A CASE STUDY OF NARCISSISTIC PATHOLOGY: AN OBJECT RELATIONS PERSPECTIVE

A mini-thesis submitted at Rhodes University in partial fulfilment of the requirements for the degree Master of Social Science

by

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January 1989

ACKNOWLEDGEMENTS

I wish to acknowledge my gratitude and appreciation to those people who both directly and indirectly contributed to this thesis:

- My supervisor, Roger Brooke, for his support and encouragement

- Nicolette, for her unflagging patience and caring

- Jacki, who finds homes for crocodiles

- Tim Bower, Steve De Wijze, and Mark Thorpe for their patient mothering of the ultimate technopeasant

- My patient, "Dianna", who remains very special to me

- The Human Sciences Research Council for their financial support

" It is the Hermit Crab, I remember from a book, that as it grows migrates from one empty shell to another...Whose shell I presently skulk in does not matter, it is the shell of a dead creature. What matters is that my anxious softbodied self should have a refuge from the predators of the deep." (In The Heart of the Country, by J.M. Coetzee)

" ...all creation is really a re-creation of a once loved and once whole, but now lost and ruined object, a ruined internal world and self. It is when the world within us is destroyed, when it is dead and loveless, when our loved ones are in fragments, and we ourselves in helpless despair - it is then that we must re-create our world anew, reassemble the pieces, infuse life into dead fragments, re-create life." (Hanna Segal)

ABSTRACT

The case-study method of psychological research was applied to the brief psychodynamic therapy of a narcissistically disordered female patient. The aim of this research was to explore, clarify and explain certain diagnostic and psychodynamic anomalies to emerge in the course of treatment, using a conceptual framework derived from select psychoanalytic object relations theorists in the area of narcissistic pathology. The author, discovering that there was no diagnostic or explanatory object relations model adequate to the therapeutic data, formulated his own diagnostic category - narcissistic neurosis - and an eclectic object relations model in order to explain the anomolous research findings. Narcissistic neurosis was defined as a form of psychopatholgy in which a primarily neurotic character structure presents with a distinctly narcissistic profile. The narcissistic false self structure serves the functional purpose of protecting the psyche from a repressed negative self-representation derived from a destructive bipolar self-object introject. The primary etiological factor to emerge was that of a narcissistic mother whose insensitivity, conditional affection and selfobject relationship with the target child necessitated adaptive premature self-sufficiency and the defensive emergence of a narcissistic surface self-representation. It was proposed that narcissistic neurosis and narcissistic personality disorder are two discrete forms of pathology differing in terms of severity, psychodynamics, defensive structure, mode of object relating, therapeutic accessibility and prognosis. Assessment criteria were proposed in order to differentiate the two areas of narcissistic pathology and assess suitability for psychotherapeutic treatment. Positive treatment results in this case-study suggest that narcissistic neuroses may receive long-term benefit from short-term psychodynamic therapy.

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CHAPTER ONE

INTRODUCTION

Pathological narcissism is not a new concept. The term itself derives from our Western mythological heritage, in Ovid's famous tale of the beautiful Greek youth who spurns the love of others only to languish and die beside a pool (see appendix one), besotted with his own reflected image. The popularity of this myth and its various reworkings over the centuries testifies to its archetypal significance and insight into the human condition. The Narcissus myth thus refers to a transhistorical and universal aspect of human experience. However, we are faced with the curious anomaly that narcissism as a clinical entity has only relatively recently emerged as the controversial focus of the international psychological community. It is common knowledge that pathological narcissism, previously considered something of a clinical rarity, is being diagnosed and treated with increasing frequency by clinicians today. Carrilio, quoted in Russell (1985) notes that:

> "...mental health professionals have been increasingly confronted with individuals who do not fit into traditional categories. They manifest a range of impulsive behaviour, feelings of emptiness, isolation, alienation and rootlessness, which may be seen as manifestations of narcissism."

One way of accounting for this is simply to attribute this increasing diagnostic incidence to more refined and sophisticated assessment procedures and psychodynamic formulations. It could thus be argued that the only reason we see more narcissists today is because, thanks to the current popularity of the concept in books and journals, we are more attuned to its manifestations than were previous generations of clinicians.
However, a more popular but diametrically opposed perspective

contends that our recently acquired knowledge of narcissism is a direct consequence of its increasing prevalence. We diagnose more narcissism today, not because we are thus conceptually predisposed, but rather because it is assuming the proportions of a cultural epidemic. More specifically, narcissism is a historically specific pathological expression of a unique configuration of sociological forces operant at this historical juncture in late capitalist society. The most articulate spokesperson for this sociological approach is the celebrated historian Christopher Lasch who, in his bestselling book The Culture of Narcissism, argues :

> " New social forms require new forms of personality, new modes of socialization, new ways of organizing experience. The concept of narcissism provides us...with a way of understanding the psychological impact of recent social changes...Narcissism appears realistically to represent the best way of coping with the tensions and anxieties of modern life, and the prevailing social conditions therefore tend to bring out narcissistic traits that are present, in varying degrees, in everyone." (Lasch 1979 pg 50)

Lasch vigorously argues that cultural narcissism is the modern day product of late capitalism's erosion of family authority, commodification of need and bureaucratization of increasingly large areas of human life. This is not the place to examine Lasch's argument. However, it is interesting to note the conceptual blend of neo-marxist critical social theory and Klein/Kernberg object relations theory that he employs in his analysis, an approach further developed by Richards (1984). Nor is the cultural epidemiological approach to narcissism the sole preserve of neo-marxists. Existentialists (Muller,1987; Levin,1987) and even the occasional Jungian (Satinover,1987) are following Lasch et al to argue that narcissism is a modern cultural artifact.

While I would endorse Lasch's claim that "every age develops its own peculiar forms of pathology, which express in exaggerated form its underlying character structure" (1979 pg 41), I will not pursue this point any further. This case study, rather, is an attempt to illustrate the phenomenology, structure and psychodynamics of narcissistic pathology as evidenced in the process of short-term therapy with a remarkable young woman. It is intended as a modest contribution to the existing clinical material on the subject.

Whether or not we embrace the epidemiological argument, the fact remains that fewer and fewer patients are presenting with a clear-cut neurotic profile. More typical is a mixed picture in which personality disorder traits are present, even in the absence of the unambiguous symptomatology necessary to satisfy the stringent DSM-3 criteria for specific personality disorder diagnoses. In fact, those of us who work within a broadly depth psychology framework tend to rely increasingly on the quality of contact with our patients and our countertransference feelings as more useful diagnostic indicators than the traditional psychiatric symptom check list. And interestingly, it is borderline and narcissistic rather than other personality disorder traits that appear to be more prevalent. What is common to both of these pathologies is an identity disturbance or disorder of selfhood in which the person's self-experience is commonly described by words such as empty, hollow, superficial, fraudulent, inauthentic, lifeless, unreal, alienated and disembodied. What specifically identifies narcissistic character pathology is a rigid surface shell of self-reliance, confidence, self-preoccupation and interpersonal shallowness/aloofness which hides a deficient sense of selfhood manifest as vulnerability, hollowness, inadequacy, envy and an ambivalent need for and fear of intimate relatedness with others. In spite of this well-documented profile diagnostic and therapeutic dilemmas abound.
In spite of the many articles on narcissism flooding the journals

it remains a poorly understood and relatively uncharted territory. It has replaced its cousin, the borderline personality, as the most controversial and hotly debated area in contemporary psychoanalytic thought. Pulver, quoted in Fine (1986) says:

> " In the voluminous literature on narcissism, there are probably only two facts on which everyone agrees, first that the concept of narcissism is one of the most important contributions of psychoanalysis, second that it is one of the most confusing ". (pg 53)

The two theoretical giants in the field of narcissistic pathology, Kernberg and Kohut, although both psychoanalysts, have argued from largely incommensurate metapsychological paradigms that echo a much earlier conceptual schism between their respective forebears, Klein and Fairbairn. The result has been a lot of heat and dust but little prospect of a completely unified theory of narcissism. This case study will avoid the finer points of the metapsychological controversies, except insofar as they have an immediate bearing on my work with this patient. However, my theoretical perspective is largely informed by the object relations tradition in psychoanalysis, particularly the work of Mahler, Kernberg, Balint, Winnicott, Guntrip and Kohut. I have adopted this perspective primarily because for over four decades it has contributed more than any other conceptual approach to the systematic understanding and treatment of character pathology in general and narcissistic pathology in particular. Although I will present a more detailed discussion of object relations theory in chapter two I propose the following working definition of this approach: " A psychoanalytic developmental account of how primary interpersonal relationships in the infant's external world become internalized, represented and metabolized at the level of phantasy into a nuclear core of personal identity which, whether healthy or deficient, determines subsequent personality development and deformation.

