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Narcissistic and Borderline Personality Disorders

Psychology of the Self and the Treatment of Narcissism

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Narcissus was a Thespian, the son of the nymph Leiriope, whom the River God Cephisus had once encircled with the windings of his streams and ravished. The famous seer Teiresias told Leiriope, "Narcissus will live to a ripe old age provided that he never knows himself."

Narcissus had a stubborn pride in his own beauty. By the time he reached the age of 16, so the myth goes, his path was strewn with heartlessly rejected lovers of both sexes. Among these lovers was the nymph Echo who could no longer use her voice except in foolish repetition of another's shout, her punishment for having kept Hera entertained with long stories while Zeus's concubines evaded her jealous eye and escaped.

One day when Narcissus went out to the woods, Echo stealthily followed him, longing to address him, but unable to speak first. At last Narcissus, finding that he had strayed away from his friends shouted, "Is anyone here?" "Here," Echo answered, and soon she joyfully rushed from her hiding place to embrace Narcissus but he shook her off

roughly and ran away; “I will die before you ever lie with me,” he cried. “Lie with me!” Echo pleaded. But Narcissus had gone and she spent the rest of her life pining away for love of him until only her voice remained. This story is reported by Ovid in the *Metamorphoses.*

Several classical authors also tell the story of how Ameineus, the most insistent suitor of Narcissus, was sent a sword by Narcissus. Ameineus took this and killed himself on Narcissus’ threshold, calling on the gods to avenge his death. Artemis heard the plea and made Narcissus fall in love though denying him love’s consummation. In Thespia he came upon a spring, clear as silver, and casting himself down near it, exhausted, to drink, he fell in love with his reflection. At first he tried to embrace and kiss the beautiful boy who confronted him but presently recognized himself and lay gazing enraptured into the pool, hour after hour.

The myth continues significantly: Although grief was destroying him as he longed to possess, *yet he rejoiced in his torments knowing that his other self would remain true to him, whatever happened.* Echo grieved with him and sympathetically responded, “Alas, alas,” as he plunged a dagger in his breast and expired. His blood soaked the earth

and up sprang the white narcissus flower from which came the well-known classical narcotic, Narcissus oil.

In this timeless Greek myth as paraphrased by Graves (1955, pp. 286-288) we see the manifestation of Narcissus' stubborn pride in his own beauty, the unempathic hostile and arrogant behavior toward others, the primary preoccupation of Narcissus that his other self, his mirroring self-object,[1] always remain true to him whatever happens, and the condensing of death, sleep, narcosis, and peace.

Narcissism

Ellis (1898) first used this myth to illustrate a psychological state in reporting a case of male autoeroticism; the term "narcissistic" was first used by Freud in a 1910 footnote to *Three Essays on the Theory of Sexuality* (Freud 1905). Freud's essay introduced the concept of narcissism into the psychiatric literature; the history of the development of this concept into the nosological entity called "narcissistic personality disorder" is carefully presented by Akhtar and Thomson (1982). These authors remind us that Rank wrote the first psychoanalytic paper on narcissism in 1911 and that Freud's paper on

narcissism was published in 1914. In 1925, Waelder presented the description of a “narcissistic personality” and, since that time, the term narcissism was used with an astonishing variety of meanings, ranging from a sexual perversion to a concentration of psychological interest upon the self (Moore and Fine 1967).

Just as the term narcissism has been used in many ways, the phrase narcissistic pathology has been used by various authors to shade over certain neuroses, psychoses, borderline conditions, and personality disorders. Freud stamped these disorders with an implication of poor prognosis for psychoanalytic psychotherapy when he distinguished them from the transference neuroses.

A more precise definition of the problem was offered in a classical paper by Reich (1960, also see Chapter 3 of this book), who conceived of narcissism as being founded on a pathological form of the regulation of self-esteem, a problem that may be found in both neurotic and psychotic individuals who “have exaggerated, unrealistic —i.e., infantile—inner yardsticks” and constantly seek to be the object of admiring attention “as a means to undo feelings of inferiority.”

It is fascinating to study the evolution of the concept of narcissism and narcissistic pathology from the phenomenological and experience-near mythological descriptions of the Greeks to the psychodynamic and experience-distant conflict interpretations used to explain the condition by Freudian and post-Freudian psychoanalysts. Built into this situation is the eventual divergence of Kohut's contributions and his psychology of the self from the mainstream of Freudian conflict interpretation.

