Chapter 5
Self-Psychology Theory: Addiction and the wounded self

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In 1977, the National Institute on Drug Abuse published a little known research monograph regarding the psychodynamics of drug dependence. The preface, written by Heinz Kohut, the founder of Self-Psychology, outlines his understanding of addiction through the lens of Self-Psychology. He writes that:

the addict, finally, *craves the drug because the drug seems to him to be capable of curing the central defect in his self* (Italics added). It becomes for him the substitute for a self-object which failed him traumatically at a time when he should still have had the feeling of omnipotently controlling its responses in accordance with his needs as if it were a part of himself. By ingesting the drug he symbolically compels the mirroring self-object to soothe him, to accept him. Or he symbolically compels the idealized self-object to submit to his merging into it and thus to his partaking in its magical power. In either case the ingestion of the drug provides him with the self-esteem which he does not possess (Blaine & Julius, 1977, p. vii)

Here, Kohut outlines the central tenants regarding substance dependence and Self-Psychology that will be explored in greater detail in this chapter. In short, the model of Self-Psychology views the driving force behind addictive behavior as the result of a defect in the structure of the self, and that addictive behavior is an attempt at self-repair in order to “fill in” what is missing in the defective self. Unfortunately, these addictive attempts at self-repair are temporary and do not succeed, because they cannot provide the missing psychic structure necessary for healing the self. Finally, as we will see, from the framework of Self-Psychology, the recovery process is more than just stopping or reducing the additive behavior, but involves interventions that aim to help the addicted individual to ameliorate the central defect in his self structure and to encourage the development of a stable and cohesive internal psychic structure.
The goals of this chapter are twofold. First, I will provide a conceptual overview of development and maintenance of addiction as understood from the perspective of Self-Psychology, and second, I will offer some preliminary guidelines for the treatment of addiction by way of this model.

Philosophical underpinnings and key concepts of the theory

Self-Psychology was developed by Heinz Kohut and colleagues through a series of publications over a 15-year period (Kohut, 1971, 1977; Kohut, Goldberg, & Stepansky, 1984). Although considered a model under the umbrella of Psychodynamic Theory, his constructs and understanding of the etiology of psychological disorders are radically different from the traditional understanding of the psyche and emotional disorders as delineated by Freudian theory (Cratsley, 2016; Fenichel, 1945). Thus, instead of unresolved intrapsychic conflicts, emotional disorders, according to Kohut, are the result of a developmental arrest, the failure to develop a normal and cohesive internal psychic structure, or “self”, due to repeated empathic attunement failures in one’s early attachment relationships (Levin, 1991). These internal psychic structures are important in one’s ability to regulate affective states, have good self-esteem, and to self-soothe and calm oneself in times of distress. As we all too often see in those suffering from addictive disorders, they show deficits in these basic capacities related to a cohesive internal psychic structure. In order to understand more fully how this self-deficit is developed, we first explore the central concepts related to the healthy development of psychic structure from the perspective of Self Psychology.

Development of self

What is psychic structure, and how is it developed? At the center of Kohut’s model for the development of psychic structure is his understanding of “the self”, which he understood as
the core of one’s personality. Kohut (1971) defined the self as “a unit, cohesive in space and enduring in time which is the center of initiation and a recipient of impressions” (p. 99). The self is not something that exists a priori, but is created over one’s life through relational experiences, primarily with one’s caretakers. In this regard, Kohut stressed the central role of parental responsiveness in the development of the self. This responsiveness is expressed in the parent’s ability to be empathically attuned to the growing child’s emotional needs. Lack of, or inconsistent empathic attunement, results in deficits in the development of psychic structure, leading to disturbances in affect regulation and self-esteem.

**Selfobject needs**

The child’s nuclear self is formed in infancy and progresses through a number of stages, starting with a primitive, fragmented self, and culminating with a cohesive, mature self. Kohut conceived the inchoate nuclear self essentially as bi-polar, developing along two lines of tension, that of the grandiose self, and the other pole, the idealized parental image (Kohut, 1977). Along this path of self-development, Kohut hypothesized that for each of these poles of development, there are basic needs, which he termed *selfobject needs*, necessary for the optimal development and internalization of psychic structure (Giugliano, 2011). A selfobject is neither an object nor a person, but rather the subjective aspect of a function performed by a relationship. Other people can serve the role of selfobjects, but as we will see later, so also can alcohol and drugs (Flores, 2001). Selfobjects are central to the developing self, and are primarily performed by the infant’s empathic caretakers (Mann, 2015).

