Self Theory, Conflict Theory, and the Problem of Hypochondriasis

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THE WIDENING SCOPE OF PSYCHOANALYTIC TREATMENT HAS initiated a controversy in psychoanalytic theory and technique. Central to this controversy is the issue of the place of the self in psychoanalytic theory. Two broad and apparently antithetical positions have been taken. The first position is that radical revision of psychoanalytic theory is necessary to account for new data relating to the self and to explain specific forms of psychopathology, particularly narcissistic personality disorders. The second position, to which I subscribe, is that current psychoanalytic theory is adequate to account for the phenomenology and psychopathology of the self and that therefore an alternative model or an alternative theory is not necessary (Richards, 1979).

The first position is represented primarily by Kohut (1971), (1977) and his followers, whose theory appears to rest on four basic principles: (1) the concept of narcissism as a separate and independent line of development; (2) the centrality of a single metapsychological point of view—the economic—and the stress on contentless mental states; (3) the delineation of two specific self-object transferences, which I view as manifest-content, descriptive designations rather than as having inherent diagnostic, dynamic, and genetic significance; and (4) the overriding importance of empathic introspective modes of observation and the downgrading of the observational, cognitive, and synthetic aspects of the analyst's functioning in the analytic situation.

This theory, I believe, severely neglects the importance of the role of unconscious conflict in mental life and views unconscious conflict and developmental deficit as polar opposites rather than interactive variables. This exemplifies a general trend and an important weakness in Kohut's theorizing—theorizing in terms of forced dichotomies.

Kohut's metapsychology starts from the proposition of two kinds of libido: narcissistic and object; two kinds of patients: narcissistic and neurotic; two kinds of transferences: idealizing and mirror; two different conceptions of the mechanism of therapeutic action of psychoanalysis: transmuting internalization and change through insight; two kinds of anxiety: disintegration anxiety and anxiety stemming from drives; two kinds of aggression: nondestructive assertiveness and destructive aggression; two kinds of objects: self-objects and oedipal objects; two kinds of dreams: self-state dreams and wish-fulfilling dreams. The theory finally resulted in two broad classifications of the human situation: guilty man versus tragic man; guilty man suffering from conflicts and tragic man suffering from developmental defects caused by parental empathic failure. For Kohut, conflict theory is applicable only to guilty man, with self theory applicable to tragic man. It is therefore hardly surprising, since Kohut sees people today as essentially tragic rather than guilty, that he considers the conflict-drive model as less relevant and less applicable to psychopathology and the clinical situation than the self model. Nor should it come as a surprise that in his later writings, particularly in the Restoration of the Self, Kohut moves toward discarding the classical drive-conflict model and toward adapting a unitary position in which the psychology of the self is transcendent. This new psychology contains, according to Kohut, "a whole new concept of man," one quite distinct and different from the Freudian concept.

Since self-theory psychopathology results from developmental deficit, Kohut is in effect proposing a deficit model of psychopathology. This raises the question: should we limit ourselves to the consideration of two models—a conflict model versus a deficit or self model—or would we do better with three, as Arnold Cooper (1980) has proposed: the conflict model for neurosis, the self model for narcissistic patients, and an object relations model for borderline patients? Or why not the five models of the mind offered by Gedo and Goldberg (1973)?

In psychoanalysis, as perhaps in all sciences, questions are more easily asked than answered. But in psychoanalysis, unlike many other sciences, questions are particularly difficult to answer because of the special problems of access to its unique data and validation of its propositions. It is not an overstatement to assert that our methodological problems have no bounds. It is rarely possible to propose or execute the crucial experiment that will resolve a particular point of theoretical controversy. It seems to me that to make dialogue more fruitful we should focus on clinical as well as theoretical issues. In line with this idea, I shall attempt to move closer to the heart of the issues I have outlined by considering a single syndrome—hypochondriasis. I hope to be able through the clinical material to assess the relative explanatory power and therapeutic yield of the alternative psychoanalytic models: the conflict model of ego-id-superego psychology and the deficit model of self psychology. I believe that hypochondriasis is a particularly suitable focus because self psychologists view the syndrome as pathognomonic of the disorders of the self and indicative of a state of self-fragmentation and loss of self-cohesion rather than a compromise-impulse defense constellation.

