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The Disorders of the Self and Their Treatment

Curative Factors in Dynamic Psychotherapy

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The Emergence of a Psychology of the Self

During recent years the psychoanalytic investigation of certain frequently encountered patients has led to the recognition of a definable syndrome which at first appeared to be related to the psychoneuroses and neurotic character disorders. It was clear from the outset that these patients are characterized by a specific vulnerability: their self-esteem is unusually labile and they are extremely sensitive to failures, disappointments, and slights. It was, however, not the scrutiny of the symptomatology but the process of treatment that illuminated the nature of the disturbance of these patients. The analysis of their psychic conflicts did not result in either the expected amelioration of suffering or the hoped-for cessation of undesirable behavior. However, the discovery that these patients reactivated certain specific narcissistic needs in the psychoanalytic situation, i.e., that they established "narcissistic transferences," made effective psychoanalytic treatment possible.

The psychopathological syndrome from which these patients suffer was designated *narcissistic personality disorder*. The narcissistic transferences

which are pathognomonic for these syndromes were subdivided into two types: (1) the *mirror transference*, in which an insufficiently or faultily responded-to childhood need for a source of accepting-confirming "mirroring" is revived in the treatment situation, and (2) the *idealizing transference*, in which a need for merger with a source of "idealized" strength and calmness is similarly revived. As the understanding of the symptomatology, core psychopathology, and treatment of the narcissistic personality disorders increased, in particular via the investigation of the narcissistic transferences, it became clear that the essence of the disturbance from which these patients suffered could not be adequately explained within the framework of classical drive-and-defense psychology. In view of the fact that a weakened or defective self lies at the center of the disorder, explanations that focused on conflicts concerning the libidinal and aggressive impulses of these patients could illuminate neither psychopathology nor treatment process. Some progress was made by expanding the classical libido theory and by revising the classical theory of aggression. Specifically, the weakness of the self was conceptualized in terms of its underlibidinization—or cathectic deficit, to speak in the terms of Freudian metapsychology—and the intense aggressions encountered in the narcissistic personality disorders were recognized as the responses of the vulnerable self to a variety of injuries.

The decisive steps forward in the understanding of these disorders,

however, were made through the introduction of the concept of the selfobject and via the increased understanding of the self in depth-psychological terms. *Selfobjects* are objects which we experience as part of our self; the expected control over them is therefore closer to the concept of the control that a grownup would expect to have over his own body and mind than to the concept of the control that one would expect to have over others. There are two kinds of selfobjects: (1) those who respond to and confirm the child's innate sense of vigor, greatness, and perfection, and (2) those whom the child can admire and merge with as an image of calmness, infallibility, and omnipotence. The first type is referred to as the mirroring selfobject; the second, as the idealized parent imago.

The *self* the core of our personality, has various constituents that we acquire in the interplay with those persons in our earliest childhood environment whom we experience as selfobjects. A firm self, resulting from the optimal interaction between the child and his selfobjects, is made up of three major constituents: (1) one pole from which emanate the basic strivings for power and success; (2) another pole that harbors the basic idealized goals; and (3) an intermediate area of basic talents and skills that are activated by the tension arc that establishes itself between ambitions and ideals.

Faulty interaction between the child and his selfobjects results in a

damaged self—either a diffusely damaged self or a self that is seriously damaged in one or the other of its constituents. If patients whose self has been damaged enter psychoanalytic treatment, they reactivate the specific needs that have remained unresponded to by the specific faulty interactions between the nascent self and the selfobjects of early life—that is, a selfobject transference is established.

Depending on the quality of the interactions between the self and its selfobjects in childhood, the self will emerge either as a firm and healthy structure or as a more or less seriously damaged one. The adult self may thus exist in states of varying degrees of coherence, from cohesion to fragmentation; in states of varying degrees of vitality, from vigor to enfeeblement; and in states of varying degrees of functional harmony, from order to chaos. Significant failure to achieve cohesion, vigor, or harmony, or a significant loss of these qualities after they have been tentatively established, may be said to constitute a state of *self disorder*. The psychoanalytic situation creates conditions in which the damaged self begins to strive to achieve or to reestablish a state of cohesion, vigor, and inner harmony.