Although psychoanalysts have led the field in this regard a significant number of Jungians and post-Jungians are writing about narcissism. (Schwartz-Saland 1982) The size and scope of this case study, however, precludes any discussion of the specific contribution of analytical psychology to the work on narcissism. I will confine my literature review to a limited cadre of psychoanalytic authors who illuminate facets of narcissistic pathology particularly well.

The outline of this case study is as follows: Chapter two is a brief methodological section on the specific use of the case study method in this thesis. Chapter three includes a brief history of the concept of narcissism in the psychoanalytic literature and presents three diagnostic systems currently in use. Chapter four is a select literature review of influential psychoanalytic authors who have contributed to the field. Chapter five contains the case study proper and details the process of therapy by briefly examining the highlights of each session and the author's interpretation of the emerging material. Chapter six is devoted to a discussion of the psychotherapy material and the formulation of an explanatory model adequate to the therapy data. Chapter seven is the conclusion.

CHAPTER TWO

THE CASE-STUDY METHOD

The case-study method of psychotherapy research is over a century old and is historically best exemplified in the work of Freud. Depth psychology owes its existence to this research method, which has undergone little significant change since its inception. This chapter thus begins with the assumption that the case-study method is a valid and valuable research strategy and is not concerned with justifying the latter's existence against the methodological critiques of empirical psychology. (This is adequately dealt with in the methodological literature e.g. Bromley (1986), Bellack and Hersen (1984), Kvale (1986)). This chapter, rather, is simply devoted to a brief description of the case-study method and the details of its application in this particular case.

The individual case-study method in psychotherapy research may be broadly defined as the ideographic description and interpretation of the psychological meaning-events that occur in the interpersonal context of a professional relationship devoted to the task of helping the patient understand, alleviate or cope more adaptively with some form of emotional distress. Although ideographic in nature, the research findings may be inductively extrapolated and productively applied to the universe of similar cases. Each case-study thus functions as a heuristic device, generating explanatory hypotheses and research questions concerning certain psychological phenomena and so adding incrementally to our understanding of those phenomena.

Kvale (1986) lists the central characteristics of the (psychoanalytic) research method as follows:

1. The focus is on the individual case study. As a consequence the therapist "obtains a unique and penetrating knowledge of the

relation of the patient's behaviour to his present life situation and to his past history, which may again provide a basis for understanding the more general conditions of human behaviour". (1986 pg 157)

2. The mode of observation is ideally open i.e. not directed by preconceived theories or expectations. The attitude of the therapist is ideally that of "a presuppositionless listener, the therapist should listen with an evenly-hovering attention, listening to what comes without engaging in selective hypothesis testing". (ibid pg 158)

3. The focus is on the interpretation of meaning. Any phenomenon is open to multiple meanings or levels of meaning. Uncertainty and ambiguity are thus intrinsic to meanings and their interpretation. The question of the validation of any particular interpretation is thus a thorny issue although a number of commonly accepted clinical criteria are acknowledged e.g deepening of rapport, emotional insight, biographical associations, symptom relief etc.

4. There is emphasis on the historical dimension of the patient's experience. As historical beings the meaning of our present experience is inextricably related to our biographical past. The therapist is thus concerned with understanding present symptoms in the context of historically formative past relationships in order to help the patient relive pertinent earlier relational conflicts and integrate these adaptively into his/her present conscious life.

5. Knowledge emerges in the context of an intimate relationship and is thus not neutral or objective. Not only is the patient's experience of the therapist refracted through the transference but the therapist's understanding of the patient is likewise filtered through countertransference feelings and fantasies.

6. Knowledge is obtained not for its own sake but in order to positively influence the life of the patient.

The above points provide a good description of this type of research. More technical rules, procedures and research criteria are outlined by Bromley (1986) and included in a seperate appendix (appendix two) at the end of the case study. The methodological procedure I employed was as follows:

The (necessarily selective) data was obtained from therapy notes written up immediately after each session. (There was no audio recording of sessions). These written entries comprised: (a) the patient's verbatim and paraphrased communications concerning associations, memories, feelings, fantasies, dreams etc., (b) the therapist's verbal and unarticulated interpretations and emotional responses to the patient's communications, (c) analysis of the changing quality of the therapeutic relationship in terms of the technical categories of transference and countertransference, (d) theoretically informed speculation on the etiological, genetic and psychodynamic significance of the patient's experience and behaviour, and (e) supervisors' comments during supervision sessions. (Owing to the limited number of supervision sessions during the course of the therapy this vital component of the therapeutic process is not developed as a sustained theme in this case-study. Instead, it is simply mentioned periodically in very specific contexts).

No case study written as an academic exercise can possibly do full justice to the experience of the participants in a therapeutic relationship. In the actual case-study write-up only highlights of each of the twenty sessions were presented. This raises the methodological question of the deliberate (or unconscious) selective presentation of only those data congenial to the author's argument and conceptual bias. Although largely informed by the hermeneutics of object relations theory the author has attempted to employ the phenomenological tenet of

remaining faithful to the patient's experience rather than to a metatheoretical position. The primary question guiding this case-study is the extent to which object relations theory is adequate to the patient's experience, rather than whether the latter can be truncated or distorted to fit this theoretical perspective. It will be argued, however, that in the context of this particular case-study the object relations approach offers a rich and penetrating, albeit limited, insight into the patient's psychological life. The truth uncovered in psychotherapy is narrative truth. Narrative truth is not concerned with the correspondence between theory and objective fact but rather with the extent to which a certain hermeneutic language allows a personally meaningful biographical story or healing narrative to unfold. Object relations theory, I hope to demonstrate later, accesses a rich world of narrative possibility.
The author makes no apologies for not pursuing alternative hermeneutic approaches to the data. The limited scope of this project makes such an undertaking impossible.

A seperate discussion chapter is devoted to a detailed interpretation of selected aspects of the therapy data. Even though the psychotherapy was short-term not all of the data presented in the case study chapter could be discussed in detail. The focus naturally falls on those sustained themes and incidents which are most alive and have the greatest emotional gravity for patient and therapist. This means, however, that the selective focus on certain data automatically consigns other material to background status. For example, I was struck by the wealth and complexity of my patient's dream material, much of which would profitably lend itself to extensive archetypal interpretation. My focus, however, necessarily precludes this, with the unfortunate result that, although I have reported all of her dreams, my (partial) interpretation of the latter does not do justice to the multiple horizons of meaning contained therein.

The authors therapy notes provided the raw material for this case

study, which was chosen on the basis of the particular research question it invited concerning narcissistic pathology. The patient was not informed at the time that she was the focus of special interest and my decision to ask her permission to use and publish the therapeutic data was made only once the therapy was complete. She readily consented to this request.

CHAPTER THREE

A BRIEF HISTORY OF THE CONCEPT OF NARCISSISM AND CURRENT DIAGNOSTIC SYSTEMS

This chapter will briefly survey the origin and development of narcissism as a theme in the clinical literature and discuss the various diagnostic frameworks that have evolved as a consequence.

Although narcissistic pathology has been recognized and treated by psychoanalysts for over half a century it was only given formal recognition by the American Psychiatric Association in 1980 when narcissistic personality disorder was introduced as a category in its diagnostic manual (DSM-3).