Although my focus will be on the clinical data, theoretical concerns are equally important. After all, the analyst's theoretical stance determines how he or she listens, what is heard, and how the analyst relates to the patient; all of these of course influence the data obtained.

CASE PRESENTATION

The patient was 27 years old, married, with one child, when he entered analysis because he was intensely anxious about his health. He presented bizarre somatic complaints and the conviction that he was sexually deteriorating. He was convinced that there was minimal but definite diminution in his public, axillary, and facial hair, that he was undergoing feminizing physiological alteration which was producing a feminine fat distribution, enlarged breasts, potbelly, and a change in the pitch of his voice. He experienced chest pains, which made him fear that he was going to have a heart attack, especially after intercourse. He was convinced that there was something wrong with the condition and configuration of his penis, a worry that could be resolved only by testing it through masturbation, often in front of a mirror. He worried that he was suffering from premature senility and that he was about to have a stroke. He linked these concerns to one another and explained them with the diagnosis that he had a generalized arteriosclerosis which was cutting off the blood supply to his heart and brain. He explained the fact that physicians had been unable to find any corroborating evidence of his diseases with the notion that the changes were subclinical: had the EEG or EKG been taken a day earlier or later, the results would have been different. He acknowledged that his thinking was illogical, and in spite of the strength of his hypochondriacal symptoms, he never ceased to function on an extraordinarily high level.

The onset of the symptoms had occurred about 4 years earlier, at a time when he was preparing to take a number of important independent steps, including going abroad (to study) and making plans to get married. During an examination occasioned by a minor illness, a physician commented that he might have a slight heart murmur; this touched off concerns about hypertension and heart disease. While he was abroad, he developed abdominal pains, which at first he attributed to bad food. A diagnostic GI series was negative for ulcer but made him worry that the X-ray had damaged his genitals. One psychiatrist he saw treated him with tranquilizers, and another saw him for psychotherapy twice a week for about a year. The latter referred him for analysis, which he agreed to start, not at all convinced that his problems were not physical, but willing to try anything to reestablish his health.

He described his childhood as "idyllic": his mother had doted on him, and his father, a passive, cautious, moderately successful businessman, had remained benignly enough in the background. It was only in the course of the analysis that more telling details emerged. The mother, whom the patient perceived as all-knowing and all-powerful, was ridden with fears and superstitions. She was afraid to handle her newborn son and worried about each new step in his development: that he would fall when he was learning to walk, would choke when learning to feed himself, would fall out of his crib during the night. Until he was an adult she advised him about his clothing, his diet, warned him about the dangers of sports, of other boys, and of encounters with girls, sexual or otherwise. And his childhood idyll was interrupted suddenly, when he was 5 years old, by the birth of a sister. So terrifying to him was his mother's pregnancy and the birth of his sister that he was totally amnestic for the year surrounding it. He was told, however, that he had responded to the loss of his mother's attention by completely refusing to eat until a doctor advised his parents to pay more attention to him. He also was told how pleased his father had been about having a daughter, and analysis revealed that the patient had felt particularly upset by his father's attention to the new baby.

The patient grew up in a one-bedroom apartment, sleeping in the same bedroom with his parents, who had twin deds. When his sister was born, she was given his crib, and he slept in one of the twin beds, his parents sharing the other. When he was 8 the family moved, and he and his sister shared a bedroom until he was 12. From then on, he slept in one bedroom with his father, his sister had a room for herself, and his mother slept in the living room. The patient described his father as quiet and passive, strong but not athletic, and not particularly bright. His mother encouraged him to think that he was intellectually superior to his father, an idea the patient absorbed as his own when he was still a boy. That he was exhibitionistic is attested to by one of his earliest memories, or it might have been a fantasy: when his grandmother was dying, he said, "Don't die, grandma, look at me in my new sailor suit."

