

Symptom Formation: An Integrative Self Psychological Perspective

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The emergence of a relational perspective in psychoanalytic thought suggests the need for new paradigms of symptom formation. In addition, biopsychosocial data on the etiology of a number of specific disorders have been accumulating. Self psychology is proposed as a relational model of psychopathology that can be incorporated into a biopsychosocial paradigm of symptom formation for Axis I disorders.

Four specific pathways to symptom formation are outlined. The first consists of a self-state of impending fragmentation that is then warded off through involvement with a substance or activity, as in addictive disorders. The second denotes a state of fragmentation without a behavioral means of self-restitution other than avoidance, seen in anxiety disorders. The third involves the use of a symptom as a compromise formation among conflicting impulses as a result of psychological trauma, as in dissociative and somatoform disorders. In the final pathway that I outline, symptoms such as depressive states and work inhibitions result from an internalized conflict between maintaining needed relationships and pursuing self-differentiation. Both internal conflict and developmental deficit are central in the genesis of symptomatic disorders.

The notion of a psychopathological symptom as a compromise formation is a tenet of classical psychoanalytic theory. The final expression of a symptom was thought to be the result of repressed sexual and aggressive drives admixed with ego defenses and superego prohibitions (e.g., Freud, 1916–1917). The recent shift within psychoanalytic thought to a relational perspective (Greenberg & Mitchell, 1983; Mitchell, 1988; Skolnick & Warshaw, 1992), in which human relationships rather than drives and defenses are seen

as central in the etiology of psychopathology, suggests the need for new paradigms of symptom formation.

Further, authors researching specific disorders outside of a psychoanalytic framework have recently emphasized a biopsychosocial perspective on the development of psychopathology (Barlow, 1988; Donovan, 1988; Garfinkel & Garner, 1982; Johnson & Connors, 1987; McGrath, Keita, Strickland, & Russo, 1990). This multidimensional approach eschews a single factor theory of pathology and instead suggests that a complete explanation must take into account biological variables such as inherited vulnerabilities and predispositions; psychological and familial experiences of the developing child; and the sociocultural milieu, including the impact of gender, race, ethnicity, and prevailing cultural norms. This inclusive approach is notable in its reliance on empirical data rather than theory alone and in moving beyond a simplistic model to explain complex events. However, biopsychosocial theories generally conceptualize psychological events from perspectives such as social learning theory, which are useful but fail to offer a convincing portrait of the internal experience of an individual.

In this article, I develop the thesis that self psychology, as a relational theory emphasizing experience-near events and subjectivity, has great explanatory potential for conceptualizing symptomatic disorders, particularly when combined with other data in a biopsychosocial formulation. The central focus is on the symptomatic behavior seen in disorders listed on Axis I in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders—Revised (DSM-IV)*; American Psychiatric Association, 1987) and how it might be understood from a relational and biopsychosocial stance. I suggest four particular ways in which symptoms express various difficulties; common to all is the notion of a vulnerable self in a relational matrix that is or was somehow inadequate.

SELF PSYCHOLOGY AND RELATIONAL THEORY

Greenberg and Mitchell (1983) and Mitchell (1988) pointed out that a number of psychoanalytic theorists had essentially replaced the classical model with a fundamentally different paradigm. In this newer perspective, which they termed a *relational model*, relationships with other people rather than drives form the basic structures of mental life. Mitchell (1988) suggested that self psychology is a relational theory, in that the stability and cohesiveness of the self develops from experiencing certain kinds of relationship with others and noted that Kohut explicitly broke away from the drive-conflict model. In this broad sense, self psychology is a relational theory. It does, however, have points of divergence with other theories also termed relational. For instance, Ornstein (1991) stated that self psychology is not adequately characterized as an object relations theory, believing that objec-

relations theories fail to recognize the importance of a focus on subjective experience and self structure.