Kohut initially described two selfobject needs: mirroring and idealizing (Kohut et al., 1984). Mirroring needs are met through the caretaker’s ability to mirror the child’s innate sense of greatness, competence, and uniqueness, whereas the idealizing needs are met through the
child’s experience of a strong, soothing, and idealized other who the child can look up to and model as a figure of calmness and strength. Kohut later added a third selfobject need, twinship, to refer to the need to experience a kinship and belonging to others (Banai, Mikulincer, & Shaver, 2005). Imagine the scene of a mother and her small child playing in the yard. When the child laughs, the mother laughs too, and when the child smiles and shows her mother a leaf she found, the mother smiles warmly, looks her child in the eye, and says “what a beautiful leaf you found for mommy!” Here, the mother is meeting her child’s mirroring selfobject needs. When mirroring needs are met, the child internalizes a sense of healthy self-esteem, appropriate ambition, assertiveness, and sense of wholeness. Or imagine the same scene again, yet this time as mother and child are playing, the child falls down, scrapes her knee, and begins to cry. Our mother runs to the child, and begins to soothe her, telling her daughter that it must have been very scary to fall down, that she knows it hurts, but that she will be ok, and to let mommy kiss her knee to make it all better. Here, the mother is now meeting her child’s idealizing selfobject needs. When idealizing needs are met, the child develops the capacity to self-sooth, identify feeling states, and to have awareness of his or her own personal ideals. Finally, twinship needs allow for the sense of community and connection with others, which translates into a sense of belongingness (Alaggia & Mishna, 2014). Overall, it is within the context of an emotionally attuned environment in which the child’s mirroring, idealizing, and twinship needs are met that psychic structure is developed and internalized.

**Transmuting Internalization**

The process of how these self-object needs are internalized and become a part of the permanent self-structure is called transmuting internalization (Kohut, 1971). This term refers to the fact that parents cannot, and do not, always accurately meet their child’s mirroring and
idealizing needs. This would require a level of perfection that most humans do not possess. However, if these empathic misalignments are minor and non-traumatic, and can be repaired vis-à-vis the child and the person providing the selfobject functions, then psychic structure can be internalized. Thus, it is not perfection, but “good enough” parenting and the provision of optimal frustration that allows transmuting internalization to take place. *Optimal frustration* represents the healthy environment by which the child experiences this rupture and repair process. Within a context of optimal frustration, the empathic failures can lead to the relinquishment of external selfobject functions and the internalization of the individuals own burgeoning capacity to self-sooth and calm oneself (Flores, 2004). Because these resources are now an internal part of one’s self, a person will be less dependent on external resources for self-esteem, soothing of self, and gratification—often the opposite of what we see in those suffering from chemical dependency: feelings of inadequacy, low self-esteem, and difficulty with self-soothing and frustration tolerance.

**INSERT SIDEBAR 5.1 HERE**

**Sidebar 5.1**

*Discuss with each other what you believe is understood as “good enough” parenting? What would that look like? How would you know when parenting was not “good enough” Would the understanding of “good enough” parenting differ among various cultural groups?*

**Development of Addictive Behavior**

The above provides an overview of the basic tenants of Self-Psychology and the process for the optimal development of the self and psychic structure. Unfortunately, this process is often not optimal. Gross empathic failures to any of these selfobject needs over time results in severe
deficits in the self and the developing self-structure. This results in profound feelings of shame, depression, anxiety, fragmentation, and emptiness, which Kohut (1971) understood to be the underlying source of pathological narcissism (see table 5.1). These feelings underlying pathological narcissism result in compensatory behaviors to either seek the presence of an idealized other (“My self-esteem and worth are enhanced by your greatness”) or mirroring selfobject (My self-esteem and worth is validated by your greatness”).

Table 5.1

<table>
<thead>
<tr>
<th>Expressions of Pathological Narcissism</th>
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<tbody>
<tr>
<td>• Cohesive, yet insecure self</td>
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<tr>
<td>• Threats of fragmentation</td>
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<tr>
<td>• Grandiosity</td>
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<tr>
<td>• Unrealistic goals</td>
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<td>• Interpersonal isolation</td>
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<tr>
<td>•Feelings of entitlement</td>
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<td>• Poor affect tolerance</td>
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As opposed to healthy narcissism, pathological narcissism becomes a defense against painful feelings of shame, inadequacy, and low self-worth (Levin, 1994). In other words, Kohut found that these psychological issues were related to deficits in the psychic self-structure due to the failure of early attachment figures to meet the child’s selfobject needs. From an attachment perspective, these failures were related to the inability of the caretaker to be empathically attuned to the child’s emotional states (Flores, 2004). Table 5.2 lists the emotional and psychological consequences of these failures to internalize mirroring and idealizing selfobject needs (Georgi, 1998).
Table 5.2