His parents, particularly his mother, severely discouraged expressions of his sexuality when he was a child. Although he did not remember her forbidding him to masturbate, a reconstruction of that possibility was made when he observed his mother's reactions to watching his own son play with his penis. He remembered how his mother made fun of any girls that he had an interest in. When the patient was in the latency period and as a young adolescent, his mother suffered several serious illnesses and operations, many details of which were replicated in his own physical symptoms.

He continued to live at home while going to college until his fourth year there, when he moved into the apartment of his girlfriend—his first girl and the one he married a few years later. I should add that this girl, the first with whom he had intercourse, found no fault with his sexual performance and had apparently had enough experience to have been able to judge. It was when he left her to go abroad that his symptoms appeared.

I turn to a brief account of the part of the analysis that is relevant to my thesis. Although the patient for many months insisted that there was nothing I could offer because his symptoms were physical and not psychological, a specific transference configuration soon emerged. He saw me as a dangerous, omnivorous person who was robbing him of his time, his money, and his independence, and who was placing him in great physical danger by treating his symptoms as though they were psychological rather than physical. A recurrent image that appeared in fantasies and dreams was that of a leech sucking his blood. He viewed me as strong and himself as weak, fragile, and needing to be taken care of. He spent many sessions ruminating about my penis, imagining himself sucking it as though it were a nipple. The accompanying fantasy was that he would thereby gain power from me which would make him more potent in relation to the woman, but would not incur the wrath of the male rival because he would be giving him pleasure as well. Other homosexual fantasies experienced in the analytic situation and about me, particularly fantasies of anal penetration, were elaborated with the idea that my penis would extend into his penis, making it harder and stronger and making him more potent.

He felt the more he told me about himself, the more he put himself in my power and control, and that only my death would liberate him. His dreams and fantasies of me as a devouring figure could be recognized as a replication of an unconscious childhood image of his mother, whom he had experienced as robbing him of his autonomy, his physical competence, and his independence by her overprotectiveness and anxious overconcern. He gradually came to see that successful independent action on his part resulted in an increase of suffering from his symptoms and was related to his symbolic movement away from his mother. His inability to tolerate autonomy and success stemmed from his identification with his weak, passive father, and even more from his need to feel inadequate and dependent in order to conform to his mother's idea of him. He feared that he would lose her as he became an adult; after all, she had told him that she was always afraid that she would lose him if he learned to do things on his own. He saw the delicate balance with which he had had to walk the line between ambition and illness, between autonomy and infantility.

When he had occasion to criticize a man considerably older than himself, he was immediately consumed with anxiety that the attack would cause him to lose the man's love and friendship. About his superiors in his firm, he brooded, "If they don't step down, how will I get ahead? But if they die, who will take care of me?" As the aggression implicit in these questions gradually became conscious, he was able to be more critical of his superiors.

The patient's conflicted feelings about surpassing his father were elucidated in the transference when he was aware of feeling anxious because he had the thought that he was intellectually superior to me. This was followed by ruminations that he had cerebral arteriosclerosis so that, on the one hand, he felt smarter than the analyst and, on the other, felt that his brain was deteriorating: the somatic concern disavowed his intense competitive wishes. He recalled how he had acquired considerable skill in playing ping-pong when he was an adolescent, but would deliberately lose when he played with his father because he did not want to embarrass him.