Mitchell's (1988) relational-conflict model—a synthesis of various ideas in interpersonal psychoanalysis, object relations theory, and self psychological thought—focuses on ways in which problematic early relationships with caregivers distort later relationships, leading individuals to cling to constricting patterns of behavior because they are both familiar and familial. The relational-conflict model is compatible with self psychology in a number of areas, but places more emphasis on patients' insistence on engaging others in old “gambits” so that the anxiety associated with change can be avoided. Self psychology stresses the possibility that derailed developmental needs may be revived in an appropriately empathic milieu, as well as patients' fears of retraumatization based on early failures in attunement. Further, self psychology posits certain essential needs that must be appropriately met to ensure healthy self-structure, whereas relational-conflict theory makes no such claim. The self psychological theory discussed in this article converges most strongly with the relational-conflict model in discussing one particular pathway to symptom formation involving depressive states.

Self psychological theory proposes that healthy self-development proceeds from adequate responsiveness of caregivers to vital needs, including the need to feel understood and appreciated (*mirroring* needs), the need to feel attached to a powerful other who can soothe and calm the self (*idealizing* needs), and the need to experience some essential likeness with others (*alterego* needs; Kohut, 1971, 1984). Chronic failure to respond to a child in an attuned fashion can result in derailments of self development and relational development that may take various forms. Adequate parental responsiveness to the child's affect states is particularly vital if the child is to achieve affect differentiation and tolerance (Krystal, 1974; Stolorow, Brandchaft, & Atwood, 1987). Self psychology stresses that individuals need to be embedded in a matrix of selfobject relationships throughout life (i.e., relationships that serve to evoke and maintain the integrity and cohesiveness of the self will always be required). Insufficient selfobject responsiveness may lead to fragmentation, a distressing affective and cognitive state indicating threatened self-cohesion. Fragmentation experiences may range from mild dysphoria to a panicked sense of impending annihilation or disintegration.

PATHWAYS TO SYMPTOM FORMATION

Symptom as Effort at Self-Restoration

Disorders such as alcoholism, substance abuse, bulimia nervosa, and compulsive gambling all involve reliance on an inanimate object or an activity for self-regulation. These disorders affect large numbers of people and con-

stitute a major public health problem; for instance, it has been estimated that there are 10 million alcoholics in the United States (National Council on Alcoholism, 1987). Much controversy currently exists concerning how to understand addictions and how to account for the addict's desperate pursuit of a substance or destructive activity despite often catastrophic consequences for his or her life. Theories that conceptualize addictions as biochemical "diseases" have some intuitive appeal in explaining the relentlessness and rigidity of addictive behaviors; however, they must be broadened by the notion of a self in an interpersonal surround that is acting and being acted on by forces other than biological predispositions. The evidence for a genetic predisposition to certain addictive disorders is quite strong, particularly for alcoholism, in which well-designed studies have found significantly higher rates of alcoholism in offspring of alcoholics, even when reared with nonalcoholic parents (e.g., Goodwin, 1984, 1986). Some recent data have also suggested that genetic predisposition plays a role in the development of bulimia nervosa (Fichter & Noegel, 1990; Kendler et al., 1990). Other studies indicate that individuals with addictions may have biochemical abnormalities that impact mood; for example, it has been suggested that alcoholics and opiate addicts may lack endorphins (Trachtenberg & Blum, 1987) and that eating-disordered patients may have a biological vulnerability to affective instability and depression (Hudson, Laffer, & Pope, 1982; Hudson, Pope, Jonas, & Yurgelun-Todd, 1983).

Researchers of addictive disorders have noted that the addictive behavior tends to be associated with negative emotional states: Individuals are more likely to abuse substances or engage in compulsive behaviors when they are angry, anxious, lonely, sad, and so forth (Donegan, Rodin, O'Brien, & Solomon, 1983; Peele, 1985). Negative emotional states are also more strongly associated with relapse into addictive behavior after a period of abstinence than any other factor (Marlatt & Gordon, 1985). Recovering alcoholics in Alcoholics Anonymous learn the acronym HALT to remind them that they are at particular risk for drinking when hungry, angry, lonely, or tired. Although recognizing the importance of emotional states, the social learning and self-help models that dominate the addictions field do not offer convincing explanations of why individuals with addictive disorders seem to have so much difficulty coping with affect other than by resorting to the addictive behavior.