Freudian psychoanalysis and the subsequent North American ego psychology school, founded on the work of Hartmann, Erikson, Rappaport and others after the Second World War and developed well into the 1960's, take as their basis an empirical scientific orientation founded on a positivist philosophy that was considered the hope of the world at the turn of the twentieth century. Human mentation and behavior are visualized as the outcome of conflicting vector forces much in the manner of classical physics, and are amenable to empirical dissection in the consulting room by the properly trained psycho-analyst-observer who takes a neutral and equidistant position with respect to the id, ego, and superego of the patient.

Kohut's psychology of the self, regardless of its later evolution, was first envisioned as built on data gathered by what he calls the method of empathy or vicarious introspection. Its experience-near emphasis focuses on the patient's sense of self, utilizing wholistic concepts at least closer to the continental philosophical movements of phenomenology and hermeneutics than concepts such as Freud's hydrodynamic model (Peterfreund 1971), based on the usual positivistic naive nineteenth century approach to the "human sciences." It is not unreasonable to argue at this point, as some psychoanalysts do, that Kohut's psychology of the self, when contrasted with Freud's psychoanalysis and the subsequent North American ego psychology school of psychoanalysis, presents a system fundamentally different in its philosophical presuppositions, moral assumptions, experience-distant hypotheses, and theoretical constructs, and, most recently (Kohut 1984), in its theory of cure, although the extent of this difference remains an unresolved issue.

Kohut (1984), on the other hand, clearly asserts that his work is "squarely in the center of the analytic tradition" [and] "in the mainstream of the development of psychoanalytic thought" (p. 95), and that there is a "palpable" continuity between ego psychology and

self-psychology. The differences from traditional psychoanalysis, he says are in the explanations provided for the process of cure and "the theories that, at least in some instances, inform the analyst's interpretations" (p. 104). He concludes, "self-psychology does not advocate a change in the essence of psychoanalytic technique" (p. 208) and it does not introduce "parameters" (Eissler 1953).

Kernberg (1975, 1976, 1980) presents another popular and comprehensive theoretical system opposed to the psychology of the self in attempting to explain the phenomena subsumed under narcissism. Kernberg's system has significantly modified the theories of Melanie Klein into a form more acceptable to American scientific thinking. The "object relations theory" of Kernberg has become in the United States the principal alternative to self-psychology in the area of the understanding, explanation, and treatment of narcissistic and borderline personality disorders (see Chapter 5, this volume).

Although Kernberg claims there is no fundamental difference between his object relations theory and the American ego psychology school, there is much disagreement on this subject which is not pertinent to the focus of the present book; *in nuance* the disagreement

on premises between Kernberg and the ego psychology school and much of the resulting controversy are, in essence, outgrowths of the earlier disagreement in principles between the theories of Melanie Klein and Anna Freud.

However, it is possible, as the British school of psychoanalysis has demonstrated, for the followers of Melanie Klein and Anna Freud to remain within the same psychoanalytic school although they may differ on the nature of the conflicts involved and on the origin of the drives with which they feel every individual must contend. Both Anna Freud and Klein agreed that, fundamentally, the eventual cure of the patient would come about by the psychoanalytic working through of unconscious conflicts that remain from the various unsatisfactorily traversed eras of psychosexual development in childhood. At the center of this set of conflicts lies the Oedipus complex, believed by Freud to be the nucleus of all psychoneuroses; without the successful working through of the increased outpouring of sexual and aggressive drives that are postulated by Freud to emerge between the ages of, approximately, 4-6 in every human being, mental health, the Kleinians and Freudians agree, would be unattainable. This is true even though the Kleinians place the origin of the Oedipus complex in infancy and

view its resolution somewhat differently.

Narcissistic Personality Disorder

Let us take a general look at the phenomena subsumed under the label narcissism and at some of the agreements and disagreements on a phenomenological and explanatory level among these various theoretical orientations. A brief description of the narcissistic personality is presented in DSM-III (Spitzer 1980, pp. 315-317) which simply represents the commonsensible characterization of people whom we usually label as narcissistic, people who manifest a sense of self-importance with an exhibitionistic need for attention and admiration, feelings of entitlement, lack of empathy for others, and interpersonal exploitativeness.