3.1 Freud's contribution to the theory of narcissism

The term narcissism was coined in 1898 by the sexologist Havelock Ellis who used it to refer to auto-eroticism, a sexual perversion in which a person takes his/her own body rather than the body of another as a love object. It was in this context that Freud introduced the term to psychoanalysis in 1910. However, it was Freud's colleague Karl Abraham who had, in 1908, first commented on the narcissistic behaviour of schizophrenics. Abraham described the main characteristic of schizophrenia as being a lack of libidinal object cathexis i.e. the autistic withdrawal from external object relations. The libido, theorised Abraham, was turned back reflexively on the ego, thus giving rise to the familiar autism and megalomania. Thus, although Freud's most important contribution on narcissism was written in 1914, the concept had already been broached by him with reference to three

different phenomena: Firstly, it designated a period in infantile development prior to object relating when the undifferentiated psychic apparatus supposedly had no relationship with the external world. Secondly, the term referred to a form of "perversion" in which self-stimulation of one's own body replaced stimulation by another as the primary sexual aim. Homosexuality was also considered a form of narcissism because the homosexual object choice was believed to unconsciously mirror the person's own body and so love of oneself in the person of the other.
Thirdly, narcissism referred to the schizophrenic's supposed withdrawal of libido from external objects and its investment in the subject's own ego, resulting in delusions of grandeur.
In the famous 1914 paper Freud distinguished ego-libido from object-libido and stated that "The more of the one is employed, the more the other becomes depleted." (pg 76) He also states that some narcissistic investment of the ego is essential for maintaining self-regard. Implicit here is a fourth meaning of narcissism: the **healthy** libidinal cathexis of the ego resulting in high self-esteem and confidence. But when ego-libido occurs at the expense of object-libido, pathology results:

> "A strong egoism is a protection against falling ill, but in the last resort we must begin to love in order not to fall ill, and we are bound to fall ill if, in consequence of frustration, we are unable to love." (Freud 1914 pg 85)

Freud never systematically developed the concept of secondary narcissism. He did, however, distinguish what he called the narcissistic neuroses from the transference neuroses and argued that the former patients, because they supposedly withdrew all libido cathexes from their objects and transferred this to their own egos, could not form transference relationships and hence could not be helped by psychoanalysis.

By noting that "...the self-regard has a very intimate connection

with the narcissistic libido" (1914 pg 98), Freud was hinting at a point that others would later develop to become the crux of all subsequent psychoanalytic work that defined narcissism as a pathological lack of self-esteem defended against by compensatory grandiosity.
In this same paper he proposes that "...the aim and the satisfaction in a narcissistic object-choice is to be loved" (pg 98), thus presaging another important insight from contemporary research.

These insights notwithstanding, Freud's 1914 seminal contribution was wedded firmly to his energic metapsychology, a doctrinal heritage that hampered rather than facilitated subsequent psychoanalytic theory. This position may be summed up in a few points:

1. Firstly, what makes object relationships possible is the subject's investment (cathexis) of a quantity of energy (libido) in the object.

2. There is a fixed amount of libido and therefore, in terms of the laws of energic economy, the more libido invested in the ego the less is available for object cathexis. Narcissists, therefore, are incapable of forming relationships with others because all of their libido is bound up in ego-cathexis. Narcissism and object relations are thus mutually exclusive.

3. Thirdly, in narcissism, not only is libido unavailable for external object relations but it is even withdrawn at the level of phantasy: "...the libido that is liberated by frustration does not remain attached to objects **in phantasy**, but withdraws onto the ego." (1914 pg 86)

4. Because transference is a precondition for analytic cure narcissists, because their libido is inwardly directed, cannot

form a workable transference relationship and hence do not respond favourably to psychotherapy.
Today every one of the above postulates has been largely invalidated by contemporary psychoanalytic theorists.
Firstly, the notion that object relations are initiated in order to satisfy instinctual needs for libidinal release has been superseded by object relations theory which has, for the most part, rejected the metapsychological primacy of libido theory. Object relations are considered to be a motivational end in themselves, thus obviating the conceptual need for the anachronistic economic premise.
Secondly, pathological narcissism and object relations are certainly not mutually exclusive. Many narcissists, in spite of their aloofness and self-sufficiency, often engage in very intense interpersonal relationships. Furthermore, even when close relationships with other people are absent, narcissists show an intense emotional involvement with **internal objects**. This finding does away with Freud's third postulate that narcissists are uninvolved with objects even at the level of phantasy.
Lastly, extensive therapeutic work with narcissists show that they are in fact capable of extremely powerful transference relationships and can be helped considerably by long-term psychotherapy.

3.2 Post-Freudian psychoanalytic contributions to the definition of narcissistic pathology

One of the most interesting and important post-Freudian conceptual developments in psychoanalysis is the concept of the self. While the self was, right from the start, a cardinal concept in Jungian thought, it has received remarkably little attention from psychoanalysts who, when they mentioned it at all, considered it a subsidiary function or aspect of the ego apparatus. Today, however, it is starting to get the attention it deserves even though the concept has not yet been systematically

dealt with at a metapsychological level in psychoanalytic theory.[1] In terms of narcissistic disorders it becomes imperative to address the issue of self for the following reason: Narcissistic character pathology is not a thought disorder. In other words, even though the narcissist's object relations and defenses are often extremely primitive, reality testing and other ego functions remain intact. Narcissism, therefore, cannot be adequately accounted for by reference to distortions in ego functioning unless the term ego is stretched elastically to cover the totality of human experience, at which point it becomes so encompassing and removed from its original usage that it proves theoretically useless. However, although narcissism cannot be explained in terms of deficient ego functioning it is an identity disorder or self-pathology [2] It was thus historically inevitable that the concept self should be smuggled into psychoanalysis by the ego psychologist Hartmann in 1950. Hartmann distinguished between ego (the system of mental functions), self (the psychosomatic totality of the person, including all body parts and psychic sub-systems) and self-representation (unconscious, preconscious and conscious representations of the somatic and psychic self-aspects.) Another ego psychologist, Edith Jacobson, referred to narcissism as the **libidinal cathexis of the self-representation** rather than the ego. Although still obviously committed to the economic model the shift in focus was important and heralded a growing interest in the relationship between ego

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[1] This can be seen even in Winnicott's work where he stubbornly persists in using the term ego, even though he uses it to refer to a psychosomatic composite sense of identity or self, a radically different meaning from that assigned to the concept ego in the topographic model.

[2] I use the term identity disorder interchangeably with the term self-pathology, to refer to a spectrum of character pathology in which the person's self-experience of being psychosomatically cohesive, complex and continuous over time is chronically deficient, resulting in the characteristic symptoms of depersonalization, hollowness, numbness, emotional instability and impoverished object relations.

and self.

Stolorow (1980) credits Annie Reich (1953, 1960) with being the first to clearly argue that the aim of narcissistic behaviour is to maintain the self-representation:

> "Reich suggested that...narcissistic patterns (e.g. grandiose self-inflation, preoccupation with the body and its appearance, and ceaseless cravings for admiring attention) may represent attempts to repair damage done to the self-representation by early traumatic experiences. Reich clearly interpreted clinically observed narcissistic disturbances as abortive attempts to restore and stabilize self-esteem." (Stolorow 1980 pg 12)

Many authors followed Reich in contending that the omnipotence and grandiosity of the narcissist are **regressive attempts to repair and protect a fragile and tenuous sense of self against the anxiety of depletion or disintegration.** This approach is most systematically and lucidly argued by Kohut (1971, 1977) who claims that the narcissist's defective self-cohesion and deficient self-esteem is buttressed by archaic "selfobject" relations in which the object is related to as the narcissist's missing self function, required to either mirror the narcissist's grandiosity or allow his/her fantasized merger with the omnipotently perceived and idealized object.