Several authors conceptualized addictions from a self psychological perspective (Barth, 1988; Connors, 1992; Geist, 1989; Goodsitt, 1985; Levitt, 1987; Sands, 1989; Ulman & Paul, 1989). Kohut (1977) noted the particular utility of self psychology for explaining the addictions. Addictive behaviors may be seen as efforts to stave off fragmentation in a vulnerable self by establishing a selfobject relationship with a substance or activity, which then becomes habitual and destructive. Individuals whose early relational experiences were lacking in needed mirroring and idealizing may have great difficulty in maintaining self-esteem, vitality, and self-cohesion in later life,

as there is inadequate structuralization of functions that ideally are gradually internalized from adequate caregivers (Kohut, 1971). Further, due to faulty early experiences, human relationships may not be seen as potential sources of comfort and help. Instead, intimacy is feared because others are viewed as potentially rejecting, attacking, critical, and unavailable. Substances such as food or alcohol are experienced as infinitely more reliable and safe than human relationships. The vulnerable individual begins to respond to disturbing interpersonal and affective experiences by engaging in the addictive behavior, which then might anesthetize or otherwise change the current emotional state. A sense of self-cohesion is restored when the person feels *calmed, numbed, or distracted* instead of overwhelmed.

Individuals who are biologically predisposed to react in particular ways to certain substances and/or to experience affective difficulty would thus be at great risk if in addition they grow up in a neglectful or abusive family milieu. Across addictions is the common difficulty of individuals whose early selfobject experiences were faulty (because of parental psychopathology and stressors and/or because of a poor fit between the biological/temperamental predispositions of the child and the character of the parents) who then learn that certain activities or substances offer surcease from pain. Another person may be involved in the activity, as in compulsive sexuality, but the driven, desperate nature of the action precludes full human relationship; the point is to restore the failing self.

The addict's primary relationship, then, is with an object or activity, not with another human being. A bulimic patient described her relationship with food by stating that "it feels like my best friend—I know it's always there for me." Addictive disorders involve taking action when self-cohesion is threatened by negative emotional states, narcissistic blows, and stressful interactions or demands. As the addiction progresses, this single mode of response to any disturbing event becomes habitual. The symptomatic behavior is both a manifestation of fragmentation and an effort at restitution through non-relational means. However, as Kohut (1977) noted, the addictive behavior does not enable the individual to accrue structure, but merely to engage in *the same behavior over and over without growth*.

It is evident that sociocultural factors play a large role in the development of addictive disorders. Different cultures vary widely in their rates of alcoholism (Marshall, 1979; Milam & Ketcham, 1981; Russell, 1986), and men have significantly higher rates of alcoholism than women (Bennett, 1983). Drinking in our culture may be considered a key component of an appropriate masculine role (Lemle & Mishkind, 1989). Sociocultural norms place women at much higher risk for eating disorders: approximately 95% of patients with diagnosed eating disorders are women (Johnson & Connors, 1987). Thinness is highly valued in our culture in general, but White women seem to experience the greatest cultural pressure to be slender (Rand & Kulda, 1990). The particular nature of the addictive disorder, then, will be at least partially determined by sociocultural factors such as gender roles and ethnicity.