Although there is nothing wrong with this description, it emphasizes the disorder aspect so that the individual described in DSM-III would clearly be somebody that no one could like, an individual who is obviously maladapted and headed for serious trouble in life. This is a reflection of the philosophy of DSM-III, which tries to describe psychiatric disorders as diseases in order to justify

their need for medical attention and, in contrast to DSM-II, backs away from the concept of a continuum between normal behavior and mental disorders in order to avoid the common accusation that psychiatrists simply treat difficulties in living and minor exaggerations in people's personalities.

Both Kernberg and Kohut agree that patients with narcissistic personalities may not appear disturbed in their surface behavior and may function well socially and show good impulse control. Their great need to be loved and admired by others, their inflated concept of themselves, their shallow emotional life, and their minimal or lack of empathy for the feelings of others may only manifest itself on careful examination. These individuals may attain high offices and even be elected President of the United States, thus raising the issue of "the culture of narcissism" and the putative increased prevalence of narcissism and narcissistic disorders at the end of the twentieth century. Both of these issues will be discussed in the next chapter.

A more careful study of narcissistic individuals shows that, when they are not getting the tribute of other people or immersing themselves either in grandiose fantasies or the pursuit of the

actualization of these fantasies, they do not enjoy life. They are bored and restless. They represent the ideal American consumer, always attempting to acquire something that simultaneously will exhibit their wealth, power, or sexual prowess in order to pass the time.

These people may overtly or covertly manifest exploitative and parasitic relations with other people and a chronic intense envy of others whom they imagine have what they want and enjoy in life. At worst, they are haughty, grandiose, and controlling, any of which they may show only privately in their relations with others or—to the common misfortune—only when they reach positions of power.

Narcissistic individuals cannot come to terms with old age and cannot accept the inevitable changes of aging as they watch the younger generation exhibit beauty and vigor. Their middle years are therefore often characterized by a so-called crisis filled with rage, depression, and sometimes strange impulsive behavior. Their selection of a hero to admire or depend upon, often is simply an extension of themselves or of their ideal, and they may suddenly transfer their feelings from one hero to the other.

This constitutes a clinical warning to psychotherapists, for at any time the idealized therapist may suddenly be dropped for even a slight frustration, regardless of how much praise the patient may have heaped upon the therapist up to that point. All authors agree that narcissists cannot experience a therapist as an independent person or relate to the therapist realistically, although therapists disagree as to the reasons for this. They also agree that the treatment of these individuals is a long one, and stressful for the therapist (Abraham 1919).

As in the myth of Narcissus, narcissistic individuals often have talents in childhood that arouse admiration; they are frequently considered to be children who have great promise. Often they were pivotal in their families—the only child, the brilliant child, "the genius"—and thus carried the burden of fulfilling family expectations. Yet these individuals often show surprisingly banal accomplishments as adults except for that rare individual, the successful narcissist. This sort of person, by dint of superior talents and luck, is enabled to realize grandiose expectations but then gets in trouble in attempting to actualize ever-increasing levels of grandiosity. The classical example of this is Lyndon Johnson getting up in the middle of the night

to decide on bombing sites in Viet Nam. Johnson, 9,000 miles away from the war, was unable to accept the shattering of his hopes to be a great president (Tuchman 1984).

For Kernberg (1975, p. 248), psychoanalysis is the treatment of choice for narcissistic personality disorders except for those narcissistic patients that he characterizes as functioning on a borderline level. He defines the latter group as showing multiple symptoms, nonspecific manifestations of ego weakness (poor impulse control, lack of anxiety tolerance, impaired reality testing, and lack of sublimation), regression to primary process thinking, and constant relentless rage and depreciation of the therapist, especially if rage is early and open. "A more supportive treatment approach seems best for this group" (p. 249). Kohut would not define such patients as narcissistic personality disorders at all, as we shall see, whereas Giovacchini (1979) is inclined to recommend formal psychoanalysis for all such patients.