3.3 Stolorow's functional reformulation of the concept narcissism

Stolorow (1980) argues that in spite of significant theoretical progress in the psychoanalytic understanding of narcissism, most definitions still embrace an energic metapsychology by defining narcissism as libidinal self-investment. The problem with this is that it says nothing about the meaning of narcissism and what defensive purpose it serves in the psychic organization. He proposes a **functional definition** according to which behaviour, fantasies and object relations are termed narcissistic when their

function is to preserve the structural cohesion, temporal stability and positive emotional valence of the self-representation. Noting the narcissistic tendency to withdraw from close relationships Stolorow says:

> "Withdrawal behaviour is narcissistic depending on its function, or the function of the accompanying fantasies. If the withdrawal behaviour and/or fantasies buttress the cohesion, stability and affective coloring of a threatened self representation, then the withdrawal may be called narcissistic. This may be contrasted with a defensive withdrawal which wards off conflicts evoked by sexual or aggressive wishes toward objects." (pg 17)

Stolorow uses this definition to clarify and integrate the various confusing uses of the concept:

1. Narcissism as a sexual perversion

A number of sexual perversions function as sexualized attempts to counteract feelings of self-depletion and self-fragmentation, to revive a shaky sense of self and restore self-esteem. When directed toward this end perversions are narcissistic in function.

2. Narcissism as a mode of object relating

Noting that the seeming isolation of the narcissist hides a wealth of internal object relations Stolorow rejects the supposed antithesis between narcissism and object relating. Object relations are considered narcissistic to the extent that their primary aim is to bolster a deficient self-system and lack of self-esteem.

3. Narcissism as a developmental stage

There has been much debate over whether or not there is a

narcissistic stage of development i.e., whether at any point the normal infant does not relate at all to external objects. Balint, for example, argues that primary object relatedness is present from birth. Narcissism, if it occurs at all, is a secondary reaction to environmental frustration. Stolorow undercuts this debate by pointing out that because the neonate cannot discriminate between self and object it is meaningless to think of this undifferentiated state in terms of either self- or object-love. Once an embryonic self-representation does emerge it is very rudimentary, tenuous and lacks cohesiveness. Primitive object relations thus serve a narcissistic developmental function by helping to strengthen the infant's fragile self-representation:

> "In other words, the earliest manifestations of the narcissistic function occur in relation to primary selfobjects, and the earliest object relationships serve a basic narcissistic function....Within the framework of a functional definition, narcissism as a developmental line pertains to stages in the growth of psychological structure that maintains the cohesion, stability and positive affective coloring of the self representation. Growth proceeds from primitive prestructural narcissistic object relationships towards higher forms of narcissism by way of a gradual accretion of psychic structure which takes on the function of maintaining the self representation." (pg 19)

4. Narcissism as self-esteem

Rather than equating narcissism with self-esteem Stolorow defines narcissistic activities as those whose function is to protect and restore self-esteem when the latter is threatened by internal or external factors. Self-esteem is compared metaphorically to a room's temperature, and narcissistic activity/fantasy to the thermostat that regulates the temperature, becoming mobilized when the temperature (self-esteem) falls beyond a certain point.

5. Narcissism as a diagnostic category

While Stolorow does acknowledge specifically narcissistic disorders his functional concept of narcissism does not refer to a diagnostic category but rather to a **dimension of psychopathology** that may be present across a wide range of nosological categories:

> "Thus, one would speak of the **degree** of narcissistic disorder, referring to the degree of structural impairment and vulnerability of the self representation, the acuteness of the threat of narcissistic decompensation, and the motivational priority or urgency of the narcissistic function in a variety of pathological states. The degree of severity of narcissistic disturbance may be evaluated with reference to the three properties of the self representation included in the functional definition of narcissism - that is, its structural cohesion, temporal stability, and affective coloration." (pg 23)

Stolorow then outlines three levels of narcissistic disturbance based on the severity of the threat to the integrity of the person's self-representation:

1. Mild narcissistic disturbance

The self-representation is frequently or predominantly negative (low self-esteem) but is mostly stable over time and structurally cohesive.

2. Moderately severe narcissistic disturbance

Here the self-representation is frequently/predominantly negative and, in addition, its organization is not stable over time (experiences of identity confusion/diffusion). However, in spite of temporary, reversible decompensation it largely retains its

structural cohesion.

3. Severe narcissistic disturbance

The self-representation is frequently/predominantly negative and, in addition, is lacking in cohesion and subject to "irreversible structural fragmentation and disintegration." (Stolorow pg 24)

Seen from Stolorow's functional perspective a schizophrenic with grandiose delusions and a neurotic woman who is promiscuous in order to reassure herself that she is attractive are both exhibiting narcissistic disturbances, albeit on very different levels of self-stability.

Stolorow, I believe, has made a valuable contribution to our understanding of narcissism by defining it according to its **structural function of preserving the integrity and stability of the self-representation accross a range of seemingly dissimilar nosological categories.** Narcissism, moreover, need not necessarily refer to a characterological structure, it also presumably applies, in the above model, to transient or episodic modes of defensive organization. A predominantly non-narcissistic neurotic, for example, might employ narcissistic defenses at a stage when his/her egoic self-understanding is called seriously into question. However, while Stolorow's clarification of narcissistic dynamics is useful, it complicates the already difficuilt task of diagnosing narcissistic character pathology. If, in functional terms, most psychopathology is partly narcissistic in function, how can we usefully talk about narcissism as a seperate diagnostic category? The problem of diagnosis is the subject of the remainder of this chapter.

3.4 Diagnostic systems and criteria for narcissistic character Pathology

Ronningstam (1988) states that, in spite of the recent (1980) inclusion of Narcissistic Personality Disorder (hereafter referred to as NPD) in the DSM-3:

> "...the question of whether NPD comprises a common, distinct and coherent cluster of diagnostic features that are distinguishable from features in other personality disorders remains controversial." (pg 300)

In her article Ronningstam sets out to compare the criteria for NPD in three different diagnostic systems, that of DSM-3, the psychoanalytic system of Otto Kernberg, and Ackhtar and Thomson's (1982) system derived from their review of existing literature.

The aim of this study was to empirically ascertain the degree of concordance between the criteria used by the respective diagnostic sysytems.

Table 1

DSM-III CRITERIA FOR NARCISSISTIC PERSONALITY DISORDER

Characteristics

A. Grandiose sense of self-importance or uniqueness, e.g., exaggeration of achievements and talents, focus on the special nature of one's problems.
B. Preoccupation with fantasies of unlimited success, power, brilliance, beauty or ideal love.
C. Exhibitionism: the person requires constant attention and admiration.
D. Cool indifference or marked feelings of rage, inferiority, shame, humiliation, or emptiness in response to criticism, indifference of others, or defeat.
E. At least two of the following characteristics of disturbances in interpersonal relationships:
   1. Entitlement: expectation of special favors without assuming reciprocal responsibilities, e.g., surprise and anger that people will not do what is wanted.
   2. Interpersonal exploitiveness: taking advantage of others to indulge own desires or for self-aggrandizement; disregard for the personal integrity and rights of others.
   3. Relationships that characteristically alternate between the extremes of overidealization and devaluation.
   4. Lack of empathy: inability to recognize how others feel, e.g., unable to appreciate the distress of someone who is seriously ill.

Table one outlines the diagnostic criteria for NPD in the DSM-3. In this system, for any personality disorder diagnosis the symptom profile must firstly be long-standing, secondly, it must not be limited to discrete and transient episodes, and thirdly, it must cause significant impairment to occupational/social

functioning or otherwise result in some form of subjective distress. One problem with the DSM-3 system is that it does not recognize the multifaceted complexity and subtlety of narcissistic pathology. For example, many narcissists who seek therapeutic help do not display any of the exhibitionism and grandiosity considered to be the hallmark of this disorder. In fact they often present as depressed, self-critical individuals who feel inferior to others and lack self-esteem in many areas of their lives. The grandiosity may be covert, subtle and manifest, for example, as rigid and remarkably high ethical standards or political/religious ideals. The DSM-3 criteria do not penetrate beneath the surface or overt features of the symptom profile to look for the equally important latent or "soft" diagnostic indicators. Ackhtar and Thomson recognize this and so divide their diagnostic criteria into overt and covert features.

