing analytic work.

What seems particularly inspirational in this clinical tale is the analyst's dogged, persistent commitment to understand the patient in his own terms and to provide, given the limitations of the analytic setup, what the patient feels he needs. Because the clinical work here is obviously of high quality and also because the tale is told so well, the morals dramatically drawn, the ending so happy, it is difficult to raise questions about it without appearing peevish and disagreeable. On first reading I found myself very much swept along by the narrative momentum of the tale. On subsequent readings, however, I began to get interested in other questions, not given prominence in this account, and began to realize that I would approach this material with some very different assumptions, which lead to a different way of organizing the issues.

Part of the problem in generating different approaches to this material, I began to feel, derives from the issues embedded in the material itself, which is organized around either/or choices. The mother demands agreement from Alan: Alan demands compliance from his girlfriends and analyst. The authors pose the key clinical choice as one between an assault on the patient's experience and a validation of the patient's developmental needs. It seems to me that the reader may also feel compelled to make a choice.

I began to think my sense that I was faced as a reader with an either/or choice between agreement or peevishness has something to do with the either/or choice the analyst was confronted with during the first seven years of the analysis. So, at the risk of appearing peevish and disagreeable, I would like now to present a reading of this clinical tale that is different in some respects from that of the authors, in the hope that the differences might generate some useful dialogue.

A key assumption in the theoretical framework that houses this case is that development proceeds in a linear fashion, from one essential prerequisite to the next. One cannot skip steps. If the requisite selfobject function is not provided, self-development is stalled in the interests of survival and self-protection, until the missing developmental selfobject function is provided. As applied to Alan, the assumption is made that because both his parents were alternately intrusive and unavailable, he never had experiences that would have led him to believe in the validity of his own perceptions, and the result is a fragile, brittle sense of self, which he continually shored up through various avoidant defensive operations. He therefore needs confirmation of his conscious experience and perceptions in order to feel safe and will flee any situation in which he fears that confirmation will not be forthcoming.

I would begin with a different assumption: children learn patterns of integrating relationships with others early on from significant caretakers, and these become the forms for connecting and loving and also for self-organization. They are necessarily limited, because all of us were raised by parents with their own particular, quirky personalities and difficulties in living; yet these limited forms of being and being with are maintained and defended as the only possible paradigms for human experience and relationship. As applied to Alan, my assumption would be that because Alan's parents were experienced as either sadistically controlling or abandoning, Alan learned and maintains a very limited, basically sadomasochistic model of relatedness: control or be controlled. He is terrified of being controlled, in particular by women, and feels at the mercy of their needs and desires. Oral sex must be an especially frightening symbol of this terror, “going down” on a woman a symbolic equivalent of kissing his mother's feet. He deals with this terror by quickly seizing the upper hand, critically scrutinizing the woman in a fashion very similar to his mother's critical scrutiny of him, and insisting that he be in total control—of sex, time, contact. As his mother forced his compliance with the threat, “You are not my son,” he literally dismisses noncompliant girlfriends.

Alan's homosexual encounters follow this same pattern. They are striking for their lack of mutuality. He offers himself as an object of pursuit and devotion and is serviced by the other man, who goes down on him. As the analyst
notes, his sense of self is restored, and the disintegrative anxiety allayed. In my view it is a particular version of self that is restored, a self in total control over, and the object of total devotion for, the other.

Because I regard Alan's way of organizing life as a pattern of relationship rather than in terms of a protective covering for developmental deficits, I would see the lesson to be learned from the opening gambit differently. My hypothesis would be that Alan is unable to bear differences in perspectives because of his deep conviction that in human relations, one or the other person is in control and prevails. Because of his terror of being at the analyst's mercy, a terror he comes by quite honestly through his experiences, he must control the analyst completely. The latter must not only be accepting of the patient's perceptions, but have none of his own, or at least keep them to himself. I do not see this claim as based simply on fragility; it strikes me as also an active, effective form of interpersonal integration.