A few variants of the narcissistic personality disorder might illustrate the numerous ways in which this situation has been described. For example, Finlay-Jones (1983) discussed a syndrome

called *acedia,* known since the fourth century A.D. Sloth, or acedia, was labelled as one of the "seven deadly sins" (Fairlie 1977) and meant a state of dejection giving rise to torpor of mind and spirit, sluggishness of will, despair, and desirelessness. This is not a DSM-III clinical depression and represents rather a disgust with life in general, as Finlay-Jones calls it, manifested by a mood of sadness, an inability to do anything useful, and an anhedonia, or insensitivity to pain and pleasure. He blames this condition on the lack of meaningful work and would thus be inclined to rename it a "suburban neurosis."

Solberg (1984) describes "lassitude" as a similar problem of growing proportions and "its synonyms (fatigue, weariness, tiredness, or listlessness) represent some of the most common complaints in primary care" (p. 3272). However, Solberg relates the psychological causes of lassitude more to "depression" without distinguishing the characteristic "empty" depression of the narcissistic middle-aged patients among, for example, the "1,050 forty-year old Danes" in a sample that showed a very high prevalence (41 percent of the women and 25 percent of the men) who felt "tired at present."

Tartakoff (1966) described the "Nobel Prize complex" involving

people who are intellectually gifted and preoccupied with the pursuit of applause, wealth, power, or social prestige and recognition. She begins with a discussion of relatively successful middle-aged individuals with characterological problems rather than crippling neuroses who have applied for psychoanalytic treatment. These individuals, for the most part, appear "healthy" from the sociological point of view. Except for one subgroup, their unifying outlook on life was manifested by "an optimistic anticipation that their virtues, their talents, or their achievements would be rewarded by success if they took appropriate steps to work toward this goal" (p. 225), in this case the goal of completing psychoanalysis successfully. This expectation of recognition for achievement constitutes an initial resistance in these cases.

The subgroup of middle-aged professionals Tartakoff isolates are those who were motivated to seek psychoanalytic treatment by an intense feeling of disillusionment with life based on their conviction that they had neither fulfilled their "promise" nor received the objective acclaim to which they aspired. In this group, depressions, anxiety attacks under stress, and psychosomatic symptoms were not uncommon.

Related especially to this subgroup are intellectually or artistically gifted patients who have often achieved a great deal but for whom "objective achievement becomes overshadowed and, often, inhibited by a preoccupation with acclaim" (p. 237). In her study of these achievers, who are also marked by hypersensitivity to minor disappointments in later life, "in particular to lack of recognition" (p. 237), Tartakoff introduces a new nosological entity, the Nobel Prize Complex. "All or nothing" is its goal and it rests on the fantasy of being powerful and special with the childhood described above for the typical narcissistic personality. Tartakoff points out that these patients are neither borderline nor psychotic. On the whole, they are well integrated and they try to express the American dream which Tartakoff describes as "a narcissistic fantasy which has become institutionalized" (p. 238). She concludes:

> Our social structure continues to reinforce narcissistically oriented attitudes throughout adolescence and into adulthood. It does so without adequate consideration for the limited institutional means of fulfilling such wishes. Moreover, preoccupation with admiration and acclaim may lead to an inhibition of the individual's capacity to function. As a consequence, dissatisfaction and disillusionment may ensue when life does not fulfill the infantile "promise." (p. 249).

Murphy (1973) focuses on the narcissistic therapist, whom he describes in terms that might be included in DSM-III. Therapists such as these look for fast results, are hypersensitive to statements made about themselves but insensitive to the feelings of their patients, and need admiration and love. Consequently, they mishandle transference and countertransference. They cannot deal with idealization, punish negative transference by techniques such as scolding, sarcasm, or premature termination, ward off anxiety over their own passivity by constant activity and over aggressiveness with patients, misuse patients, considerably overcharge them, and finally, are seducible and manipulable.