Once the self has crystallized in the interplay of inherited and environmental factors, it aims toward the realization of its own specific program of action—a program that is determined by the specific intrinsic pattern of its constituent ambitions, goals, skills, and talents, and by the

tensions that arise between these constituents. The patterns of ambitions, skills, and goals; the tensions between them; the program of action that such patterns create; and the activities that strive toward the realization of this program are all experienced as continuous in space and time—they are the self, an independent center of initiative, an independent recipient of impressions.

The Secondary Disturbances of the Self

The experiential and behavioral manifestations of the *secondary disturbances of the self* are seen in the reactions of a structurally undamaged self to the vicissitudes of life. A strong self allows us to tolerate even wide swings of self-esteem in response to victory or defeat, success or failure. Various emotions—triumph, joy; despair, rage—accompany these changes in the state of the self. If our self is firmly established, we will be afraid neither of the dejection that may follow a failure nor of the expansive fantasies that may follow a success—reactions that would endanger those with a more precariously established self.

Among the secondary disturbances are the reactions of the self to physical illness or to the incapacities of a structural neurosis, e.g., the dejection or the anger experienced when incurable muscular paralysis or chronic neurotic anxiety inhibits a person from pursuing his central self-

enhancing goals. And even certain reactions of relatively undamaged layers of the self to the consequences of its own primary disturbances—such as dejection over the fact that a damaged self's vulnerability has led to social isolation—should be counted among the secondary disturbances of the self.

The Primary Disturbances of the Self

The *primary disturbances of the self* can be divided into several subgroups, depending on the extent, severity, nature, and distribution of the disturbance. If serious damage to the self is either permanent or protracted, and if no defensive structures cover the defect, the experiential and behavioral manifestations are those that are traditionally referred to as *the psychoses*. The nuclear self may have remained noncohesive (schizophrenia) either because of an inherent biological tendency, or because its totality and continuity were not responded to with even minimally effective mirroring in early life, or because of some combination of biological and environmental factors.

In other instances, the self may have obtained a degree of cohesion, but because of the interaction of inherent organic factors and a serious lack of joyful responses to its existence and assertiveness, it will be massively depleted of self-esteem and vitality ("empty" depression). During the crucial periods of its formation the self may have been almost totally deprived of the

repeated wholesome experience of participating in the calmness of an idealized adult (i.e., of a merger with an idealized selfobject), with the result —again decisively influenced by inherent biological factors—that an uncurbed tendency toward unrealistically heightened self-acceptance (mania) or self-rejection and self-blame ("guilt" depression) remains a serious central weak spot in its organization.

A second subgroup of primary disorders of the self is the *borderline states*. Here the breakup, enfeeblement, or functional chaos of the nuclear self is also permanent or protracted, but, in contrast to the psychoses, the experiential and behavioral manifestations of the central defect are covered by complex defenses. Although in general it is not advisable for the therapist to tamper with these protective devices, it is sometimes possible to make the patient's use of them more flexible by reconstructing the genesis of both the central vulnerability and the chronic characterological defense. For example, it may be helpful to the patient to understand the sequence of events, repeated on innumerable occasions, when as a child his need to establish an autonomous self was thwarted by the intrusions of the parental selfobject. In other words, at the very point when the nascent self of the child required the accepting mirroring of its independence, the selfobject, because of its own incompleteness and fragmentation fears, insisted on maintaining an archaic merger.

A significantly more resilient self is found in the next subgroup, the *narcissistic behavior disorders*, even though the symptoms which these persons display—e.g., perverse, delinquent, or addictive behavior—may expose them to grave physical and social dangers. But the underlying disorder—the breakup, enfeeblement, or serious distortion of the self—is only temporary in these cases, and with the support of increased insight into the genetic roots and the dynamic purpose of their symptomatic behavior, they may become able to relinquish it in favor of more mature and realistic supports for their self-esteem.

Closely related to the narcissistic behavior disorders are the *narcissistic personality disorder*, where breakup, enfeeblement, or serious distortion of the self is also only temporary but where the symptoms—e.g., hypochondria, depression, hypersensitivity to slights, lack of zest—primarily concern the person's psychological state rather than his actions and interactions.

Of the patients who suffer from disorders of the self, only those with narcissistic behavior and personality disorders are capable of tolerating the frustrations of the narcissistic needs of their vulnerable self that are reactivated in the working through process of analysis without a protracted fragmentation or depletion of the self. In other words, of all the primary disorders of the self, only narcissistic behavior and personality disorders are analyzable.