The account of Alan's visit to his mother is very interesting in this respect. We had been told about how controlling and intrusive she was, and this visit certainly provides more evidence of this, but with a new twist. Alan's mother controls through an obviously manipulative "weakness." If Alan does not surrender to her oppressive control, she will disintegrate, kill herself in actuality, or attack herself psychologically. In fact, it now becomes apparent that the whole family was organized around the coercive weakness of the mother. "Take good care of mommy" was the father's injunction to Alan and the greatest priority for all three of them.

On first reading this case, I found myself thinking about what a creep the mother was and how difficult she made it for Alan to have any breathing space at all. On second reading, I realized how similar Alan is to his mother, how identified he is with her manner of seizing control in relationships, in which weakness and fragility are very powerful postures. Compare these two descriptions: "When Alan spoke up and tried to defend his right to make his own decisions, she became self-depreciating and despondent, and he felt increasingly guilty and powerless." That is mother. "Any deviation by the analyst from articulating Alan's perspective would result in the patient becoming acutely depressed and attacking himself cruelly." That is Alan. In the author's narrative, the mother is intrusive, and Alan is fragile and lacking in cohesion.

I find it useful to think of both Alan and his mother as both fragile and controlling. These features in Alan were shaped in complex interaction and identification with the mother. This is a similarity I think Alan would benefit from knowing about. Mother suggests Alan is not her son if he does not comply. Alan suggests that the analyst is not his analyst if he questions Alan's manner of organizing his experience. Alan believes his compliance is a way to take good care of mommy. The analyst believes his compliance is a way to take good care of Alan. In my view, in confirming Alan's experience, the analyst is not simply doing something new—providing a missing selfobject function—but also repeating something old, playing Alan's role vis-à-vis his mother in the familiar and familial model of caring.

I want to stress that I do not think it is ever possible or that it would be at all useful for the analyst to provide a purely new experience, to be totally different from the parents. I believe the analyst comes to know and to help the patient not outside the countertransference, but through the countertransference. The new is never simply alternative to the old, but emerges through a transformation of the old. This is why I think molting is a better metaphor for the analytic process than hatching.

Why the shift after seven years? This is impossible to say with certainty. In the authors' view, prolonged provision of the missing selfobject function restored self-cohesion. My way of putting it would be that the extraordinary commitment and dedicated willingness of the analyst to sit on his interpretive hands, so to speak, for so long convinced the patient that he was in the presence of someone who deeply cared about his welfare and whom he could count on not to control him maliciously and count on to cede control to him when he felt panic. The most interesting clinical question is whether the analyst could have found another way to participate that would also have enabled the patient to feel safe, or safe enough. Seven years are a big chunk of someone's life.

Central to the patient's difficulties is not only that he has not had crucial growth-enhancing experiences, but also that this deficiency has led to his tendency to see relationships in either/or terms: control or be controlled. The particular kind of developmental framework employed here leads to a similar either/or choice. Either the developmental need, in this case the need for confirmation of perceptions, is provided, or it is not. I think it would be helpful for the analyst not to see his options vis-à-vis the patient in either/or terms and, in fact, for the analyst to struggle to find another way to be with the patient and help him become interested in other options.
Self psychology developed in dialectical reaction to classical theory and its aggressive approach to the analysis of resistance. Kohut made very important contributions to our understanding of the self-preservative function of defenses and resistances. But it is precisely because of this shift in conceptualization that it is possible, in my view, to question and speak to, not attack or confront, but question and speak to self-protective, defensive positioning from early on in the analysis. Kernberg is always posed as representing the alternative to the kind of approach adopted here during the first seven years of analytic work. But Kernberg, with what Searles (1979) calls his “coolly Olympian” tone (p. 216) and his invariably dim view of the patient's character and motives, is not the only alternative. It is very difficult, but generally not impossible, to help the patient get interested in the way his relationships, both outside and inside analysis, reenact features of his relationships with his parents, a reenactment and reversal that are based on terror and deep convictions about threats to his own survival.