Relation of the Narcissistic and Borderline Personality Disorders

The existence of a continuum between narcissistic personality disorders and borderline patients remains hotly debated. Adler (1981) tries to establish such a continuum which runs from the patient with a stable narcissistic personality disorder to the borderline patient capable of a serious regression, using "lines" that Adler describes as cohesiveness of the self, self-object transference stability, and the

achievement of mature aloneness. Kernberg (1975) delineates "higher" and "lower" levels of ego functioning on which he attempts to differentiate between borderline and narcissistic personality disorders, but there is nothing in his descriptions that would theoretically preclude placing patients on a continuum based on the extent to which they use the higher and lower levels. Kernberg characterizes the borderline personality organization as marked by identity diffusion based on pathology of internalized object relations and reflected in lack of integration of the self-concept and of the concept of significant others. The borderline personality is typified by the predominance of primitive defensive operations centering around the mechanism of splitting, which occurs, however, in the presence of relatively well-maintained reality testing. This borderline personality organization, according to Kernberg, includes a spectrum of severe types of personality disorders among which are the borderline personality disorder described in DSM-III, the narcissistic personality disorder of DSM-III, and to some extent the schizoid, paranoid, and hypomanic personalities.

The problem of reaching agreement and definition about the borderline patient or borderline personality disorder is much greater

than the situation involving narcissistic personalities (see Chessick 1966-1984b). A neurosis implies that the patient has traversed the pregenital stages of personality development fairly well and has formed a relatively well-functioning ego with a solid repression barrier and a strong superego. The assessment of the strength of the ego and its functioning has been given (Chessick 1974, 1977), described in greater detail by DeWald (1964) and in complete metapsychological detail by Kernberg (1976). The diagnosis of a neurosis implies that the therapist has assessed the ego functioning of the patient and finds it to be relatively strong and solid, employing for the most part so-called classical higher defenses of repression with related mechanisms that presume and require consolidation of the tripartite intrapsychic structure or, in Kohut's terminology, a cohesive sense of self.

Authorities disagree as to whether a sharp distinction ought to be made between the borderline patient and many character disorders. DSM-III (Spitzer 1980) recognizes this disagreement and places borderline patients under personality disorders, noting the presence of a "cluster" of "dramatic, emotional or erratic" personality disorders: histrionic, narcissistic, antisocial, and borderline. DSM-III continues,

"Frequently this disorder is accompanied by many features of other Personality Disorders such as Schizotypal" [and here I would add the Paranoid and Schizoid from their 'odd or eccentric' cluster] "Histrionic, Narcissistic, and Antisocial Personality Disorders" (p. 322).

Diagnosis of Borderline Personality Disorder

In this confusion one may try to make a diagnostic distinction again by reference to the ego as it manifests itself in the kind of acting out and reality testing employed by the patient. I prefer to maintain the diagnostic difference between borderline patient and character disorder on the descriptive criterion that, in character disorder, one set of well-known characterologic features consistently predominates the clinical picture in a relatively rigid and all-pervasive way; thus, we have the obsessive-compulsive character, the narcissistic character, the hysterical character, and so forth. The more extreme forms of these disorders, as adaptation becomes increasingly hampered, shade off into the disorders of the borderline patients, but there are certain typical descriptive clinical features of the borderline patient that in my opinion (1974b, 1983a), when they are present, greatly aid in the diagnosis.

Any variety of neurotic or quasi-psychotic, psychosomatic or sociopathic symptoms, in any combination or degree of severity, may be part of the initial presenting complaint. A bizarre combination of such symptoms may cut across the standard nosology, or the relative preponderance of any symptom group changes or shifts frequently. Vagueness of complaint or even a bland, amazingly smooth or occasionally socially successful personality may be encountered. Careful investigation reveals a poverty of genuine emotional relationships well hidden behind even an attractive and personable social facade. The borderline patient may present either a chaotic or stormy series of relationships with a variety of people or a bland and superficial, but relatively stable, set of relationships. In both cases a lack of deep emotional investment in any other person may be carefully—consciously or unconsciously—concealed.

The capacity for reality testing and ability to function in work and social situations are not as catastrophically impaired in borderline patients as in schizophrenics although the degree of functioning may vary periodically and may be quite poor. On the whole, these patients are able to maintain themselves, sometimes raise families, and otherwise fit more or less into society. They do not present as isolated

drifters, chronic hospital or long-term person cases, totally antisocial personalities, or chronic addicts. They have, however, often tried everything and may present a variety of sexual deviations, but they are not functionally paralyzed for very long periods of time by these deviations or by their various symptoms or anxieties. Borderline patients suffer from a relatively stable and enduring condition. They may experience what appear to be transient psychotic episodes either for no apparent reason or as a result of stress, alcohol, drugs, or improper psychotherapy, but they do not remain psychotic for long. They quickly reintegrate, often learning what will help them to do so and administering a self-remedy.