The Etiology of Self Pathology

In view of the fact that the disorders of the self are, by and large, the results of miscarriages in the normal development of the self, we will first present an outline of the normal development of the self. It is difficult to pinpoint the age at which the baby or small child may be said to have acquired a self. To begin with, it seems safe to assume that, strictly speaking, the neonate is without a self. The newborn infant arrives physiologically preadapted to a specific physical environment—i.e., the presence of oxygen, food, a certain range of temperature—outside of which it cannot survive. Similarly, the infant's psychological survival requires a specific psychological environment—i.e., the presence of responsive-empathic selfobjects. It is in the matrix of a particular selfobject environment that, via a specific process of psychological structure formation called *transmuting internalization*, the *nuclear self* of the child will crystallize. Without going into the details of this structure-building process, we can say: (1) that it cannot occur without a previous stage in which the child's mirroring and idealizing needs have been sufficiently responded to; (2) that it takes place in consequence of the minor, nontraumatic failures in the responses of the mirroring and the idealized selfobjects; and (3) that these failures lead to the gradual replacement of the selfobjects and their functions by a self and its functions. And it must be added that, while gross identifications with the selfobjects and their functions may temporarily and transitionally occur, the ultimate wholesome result—

the autonomous self—is not a replica of the selfobject. The analogy of the intake of foreign protein in order to build up one's own protein is very serviceable here—even as regards the splitting up and rearrangement of the material that has been ingested.

If we keep in mind the processes by which the self is created, we realize that, however primitive the nuclear self may be in comparison with the adult self, at its very inception it is already a complex structure, the endpoint of a developmental process which may be said to have its beginnings with the formation of specific hopes, dreams, and expectations concerning the future child in the minds of the parents (especially the mother). When the baby is born, the encounter with the child's actual physiological and psychological equipment will, of course, influence the parents' preconceived imagery about its future personality. But the parental expectations will exert a considerable influence on the baby's developing self from birth onward. Thus the self arises from the interplay between the newborn's innate equipment and the selective responses of the selfobjects through which certain developmental potentialities are encouraged while others are not encouraged or are even actively discouraged. Out of this selective process there emerges, probably during the second year of life, a nuclear self which, as stated earlier, is currently conceptualized as a bipolar structure: archaic nuclear ambitions form one pole; archaic nuclear ideals form the other. The tension arc between these two poles enhances the development of the child's nuclear skills and

talents—rudimentary skills and talents that will gradually develop into those that the adult employs in the service of the productivity and creativity of the mature self.

The strength of these three major constituents of the self, the choice of their specific contents, the nature of their relationship—e.g., which one of them will ultimately predominate—and their progress toward maturity and potential fulfillment through creative actions will be less influenced by those responses of the selfobjects that are shaped by their philosophy of child rearing than by those that express the state of their own nuclear self. In other words, it is not so much what the parents *do* that will influence the character of the child's self, but what the parents *are*. If the parents are at peace with their own needs to shine and to succeed insofar as these needs can be realistically gratified, if, in other words, the parents' self-confidence is secure, then the proud exhibitionism of the budding self of their child will be responded to acceptingly. However grave the real-life blows to the child's grandiosity, the proud smile of the parents will keep alive a bit of the original omnipotence, which will form the nucleus of self-confidence and inner security that sustains the healthy person throughout life. And the same holds true with regard to our ideals. Despite our disappointment when we discover the weaknesses and limitations of the idealized selfobjects of our early life, their strong, confident, secure caretaking and the merging of our anxious selves with their tranquility—via their calm voices or via our closeness with

their relaxed bodies as they hold us—will be retained by us as the nucleus of the strength and calmness we experience as adults under the guidance of our inner goals.

It is only in the light of our appreciation of the crucial influence exerted on the development of the self by the personality of the selfobjects of childhood that we are able to trace the genetic roots of the disorders of the self. Psychoanalytic case histories have tended to emphasize certain dramatic incidents, certain grossly traumatic events—from the child's witnessing the "primal scene" to the loss of a parent in childhood. But we have come to believe that such traumatic events may be no more than clues that point to the truly pathogenic factors, such as the unwholesome atmosphere to which the child was exposed during the formative years of the self. In other words, individual traumatic events cause less serious disturbances than the chronic ambience created by the deep-rooted attitudes of the selfobjects. Even the still vulnerable, developing self can cope with a serious trauma if it is embedded in a healthy, supportive milieu.