Before I offer some suggestions on how this might be done, I want to consider a bit more closely the term “developmental” and the way in which it is used here. I believe that some of the claims made in connection with this term contradict other valuable features of the self-psychological approach, particularly in its intersubjective form as developed by Stolorow and his colleagues.

In a general sense, all psychoanalysts are developmentalists. Everyone I know believes that the past, early childhood, and early relationships with caregivers are all very important and part of analytic inquiry. Also, everyone believes that there is a continuity between past and present, that early longings, needs, and organizations of self and others remain active and seek expression and fulfillment, that children of different ages are different, cognitively and affectively, from adults, and so on. So, “developmental point of view” must refer to a specific sort of developmental approach, one based on the assumption I noted earlier, that development proceeds in a linear fashion, from one stage or need to the next, and that omissions halt the process until the right selfobject provisions can be found.

One problem I have with this use of the term is that it seems to imply that we know, in some sort of objective, scientific sense, how development actually does work, as if there were a clear consensus about these things. As far as I know, this is not the case. Even within psychoanalysis, we have many different developmental theories, many different points of view about what the baby needs most and in what order. Daniel Stern, whose work is very compatible in many respects with much relational theorizing, including self psychology, is careful to distinguish recently gained, fragmentary pieces of empirical evidence from comprehensive models of child development, like his own, which are not empirically mandated at all. Our developmental theories provide clinically powerful metaphors, but not empirically validatable causal explanations. This does not diminish their clinical importance, which is enormous, but it does effect the way in which one thinks about one's theoretical framework.

Consider the piece of developmental theory that seems taken for granted in this paper — that babies first need a long period of time in which their perceptions are being confirmed and validated before they are interested or can tolerate the possibility of another perspective or subjectivity different from their own. How do we know this is true? Babies require familiarity, but they also seek novelty. In observations such as Stern's of the way in which the good-enough mother remains “attuned” to her baby, is she simply confirming, staying with the child's perceptions and experience, or is difference also important (see Benjamin, 1988, p. 26)? What appears crucial is a delicate balance between sameness and difference; this makes “mirroring” an interpersonal process very different from looking into a mirror as a physical object. But how much difference is useful?

Children and adults, including analysands, need and seek both confirmation of their experience and the stimulation that is inherent in living in a world of othersubjectivities. But whether they need them in sequence or in a dialectical balance, whether the need for difference emerges naturally when enough confirmation has taken place — this has not been established. Is Alan's insistence on confirmation purely a striving for crucial experiences missed in his development, or is it also an adaptation to his experience of a very limited range of interpersonal options? Alan himself is in no position to provide us with a clear and easy answer to this question. I have no problem with the authors' taking a position; clinicians are forced to do this every day. But cloaking this preference, this choice, in the term “developmental” seems to me to claim for it an arbitrary authority and to shelter it from open consideration on its own merits.
I also have some questions about the clinical impact of coming to the conclusion that one has discovered a developmental need, because at that point, analytic options may be foreclosed and subtly impeded. One assumes that one is seeing a generic, universal need, built into the child, rather than a wish that has been generated and shaped in the mutually regulatory field between child and others.

There appears to be a kind of fixity that goes along with the diagnostic judgment inherent in this developmental determination. It seems at odds with a more open inquiry into the patient's phenomenology, without presuming ahead of time what one will find, the kind of attitude that Bion has in mind with his aphorism that the analyst should come to the session with “neither memory nor desire” and the attitude Kohut (1984) had in mind when he said, “Every explanation … must not only be considered a gain, but also a barrier to further thought, a potential obstacle to seeing the new and appreciating the unexpected” (p. 125).