At the beginning of the analysis, he had no recollection of observing or hearing anything sexual going on between his parents. He could only imagine them lying motionless next to each other all night. He reported experiencing a profound sense of disbelief when he learned about the details of sexual intercourse. His denial of the relevance of primal scene experiences was countered by the following dream, which he reported: "I am in a large empty room sitting against the wall. A couple on the other side of the room are having intercourse. I can see the man's back and not his penis, and I feel relieved. He motions to me to have intercourse with my wife. I feel relieved because he will not be able to see me, just as I couldn't see him. I wake up and have a feeling that I am in a twin bed and my wife is in the bed next to me." The connection between the dream and the sleeping arrangement as a child was clear enough, given the fact that he and his wife slept in a double bed. Clarification of primal scene memories showed that he experienced intercourse as an attack by the woman on the man. His sickness had protected him from the dangers of a sexual relationship with a frightening woman. Success in the sexual area was just as frightening as it was at work: he consulted a physician for a recurring pain in the groin following intercourse, a time when he felt in greatest danger of suffering a heart attack. He could recognize the extent to which his sexuality had been discouraged by his mother, who viewed it as an area over which she had no control. For her, he realized, his sexual maturity meant that he would inevitably leave her to seek another woman. Fantasies of invagination or a vagina appearing on his abdomen suggested he would be willing to give up his penis altogether to please her. This fantasy

had both positive and negative oedipal determinants, and could also be understood in context as a relinquishment of an organ which pushed him to be independent of his mother. He recalled that the development of his potbelly and the enlarging of her abdomen were parallel processes. I asked him what came to his mind about the thought that he was like a pregnant woman, and he replied, "A woman with a penis."

Turning into a woman, as in his almost delusional preoccupation with his feminizing changes, was both a regressive solution to his positive and negative oedipal conflicts and a means of avoiding separation from the preoedipal mother by identifying with her. Being sick fit nicely into this entire conflictual nexus because sick meant feminine, weak, and castrated, but also pregnant and powerful. The constant perusal of his body for suspected tumors as well as other features of his hypochondriacal concerns could be connected with pregnancy, specifically with his mother's pregnancy when he was 5. Repressed memories of that experience returned, directly represented in his symptomatology, and served to organize his illness. For example, he connected his concern about losing his hair with an image of the smooth, hairless skin of his baby sister. The disturbing nature of this experience for him had to do with his losing not only his mother's undivided attention but also the exclusive love of his father. Hence his refusal to eat until his mother's worry over his health restored her to him.

As these conflicts were worked through, the patient offered what seemed to me a telling insight: "I split myself into two persons when I am worried about my health. One is being taken care of and one is taking care of me. I have become in effect the child and the mother. I am my mother and my body is myself as a baby. I attend to every hair on my body. I attend to my own aches. There is no one to take care of me, to watch over me, so I do it myself. I am afraid to let go. I have a fear of something terrible happening if no one is watching me."

Although this insight was followed by marked improvement in his symptoms and a more positive feeling toward me and the analysis, this transference developed as a resistance to termination. He wished the analysis would go on forever, to achieve in this way the longed-for union with his mother. Contemplating termination, "a step toward independence," exacerbated symptoms that had abated considerably during the previous years. In fact, there was a recurrence of the very symptom that had plagued him during a previous period of decompensation. He developed abdominal pains and the conviction that he had an ulcer. This time, however, he was able to undergo a GI series without the dire psychological consequences that had occurred the first time. Central to this was his newly gained ability to see that his concerns were related to the impending termination and his fears of being independent. He was able to accept the negative findings of the internist, and the pains gradually subsided.

DISCUSSION

According to the psychology of the self, hypochondriacal preoccupations indicate the lack of a cohesive self, a lack consequent to the mother's failure to respond in a properly empathic fashion to the child's bodily and emotional needs. Hypochondriacal states are pathognomonic of self psychopathology and, along with feelings of fragmentation and depersonalization, can best be understood as indicating disturbance, or impending disturbance, of the self or self representation, rather than as a consequence of unconscious conflict. Kohut (1977) regards hypochondriasis as a displacement onto the body of what he calls disintegration anxiety—an unverbalizable dread of loss of the self, "the fragmentation of and the estrangement from his body and mind in space, the breakup of the sense of his continuity in time" (p. 105). The worries about physical defects are "replicas of the anxieties of childhood and [the] need for the attention of the missing self-objects" (p. 161). Kohut's concept seems to hark back to Freud's (1914) explanation of hypochondriasis as a withdrawing of libidinal cathexis from objects and a turning of it onto the self—of transforming object libido into narcissistic libido. Freud consistently placed hypochondriasis in the same category as actual neurosis. Both were "toxic" in nature and more medical than psychological (1916–17, p. 389).