Symptom as Fragmentation With Avoidance

A second group of Axis I disorders seems to involve the experience of impending fragmentation, but without the active effort to ward this off through behavioral means seen in addictive disorders. Anxiety disorders are characterized by a sense of vulnerability (Beck & Emery, 1985). Anxious individuals feel threatened and fear internal or external catastrophe. The feared stimulus may be a cognition, as in obsessive-compulsive disorder; a sensation, as in panic disorder; or an external object or situation, as in simple phobia and social phobia (Barlow, 1988). In all of these disorders, the individual experiences distressing anxiety without a functional solution other than avoidance. Kohut (1984) suggested that agoraphobics may have had inadequate idealizing experiences in the course of their development and have difficulty soothing themselves because they were insufficiently calmed by parents. This is likely for patients with other anxiety disorders as well. Anxious patients may experience what Kohut and Wolf (1978) described as an "overburdened self . . . a self that had suffered the trauma of unshared emotionality" (pp. 419-420). Kohut and Wolf noted that the result of the empathic failure in childhood was the absence of the capacity to protect oneself from the traumatic spreading of affects, particularly anxiety.

Anxiety disorders have a number of different manifestations, but I propose that all of them relate to concerns about maintaining self-esteem and self-cohesion within a particular relational context. Patients with panic disorder give especially clear and poignant descriptions of an acute fragmentation experience, using phrases like "falling apart," "coming unglued," and "going crazy." Panic attacks can involve losing one's sense of bodily integrity and mental stability; patients frequently mistake them for heart attacks because the aversive sensations are so intense (Mitchelson et al., 1990). Anxiety without panic is less dramatic but nonetheless causes great distress. In social phobia, the patient fears the critical scrutiny of others; patients with simple phobias doubt their capacity to withstand exposure to a difficult situation, and patients with generalized anxiety disorder are anxious and hypervigilant about any number of internal and external worries. Some sexual dysfunctions likewise revolve around anxieties related to adequate "performance" in an intimate situation.

The relational and self-calming difficulties often noted in anxious patients are particularly clear in agoraphobia, in which the patient fears becoming overwhelmed (usually in the form of a panic attack) in an unsafe place away from home. Other people are not expected to be a source of help should a problem occur; however, if the agoraphobic travels with a particular other person (the phobic companion, who is often a family member) he or she may feel much safer, relying on the companion to obtain medical help or otherwise rescue him or her if need be (Chambless & Goldstein, 1982). It has been

noted that the experience of the agoraphobic is much like that of a small child away from home (Beck & Emery, 1985). The need for an attachment figure (Bowlby, 1969) who can be relied on for the idealizing functions of calming, soothing, rescuing, and lending competence is more concretely seen than in most disorders. However, it appears that in anxiety disorders in general, individuals doubt their capacity to manage themselves or to maintain their cohesion and ability to perform tasks adequately. They may fear being overwhelmed by affects in a relational context that will be traumatizing rather than soothing and containing. Anxious patients expect that other people will be more inclined to be harshly critical and deprecating than calming and helpful, reflecting their experience of negative parental attitudes. A recent report on patients with panic disorder found that these patients described growing up with unsupportive parents who were critical, frightening, and controlling. Their self-esteem regulation was impaired, and they were fearful of experiencing trauma in other relationships (Shear, Cooper, Klerman, Busch, & Shapiro, 1993).

Parental harshness and lack of provision of adequate idealizing needs probably occur in all the symptomatic disorders I am discussing, but they may be more salient in the anxiety disorders. In addition, biological/temperamental factors may be quite important with anxiety disorders. Evidence suggests that some anxiety disorders, especially panic disorder and agoraphobia, have some degree of heritability (Torgersen, 1983). Kagan (1989) identified temperamental differences among children that may be related to the risk of developing an anxiety disorder. He found that approximately 10% of children are inhibited from birth, exhibiting characteristics such as disliking novelty and being easily startled, and he suggested that these children may be more prone than noninhibited children to experience panic states and agoraphobia. Likewise, Cloninger (1987) proposed underlying genetic dimensions of personality, including heritable tendencies toward novelty seeking, harm avoidance, and reward dependence. Individuals who develop anxiety disorders may be temperamentally inclined toward inhibition and avoidance rather than the impulsive action often seen in patients with addictions.