The approach in this presentation seems to demand that the analyst remember all the time to organize his experience of the patient into a scheme that does not change in any fundamental way for seven years. In this sense, what is understood as an “empathic failure” in the eighth year may have been made more likely by the very authority invested in the developmental diagnosis. In my view, the greatest undiscovered fact of practicing analysis is the importance of trial and error. One of my concerns about the developmental approach suggested here is that it implies too great a certainty about what is and what is not possible at any particular time.

Further, I find the apparent fixity here at odds with my sense of how people generally operate — inconsistently. Rather than see someone as stalled, in a consistent fashion at a particular developmental need, I tend to find people living in different states of mind, organized in different ways at different times. Sometimes they are much more threatened and brittle; sometimes they are much more open and receptive. Was there never unevenness in Alan's position vis-à-vis the analyst? Does the determination of a stable developmental deficit make it harder to perceive unevenness and to take analytic advantage of it?

What is also lost in this process is inquiry into a whole array of questions, which I would be struggling to find a way to get the patient interested in from fairly early on. In Alan's case, the questions might include: How did Alan develop the idea that relationships operate on a “control or be controlled” basis? How does he manage to maintain it in spite of what I would assume must be at least some evidence to the contrary? Why this need and not others? Why the belief that differences in perspectives are so dangerous? Does he tend to assume his parents are representative of the human race? What is his idea of the impact of this approach on the experience of others he interacts with, including the analyst? Is he curious about this? Does he feel he has to surrender too much even to be curious about this? Why? How has curiosity about differences between his experience and the experience of others become so dangerous?

These questions, I think, would be considered to be part of defense analysis, as the authors frame it in this paper. But what I am suggesting is not an accusatory confrontation in which the patient is blamed for a cowardly running away from something. The framework I am suggesting presupposes that the patient feels quite endangered and comes by these beliefs very honestly through chronically traumatizing experiences. I would further assume that the patient deals with the sense of endangerment by adaptive, self-protective measures, learned largely through identifications with precisely those who endangered him in the first place. Where else should he have learned what it means to become a person? I believe that an appreciation of the subjective context in which defenses operate opens up a third possibility besides acceptance and challenge — genuine curiosity, sometimes with astonishment, sometimes with puzzlement, sometimes with humor, always with respect.

I hope it is clear that I regard my alternative interpretive ideas about this material as hypotheses that may or may not be useful to the patient at any particular time. Using these hypotheses to form questions is meant to reflect both the lack of certainty and also the deep conviction that engaging the patient in the process of inquiry is infinitely more important than any particular interpretive understanding arrived at.

The last questions I posed in relation to Alan concerned his impact on others, including the analyst — countertransference — and it is in this area in particular that I think there are important differences in approach. I do not have the time to develop these, but it might be useful to state them in greatly collapsed terms. The focus in the approach taken in this paper is on the subjective experience of the patient. An intersubjective field is assumed, but the analyst's subjective experience of the patient is not of primary interest. It appears largely as a contaminant, distracting the analyst from the primary task, listening to and articulating the patient's experience.
For me there are two foci — the patient's experience and the analyst's. My presumption is that the analyst's experience usually contains valuable information about the patient's experience. In this case, I would want to know a whole lot about the consequences for the analyst of coming to the conclusion in the opening gambit that it was necessary for him to squelch his excitement regarding the patient's behavior. How is it possible to remain so well behaved for seven years? Does the formulation of the patient as child serve as a vehicle for controlling more spontaneous affective responses to the patient? Were there changes in the analyst's experience of this over time? What are the patient's ideas about what is going on with the analyst during all this time? Does the patient really believe that the analyst agrees with his judgments about women? Or does the patient experience this as a compliance on the analyst's part out of concern for him? How does the patient feel about that?

I would like to conclude with the hope that I have found a way to introduce some different ways of thinking about this thought-provoking clinical material that have avoided the either/or polarity of agreement or attack and have contributed to the possibility of a more dialogic development of ideas. If not, I will try again another time.

References