Freud's earliest reference to a case of hypochondriasis occurs in an 1893 letter to Fliess. There he writes of a man, age 42, who upon the death of his father developed hypochondriacal fears of cancer of the tongue. The man also reported that he had practiced coitus interruptus for the previous 11 years, a fact Freud considered of primary etiological significance. The death of the father, he felt, was only an immediate precipitating factor. In the discussion of masturbation, Freud (1912) said, "I see nothing that could oblige us to abandon the distinction between 'actual neuroses' and psychoneuroses, and I cannot regard the genesis of the symptoms in the case of the former as anything but toxic" (p. 248). Freud chided Stekel for "overstretching pathogenicity" and seemed concerned with maintaining his position that the symptoms of actual neurosis, whether neurasthenia or hypochondriasis, are essentially contentless and essentially unanalyzable. This is certainly evident in Beyond the Pleasure Principle(1920) where Freud refers to hypochondriasis as akin to traumatic neurosis, referring presumably to the

view that it is caused by an unmanageable flood of sexual exertion which causes toxic changes in the hypochondriacal agents.

Although these references indicate that Freud included hypochondriasis in the category of the actual neurosis and stressed its traumatic and somatic origins, there is some evidence that at least prior to 1912 Freud struggled with choosing between a somatic and psychogenic etiology. Although his theoretical remarks clearly favor the somatic view, several clinical comments suggest the psychogenic view. In 1898, Freud was advancing the idea that hypochondriasis can be caused by self-reproach. He said, "Self-reproach (for having carried out the sexual act in childhood) can easily turn into shame (in case someone should find out about it), [or] into hypochondriacal anxiety (fear of the physical injuries resulting from the act involving the self-reproach)" (p. 171). Finally, Freud's uncertainty about the issue of a somatic versus psychogenic origin of hypochondriasis and his dissatisfaction with his classification of hypochondriasis as an actual neurosis may be indicated by the following comment in a letter to Ferenczi dated March 18, 1912. "I always felt that the obscurity in the question of hypochondria to be a disgraceful gap in our work" (see Jones, 1955, p. 453).

In the psychology of the self, the course of the analysis would focus on variations in the cohesiveness of the self, particularly as they can be related to empathic failures on the part of the analyst and manifested symptomatically in the patient by feelings of fragmentation, depersonalization, and hypochondriacal preoccupations. The analyst would help the patient see the connection between the empathic failures he experienced in the analysis and the empathic failures he had experienced as a child. This process would result in what Kohut calls transmuting internalizations, thus repairing the structural deficit in the patient.

A diagnosis would be based on the manifest content of the transference and of the patient's symptoms and pathology. Genetic explanation would be, on the one hand, very specific and, on the other hand, presented as universally operating; namely, of parental empathic failures in childhood. Issues related to drive derivatives and conflicts with regard to the patient's past or in the here and now of the analytic situation would not be stressed. I consider this view unidimensional, for it looks only at the self, a concrete and reified entity which is never really defined but whose state of being—cohesive, fragmented, overstimulated, understimulated, overburdened, or underburdened—is presented as of paramount importance. Clinical findings not relevant to this construct are discarded.