Table 2

AKHTAR AND THOMSON: CLINICAL FEATURES OF NPD

Areas	*Overt Features (ov)*	*Covert Features (cv)*
Self-concept	Inflated self-regard Haughty grandiosity Fantasies of wealth, power, beauty, brilliance Sense of entitlement Illusory invulnerability	Inordinate hypersensitivity Feelings of inferiority, worthlessness, fragility Continuous search for strength and glory
Interpersonal Relations	Lack of depth Contempt of other people Devaluation of other people Occasional withdrawal into splendid isolation	Chronic idealization of others Intense envy of others Enormous hunger for acclaim
Social Adaptation	Social success Sublimation in the service of exhibitionism (pseudosublimation) Intense ambition	Chronic boredom Uncertainty Dissatisfaction with professional and social identity
Ethics, Standards and Ideals	Apparent zeal and enthusiasm about moral, sociopolitical and aesthetic matters	Lack of any genuine commitment Corruptible conscience
Love and Sexuality	Seductiveness Promiscuity Lack of sexual inhibitions Frequent infatuations	Inability to remain in love Treating the love-object as extension of the self rather than as a separate and unique individual Perverse fantasies Occasionally, sexual deviation
Cognitive Style	Egocentric perception of reality Articulate and rhetorical Circumstantial and occasionally vague, as if talking to self Evasive but logically consistent in arguments Easily becomes devil's advocate	Inattention toward objective aspects of events Subtle gaps in memory at times "Soft" learning difficulties Autocentric use of language Fluctuations between being overabstract and overconcrete Tendency to change meaning of reality when self-esteem is threatened

From this perspective contradictory features can exist concurrently as manifest and latent (unconscious) aspects of the same pathology. For example, manifest symptoms of grandiosity coexist with covert (split-off) feelings of smallness, inferiority, worthlessness etc. This diagnostic system is, I believe, far more valuable than the DSM-3 system because firstly, it recognizes the bipolar structure and dynamics of narcissistic pathology and secondly, it throws a larger dragnet over a range of symptomatic indicators that the DSM-3 might miss.

The third diagnostic system is that of Otto Kernberg, one of the leading authorities on narcissistic disorders. His criteria are more comprehensive than those of the other systems and emerge from decades of therapeutic experience with narcissistic patients. (See table 3)

After comparing the three diagnostic systems Ronningstam concludes that only 6 % of the criteria are common to all systems, although the concordance among broad conceptual themes in all systems is somewhat higher at 40 %. This rather low concordance level is perhaps attributable to fundamental conceptual differences intrinsic to the respective

approaches.

However, Ronningstam notes that the above fact is partly attributable to the same clinical phenomena in each system being described using different descriptive criteria. She thus concludes that "...clinical consensus exists among the three

Table 3

KERNBERG'S DIAGNOSTIC SYSTEM FOR NARCISSISTIC PERSONALITY

Aspects	*Symptoms*
Pathological Self-love	Excessive self-reference and self-centeredness
	Grandiosity[a] – exhibitionism
	– superiority
	– recklessness
	– discrepancies between capability and ambitions (grandiose aspects of ambitions)
	– grandiose fantasies of superiority[b]
	Overdependency on admiration
	Emotional shallowness
	Bulk of insecurity ("all or nothing" view) and feelings of severe inferiority
Pathological Object-love	Envy[a] – conscious and unconscious
	Devaluation of others[a] – depreciation of others[b]
	– contempt of others[b]
	– tendency to spoil what they receive
	Exploitiveness – greedy attitude
	– sense of entitlement
	– tendencies to steal ideas and things[b]
	Incapacity to depend on others
	Lack of empathy[a] (lack of capacity of deep understanding of what happens in other people, lack of capacity to feel what other people feel)
	Lack of commitment
Superego Pathology	Incapacity to experience depression (enraged helplessness and hopelessness instead of sadness and guilt)
Milder forms[d]	Severe mood swings
	Shame-regulated behavior toward others[b]
	Lack of integrated sense of values[b]
Severer forms[d]	Antisocial features
	Ego-syntonic aggression and ego-syntonic sadism
	Generalized paranoid orientation[b]
Special Characteristics (for all patients with narcissistic disturbances)	Chronic experience of emptiness
	Incapacity to learn
	A sense of aloneness (no longing for others)
	– a sense of "being boomed" and alone in the world[c]
	– a chronic hunger for something[c]
	– a sense of meaninglessness[c]

[a]Key symptoms.
[b]Additional criteria included 1985.
[c]Ego states.
[d]Division of superego pathology made 1985.

systems about many core features of NPD." (pg 308) These include the following:

1. **Grandiose self-experience/fantasies:** the belief that one is (or the desire to be) remarkably special, talented, attractive or in any way superior to most people. This might be manifest as a fear of being ordinary. The latent underside of this grandiosity is the experience of **chronic inferiority, self-doubt, badness, weakness, worthlessness** etc. (Narcissistic people usually only come voluntarily to therapy when their defences have been ruptured and the underlying negative self-representations leave them feeling uncharacteristically helpless and vulnerable.) It has been my (limited) experience that in these periods of deflation narcissistic patients often describe themeselves metaphorically as being cripples, mutants and half-humans. This also means that narcissists often experience **intense envy** towards those who have qualities missing in themselves.

2. **Exhibitionism:** this is manifest as behaviour directed toward obtaining constant praise/recognition from others. This is often evident in conversation, which the narcissist greedily uses as a chance to speak about his/her own experience without sincerely listening to or inviting any contribution from the "audience".

3. **Devaluation:** Narcissists tend to be highly critical and disparaging towards others. This is usually expressed as verbal hostility or contempt for specific people or, otherwise, as a generally cynical and condescending attitude. Devaluation often coexists or oscillates with the opposite tendency to **idealize or uncritically worship** certain people/ideas/ideologies etc.

4. **Exploitativeness:** Narcissists tend to be selfish, opportunistic, insensitive and manipulative in their relationships, using and exploiting these without genuine concern for the other's welfare. However, I have also noticed a

coexisting tendency towards the experience of **severe guilt and self-remorse** in some narcissistic patients who experience themselves as evil and destructive, contaminating those who attempt to get close to them. One patient of mine experienced himself as being poisonous to others and said : "Everything I touch turns to shit!"

5. **Pseudo-self-sufficiency:** One of the most striking narcissistic characteristics is an apparent **self-reliance and autonomy.** Many narcissists are loners and appear not to need other people except at a rather superficial level. However, this extreme surface independence masks a deeper **neediness and hunger for intimate relatedness** that is very threatening for the narcissist to admit to. This defensive self-sufficiency is manifest in therapy (at least in the early stages) as a somewhat aloof and detached attitude in which the narcissist attempts to do **self-therapy** rather than become dependent on his/her therapist. (It is this that some therapist's mistakenly identify as the absence of transference feelings). In my own work with narcissists this usually manifests as a countertransference feeling of being a spectator to the narcissist's attempts at self-healing. [3] The aloofness and independence, when not egosyntonic, is experienced negatively as an aching **loneliness, isolation and alienation** from human contact. (Images of watching the world from behind a thick

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[3] The narcissist's excessive (pseudo-)independence contrasts strongly with the borderline's extreme dependency. Countertransference feelings, I find, are often a very useful differential diagnostic indicator in this regard. Often, in the initial session, I feel very close to and warm toward borderline people because of their symbiotic need for closeness, intimacy and fusion with a benevolent nurturant figure. With most narcissists, however, I initially feel distant, removed and emotionally detached as they communicate the unspoken message "I don't want to get close to you, so keep your distance while I try to sort this out on my own." Some borderlines, however, may present using narcissistic defences against their extreme dependency needs because the prospect of fusion with the therapist threatens to obliterate their tenuous sense of self.

wall of glass or ice are common.) The narcissist's fear of dependence and intimacy is expressed in his/her sexual relationships as a **lack of committment** and an **inability to remain in love** once the initial excitement of the relationship has worn off and the reality of the other's limitations can no longer support the narcissist's perfectionist fantasies.