This description is meant to supplement, not to replace, the DSM-III delineation (with which I agree) in order to further sharpen the diagnostic criteria. Any practicing psychotherapist can attest that these patients are commonly found and pose extremely difficult therapeutic problems because of the unpredictable fluctuations in their ego state and the intensity of the emotional impact they have on the therapist. Thus the debate in the literature does not address the real issue. The question ought not to be whether there are borderline patients—which there certainly are—but rather whether there exists

a pure metapsychological formulation that identifies the borderline patient as a distinct, different metapsychological entity from other patients. I believe, however, that "borderline patient" is primarily a clinical and practical diagnosis (Grinker and Werbel 1977) rather than an identification of an autonomous disorder. My views are closer to those of Kohut (see Chapter 11) and the Kris study group (Abend et al. 1983). The latter (pp. 19-20) presents the conclusion that "the borderline diagnosis is no more than a broad loose category of character pathology and not a clear diagnostic entity with specific conflicts, defenses, and developmental problems" (p. 237).

Meissner (1978) points out that the continuum concept that I have employed is "adhered to by analytic thinkers with a basically ego-psychological orientation." Criticizing Kernberg's insistence that "splitting" is the characteristic defensive mechanism of the borderline personality, Meissner states:

> It is not at all clear that the splitting mechanism adequately distinguishes the borderline from more primitive schizophrenic entities, nor is his [Kernberg's] argument that the borderline condition is satisfactorily distinguished from the neuroses on this same basis beyond question. It may be that splitting can be found in many neurotics just as

> repression may be found in many borderline cases, (p. 304)

Meissner (1978a) agrees with my main objection to Kernberg's theory, seriously questioning "the extent to which [adult] defensive defects can be read back from a more differentiated and evolved state of intrapsychic organization to early primitive developmental levels." He concludes that it is "too simplistic or 'neat' to be able to ascribe the multiple impairments found in borderline pathology to a single type of ego defect." He continues:

> We need to think of multiple deviations in many areas of ego functioning as possibly operating on a different level of disturbance in each area. Such ego functions, which may be subject to a series of gradation of impairments or levels of functioning, may also be subject to a partial reversibility in their level of integration of functioning which is particularly labile in borderline pathology, (p. 578)

Following Sadow (1969), we can devise a scheme using the central role of the ego as the axis of a continuum along which are located the psychoses, borderline states, transference neuroses, and conflict-free capacities. Movement along this axis is a regressive or a progressive shift that could take place, for example, due to successful psychotherapy, the vicissitudes of life, and organic states. Borderline

patients have an amazing and tremendous range and flexibility of movement along the ego axis. Therefore, we must study the ego's levels of defenses for "higher" or "lower," as Kernberg (1975) suggests, and also evaluate the ego's capacity for motility along the ego axis in making the diagnosis of borderline patient. Many therapists have been tricked into a pessimistic or hopeless prognosis for treatment of borderline patients because they observed these patients during a period when they were temporarily residing in the regressed area of the ego axis.

For example, after the therapist's two-week vacation, a male patient reports the following dream:

> I'm looking over a beautiful pond, sun, trees. A girl there is fly-casting but gets the line knotted up and asks me to help; I am the hero in this dream.
>
> I'm at your office, but [contrary to the patient's actual complaint that it is too small] in the dream it is impressive, extensive, with a conference room and a secretary. However, there is a hole in the floor and workmen are there fixing or installing something. I am impressed with all the cables and electric wires hidden in the floor, walls, and ceiling. These are just for the ordinary purposes, not dangerous, not recording devices, etc., just awe-inspiring

apparatus.

As part of a project, I am to describe three kinds of men who need love.

Self-psychologists might view this dream as an example of incipient fragmentation along with some grandiosity, and as a reaction to loss of the therapist due to a vacation. If it progressed further, I would expect an influencing-machine type of delusion, in which case the fragmented patient would show a paranoid psychotic core. The dream illustrates the apparent gradation or continuum between the borderline and the paranoid psychotic. Note the incipient idealizing transference in making my office more godlike. Traditional psychoanalysts might stress the ending of the dream and view the paranoid elements as defensive against homosexual yearnings.