<table>
<thead>
<tr>
<th>Unmet Mirroring Needs (Grandiose Pole)</th>
<th>Unmet Idealized Needs (Idealized Pole)</th>
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<tbody>
<tr>
<td>• Feelings of inadequacy</td>
<td>• Profound insecurity</td>
</tr>
<tr>
<td>• Emptiness</td>
<td>• Ill defined sense of self</td>
</tr>
<tr>
<td>• Low self-esteem</td>
<td>• Unclear personal boundaries</td>
</tr>
<tr>
<td>• Feelings of worthlessness</td>
<td>• Need for black/white thinking</td>
</tr>
<tr>
<td>• Overly critical of self and others</td>
<td>• Feeling states unclear</td>
</tr>
<tr>
<td>• Need for control</td>
<td>• Difficulty self-soothing</td>
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How does this set the stage for addictive behavior? Failures to meet the child’s selfobject needs, in other words, lack of appropriate mirroring and idealizing due to repeated failures in empathic attunement of the child’s caretakers, results in deficits in the self and a lack of cohesive self structure. This lack of structure produces a compensatory drive to “fill in” what is missing. In a nutshell, addiction is the unsuccessful attempt to compensate for this failure in internalization, regulate affect, and provide or “fill in” this missing self-structure.

Deficits in one’s ability to regulate affective states is also a consequence of inadequate psychic structure (Khantzian, Halliday, & McAuliffe, 1990). Without clear internalized psychic structure, the ability for self-regulation is limited. In this regard, Khantzian (2001) considers addiction to be a disorder of self-regulation, and through his clinical observations, he found deficits not only in addicts’ ability to regulate affect, but also their self-esteem, relationships, and behaviors. Thus, his clinical experiences built upon and corroborated Kohut’s theoretical understanding and formulation of addiction. Khantzian observed that addiction is not just an attempt to achieve pleasurable states, but also serves the function of helping clients regulate their emotional states by soothing their internal feelings of shame, emptiness, and deprivation. The addiction (drugs, alcohol, sex, etc.) becomes the new selfobject.
Because mirroring and idealizing selfobject needs were not adequately internalized, the addictive behavior becomes a “surrogate” selfobject, attempting to provide the individual with those selfobject functions that can reduce tension and regulate self-esteem. Kohut writes:

It is the tragedy of all these attempts at self-cure that the solutions which they provide are impermanent, that in essence they cannot succeed…They are repeated again and again without producing the cure of the basic psychological malady…It is as if a person with a wide open gastric fistula were trying to still his hunger through eating. He may obtain pleasurable taste sensations by his frantic ingestion of food but, since the food does not enter that part of the digestive system where it is absorbed into the organism, he continues to starve (Blaine & Julius, 1977, p. viii).

As such, addicted clients are always vulnerable to compulsive and obsessive behaviors, and will substitute one addictive behavior for another, until they can achieve a restoration of the vulnerability in their self-structure (Flores, 2004). This explains why addiction is often so entrenched as part of one’s psychological and behavioral system of functioning, and also hints to an important treatment consideration. If we conceptualize addictive behavior to be the result of missing psychic structure and understand that one’s addictive behaviors is actually an attempt to heal oneself and “fill in” what is missing, then our interventions need to be tailored to provide a set of experiences that can help to “fill in”, in a healthy and adaptive way, those unmet selfobject needs our client is so desperately seeking. If the stage for addiction was set in relationships, then the healing process also needs to take place through relationships.

**How the theoretical approach is utilized by practitioners**

At the heart of Kohut’s understanding of addiction is a disruption of the healthy development of the self. This wounded self seeks healing experiences and addictive behavior is a
failed attempt to provide that. As we saw above, the key to the healthy development of the self is the extent to which one’s caretakers could empathically respond to the child’s grandiose (mirroring) and idealizing selfobject needs. As such, *relational empathy and mirroring* of both your client’s self-experience and affective states play a central role in this treatment approach.

We must keep in mind, however, for the purposes of this chapter, that the focus on treatment interventions as they pertain to Self-Psychology will be based mainly on relational and psychological interventions. Addiction is a complex interplay of biological, interpersonal, psychological, and spiritual components, and the treatment of such should be comprehensive in addressing the deficiencies of each of these domains (Miller, 2010). For example, it is difficult to heal psychic structure if one is currently in need of detoxification first! Obviously, such issues of crisis intervention and management, physiological stabilization, detoxification, managing suicidality, etc. will need to be addressed first before the interventions based on the model of Self-Psychology can begin.