The essence of the healthy matrix for the growing self of the child is a mature, cohesive parental self that is in tune with the changing needs of the child. It can mirror the child's grandiose display with a glow of shared joy one minute, yet, perhaps a minute later, if the child becomes anxious and overstimulated by its own exhibitionism, the parental self will curb the

display by adopting a realistic attitude vis-à-vis the child's limitations. Such optimal frustrations of the child's need to be mirrored and to merge into an idealized selfobject, hand in hand with optimal gratifications, generate the appropriate growth-facilitating matrix for the self.

Some parents, however, are not adequately sensitive to the needs of the child but instead respond to the needs of their own insecurely established self. Here are two characteristic illustrations of pathogenic selfobject failures. They concern typical events that emerge frequently during the analysis of patients with narcissistic personality disorders during the transference repetitions of those childhood experiences that interfered with the normal development of the self. We must add here that the following events are indicative of a pathogenic childhood environment only if they represent the selfobjects' *chronic* attitude. Put differently, they would not emerge at crucial points of a selfobject transference if they had occurred as the consequence of a parent's unavoidable *occasional* failure.

First illustration: A little girl comes home from school, eager to tell her mother about some great successes. But the mother, instead of listening with pride, deflects the conversation from the child to herself and begins to talk about her own successes, which overshadow those of her little daughter.

Second illustration: A little boy is eager to idealize his father; he wants

his father to tell him about his life, the battles he engaged in and won. But instead of joyfully acting in accordance with his son's need, the father is embarrassed by the request. He feels tired and bored and, leaving the house, finds a temporary source of vitality for his enfeebled self in the tavern, through drink and mutually supportive talk with friends.

Psychopathology and Symptomatology

We shall now describe some syndromes of self pathology that arise in consequence of the developmental failures described in the preceding section. It is clear that in many, if not most, patients the various forms of self disturbance which we distinguish in the following classification will not be clearly identifiable. Mixtures of the experiences characteristic of different types will often be present and, even more frequently, the same patient will experience different pathological states of the self at different times, often in close proximity to one another. The following descriptions should be clinically helpful, however, because they point out frequently occurring clusters of experience.

The *understimulated self* is a chronic or recurrent condition of the self that arises in consequence of a prolonged lack of stimulating responsiveness from the selfobjects in childhood. Such personalities are lacking in vitality. They experience themselves as boring and apathetic, and they are

experienced by others in the same way. Persons whose nascent selves have been insufficiently responded to will use any available stimuli to create a pseudo excitement in order to ward off the painful feeling of deadness that tends to overtake them. Children employ the resources appropriate to their developmental phase, such as head-banging among toddlers, compulsive masturbation in later childhood, and daredevil activities in adolescence.

Adults have at their disposal an even wider armamentarium of self-stimulation—in particular, in the sexual sphere, addictive promiscuous activities and various perversions; and, in the nonsexual sphere, such activities as gambling, drug- and alcohol-induced excitement, and a lifestyle characterized by hypersociability. If the analyst is able to penetrate beneath the defensive facade presented by these activities, he will invariably find empty depression. Prototypical is the compulsive masturbation of lonely, "unmirrored" children. It is not healthy drive pressure that leads to the endlessly repeated masturbation, but the attempt to substitute pleasurable sensations in *parts* of the body (erogenous zones) when the joy provided by the exhibition of the *total* self is unavailable.

The *fragmenting self* is a chronic or recurrent condition of the self that arises in consequence of the lack of integrating responses to the nascent self in its totality from the selfobjects in childhood. Occasional fragmentation states of minor degree and short duration are ubiquitous. They occur in all of

us when our self-esteem has been taxed for prolonged periods and when no replenishing sustenance has presented itself. We all may walk home after a day in which we suffered a series of self-esteem-shaking failures, feeling at sixes and sevens within ourselves. Our gait and posture will be less than graceful at such times, our movements will tend to be clumsy, and even our mental functions will show signs of uncoordination.

Patients with narcissistic personality disorders will not only be more inclined to react to even minor disappointments with such fragmentation symptoms, but their symptoms will tend to be severer. If a normally well-dressed patient arrives in our office looking disheveled—if his tie and shirt are grossly mismatched and his socks out of harmony with his shoes—we will usually not go wrong if we ask ourselves whether we were unempathic in the last session, whether we failed to recognize a narcissistic need.