Sociocultural factors also play a role in the development of anxiety disorders. The demands of life in a complex culture that values performance and individualistic achievement surely increase the risk that members will suffer stress-related disorders. Anxieties centered around being evaluated by others will be most prominent in a society that esteems academic grades, standardized tests, performance reviews, and so on. Interestingly, gender differences are not very evident in the anxiety disorders, with the exception of agoraphobia, for which more than 75% of patients are women (Barlow, 1988). Differences in male and female relational socialization and the greater acceptability of women's remaining at home may account for the disparity.

Symptom as Compromise Formation

The classical concept of a symptom as reflecting a compromise between conflicting impulses remains a useful one when thought of in relational terms. Some patients, particularly those that have suffered trauma, may manifest a reduction in functioning to protect the self from overwhelming and unacceptable affects and knowledge. The content of the affects may be sexual or aggressive, but it frequently refers to what has been done to the self in abusive experiences rather than to the wishes for sexual and aggressive expression emphasized by classical theory. Herman (1992) noted that trauma survivors always face a conflict between forgetting and keeping secrets about the trauma on the one hand, and remembering and telling about it on the other. Many symptoms seen in traumatized patients may represent a compromise between the two. For example, a number of female Cambodian refugees who witnessed atrocities later suffered loss of vision that was found to have no organic basis (Roze & Van Boemel, 1989). Group treatment and support was effective in restoring some vision in these trauma survivors who could not bear to see any more horror.

Traumatized patients must find a symptomatic compromise that achieves multiple purposes. First, the self must be protected from knowledge of horrific events (often perpetrated by family members) and the accompanying rage, pain, grief, sense of betrayal, and hopelessness. Second, ties with caregivers must be preserved to ensure physical and psychological survival; in fact, abusive experiences seem to induce greater than average attachment-seeking (van der Kolk, 1987). Affects such as rage may be far too dangerous ever to permit in an abusive interpersonal environment, so that relational bonds are maintained at the expense of disavowing and denying large sectors of self-experience, including affects and memories. Finally, a part of the self might retain hope that someday one's story may safely be told, and it finds a way to hint at it through disguised representations of actual experiences.

It is common for trauma survivors to be amnesic for the traumatic experiences, including those taking place after childhood (Herman & Schatzow, 1987). The use of dissociation as the major defense for trauma patients has received much attention in recent years, including the recognition that multiple personality disorder and other major dissociative disorders are much more common than was previously thought (Putnam, 1981). Braun's (1988) BASK model of dissociation delineates how in integrated functioning, an individual's capacities (Behavior, Affect, Sensation, and Knowledge) act in concert with one another but in dissociated functioning, any of the spheres may be isolated from the others. This might result in such symptoms as self-mutilation with no affect or memory, or physical pain detached from its psychological origin. The integrative functions of consciousness have been split to protect the self from unbearable pain. Patients with multiple personality disorder, fugue states, psychogenic amnesia, and

other dissociative disorders have found ways to survive often horrific experiences, but at the expense of a sense of full continuity of identity in time.

Many patients with somatoform disorders may have symptoms that reflect a compromise between concealing and revealing. Recent research has suggested that a high proportion of patients with somatoform disorders have been sexually abused (Loewenstein, 1990; Morrison, 1989). The “hysterical” conversion reactions Freud noted in some of his patients are not surprising, given recent evidence concerning actual sexual abuse and concomitant dissociation in his female patients (cited in Herman, 1992). It is not uncommon for sexually abused patients to have a host of physical symptoms, including abdominal and genital pain and other specific pains and sensations that derive from the abuse, yet have no conscious memory of it.

Although this category of symptom as compromise formation is most applicable to traumatized patients with dissociative and somatoform disorders, it may also describe some patients whose background does not include egregious trauma. Obsessive–compulsive disorder patients who develop compulsive rituals may too be seen as struggling with affects they find unacceptable and forming symptoms that both reveal and conceal the underlying experience. It is common for obsessive–compulsive patients to have particular difficulty with anger and to develop symptoms ostensibly designed to protect loved ones from harm. Even without the overt trauma of sexual or physical abuse, these patients may have experienced such significant failures of parental responsiveness that affect tolerance and integration were hampered. Emotions such as anger are deemed too dangerous to self and others and must be ritualistically undone, but yet they manifest in disguised form.