The deficits in self-structure leave these clients narcissistically vulnerable with an intense need for mirroring and approving responses, as well as a tendency to strongly idealize (or devalue!) the therapist. In general, the treatment should focus on damages to the client’s already low self-esteem, exploration of the failures in their childhood environment to adequately receive the phase appropriate mirroring and idealizing experiences from their caretakers, and the management of the client’s rage and anxiety (Levin, 1994).

**Early stage treatment issues**

A self-psychological approach to treating substance dependency can take place in either individual or group therapy, although the optimal approach would be a combination of the two. In early treatment, the therapist’s stance should be one that is active and supportive, by providing
structure, education, and interventions that are simple and clear. Since the primary function of the addiction was to fill in what is missing and to meet the client’s mirroring and idealizing needs, helping the client to detach from his or her object of addiction, achieving abstinence, and dealing with any physiological or medical issues is the first order of business. Otherwise, more in-depth psychological interventions will fall flat or exacerbate symptoms.

Because the client has an impaired capacity for healthy attachments and relationships, one of the counselor’s first tasks in early stage treatment is the building of the therapeutic relationship. In fact, deepening and expanding the client’s ability to relate to both the therapist and other group members is one of the primary goals of this approach (Levin, 1994). The relationship is built by providing active listening, supportive statements, and non-judgmental positive regard for the client. Also, providing an atmosphere of gratification, support, and containment is necessary for the building of the alliance and enhancing healthy attachments (Flores, 2004). Finally, empathy and mirroring of the client’s needs and vulnerabilities is central to the relationship building process and sets the stage of the healthy transmuting internalization of the client’s selfobject needs and the rebuilding of psychic structure.

**Individual counseling**

As noted above, individual counseling can be used as an adjunct to group counseling. Once abstinence and detachment to the object have been obtained, then the aim of individual counseling is increased self-awareness and the repair of structural deficits of the self. This is accomplished through developing the alliance, building trust, and allowing the space for the analysis of transference reactions and the interpretation of defenses as wounds to the client’s narcissistic vulnerability (Davis, 2015). From the vantage of Self-Psychology, addicted clients have tremendous wounds to their self-image and self-esteem. Thus, in individual therapy, they
often develop an intense need for mirroring (approval) responses from the counselor, or the need to idealize the counselor. These mirroring or idealizing transferences are to be considered a normal part of the treatment process and are welcomed, as the counseling relationship offers an opportunity for the expression of the client’s grandiose self and the development of an idealizing transference. In turn, these reactions are analyzed and interpreted, whereby the counselor and client can explore and understand the genesis of these needs as being related to failures in the childhood environment to provide the phase appropriate mirroring and idealizing experiences to the client (Levin, 1991).

**Development of new psychic structure**

As discussed above, the development of healthy psychic structure takes place in an environment of optimal frustration, where the caretaker’s non-traumatic failures in meeting the child’s self-object needs can be repaired. As in the family environment, the therapy relationship is no exception, as it is impossible for the therapist to accurately meet the client’s moment-to-moment mirroring and idealizing needs. Thus, each nontraumatic failure on the part of the counselor to provide empathy or to protect/sooth the client can be explored, worked through, and repaired. It is important that this not just be an intellectual process, but that the counselor directly encourage the client to feel, express, and work through the feelings (i.e., anger, rage, pain, grief) related to these empathic misattunments. It is the small repetitions of this process, over and over, that the capacities done by the therapist (affect regulation, self-awareness, repair, support, identifying feelings, etc.) can slowly be taken in by the client, and become part of his or her self structure and internal capacities.

Over time and by transmuting internalization, psychic structure is built.
The therapist can serve as a temporary selfobject that provides those needed functions. In this way, the therapy relationship becomes a corrective emotional experience for the client (Alexander, 1946). With the internalization of their mirroring and idealizing selfobject needs, clients can develop their own capacities for healthy self-esteem, affect regulation, and self-soothing abilities. These capacities replace the need for the client to rely on drugs and/or alcohol to meet their selfobject needs.