Certainly, the etiological significance of my patient's mother's intrusiveness is clear; but what has to be worked out in the analysis is the specific way in which conflicts produced by the unpleasure of this experience and others, the vicissitudes of both libidinal and aggressive drives, have influenced the patient's unconscious mental organization. Only by understanding how he defended himself against the anxiety evoked by conflict can the nature of the patient's symptoms and of his relations to his analyst and to others in his life be modified.

Before explaining my patient's symptom in terms of conflict theory, I had best define what I mean by conflict theory. I am in accord with Brenner (1976) who believes that intrapsychic conflict develops when a drive derivative or self-punitive trend is perceived as dangerous. The danger produces unpleasure—anxiety or depression—which evokes unconscious defenses against the unconscious wish. The resulting symptom is a compromise between the wish and the defense; anxiety is either diminished or abolished, depending on the success of the defense. The aim is to avoid unpleasure. The conflict may be between ego and id or between ego and superego. The four calamities producing unpleasure are object loss, loss of the object's love, castration anxiety, and superego condemnation. Conflict can thus be preoedipal as well as oedipal. I also agree that the origin of hypochondriasis is similar to that of conversion symptoms: the symptom expresses in body language a fantasy which is a compromise between wish and defense (Arlow and Brenner, 1964, p. 173). Clinical illustrations of this view in the literature include a paper by Macalpine and Hunter (1953) on the Schreber case which identifies an unconscious fantasy of intestinal pregnancy as underlying Schreber's hypochondriachal symptoms, and a paper by Broden and Myers (1980) who relate several hypochondriacal preoccupations in several of their patients to underlying unconscious beating fantasies.

Conflict theory is multidimensional: it stresses the principles of multiple function, multiple determination, the importance of the repetition compulsion, and of unconscious fantasies which are linked with childhood memories and perceptions, with all their distortions. Of course, this complicates both conceptualization and interpretation.

Returning to my patient, I contend that viewing his symptom in terms of cathexis, recathexis, and hypercathexis, or in terms of developmental deficit keeps us on a descriptive, manifest-content level which seriously impairs our ability to help the patient understand why he feels the way he does. I believe that this understanding is necessary for successful treatment. Equally inadequate are formulations that view the symptom simply as preoedipally rather than

oedipally determined, or that rely on the positing of a prestructural, preconflictual realm, for they pose false dichotomies and result in excluding from consideration a large sector of the patient's experiences.

What were the childhood experiences that were crucial in this case? I would cite the following: (1) the patient's mother's oversolicitousness and overprotectiveness when he was an infant; (2) the child's exposure to great admiration for his intellectual achievements, simultaneously with strong physical discouragement of physical activities and equally strong discouragement of all sexual behavior; (3) his father's passivity, timidity, and remoteness, and the patient's sense that he was smarter than his father; (4) the sudden expulsion from his special position when his sister was born; (5) his observations of the bodily changes that occurred in his mother during her pregnancy, observations of her genital, and observation of the anatomy of his newborn baby sister; and (6) primal scene observations.

We can point out some of the multiple determinants of the patient's hypochondriacal symptoms with regard to both their form and content. In a general way the symptoms represent a continuation of his childhood relationship with his mother; he hovers over himself as she hovered over him. The symptoms enable him to maintain the illusion of the persistence of this special relationship between himself and his mother and to defend against the twin dangers of losing her and her love.

This state of affairs is very similar to the attitudes toward health of motherless, institutional children described by Anna Freud (1952). "The child actually deprived of a mother's care adopts the mother's role in health matters, thus playing 'mother and child' with his own body" (p. 79). Anna Freud asks whether this behavior does provide a clue to the understanding of adult hypochondriacal attitudes. She states, "With children analytic study seems to make clear that in the staging of the mother-child relationship, they themselves identify with the lost mother, while the body represents the child (more exactly: the infant in the mother's care)" (p. 80). The similarity between my patient's statement, already quoted, "I am my mother and my body is myself as a baby" and Anna Freud's formulation is striking indeed.