Still more serious degrees of fragmentation will be encountered during the psychoanalytic treatment of the most severely disturbed patients with narcissistic personality disorders. Such a patient might respond to even minor therapeutic or real-life rebuffs with a deep loss of the sense of the self's continuity in time and cohesiveness in space—a psychic condition that produces profound anxiety. In particular, the feeling that various body parts are no longer held together by a strong, healthy awareness of the totality of the body self leads to apprehensive brooding about the fragments of the body,

often expressed by patients in the form of hypochondriacal worry. Unlike the chronic hypochondriacal preoccupations encountered in some psychoses, however, even the severest, quasi-delusional analogous worries in the narcissistic personality disorders are the direct consequence of some specific, identifiable narcissistic injury, and they disappear, often with dramatic speed, as soon as a bridge of empathy with an understanding selfobject has been built. A typical sequence of events in the analysis of patients who have established a mirror transference will demonstrate this point. When the mirror transference is in balance, the patient, sensing the analyst's empathic attention, feels whole and self-accepting. Subsequent to an erroneous interpretation, however—e.g., following a session in which the analyst addressed some *detail* of the patient's psychic life when, in fact, the patient had offered his *total* self for approval—the patient's feeling of wholeness, which had been maintained via the transference, disappears. It is reestablished when the analyst restores the empathic tie to the selfobject by correctly interpreting the sequence of events that led to its disruption.

The *overstimulated self* tends toward recurrent states of overstimulation in consequence of unempathically excessive or phase-inappropriate responses from the selfobjects of childhood to the activities of the grandiose-exhibitionistic pole of the child's nascent self, the activities of the pole that harbors the guiding ideals, or both.

If the grandiose-exhibitionistic pole of a person's self was exposed to unempathic overstimulation in childhood, then that person cannot obtain a healthy glow of enjoyment from external success. Since such people are subject to flooding by unrealistic, archaic fantasies of greatness that produce painful tension and anxiety, they will try to avoid situations in which they could become the center of attention. In some such persons creativity may be unimpaired so long as no exhibition of the *body* self is involved, directly or indirectly. In most of them, however, the creative-productive potential will be diminished because their intense ambitions, which have remained tied to unmodified grandiose fantasies, will frighten them.

Furthermore, in view of the fact that the selfobjects' responses focused prematurely and unrealistically on the fantasied performance or products of the self but failed to respond appropriately to the exhibitionism of the nascent nuclear self of the child as the initiator of the performance and as the shaper of the products, throughout life the self will be experienced as separate from its own actions and weak in comparison with them. Such people will tend to shy away from creative activities because their selves are in danger of being destroyed by being siphoned into their own performance or products.

If the pole that harbors a person's ideals was overstimulated in childhood—e.g., by the unempathically intense and prolonged display of a parental selfobject in need of admiration—then it will be the persisting

intense need for the merger with an external ideal that will threaten the equilibrium of the self. Since contact with the idealized selfobject is therefore experienced as a danger and must be avoided, the healthy capacity for enthusiasm will be lost—the enthusiasm for goals and ideals which people with a firm self can experience vis-à-vis the admired great ones who are their guides and examples, or with regard to the idealized goals that they pursue.

Closely related to the overstimulated self is the *overburdened self*. But whereas the overstimulated self's ambitions and ideals have been unempathically responded to in isolation, without sufficient regard for the self *in toto*, the overburdened self has not been provided with the opportunity to merge with the calmness of an omnipotent selfobject. In other words, the overburdened self has suffered the trauma of unshared emotionality. The result of this specific empathic failure of the selfobject is the absence of the self-soothing capacity that protects normal persons from being traumatized by the spreading of their emotions, especially anxiety. A world that lacks such soothing selfobjects is an inimical, dangerous world. No wonder, then, that a self that was exposed in early life to states of overburdenedness because of the lack of soothing selfobjects will in certain circumstances experience its environment as hostile.