**Group counseling**

Because shaming, painful, and often rejecting relationships resulted in deficits in self, clients found it hard to turn to others to get their emotional needs met. However, it is precisely in the context of relationships that the wounds of the self can be healed and psychic structure restored. Therefore, group therapy offers the optimal platform by which the concepts of Self-Psychology can unfold in the treatment of those suffering from addiction. Group therapy offers the unique opportunity to provide the client with a consistent nurturing, mirroring, and holding environment that can help contain strong affects while providing the client with the opportunity to incorporate a healthy internal object and self structure (Flores, 2001). Over and above individual counseling, group therapy provides the perfect opportunity to transmute mirroring and idealizing selfobject needs into one’s own sense of self.

**Guidelines for group**

The Self-Psychology group should be a supportive, *process-experiential* group experience, allowing members to examine, challenge, and change their vulnerabilities in four main areas (Georgi, 1998):

1. Problems in relationships
2. Accessing, tolerating, and regulating affects
3. Self-care failures

4. Self-esteem deficits

Because the group is process-experiential, versus psychoeducational, it is vital the leader work to promote and maintain an atmosphere of safety. This is based on the understanding that clients are more likely to change if they feel safe enough to do so. As the focus of the group is on the “here-and-now”, client issues and the present relational dynamics taking place between member-to-member, member-to-leader, and member-to-group as a whole, are examined and explored. There is less of a focus on content issues and “there and then” items, except as is relates to what is taking place.

In addition to creating a space of safety, there are also a number of tasks the group leader can do to facilitate the incorporation of psychic structure. These include (Georgi, 1998):

1. Keep the group focused on the “here-and-now” experience of the members. This can promote the development of group cohesion and allow for the member-to-member unfolding of selfobject needs and experiences.

2. The most fundamental concept that orients a Self Psychology group is the selfobject experience. The intervention of choice is whatever facilitates members’ ability to clarify what they need from others, how to ask for it, and what they experience when they do and don’t get some level of optimal responsiveness from either the leader or other members in the group.

3. Directly encourage the group members to explore how they are in the group, and how they experience themselves with others.

4. Encourage members’ interpretation of their interpersonal behavior and the expression of their inner experiences and vulnerabilities.
5. Protect group members and provide emotional regulation to the group when needed. Do not let emotions get too overwhelming or out of hand. For example, too much anxiety can interfere with the trust and safety necessary for the exploration and openness that members need to reveal themselves.

6. Provide affect regulation by naming and mirroring feelings when they occur in the group.

7. Create an environment that meets the member’s need to be mirrored, to be seen, and to be seen as wonderful. Do this by going slowly, making eye contact with each member, and by believing that the members have the capacity to do the hard work necessary for recovery.

8. Be aware of shame as the driving force behind narcissistic wounds. Be sensitive to potential comments from members (or yourself!) that could be shaming and encourage other ways of communicating and relating.

From a Self-Psychology perspective, what is ultimately healing is not “content”, but connection, mirroring, “here and now” experience, and the safe expression and mirroring of feelings. The “here and now” experience is healing because addicts, due to their narcissistic wounding and lack of internal structure, avoid being in the “here and now”. The group allows them to experience that in a safe place.

**Assessment and prevention implications**

The implications for assessment are related to identifying if your client is expressing a vulnerability of the self and if treatment informed by Self Psychology would be warranted. In addition to a thorough bio-psycho-social assessment (Miller, 2010), assessment should also be focused on specific manifestations of your client’s narcissistic injury. These include issues of deep pain, intense levels of shame and impoverished self-concept, as well as compensatory
behaviors such as grandiosity, feelings of entitlement, and isolation from others. Because there is a paucity of cohesive self-structure, the clinician should assess for examples of deficits in the four key areas discussed above: (a) pattern of difficulties in relationships, (b) accessing and tolerating affective states, (c) self-care failures, and (d) deficits in self-esteem. Finally, difficulty regulating affective states, impulsivity, the inability to delay gratification, lack of clear boundaries, and heightened levels of anxiety are also common expressions of deficits in self structure due to failure to internalize healthy mirroring and idealizing selfobject functions.

Strengths and weaknesses

The strength of this model is that it provides a conceptual tool for not only understanding the formation and cause of addictive behavior, but for the development and utilization of specific treatment interventions aimed to repair the self and promote healthy internalizing of selfobject needs. Understanding addiction from the perspective of Self-Psychology provides both the counselor and client a way of making sense out of the substance abuser’s often puzzling self-destructive behaviors and relapses. Reframing addictive behaviors as one’s attempt at self-cure lessens the shame and stigma associated with addiction, and provides a theory that explains drug use as an attempt to fill inner emptiness and regulate affect and self-esteem.