Biological predispositions may play a lesser role in dissociative and somatoform disorders compared to some others. The traumatically induced nature of these disorders has become very clear; for instance, 97% of a large sample of patients with multiple personality disorder reported significant childhood trauma (Putnam, Guroff, Silberman, Barban, & Post, 1986). It is possible that there are inborn differences in dissociative capacity among individuals (Braun & Sachs, 1985). Relevant sociocultural factors are those that contribute to certain types of traumatic experiences for various populations. Women’s devalued status in patriarchal culture contributes to the high rates of sexual abuse, rape, and battering perpetrated on girls and women. Men’s posttraumatic syndromes often result from the combat experiences that they are socialized to endure as part of the masculine role.

Symptom as Internalized Conflictual State

Stolorow and colleagues (Brandchaft, 1988; Stolorow et al., 1987) articulated the difficulties for an individual whose caregivers responded traumati-

cally to affect states and behaviors relating to the development of his or her individualized selfhood. Ties with caregivers must be preserved to ensure physical and psychological survival, so that when the needs of caregivers conflict with the needs of the evolving self, the potential for a problematic resolution is great. These authors noted that this conflict may be resolved in one of three ways. The individual may protect the core of his or her selfhood by rebellion and nonconformity, preserving the self but at the expense of object ties, resulting in isolation and estrangement. Second, the individual may submit and compromise self-differentiation to maintain the relationship. Finally, an individual may oscillate between the two positions. These authors suggested that depression will become the dominant affect in a person for whom this is a chronic conflict; there is loss of hope for a solution to the dilemma of maintaining individualized selfhood and needed selfobject ties.

Similarly, in Mitchell's (1988) relational-conflict model, much behavior that might be called "self-defeating" actually represents attempts to maintain allegiance to needed internal object ties. A sense of safety, connectedness, and loyalty is imparted by maintaining fidelity to parental injunctions and styles. Stern (1992) noted that several authors, including Winnicott, Sullivan, and Kohut in addition to those just mentioned, identified a pathological configuration consisting of two dissociated motivational systems that exist side by side: one organized around the requirements of needed others and one that contains the hidden true self, with its disavowed affects and developmental strivings.

Mitchell (1992) pointed out the difficulties in separating internal and external—self and other—in that all personal motives have developed within an interpersonal matrix. Concepts such as self-strivings should not be thought to exist outside of a relational context. However, individuals may generally resonate with experiencing strivings for achievement, passion, mastery, novelty, stimulation, and creativity that seem "authentic" and promise fulfillment and satisfaction to the self, however much the interpersonal surround might have had to do with their internalization. These are versions of the needs for exploration and assertion identified by Lichtenberg (1983) as central motivating forces beginning in infancy.

The first two adaptations to a conflict that Stolorow and colleagues described between these strivings and the need to maintain vital relational ties probably become crystallized into character pathology. The comparatively greater flexibility of response and the high level of subjective distress that characterize the third solution denote Axis I disorder. This chronic internalized conflict between self-strivings and the need for relationship may characterize a number of symptomatic disturbances, particularly depressive states, work inhibitions, and some sexual disorders such as lack of desire. Again, in a broad sense, most psychopathology probably involves some conflict between relational needs and self needs, but in the group of disorders under discussion here, the conflict is unrelenting, appears insoluble,

the individual, and involves oscillating between the two imperatives with no sense of resolution. Patients in this situation feel chronically guilty no matter what choices they make.