During states of overburdenedness in adult life—e.g., after the therapist has been unempathic, particularly by failing to give the patient the right

interpretation with regard to his emotional state, or by pouring too much insight into him all at once, oblivious to the fact that the patient's capacity to absorb new understanding has been exceeded—a patient might dream that he lives in a poisoned atmosphere or that he is surrounded by swarms of dangerous hornets; and, in his waking awareness, he will tend to respond to otherwise hardly noticeable stimuli as if they were attacks on his sensibilities. He will, for example, complain of noises in the therapist's office or of unpleasant odors. These reactions of patients with narcissistic personality disorders, especially when they involve an overall attitude of irritability and suspiciousness, may at times strike us as alarmingly close to those we encounter in the psychoses, particularly in paranoia. Unlike the more or less systematized, chronic suspiciousness and counterhostility of the paranoiac, however, these manifestations of the overburdened state of the self—like the analogous hypochondriacal preoccupations in states of self-fragmentation—always appear as the direct consequence of a specific narcissistic injury, i.e., the unempathic, overburdening response of a selfobject. They disappear speedily when an empathic bond with the selfobject has been reestablished, i.e., when a correct therapeutic interpretation has been made.

Characterology

The suffering associated with diseases of the self impels the sufferer to undertake psychological moves that will ameliorate his condition. The

resulting behavioral manifestations, however, are not the direct expression of the still persisting, normal self-assertive needs of childhood. Because of the intensity of these needs and the patient's conviction that they will not be responded to, they arouse deep shame which, in turn, leads to their suppression. Sometimes, particularly in the narcissistic behavior disorders, suppression alternates with bursts of ragefully expressed but ineffectively pursued demands that the wrong that has been done be set right. But it is not only the fact that total suppression of narcissistic needs alternates with stridently expressed demands for their immediate fulfillment that differentiates the behavior of the adult with self pathology from the healthily assertive behavior of the normal child. The demands themselves—whether they take the form of fantasies (in the narcissistic personality disorders) or are openly expressed through words and behavior (in the narcissistic behavior disorders), and whether they involve grandiose-exhibitionistic display or acceptance by idealized figures—are not a manifestation of the normal narcissism of childhood. Having been deprived of the appropriate responses from their selfobjects in childhood, such persons either chase after fragments of the never experienced normal narcissistic fulfillment or disavow their needs by the imperious assertion of invulnerability and omnipotence.

The delineation of various character types in the narcissistic realm, especially when combined with the study of the specific failures of the selfobjects of childhood that are the decisive genetic factors in character

formation, will serve as a guide for the therapist's activities vis-à-vis patients' self pathology. Some of the narcissistic character types that we will delineate overlap to some extent with some of the syndromes of self pathology presented in the preceding section. In contrast to the earlier descriptions, however, our emphasis here will be not primarily on chronic or recurring states of the self but on the behavior and experiences of those who suffer from various specific self disorders. The same qualifications that we gave concerning mixed and shifting cases of self pathology also apply to the following attempt to delimit some specific personality types in the narcissistic realm.

Mirror-hungry personalities thirst for selfobjects whose confirming and admiring responses will nourish their famished self. They are impelled to display themselves and to evoke the attention of others in order to counteract, however fleetingly, their inner sense of worthlessness and lack of self-esteem. Some of them are able to establish relationships with reliably mirroring others that will sustain them for long periods. But most of them will not be nourished for long, even by genuinely accepting responses. Thus, despite their discomfort about their need to display themselves and despite their sometimes severe stage fright, they must go on trying to find new selfobjects whose attention and recognition they seek to induce.

Ideal-hungry personalities are forever in search of others whom they can

admire for their prestige, power, beauty, intelligence, or moral stature. They can experience themselves as worthwhile only so long as they can relate to idealized selfobjects. Again, in some instances, such relationships last a long time and are genuinely sustaining to both people involved. In most cases, however, the inner void cannot forever be filled by these means. Ideal-hungry persons feel the persistence of the structural defect and, as a consequence of this awareness, begin to look for—and, of course, inevitably find—some realistic defects in their god. They then continue the search for new idealizable selfobjects, always with the hope that the next great figure they attach themselves to will not disappoint them.

Alter-ego-hungry personalities need a relationship with a selfobject that confirms the existence and the reality of the self by conforming to the self's appearance, opinions, and values. At times, alter-ego-hungry personalities, too, may be able to form lasting friendships—relationships in which each of the partners experiences the feelings of the other as if they had been experienced by one's self.