6. **Constricted affect:** A common indicator of narcissistic pathology is a largely constricted emotional range and depth. A common symptomatic complaint in this regard is a **cold aloofness** or **inability to feel strong emotion, show affection** etc. This certainly does not mean that emotion is absent: many narcissists experience periods of passionate inspiration, sexual arousal, anger, hatred etc. However, these tend to be reactive pockets or islands of emotion separated by barren tracts of **neurasthenic emptiness, phlegmatism and lack of spontaneous aliveness.** Unlike borderlines who experience intense, unpredictable mood swings the narcissist's moods are more stable, less volatile and extreme. They are, however, **inordinately sensitive to criticism, rejection or indifference** and often respond to this with feelings of hostility, humiliation, inferiority or emptiness.

Most of the above themes are common to all, or at least two out of three, of the diagnostic systems in Ronningstam's study. While they are not exhaustive they do indicate some of the core, commonly accepted features of narcissistic pathology. The author would like to add another two more diagnostic features because they have been so conspicuous in narcissistic people he has assessed:

7. **Intellectualization:** Many narcissists tend to be excessively cerebral people who use their often highly developed intellectual powers to analyze, dissect and speculate about their own (and

others') experience. [4] The dynamics of this are particularly clear in the case I will present later.

8. **Disturbed sexuality:** Although most psychopathology results in disturbed sexual relations my experience is that narcissists are particularly prone to certain sexual problems/trends. One of these appears to be an **inclination towards homosexuality or bisexuality.** (If I am correct this would support Freud's early thesis about the relationship between narcissism and homosexual object choice.) A second feature appears to be the **compulsive genitalization** of erotic relationships. Narcissists tend to see sexual organs and orifices rather than sexual partners. (This makes psychodynamic sense once we realize that narcissists relate to people as **part-** rather than **whole objects.** Although they are often promiscuous this is not necessarily so. An interesting phenomenon the author has noticed is that some narcissists avoid sexual relationships because they have impossibly high ideals about the perfect partner/relationship. Rather than settle for anything less than perfection they refuse to compromise and so opt for celibacy instead.

3.5 Chapter summary

This chapter began by tracing the origin of the concept narcissism in the work of Freud. We saw that he used the concept to refer to a number of phenomena, including a posited

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[4] Most of the narcissists I have dealt with have been university students who are not statistically representative (in terms of intelligence and education) of the general population. Perhaps less educated narcissists are not as prone to intellectualization as the skewed sample I am familiar with. However, as I will argue later, the narcissistic child's premature maturity would naturally incline him/her towards intellectual precocity. This would support my hypothesis that narcissists are more intellectually inclined than other diagnostic categories.

developmental stage prior to object relating, homosexual object choice and "autoerotic" phenomena, the healthy libidinal cathexis of the ego i.e. self-esteem, and the pathological withdrawal of libido from external objects e.g., schizophrenia. According to Freud all these diverse phenomena were characterized, according to his energic metapsychology, by ego-libido rather than object-libido i.e., the ego's libidinal cathexis of itself rather than external objects. We then briefly reviewed selective post-freudian contributions to the definition of pathological narcissism, culminating in the functional conception of Stolorow, according to which narcissism is defined by the defensive function it serves in protecting the stability, cohesion and emotional flavouring of the self-representation.

Thirdly, three diagnostic sytems of narcissistic pathology were presented and briefly discussed. Lastly, a number of common diagnostic criteria for narcissistic personality disorder were outlined.

CHAPTER FOUR

A SELECTIVE LITERATURE REVIEW OF SEMINAL CONTRIBUTIONS TO THE THEORY OF NARCISSISTIC PATHOLOGY

This theoretical chapter presents the contributions of important object relations theorists to our understanding of the psychodynamics and etiology of narcissistic pathology. To comprehensively review every important contribution to this field is beyond the scope of this case study. I will focus selectively on a small number of psychoanalytic theorists who have each made important conceptual advances in this area. This review, moreover, is expositary rather than critical. The metatheoretical minutae and nuances of perspective that distinguish the various contributions will be largely ignored. Because of the theoretical orientation of this case study, however, it is necessary to briefly discuss the concept of internal object relations before considering the individual theorists.

4.1 The concept of internal object relations

> "Of every individual who has reached the state of being a unit with a limiting membrane and an outside and an inside, it can be said that there is an inner reality to that individual, an inner world that can be rich or poor and can be at peace or in a state of war." (Winnicott 1958)

Earlier on I defined object relations theory as a psychoanalytic developmental account of how primary interpersonal relationships in the infant's external world become internalized, represented and metabolized through the medium of phantasy into a nuclear core of personal identity which, whether healthy or deficient, determines subsequent personality development and deformation. In

other words, primary formative infant-parent interactions, both positive and negative, are **introjected** as affectively charged self-other images into the plastic psychic world of the infant. These provide the developmental nuclei for subsequent personality growth. These primordial self-other relational introjects are gradually transformed or " **metabolized** " and in this way evolve into enduring **intrapsychic structures** that provide the foundation for a stable sense of individual identity. ([1]) In the same way that normal good introjects (self-other interactions experienced as gratifying) become the catalytic nuclei for psychic **structuralization** (the differentiation and maturation of self-components/functions), abnormally bad introjects (self-other interactions experienced as destructive, painful or otherwise negative) retard or distort psychic structuralization and thus impede healthy identity formation. Object relations theory is not only interested in psychic ontogenesis (the normal process of psychological maturation), but is also particularly concerned with the developmental deficits or distortions that negatively influence normal personality growth and result in adult psychopathology.

Because object relations theory is concerned with the healthy and pathogenic internalization of **interpersonal** relations, the use of the term object relations rather than interpersonal relations requires justification. Psychoanalysis began with Freud's realization that the people who his patients spoke about did not correspond in a one-to-one fashion with the "real" people in the patient's external world. Freud saw that actual persons are transformed or refracted through fantasy and expressed as psychologically meaningful figures or characters in our

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[1] This process is metaphorically analogous to the process of digestion whereby an external source of nourishment is internalized and transformed by digestive enzymes into nutritive compounds that are then absorbed to become part of our body tissue.

individual developmental histories. We all interact not only with actual external others but also with **internal** others i.e., psychic representations of other people which are no less real and which greatly influence our experience and behaviour. These internal representations are phantasy-filtered residues of actual interpersonal relations with significant others. The term object relations is thus meaningful for the following reasons:

1) It describes both external real people and the affectively charged internal psychic representations (object-images) of them while accepting the phenomenological (although not necessarily physical) reality of the latter for the person concerned.

2) Many patients do not relate psychologically to whole individuals but only to certain functions or parts of people (part-objects). The other person, for example, may be experienced as a part-object in the following way: as an intrusive penis, a hollow breast, a devouring mouth etc. The terms object and part-object are descriptively suited to these modes of relatedness.

3) Internal objects, unlike actual people, are manipulated and modified, introjected and projected, killed and resurrected by phantasy-determined intrapsychic processes which have enormous consequences for the person's psychological world. The term object thus establishes the **experiential primacy of phantasy over literal reality** while in no way minimizing the impact of external reality on our internal object world.

A final general point to be made about internal object relations is that they are not simply memories, feelings or free-floating fantasies but rather **structures - relatively stable, enduring and semi-autonomous psychic configurations comprising self- and object-representations linked by an emotional charge.**

Classical psychoanalytic theory did not have a clear concept of

internal objects. Freud, however, toward the end of his life, presaged later theoretical advances by introducing the mechanism of identification, whereby one not only remembers a lost one but unconsciously models an aspect of oneself after the person:

> "A portion of the external world has, at least partially, been abandoned as an object and has instead, by identification, been taken into the ego and thus become an integral part of the internal world. This new psychical agency continues to carry on the functions which have hitherto been performed by people (the abandoned objects) in the external world." (Freud quoted in Ogden 1983 pg 228)

As Greenberg and Mitchell (1983) note, there have been two major psychoanalytic conceptual approaches developed in order to deal with the increasing emphasis on object relations in clinical psychoanalysis:
The first is the classical attempt to preserve Freud's original instinctual or drive/structure model and simply extend it to accomodate the contemporary emphasis on object relations. From this perspective all facets of personality and psychopathology are understood to be derivatives of drives and their transformations. Object relations are thus understood to derive from the need for instinctual release and energic homeostasis. Object relations are primarily a means to this end.

