Visions of the Self

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Karasu presents an intellectually comfortable and conceptually neat integration of what have been clashing and competitive theories of the salient features in the development of the self. While his emphasis is on pathological outcomes, this approach highlights the stresses besetting the child and their ultimate impact on his or her sense of self.

There was a time when the public watchword was “Make love, not war.” Karasu reminds the psychoanalytic clinician that we should seek theoretical integration and eschew schism so that we may, in parallel fashion, enhance the integration of the self of the patient.

CONFLICT AND DEFICIT: TOWARD AN INTEGRATIVE VISION OF THE SELF

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CONFLICT VERSUS DEFICIT MODELS

Nearly a century of diverse currents of psychoanalytic thinking have given rise to two predominant paradigms of both theory and treatment today: conflict and deficit. In encapsulated form, the conflict model posits an intrapsychic struggle between incompatible forces of the mind, especially repressed sexual or aggressive urges and the ego defenses that guard against them (Freud, 1933; Kernberg, 1984). Alternatively, the deficit model postulates that early environmental events of interpersonal insufficiency, especially lack of empathic attunement between caregiver and infant, results in defects of the self (Kohut, 1971). These pivotal positions of contemporary conceptual controversy in the complex understanding of the
psyche have been broadly regarded as a chronology of separate psychologies for portraying basic human motivation and psychopathology. Within the temper of their respective times, an earlier prototype, termed "guilty man," embodies the search for gratification of forbidden libidinal desires; whereas a later prototype, termed "tragic man," expresses the basic striving for cohesion of a fragmented or missing self (Kohut, 1977). As Erikson (1963) more pragmatically put it, "The patient of today suffers most under the problem of what he might . . . be or become, while the patient of early psychoanalysis suffered most under inhibitions which prevented him from being . . . who he thought he knew he was" (p. 279).

The conflict-deficit dichotomy also represents a fundamental diagnostic duality: neuroses versus characterological or personality disorders. These in turn reflect separate etiologies, with the preeminent source of psychopathology largely ascribed to different phases of child development: the former's most significant scenario has long been attributed to oedipal events (i.e., rivalrous wishes and castration fears that have their height at age two to five years) (Freud, 1905/1953), whereas the latter places priority on pre-oedipal events (i.e., deficiencies of the earliest object bond beginning at birth) (Kohut, 1971). The evolution of psychoanalytic thought has also wrought a parallel phenomenon: a marked change in the respective significance of classic father-mother-child (triadic) versus core mother-child (dyadic) influences on infant and adult development. As Wright (1991) has observed:

Psychoanalysis makes a major distinction between two-person and three-person relationships. . . . It started with three-person relationships and the discovery by Freud of the Oedipus Complex. . . . Only after this situation had been thoroughly worked through did psychoanalysis push back into the area of two-person relationships and all that had to do with the founding and development of the self and the beginnings of psychic life (p. 112).

These developmental and diagnostic differentiations naturally have had direct implications for psychotherapy practice: they broadly coincide with major therapeutic shifts in the parameters of psychoanalytic treatment: from expressive (uncovering) to supportive (strengthening) strategies (Karasu, 1995); from the pivotal vehicle of insight (Schonbar, 1964) to that of empathy (Basch, 1983) as a critical agent of change or cure; and in terms of major techniques, from a dispassionate therapist's interpretation and confrontation of a primarily erotic (advanced) transference, to a responsive therapist's replacement of sustaining self-objects within a largely narcissistic (primitive) transference. These two major models of theory and treatment—in their polar positions—are contrasted in Table 1.