> If thou sorrow, he will weep; If thou wake, he cannot sleep. Thus of every grief in heart He with thee doth bear a part.
>
> Shakespeare, *The Passionate Pilgrim*

But again, in most instances, the inner void cannot be permanently filled by the twinship. The alter-ego-hungry person discovers that the other is a

separate self and, as a consequence of this discovery, begins to feel estranged from the other. It is thus characteristic for most of these relationships to be short-lived. Like the mirror- and ideal-hungry personalities, the alter-ego-hungry personality is prone to look restlessly for one replacement after another.

The above-mentioned three narcissistic character types are frequently encountered in everyday life and, in general, should be considered variants of the normal human personality, with its assets and defects, rather than forms of psychopathology. Stated in more experience-distant terms, it is not primarily the *intensity* of their need that brings about the attitude and behavior typical of these types, but rather, the *specific direction* in which they are propelled in their attempt to remedy a circumscribed weakness in the self. It is the location—not the extent—of the self defect that produces the characteristic stance of these individuals. By contrast, the following two types are characterized less by the location of the defect and more by its extent. In general, they must be considered as lying within the spectrum of pathological narcissism.

Merger-hungry personalities impress us by their need to control their selfobjects in an effort to obtain self structure. Here, in contrast to the types sketched above, the need for merger dominates the picture; the specific type of merger, however—i.e., merger with a mirroring selfobject, an idealized

selfobject, or an alter ego—is less important in determining the person's behavior. Because the self of such persons is seriously defective or enfeebled, they need selfobjects in lieu of self structure. Their manifest personality features and behavior are thus dominated by the fact that the fluidity of the boundaries between them and others interferes with their ability to discriminate their own thoughts, wishes, and intentions from those of the selfobject. Because they experience the other as their own self, they feel intolerant of his or her independence: they are very sensitive to separations from the selfobject and they demand—indeed they expect without question—the selfobject's continuous presence.

Contact-shunning personalities are the reverse of the merger-hungry types. Although for obvious reasons they attract the least notice, they may well be the most common of the narcissistic character types. These persons avoid social contact and become isolated, not because they are uninterested in others, but, on the contrary, just because their need for them is so intense. The intensity of their need not only leads to great sensitivity to rejection—a sensitivity of which they are painfully aware—but also, on deeper and unconscious levels, to the apprehension that the remnants of their nuclear self will be swallowed up and destroyed by the yearned-for, all-encompassing union.

The Treatment of the Narcissistic Behavior and Personality Disorders

The essential therapeutic goal of depth psychology is the extensive amelioration or cure of the central disturbance, not the suppression of symptoms by persuasion or education, however benevolently brought to bear. Since the central pathology in the narcissistic behavior and personality disorders is the defective or weakened condition of the self, the goal of therapy is the rehabilitation of this structure. True, to external inspection, the clusters of symptoms and personality features that characterize the narcissistic behavior disorders, on the one hand, and the narcissistic personality disorders, on the other hand, are completely different: the self-assertive claims of the first group appear to be too strong, and those of the second group not strong enough. But depth-psychological investigation demonstrates that the psychopathological basis of both disorders—the disease of the self—is in essence the same.

With regard to those patients with narcissistic behavior disorders who make overloud narcissistic claims and whose behavior appears to be too self-assertive, the therapist might be tempted to persuade them to relinquish their demands and to accept the limitations imposed by the realities of adult life. But doing this is like trying to persuade patients who suffer from a structural neurosis to give up their phobia, hysterical paralysis, or compulsive ritual. The overtly expressed, excessive narcissistic demands and self-assertiveness of these patients are not the manifestations of an archaic narcissism that was never tamed, but are instead a set of characterologically embedded

symptoms.

Indeed, it is the essence of the disease of these patients that access to their childhood narcissism is barred. The unfulfilled narcissistic needs of their childhood, which they must learn to get in touch with, to accept, and to express, lie buried deep beneath their clamorous assertiveness, guarded by a wall of shame and vulnerability. If, on the basis of a therapeutic maturity- or reality-morality, the therapist concentrates on censuring the patient's manifest narcissism, the patient's repressed narcissistic needs will be driven more deeply into repression—or the depth of the split in the personality that separates the sector of the psyche that contains the unresponded-to autonomous self from the noisily assertive one that lacks autonomy will increase—and the unfolding of the narcissistic transference will be blocked.