A second model has emerged which is not committed to preserving and extending the edifice of Freudian metapsychology. Instead, it attempts to supplant the latter by a radical alternative conceptual formulation of psychological life in which interpersonal relations replace instinctual release as the primary motivational force. To paraphrase Fairbairn, the pioneer of the most purified variety of object relations theory, **we essentially seek persons not pleasures**. In other words, intimate relatedness with others is a primary motivational end in itself rather than being merely a vechile or a means to the end of

libidinal discharge. Psychopathology, then, does not spring from conflicts over instinctual impulses but rather expresses the pathogenic disturbance of our quest for object relatedness. Where sex and/or aggression appear to be the chief determinants of psychic life this indicates a secondary pathological truncation of a more primordial need for emotionally gratifying human contact. Psychopathology indicates the maladaptive and frustrated attempt to protectively deal with bad internalized interpersonal experiences by using defenses that invariably deplete and impoverish the person's internal world. Greenberg and Mitchell call this the relational/structure model, in contrast to the classical drive/structure model. Structure in both cases refers to enduring, characteristic psychological functions that typify the personality, organize experience and change only slowly (if at all) over time.

Because these two psychoanalytic models begin from fundamentally different metatheoretical postulates they constitute mutually opposed rather than complementary perspectives:

> "The drive model and the relational model are complete and comprehensive accounts of human experience. The premises upon which they rest constitute two incompatible visions of life, of the basic nature of human experience." (Greenberg and Mithchell pg 406)

Some theorists refuse to committ themselves to either model and instead try to combine what they see as useful in both perspectives. Kernberg, as we shall see later, chooses this **mixed model strategy** (arguably a theoretically ungainly hybrid) by superimposing object relations theory onto the classical drive/structure model.

A fourth strategy, which I propose to call the **split-level model** to differentiate it from the mixed model mentioned above, preserves intact both classical and object relations theory by

delimiting the range of application of the respective models to specific levels of psychopathology. Stolorow and Lachman (1980) thus seperate psychopathology into two subtypes by arguing that:

> "...it is necessary to distinguish between psychopathology that is the product of intrapsychic conflicts and psychopathology that is the remnant of developmental voids, deficits and arrests." (pg 171)

Most narcissistic pathology falls into the latter category although, as this case study will demonstrate, the absolutist split-level conception of psychopathology cannot account for the mixed picture evidenced by certain clinical phenomena. However, according to this model, which clearly echos Melanie Klein's distinction between paranoid-schizoid and depressive position pathology, oedipal and pre-oedipal disorders are fundamentally distinct in terms of symptomatology, etiology and psychodynamics. They thus require different hermeneutic models and treatment strategies. Heinz Kohut (to be discussed later) exemplifies the split-level approach.

For the purposes of this case study it is not necessary to review the history of object relations thought or to trace its genealogy from the work of Klein and Fairbairn. These two theorists, however, are relevant to the topic of narcissism insofar as both made seminal contributions to our understanding of schizoid dynamics and psychopathology i.e. the process of pathological splitting and primitive projection of bad internal objects resulting in a weakened ego and an experience of inner emptiness. Fairbairn and his follower Guntrip are the two British object relations theorists who focused their work on the dynamics and treatment of schizoid pathology, which Guntrip (1961) describes as follows:

> "The tragic dilemma of the schizoid person is that his specially intense need of a good love-object is matched by an equally great fear of object-relationship, so that his love-hunger is hidden from the outer world beneath his mask of detachment, aloofness and emotional apathy." (pg 282)

The above description, as we will see, is a central dynamic of the narcissist. In fact, in a later work Guntrip (1980) describes the following diagnostic criteria for schizoid pathology: Introversion, withdrawness, narcissism, self-sufficiency, a sense of compensatory superiority, loss of affect, loneliness and depersonalization. It could thus be argued that even though DSM-3 lists them as distinct diagnostic categories, narcissism and schizoid pathology are symptomatically and dynamically similar if not identical. However, I will not pursue this point or discuss the Fairbairn/Guntrip contribution to our understanding of narcissism. I will focus, rather, on the work of Michael Balint, Donald Winnicott, Heinz Kohut and Otto Kernberg.

4.2 Michael Balint's concept of the basic fault

One of the richest metaphors describing narcissistic injury arose from the work of Hungarian psychoanalyst, Michael Balint. After emigrating to Britain he became one of the leading theorists in the British independent tradition. His innovative contribution to object relations psychoanalysis culminated in 1968 with the publication of his seminal work The Basic Fault. The basic fault is a metaphor describing a profoundly regressed level or area of functioning that indicates a pre-oedipal narcissistic injury or developmental arrest that needs to be accessed in order for psychotherapeutic healing to occur. Balint's work is an important contribution to conceptualizing and managing regression to and through this level of pathology.

Balint belongs to what I would call the environmentalist

tradition of object relations theory. He believes that serious pathology is primarily the ontogenic consequence of real deficits in maternal provision rather than the product of endogenous or constitutional factors. [2] According to Balint infancy begins not with a stage of primary narcissism but with a mode of primitive object relatedness called "primary love". This is defined by the following:

> "a) there is complete harmony between individual and environment; b) the individual does not care and is not in a position to say where he ceases and the external world begins; and c) neither can an external observer define exact boundaries. At this stage of development there are as yet no objects, although there is already an individual, who is surrounded, almost floats, in substances without exact boundaries; the substances and the individual mutually penetrate each other...they live in a harmonious mix-up." (Balint quoted in Kahn 1969 pg 241)

This symbiotic union with the mother ends with the infant's gradual awareness of separateness and the resulting anxiety over his/her vulnerability and absolute dependence on maternal care. If this care is deficient at this vital stage then a basic fault arises as a consequence. This fault finds expression in one of two pathological modes of object relating which Balint calls **ocnophilic** and **philobatic** respectively:

Ocnophilia refers to a mode of relating characterized by clinging behaviour, excessive dependence on others, severe seperation anxiety, overvaluation of the object and inhibition of moves to

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[2] The environmetal emphasis is particularly evident in the work of Winnicott, Fairbairn, Guntrip and Kohut, all who emphasized the pathogenic role played by chronically deficient parenting in the etiology of self-pathology. I would contrast this position with the classical and Kleinian emphasis on instinctual/constitutional givens e.g. excessive constitutional aggression, as the primary determinants of severe pathology. These respective emphases are merely trends rather than absolutes.

independence and relative self-reliance. Although Balint does use the term we recognize in this description the typical characteristics of borderline pathology. Normal ocnophilic behaviour is a natural response to the seperation anxiety elicited by self-object differentiation. However, when this normal anxiety is aggravated by deficient maternal care [3] excessive ocnophilia becomes a defensive strategy against severe anxieties concerning abandonment, starvation, annihilation etc.

Philobatic object relating is the opposite of this. Other people are perceived as dangerous, unreliable etc and the infant, rather than clinging, adopts the compensatory fantasy of self-sufficiency in order to sever the dangerous dependence on a world of untrustworthy objects. Once again, although Balint doesn't point this out, philobatism is the hallmark of the narcissistic character who withdraws from all close relationships into a world of self-sufficient isolation defended by a grandiose facade.