The danger of castration is warded off through identification with his mother in which the perception of her as being injured and castrated is countered by the unconscious fantasy of her having an internal penis (the illness growing inside), the model for which is pregnancy, in which baby equals penis. The danger of castration connected with his oedipal wishes is countered by his assertion that he is "old, ill, impotent, or female." Superego condemnation is also avoided by the formula: I am not bad, just sick. Castration anxiety is defended against by displacement—the body as phallus—and by turning passive into active: "You can't do it to me; I have already done it to myself."

The prospect of termination and the impending separation from the analyst were similar to the situation he experienced when he was abroad. In both instances he developed a hypochondriacal conviction that he had an ulcer. Both situations revived the childhood situation when he was 5. The danger then was loss of the object, his mother—and to some extent his father—as well as loss of their love. He also risked moral condemnation because of his aggressive wishes toward his father, his mother, and his sister. Being in the oedipal phase, his heightened libidinal needs for his mother increased his competitive striving toward his father. His aggressive wishes as well as his libidinal needs toward his mother were exacerbated by her unavailability for him because of her attention to his sister. Finally, the aggression of sibling rivalry was ushered in for him by his sister's unwelcome appearance on the household scene. When he was 5, his compromise solution was not to eat, thereby at once infuriating his mother, forcing her attention from his sister to himself, and, as he himself put it, "punishing myself for my own greediness." Similarly, in the analysis, if his symptoms returned, I would continue to have to spoon-feed him and would not replace him with another patient.

During the termination phase of his analysis, as well as at the time of his mother's pregnancy, my patient was experiencing intense conflicts. He wanted to depend on me and hated me for this dependency. He experienced both libidinal and aggressive feelings toward his mother, his father, and his sister. Yet, anger toward his parents made him feel diminished as an independent person and as a man. The patient's symptom of not eating during the crucial time when his mother gave birth was shortlived, and the basic conflicts—which were both oedipal and preoedipal—were not resolved; a temporary peace was achieved at the expense of marked repression. He denied his angry feelings, remembered his childhood as idyllic, maintained the view that his parents never had intercourse with each other, became a model boy and student, looked after his sister and never teased her, and never masturbated. His envy of his sister was submerged; his envy of his father, the oedipal rival, was made nonoperative by the idea that his parents did not have a private sexual relationship which excluded him.

But the whole scenario became unstuck when he was confronted with the prospect of leaving home and getting married, and subsequently at times when independence, active mastery, sexual performance, and the surpassing of rivals were called for. The hypochondriacal symptom then appeared as a compromise formation.

Why this particular choice of symptom rather than some other? This brings up the issue of choice of neurosis, which is one that Freud struggled with and one that has never been resolved. In this instance, however, the details of the hypochondriacal symptom, its specific content, can be related almost point for point to specific details of the traumatic childhood situation, his mother's pregnancy, and to a lesser extent her illnesses during his latency period and early adolescence. The symptom is meaningful in terms of conflict, content, and genesis, rather than merely indicative of a general failure to develop a cohesive or stable self representation in response to his mother's general failure of empathy.

I have reserved one question in order to raise it only after the patient had been described as fully as is possible in a brief presentation—the question of diagnosis. Some analysts might ask whether the patient was suffering from a symptom neurosis or from a narcissistic personality disorder. I think he was suffering from both. Indeed, this brings me to my basic point—the unnecessary confusion caused by positing two separate lines of development. That my patient was narcissistic is indisputable—his intellectual grandiosity, his exhibitionistic traits, his preoccupation with his body, all attest to it. It did not occur to me at the time I treated him, nor would I find it particularly helpful today, to view these traits apart from his problems in separation from his mother, from his fiancée, or from me. The problem he had in separating from his mother profoundly affected his choice of a wife and his subsequent relationship to her, sexual and otherwise; his rivalry with his father affected his relations with other real or imagined rivals. At the same time, the difficulty he had in enjoying success when on his own made it harder for him to loosen the tie to an intrusive and engulfing mother.