This same patient, a minister, in associating to the dream remembers lying on the floor of the living room as a child in his somber, gloomy, religious home in the position of Christ on the cross and wondering how it was to be crucified and to ascend to God. As an adult, the patient felt many times “as if” he were being crucified but always used this metaphorically. Also, he often wished he were Jesus

or God. But he never actually thought that he *was* God or Jesus. Thus, under pressure, the yearning to fuse with the idealized parent imago (Kohut 1971) shows itself but fragmentation never becomes so complete that delusion formation becomes necessary; therefore, the patient can function successfully as a minister.

Since this book is not primarily about the borderline personality disorder, I will discuss further contributions to the understanding of that disorder at length only when they emanate from the psychology of the self. For a more extensive discussion of the borderline personality disorder, see *Intensive Psychotherapy of the Borderline Patient* (Chessick 1977) and my subsequent papers (1978, 1979, 1982, 1983a) on the subject. Also valuable is Meissner's (1984) *The Borderline Spectrum*, Chapters 1-6.

Aspects of Narcissistic Style

Akhtar and Thomson (1982) have reviewed a number of authors who have contributed ideas about the narcissistic personality disorder. Bach (1975, 1977, 1977a) has made many phenomenologic contributions, describing what he calls "the narcissistic state of

consciousness."

He emphasizes the way in which narcissistic individuals use language in an autocentric manner rather than for communication, their typical fruitless pseudo-activity and, above all, the extreme dependence of their mood regulation on external circumstances. In his description of the depression following a narcissistic loss, Bach points out that this depression has apathy and shame as its primary qualities rather than guilt and, thus, focuses on a matter that is discussed at length by Kohut in his distinction between Tragic Man and Guilty Man.

Modell (1976) described what he called the initial cocoon phase in the psychoanalytic treatment of narcissistic individuals who live by themselves in a glorious but lonely way. This formulation follows from the work of Winnicott (1953), who stressed the trauma that narcissistic individuals experienced as children when their sense of self was developing. Winnicott stated that deficient maternal empathy during childhood necessitated the establishment of a precocious and vulnerable sense of autonomy supported by fantasies of omnipotence and around which the grandiose self develops (Chessick 1977a). For this and other reasons Kohut is said to have been strongly influenced

by the work of Winnicott.

Our preliminary discussion of narcissism would not be complete unless we pointed out the intimate relationships that are known to exist (since the writing of Freud at least) among falling in love, romance, creativity, and narcissism. For example, some authors such as Gediman (1975) call attention to the distinction between loving—conceived as a rational, more durable, mature, genital object relationship—and being in love—a transitory state often experienced as an irrational, stormy, grand passion. These two states, Gediman points out, can be understood according to Kohut's position of a separate developmental line for narcissism which is never outgrown but rather transformed. Kohut (1966) tells us that, for the average individual, intense idealization, a transitional point in the development of narcissistic libido, survives only in the state of being in love, although he adds that gifted individuals idealize and despair about their work as well.

Thus any discussion of narcissism will have to carry with it some insights on states of being in love and states of creativity. Furthermore, Bak (1973) points out that "being in love" is often preceded by

separation or by an important object loss—real, imaginary, or threatened—"or by one of the numerous losses of object representations that lead to melancholia." He adds:

> To these precipitating causes I might add damage to the self-image and lack of fulfillment of strivings of the ideal-ego which indirectly lead to the threat of object loss. But whereas in melancholia the lost object is regained by identification, or, as Freud put it, "love escapes extinction" by regressing to narcissism, the person who suffers from "being in love" finds a substitute object; the loss is undone and the object is replaced or resurrected, (p. 1)

Bak states that sometimes when another love object cannot be substituted, there may be a turning towards severe depression and suicide, as perhaps most dramatically illustrated in Goethe's (1774) *The Sufferings of Young Werther.* We shall turn again shortly to the subject of love when we review the contributions of Freud to the study of narcissism.

Notes

1 Following Kohut's (1984) later writing, I will use the unhyphenated term selfobject throughout, but only when it is employed in his special sense of the term, as will be explained in Part II.

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