Although providing a cohesive conceptual tool for understanding the psychological and emotional antecedents to addictive behaviors, the model lacks sound empirical support for both the specific constructs (i.e. transmuting internalization) as well as the efficacy of treatment interventions that are based on this model. Also, as this model is a deficit model, one that understands addiction as an attempt to provide something that is missing, it remains uncertain if this “missing structure” is the cause of addiction or the consequence of addiction. The model speaks very little to the societal and cultural influences of addiction. It does not take into account
the severe impact of poverty, discrimination, and oppression. The model also does not speak to ways this approach would be modified or adapted to different cultural groups. In addition, there is the risk of this approach becoming one-sided, as the primary focus on internal psychic structure deficits could cause counselors to downplay the important influences of culture, peer group, poverty, and discrimination, as well as biological and hereditary factors, related to addiction.

Case Study

The case of Gabriel exemplifies many of the facets of an individual suffering from deficits in the self, and the compensatory use of alcohol and other drugs as an attempt at self-cure to “fill in” what is missing and to repair his narcissistic injuries. Gabriel is a 26-year old, biracial male, questioning his sexual orientation, and who has a history of stormy interpersonal relationships, sexual acting out, intense shame, and lack of clear boundaries between self and others. Thus, from the purview of Self-Psychology, Gabriel is suffering from an unclear and fragmented sense of self due to a lack of healthy internalization of selfobject functions. As the case shows, this deficit of internalization is related to his caretakers’ inability to meet his age appropriate selfobject needs. The result for Gabriel is a state of pathological narcissism.

Pathological narcissism is a regression to a stage of the archaic self. Gabriel’s archaic self is crippled with shame, has difficulty differentiating between self and others, and has extreme self-regulation deficits. Gabriel’s self is one that is continually threatened by regressive fragmentation and massively low self-esteem, which is expressed as anxiety and shame. These symptoms, in turn, are compensated through feelings of entitlement and the need for omnipotent control via Obsessive Compulsive Disorder and his sexual conquests. Because the self of Gabriel is tenuous, it is continually subject to high levels of anxiety, which is the consequence of
his fear of annihilation and fragmentation of self. For instance, this fragmentation is displayed in his uncertainty regarding his sexual orientation and his inability to commit to or be faithful to one woman, constantly jumping from one romantic relationship to the next. He attempts to boost his damaged self-esteem through a series of sexual escapades, seeking mirroring and idealizing selfobject experiences through others.

It is clear from the case study that Gabriel’s caretakers did not adequately meet his mirroring and idealizing selfobject needs. For example, his mirroring selfobject needs would have been met through his caretaker’s ability to mirror Gabriel’s innate sense of greatness, competence, and uniqueness, whereas his idealizing needs would have been met through his experience of a strong, soothing, and idealized other—one who he could look up to and model as a figure of calmness, strength, and self-soothing capacities. Unfortunately, there is very little evidence in the case study that this took place on a consistent and “good enough” basis. For instance, he was raised in an environment with very poor interpersonal boundaries and history of unstable relationships; his own father not only used drugs with him, but also was the one who first introduced him to cocaine. And not only did his father abuse alcohol and drugs for as long as Gabriel could remember, but he also was emotionally and physically abusive to his family, leaving Gabriel to defend his mother and sister from his father’s violent behaviors when his father was on a binge. It would be a Herculean feat for an addicted father and terrified mother to, in any way, consistently meet Gabriel’s selfobject needs and to be empathically attuned to his emotional states. Because of this, Gabriel was never able, via transmuting internalization, to incorporate his selfobject needs into his own, internalized, psychic structure and sense of self.

The case provides clear examples of the emotional and psychological consequences of this failure. For one, Gabriel displays difficulty regulating affects in a healthy way, turning to
alcohol, drugs, and sexual acting-out to regulate his emotions and self esteem. Related to this is also the extreme difficulty he has in self-soothing his affective states. Without these internalized selfobject functions in place, he has to turn to “outside” sources for help. The missing parts of his self he experiences as a void, which he tries to fill with alcohol, drugs, and compulsive sexual relationships. As was noted earlier in the chapter, these attempts at “self-cure” are impermanent. Kohut asserted that the solutions these “self-cure” behaviors provide are temporary and bound to fail, and are thus repeated again and again and without producing the desired cure. This would explain Gabriel’s history of relapse and continued use despite consequences. For example, Gabriel has a history of failed attempts to stop using alcohol and drugs, and has even been through two in-patient hospitalizations, all without success. In spite of the consequences to his relationships, family, and personal health, he continues to use again and again. He is desperately seeking, and failing, to find psychic structure to fill in his internal void.