The diagnostic question I asked myself was of a different order. It had to do with the severity of the illness. The high level of certain aspects of my patient's functioning and his capacity for meaningful object relations, many of the details of which I have not presented at length in this report, favor a "less sick" diagnosis. On the other hand, other features of the psychopathology, particularly the bizarre quality of some of the details of his preoccupation and the almost delusional way in which he clung to some of his beliefs suggest a "more sick" diagnosis. I would suggest that the unevenness manifest in the patient is not unusual in clinical work and points up the difficulty posed by setting up clear-cut diagnostic categories. It also calls into question theoretical approaches that rely upon clear-cut diagnostic categories to justify technical departures.

I return to the four basic principles of the psychology of the self which I enumerated at the beginning. I have already dealt with the issue of making a sharp distinction between narcissistic and object-libidinal developmental lines. It seems to me that for this patient these issues were interactive and intertwined. Secondly, the material points up the limitations of making a single metapsychological point of view, the economic, with its stress on contentless mental states the central issue. From time to time the patient said, during a session, that he felt as if his body was flying off in all different directions. Perhaps this is what is meant by disintegration anxiety. But this patient's mental states were never, as far as I could tell, devoid of specific mental content that could be expressed in everyday language—the language of current need and wish and fear, and the related language of childhood need, wish, and fear. With regard to the third principle, specificity of the two major self-object transferences, I found that I was able to understand the analysand-analyst interactions as they emerged without them. Idealizing and mirror transferences are broad, descriptive designations, useful in the early stages of treatment when we do not yet know too much about the patient. It seems to me that the self psychologists assign to these transferences more weight than they can bear and, even more to the point, thereby narrow the analyst's focus.

With regard to the final principle—the overriding importance of empathy and introspection—my position, in contradistinction to Kohut's, is that the psychoanalytic method of inquiry depends upon a wide range of affective, perceptual, and cognitive processes applied by the analyst to his own observations of, and reports from, the analysand. Empathy and introspection clearly are part of this method but are neither primary nor exclusive. In any case, it is my firm conviction that this patient's achievement of insight and the resulting change in his psychic structure and subsequent modes of adaptation would not have been possible without the calling into operation of the ego's cognitive and synthesizing functions on both my part and his.

I think there can be no question but that this patient was struggling with severe conflicts. He wanted to be rid of his sister, but he wanted to retain his parents' approval—and his own self-approval. He wanted to be close to his mother and win her approval by being like her; but if he did this, he would feel castrated because she did not have a penis. He wanted to replace his father in his mother's affections, but he also wanted to retain his father's love and approval.

He wanted to be independent, but this would have meant losing his mother because to have her was to need her. And so he developed symptoms which expressed his need for his mother, his identification with her, his fear of castration, and punishment for his hostile wishes.

CONCLUSION

I do not argue against the usefulness of the concept of the self as it relates to the importance of certain broad identity themes which characterize each of us, themes by which we organize our experience. But I want to stress that these themes are inevitably the result of the outcome of the vicissitudes of the important childhood conflicts and are related to the expressions of these conflicts in adult life. And at the root of these conflicts are indeed the core calamities of childhood—loss of object, loss of love, castration anxiety, and guilt. Evidence of the importance of all four could be found in my patient.

If Freud's drive theory is not relevant to disorders of the self (see Kohut, 1977, p. 68), then perhaps we should add a fifth calamity—loss of the self—to the usual four. This, I would suggest, is the essential point raised by those advocating a psychology of the self. My own opinion is that, before we accept the fifth calamity, we should be certain that it is not reducible to the other four. I think the law of parsimony prevents us from doing otherwise. For the fifth calamity to be useful, it would have to be firmly rooted and situated in the conflict-compromise formation nexus that includes the other four dangers, the drive derivatives, and the concept of defense. This the psychology of the self has not achieved or even attempted. We must wonder why.

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