Depression is a heterogeneous phenomenon, as can be seen in the numerous *DSM-IV* listings for subtypes of depression. The focus here is on the experiences that typify unipolar depression: low self-esteem, helplessness and hopelessness, harsh self-criticism, sad mood, and inhibitions in action. Patients may have some self-deficits as well as conflicts about how to crystallize and pursue their own goals if parents have communicated that relationship is contingent on adhering to their agenda. Depressed patients appear to have numerous unmet needs for alterego experiences. They tend to feel alienated, not fully part of the human community, and unable to impact others (Beck, Rush, Shaw, & Emery, 1979).

Depressed and inhibited patients have profound fears regarding the consequences of self-initiated activity. Oedipal anxieties have often been invoked in classical theory to explain "masochistic" or "self-sabotaging" behavior. However, self-strivings may portend an anticipated relational disaster not necessarily linked to fear of castration. Patients may expect retraumatization associated with failed mirroring experiences, in which the child's display of his or her talents and abilities resulted in parental contempt, fragmenting, or withdrawal. Patients may also fear overstimulation from unintegrated grandiose strivings. *The bond with parents* may be preserved by agreeing that it is bad and selfish to want things for oneself and that only the parents' needs are valid. Patients fear not infrequently that their parents will die, literally or psychologically, if they pursue their own ends and that the price for doing what they wish is living an utterly isolated and abandoned existence. Yet the wishes for one's own life persist despite the sense that this constitutes a betrayal of the family, and helpless paralysis may result from the seemingly irresolvable conflict.

Depression has been linked to genetic vulnerability (Allen, 1976). Temperamental predispositions to inhibited behavior may also be important (Cloninger, 1987). Sociocultural issues such as gender roles have impact as well. Numerous studies suggest that about twice as many women as men are depressed—a difference not explained by women's greater willingness to admit to symptoms or seek help (McGrath et al., 1990). Several factors have been proposed to account for this robust finding, including (a) socialization in traditional female gender roles that promote passivity, helplessness, and caretaking others; and (b) women's typically greater investment in relationships and resulting vulnerability to self-esteem loss from relational "failure" (Kaplan, 1991; McGrath et al., 1990). Sociocultural stressors including poverty, discrimination, and victimization have also been linked to depression (McGrath et al., 1990).

CONCLUSION

The four categories briefly outlined here provide a framework for conceptualizing symptom formation. It is by no means a perfect schema; there may be overlap between categories, and one individual could have symptoms that span all four types. However, it may be useful in integrating etiological factors in psychopathology that are too often viewed in isolation and in suggesting how both self-deficits and internal conflict are central in the genesis of psychopathology.

The unfortunate separations among academic psychology, biological psychiatry, and clinical psychotherapy or psychoanalysis have often resulted in the disconnection of empirical research and clinical practice to the detriment of all. An empirical and objective stance toward complex human events can produce findings that are statistically significant but meaningless; clinical work that is not infused by empiricism may perpetuate rather than alleviate suffering. The self psychological conceptualization described here is compatible with other approaches that focus on the centrality of relatedness and connection, including Stern's (1985) infant research and literature on attachment (Bowlby, 1969).

Sociocultural issues related to the genesis of psychopathology require much further study. Cushman (1990) noted our tendency to confuse our particular notions of the self—the Western, bounded, individualized self—with human development in general. Gender issues in psychopathology have received serious attention only in the last decade, and factors such as race and ethnicity continue to be neglected (Betancourt & Lopez, 1997). It is hoped that our appreciation of the myriad ways in which we are shaped by our extrafamilial culture continues to deepen.

An advantage of a self psychological framework is its inclusion of a focus on subjective experience that resonates with the inner world of therapist and patient alike, so that psychopathology is seen as spanning a continuum, rather than delineating "us" from "them." Kohut (1984) stated that our inner lives are not graspable via extrospection; it is only through introspection and empathy that our internal states and those of others can be apprehended. He suggested that the psychological approach, with all its limits, is nonetheless the only useful one for investigating the inner life, including psychopathology. I propose that the integration of self psychological theory with a biopsychosocial perspective has potential for infusing our understanding of internal experience with an appreciation of the multiple factors that affect development.

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