**Internalization of recovery**

The treatment and healing of the self cannot begin as long as Gabriel continues to use. It would be impossible to see who is “really there” while he is still under the physiological effects of his drug and alcohol use. The first order of treatment then would be referral to a level of care in order to provide structure and safety to promote sobriety. Although more information is needed from the case, I would feel comfortable referring Gabriel to at least the level of Intensive Outpatient, or possibly brief In-patient treatment, to begin with, and to monitor his progress and adjust level of care accordingly (Cavaciti, 2011).

The approach to treating addictions from a Self-Psychology perspective is not unilateral. It can integrate other models and approaches, while still maintaining the stance of the treatment components to be discussed below. Therefore, I would also incorporate the principals and
techniques of Motivational Interviewing, as I would want to shore up Gabriel’s motivation for change (Miller, 2012). To both strengthen and internalize his motivation to change, as the case states he is coming to treatment at the request of his mother and sister, indicating an external locus of motivation. I would want to explore more fully his concerns about his use, the effects on his life and relationships, how important it is for him to change, and how confident he is that he can do it.

Gabriel has a number of strengths that I would also want to highlight to him and promote. For instance, he is willing to attempt treatment and has also shown a past willingness to attend treatment and AA meetings. He has been able to achieve sobriety before, and was able to complete the requirements of his court-mandated treatment. There are members of his family that are important to him (mother and niece), and these would be sources of support I would draw upon.

Due to space limitations, I will only speak to the focus of the recovery work in individual therapy, keeping in mind that the individual work would be an adjunct to group therapy, family counseling, and self-help meetings.

As the wounds of the self were created in relationships, then the healing can only take place in relationships. That is, healthy relationships that can promote a corrective emotional experience and the internalization of psychic structure. Thus, the first task in our individual work together is the development of the relationship and the creation of safety and trust. This would be done through a non-confrontational approach and the use of mirroring interventions to reflect back to Gabriel that the therapist is able to empathically attune to his inner states. This requires an attitude of active listening, empathic reflections, eliciting feelings, and a stance of unconditional acceptance. This does not mean that resistances (which will come up) would be
ignored, but would instead be interpreted as expressions of his vulnerable self and need to self-sooth. For example: “Right now a part of you thinks it is still ok to have a drink again, because you want so badly to feel that you are in control of your life, and to calm the inner turmoil you often experience”.

Early in the stage of treatment with Gabriel, I would provide structure, keep interventions clear and simple, provide education and support, and avoid trying to break down any manifestations of denial. Instead I would put forth efforts to help teach Gabriel how to best use his internal capacities. Treatment goals with Gabriel should be both realistic and co-determined. They should take into account his strengths, resources, and life situation, and they should be provisional; they are subject to change over the course of treatment. From a Self Psychology perspective, the overarching goal is the expansion of self-awareness and to repair the structural deficits in Gabriel’s self. Specifically, we would (a) explore specific examples of his narcissistic injuries and how he attempts to ameliorate the pain of these through drug/alcohol use, (b) explore the failures he experienced in his life from his caretakers to appropriately meet his mirroring and idealizing needs, (c) help him to see how his narcissistic rage is either acted-out in the form of relapses, or is turned against the self in the form of depression, (d) show him that his profoundly low self-esteem resulted in drug use and sexual acting out as way to soothe his pain, and (e) illustrate the centrality of his shame experiences (Flores, 2013).

**Shame**

One of the reasons for Gabriel’s use of alcohol and drugs, as well as his sexual acting out, is that it confirms his grandiosity and compensates for intense feelings of shame, self-hatred, and low self-regard. Gabriel feels empty inside and has one long experience of narcissistic injuries to confirm this: loss of loved ones, humiliation, job set-backs, failures at recovery, legal issues, etc.
Each outside negative experience is another narcissistic wound for Gabriel. To intervene effectively, it is important to empathize with his suffering to facilitate his experiencing of this pain in a healthy way, instead of him having to act it out. For example, I might say “You have lost so much in life and have lost so many relationships, yet being unloved is what you have always feared” or “You have had numerous affairs, and this has only further confirmed to you that you have lost respect for both yourself and others.” Also, it is important to interpret how he has formed mirroring and idealizing transferences to alcohol and drugs, so he can begin to understand the motivation behind his addictive behaviors and to feel the pain and shame they were defending against. “Drinking gave you the sense of love and power that you so desperately wanted” or “Pot felt like the good and soothing parent that could help calm you down and make everything seem ok again. Now that you are getting sober, let’s talk about those feelings of shame, anger, and disillusionment.”