These considerations apply whether the patient's overt narcissistic demands are expressed via quietly persistent pressure, attacks of scathing narcissistic rage, or emotional means that lie between these two extremes. We all know people who annoy us by asking us again and again to repeat our favorable comments about some successful performance of theirs. And we all also know others who, throughout their lives, go from one selfishly demanding rage attack to another, seemingly oblivious to the rights and feelings of those toward whom their demands are directed. If the analyst responds to these demands by exhortations concerning realism and

emotional maturity or, worse still, blamefully interprets them as the expression of an insatiable oral drive that needs to be tamed or of an evil primary destructiveness that needs to be neutralized and bound by aggression-curbing psychic structures, then, as we said, the development of the narcissistic transference will be blocked.

But if the analyst can show to the patient who demands praise that, despite the availability of average external responses, he must continue to "fish for compliments" because the hopeless need of the unmirrored child in him remains unassuaged; and if the analyst can show to the raging patient the helplessness and hopelessness that lie behind his rages, can show him that his rage is indeed the direct consequence of his inability to assert his demands effectively, then the old needs will slowly begin to make their appearance more openly as the patient becomes more empathic with himself. And when the repressions are thus ultimately relinquished—or when the split maintained via disavowal is bridged—and the narcissistic demands of childhood begin to make their first shy appearance, the danger is not that they will run to extremes, but that they will again go into hiding at the first rebuff or unempathic response. In other words, experience teaches us that the therapist's major effort must be concentrated on the task of keeping the old needs mobilized. If the therapist succeeds in this, then they will gradually —and spontaneously—be transformed into normal self-assertiveness and normal devotion to ideals.

The foregoing conclusions also hold with regard to those with self pathology or narcissistic personality disturbances who are overtly shy, unassertive, and socially isolated, but whose conscious and preconscious fantasies—"the secret life of Walter Mitty"—are grandiose. If the therapist believes that the patient's timidity, shyness, and social isolation are due to the persistence of archaic illusions, specifically, to the persistence of untamed childhood grandiosity as manifested in grandiose fantasies, then he will feel justified in applying educational and moral pressure to persuade the patient to relinquish these fantasies. But neither the patient's fantasies nor his social isolation are the cause of his illness. On the contrary, together they constitute a psychological unit which, as a protective device, attempts to maintain the patient's precariously established self by preventing its dangerous exposure to rebuff and ridicule. If the therapist is educational rather than analytic, merely trying to persuade the patient to give up his fantasied grandiosity, then the distance between the patient's defective self, on the one hand, and the therapist as the hoped-for empathic responder to the patient's narcissistic needs, on the other hand, will increase, and the spontaneous movement toward the first significant breach in the wall of sensitivity and suspicion—the establishment of a narcissistic transference—will be halted.

If, however, the therapist can explain without censure the protective function of the grandiose fantasies and the social isolation, and thus demonstrate attunement with the patient's disintegration anxiety and shame

concerning his precariously established self, then the spontaneously arising transference mobilization of the old narcissistic needs can proceed unhindered. Despite disintegration fears and shame, the patient will then be able—cautiously at first, later more openly—to reexperience the need for the self-object's joyful acceptance of childhood grandiosity and for an omnipotent surrounding—healthy needs that were not responded to in early life. Again, as in the case of the narcissistic behavior disorders, the remobilized needs will gradually and spontaneously be transformed into normal self-assertiveness and normal devotion to ideals.

In the foregoing we demonstrated that our therapeutic principles and correlated therapeutic strategy are based on the understanding of the central psychopathology of the analyzable disorders of the self and that they have as their aim the amelioration and cure of this central psychopathology. Since in both major types of analyzable disorders the psychopathology is the same, it follows that despite their divergent symptoms—noisy demands and intense social activity in the narcissistic behavior disorders, shame and social isolation in the narcissistic personality disorders—the process of treatment too is, in essence, the same. And, of course, the nature of the wholesome result that is achieved by the treatment is also the same: that is, the firming of the formerly enfeebled self, both in the pole that carries the patient's self-confidently held ambitions and in the pole that carries his idealized goals. We need only add that the patient's revitalized self-confidence and enthusiasm

for his goals will ultimately make it possible for him to resume the pursuit of the action-poised program arched in the energic field that established itself between his nuclear ambitions and ideals—thus making it possible for him to lead a fulfilling, creative, and productive life.

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