**Affect regulation**

As anxiety plays a large role in his life, I would help Gabriel to understand that his anxiety stems from the fear and panic of psychic fragmentation and his inner void, which is bound up with strong unconscious feelings of rage, guilt, and shame. To help him work through this, I would begin to explore the feelings *under* the anxiety in the sessions with me, and to begin to help him tolerate larger and larger approximations of these painful feelings. For example “right now as we speak about your father I notice you becoming anxious. I wonder what is beneath that anxiety? Would you be interested to see? What feelings are getting stirred up as we talk about him?” It is important for Gabriel to experience his powerful affects in a safe and constructive way, as this was not allowed in his family environment. I would want to help him tolerate strong feelings in the session without having to act them out, and to encourage what it is
like for him to feel these in the presence of me. For example “I wonder how you experience your anger inside, right now? What do you feel inside that tells you that you are angry? “Where is this rage and pain coming from?” “How was it to feel these feelings with me?” This encourages both the experience of warded off feelings and the cognitive reflection and understanding of them. The more Gabriel is able to experience and tolerate these powerful emotions with me, the less likely that they will be acted out in unhealthy ways, and this dual process of experience and reflection builds his internal capacities and promotes psychic structure (Goldin, 2014).

**Empathic attunement and transmuting internalization**

It is vitally important that I strive to empathically attune and mirror Gabriel’s internal states in the session as they are explored and experienced. For example: “Your disease has cost you so much, and it is painful to face how this has impacted your life,” “Your self-image is gone, yet you want so much to be seen, and to be seen as wonderful,” “Your father was often not there for you, and you wanted so much to be a part of his life,” and “You felt so empty inside, and you sought other women to help fill the void.” These interventions provide the missing mirroring selfobject needs that Gabriel was denied in life. However, can the therapist always accurately empathically attune to Gabriel? Obviously not. There will be hundreds of times I would fail to accurately attune with his internal emotional states. Yet, as we recall from earlier in the chapter, it is precisely the failures to empathically attune to Gabriel, and the exploration and working through of these failures, that psychic structure can be built from within (Ulman & Paul, 2013). My relationship with Gabriel needs to be “good enough”, and not perfect. Therefore, each non-traumatic failure of empathy (mirroring needs) or failure to protect (idealizing needs) and subsequent working through of these leads to the piece-by-piece internalization of new psychic structure. The working through of hundreds of these injuries in the session and his emotional
reactions to them, allows for the gradual accretion of the internalization of those functions that I had failed to adequately provide. Thus, Gabriel’s psychic structure, the ability to do for himself what was previously done by drugs or other people, can now become a part of his developing self-capacities and self-worth. What does this process look like? It begins by openly acknowledging the failure: “I see that I was off base just now when I said your father did the best he could.” Next includes exploring and mirroring the emotional impact of this: “I can see this was really hurtful to you just now, and stirred up the old pain of being misunderstood.” And finally is exploring his reactions to my attempts at repair: “What is it like for you to hear my words right now?”

Outcome

What would be the outcome of a successful treatment with Gabriel? Ideally, he would report feeling “full” or more complete inside. The inner urgency to use drugs, or act out sexually, would be greatly diminished. He would feel more comfortable in his own skin. The emptiness and free floating anxiety would dissipate, his sense of reality testing would be improved, he would be better able to consistently hold a stable level of self-esteem, and he would demonstrate the ability to both feel and manage his affects in an adaptive way. I would inquire about specific examples of his ability to modulate his anxiety, to regulate tension, and to self-sooth in times of need, and celebrate with him in these successes.

Summary

Conceptualizing drug use as well as other addictive behaviors from the perspective of Self-Psychology provides both an explanatory tool for understanding the genesis of addictive behaviors as well as providing a way of intervening to facilitate the process of recovery. Addictions are seen as the result of deficits in the self-structure due to failures on the part of the
caretakers to meet their child’s mirroring and idealizing selfobject needs. This results in an individual that lacks a clear sense of self and the functions that come with a cohesive sense of self: the ability to self-sooth, to experience healthy self-esteem, the ability to regulate affects, and the use of healthy self-care behaviors. Addictive behaviors are failed attempts to “fill in” what is missing and heal the wounds of the self. Treatment is aimed to begin the process of allowing the client to internalize these components into a new and secure sense of self.
References


**Resources**

**Books:**


**Websites**

- [http://www.selfpsychology.com/](http://www.selfpsychology.com/)