Balint does not explain why some people resort to ocnophilia rather than philobatism and he does not deliniate mature symptom profiles specific to these two pathological modalities. [4] His strength lies more in describing the phenomenology of the basic fault and how it is to be managed psychotherapeutically.
The basic fault metaphor derives from geology where it is used to describe a structural flaw in the rock strata which, although not visible at the surface, is susceptible to stress fractures, collapses etc, thus disrupting the overall rock formation. When applied to the "strata" of psychic life this metaphor is

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[3] A catch-all term that embraces every serious disruption of normal mothering, from actual seperation to emotional absence, maternal depression, anxiety, clinging, overidentification, unconscious resentment etc.

[4] I will later show, drawing on the work of Margaret Mahler, how and why these two relational modalities predispose the child to either narcissistic or borderline self-pathology.

particularly apt. Balint outlines his reasons for selecting this term:

> "First, because...the patient says he feels that there is a fault within him, a fault that must be put right. And it is felt to be a fault, not a complex, not a conflict, not a situation. Second, there is a feeling that the cause of the fault is that someone has either failed the patient or defaulted on him; and third, a great anxiety invariably surrounds this area, usually expressed as a desperate demand that this time the analyst should not - in fact **must** not - fail him." (Balint 1968 pg 21)

Unlike neurotic disorders which are characterized by conflict over impulses or feelings the dynamics of the basic fault are completely different. It is experienced as a deficit, a psychic lesion, an internal flaw or absence rather than an anxiety over repressed egodystonic material:

> "Although highly dynamic, the force arising from the basic fault has the form neither of an instinct nor of a conflict...It is not something dammed up for which a better outlet may be found, but something missing either now, or perhaps for almost the whole of the patient's life." (1968 pg 21)

Therapeutic work in the area of the basic fault differs radically from work with neurotic pathology in the following ways:

Firstly, therapy with neurotics takes place by means of conventional adult language with its taken-for-granted meanings. Interpretation is thus the therapist's primary form of intervention. In the area of the basic fault, however, language breaks down, meanings are not shared and words often cannot grasp

the patient's experience. [5] Moreover, interpretations are often experienced as attacks, failures in empathy, intrusions, criticisms etc.

Secondly, neurotic pathology usually involves ambivalent triadic relationships arising from the oedipal stage of development. Basic fault pathology, on the other hand, is primarily **dyadic**, located in the pathogenic mother-infant relationship (hence the concept of pre-oedipal pathology).

Thirdly, the structure of neurosis concerns psychic conflict over ambivalent feelings toward parental objects. But in the area of the basic fault the issue is not one of conflicting feelings but rather an internal deficiency, a feeling of something vital missing within.

In order to heal this fault the patient needs to relinquish his/her defensive coping strategies and regress to the level of the fault. Balint identifies two forms of regression: **regression for gratification** and **regression for recognition**. The first form is a "malignant" regression characterized by the greedy craving for immediate instinctual gratification from the therapist, impulsive destructive acting out and the constant threat of an unending spiral of vociferous untherapeutic demands. The patient is not looking for insight or understanding but rather the immediate relief of intolerable needs and feeling states. (I have

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[5] I have noticed, with both narcissistic and borderline patients, that they frequently feel misunderstood by me even though I feel empathically attuned to their experience i.e. that I do in fact understand. My attempts to language their unlanguaged feelings are often unsuccessful because, Balint would say, we are talking about regressive **preverbal** experience, a world before words that is not accessible to adult language. I have found that therapy at this level means acknowledging that there aren't at present words to grasp the feelings and that our time together is largely about discovering or creating a shared language that will in time allow the patient to understand and feel understood.

seen this particularly strongly in borderlines and eating disorders.)

The second form, regression for recognition, Balint describes as "benign", in contrast to the malignant regression mentioned above:

> "In one form the regression is aimed at gratification of instinctual cravings; what the patient seeks is an **external event**, an action by his object. In the other form what the patient expects is not so much a gratification by an external action, but a tacit consent to use the external world in a way that would allow him to get on with his internal problems- described by my patient as "being able to reach himself". Although the participation of the external world, of the object, is essential, the participation is entirely different in nature; apart from not interfering with, not causing unnecessary disturbance in, the patient's internal life...the chief form of this expected participation is the **recognition of the patient's internal life** and of the patient's unique individuality." (1968 pg 144)

Balint says that regression for recognition implies the patient's search for "**a new beginning**", an object relationship in which the pliable, indestuctible and unintrusive therapist can be internalized to ameliorate the destructive effects of the basic fault. Since the basic fault determines the nature of all the person's object relations it is only by regressing to the atavistic relationship that caused the deficiency that healing can begin. This occurs when the patient trusts the therapist enough to surrender to the archaic love and hate that s/he protected others and herself from before.

Balint offers a number of important techinical reccommendations which need not be discussed here. What is important though, is his recognition of the therapeutic limitations of working with basic fault pathology. If the therapist can meet the regressive need for recognition a degree of healing is possible:

> "...a new relationship may develop which will enable the patient to experience a kind of regret or mourning about the original defect and loss which led to the establishment of the fault or scar in his mental structure. This mourning differs fundamentally from that caused by the loss in reality of a beloved person or that caused by damage to, or destruction of, an internal object, characteristic of melancholia. The regret or mourning I have in mind is about **the unalterable fact of a defect or scar in oneself which, in fact, has cast its shadow over one's whole life, and the unfortunate effects of which can never fully be made good.**" (1968 pg 183).

The fault may heal off but the psychic scars remain, an everpresent reminder and influence on the person's internal and external object worlds. Balint is a frustrating author. He paints the basic bault in broad brush strokes, with little care for detail. There is a lack of specificity concerning the symptomatology, etiology and psychodynamics of basic fault pathology. We are told only that the fault arises from a "mismatch" between mother and infant that disrupts the "primary love" relationship mentioned earlier. The outcome is one of two pathological modes of object relating: ocnophilia or philobatism. Balint is more concerned with the philobatic and it is clear that this describes an essentially narcissistic way of object relating. The basic fault is hidden behind a "shell" or facade which, Balint hints, derives from the internalization of a parental figure whose own pathology demands self-reliance and a relinquishing of internal needs on the part of the child. The external shell learns certain social skills that enable the person to cope with the world, but only at the expense of impoverished object relations and inability to feel intensely, spontaneously alive. Balint notes that the philobat often searches for intense experience to penetrate the anaesthetic shell and momentarily contact the vitality buried deeply within. Despite the frustrating lack of detail in Balint's account, his metaphor of the basic fault offers an intuitively perceptive and prognostically hopeful understanding of narcissistic injury. In

the following section I hope to show that Winnicott addresses precisely the same issues as Balint, using a similar metaphor and a more comprehensive theoretical structure.

4.3 Winnicott's conception of the false self organization

Winnicott is commonly acknowledged as the most influential contributor to psychoanalytic theory and practice since Melanie Klein. His most valuable theoretical contributions have undoubtedly been the concept of transitional space and its phenomena and, secondly, his distinction between the true and false self evident in pre-oedipal pathology. Both of these closely related concepts are essential to understanding the various manifestations of self-pathology. There are a number of remarkable parallels between Winnicott and Balint and I will illustrate these during the chapter.

The entirety of Winnicott's work deals basically with one single problematic: the embryonic ego's developmental struggle to attain a secure sense of selfhood in the face of interpersonal impediments and their internal representation. Greenberg and Mitchell express this point slightly differently:

> "Almost all his contributions center around what he depicts as the continually hazardous struggle of the self for an individuated existence which at the same time allows for intimate contact with others....The processes leading to the development or inhibition of the self are depicted and understood solely in the context of the interaction between the child and the environmental provisions supplied by significant others. (1983 pg 190)

Winnicott starts from the assumption that selfhood is not a given but a developmental task. This task is made possible (and often impossible) by the quality of maternal care provided in the first critical months of infancy prior to the consolodation of clearly

deliniated boundaries between infants and their objects. It is this process of psychogenesis and its truncation that provides the focus for Winnicott's work.

A problem with classical psychoanalysis is its taken-for-granted assumption that all psychoanalytic patients are persons (selves) who symptomatically express aspects of a repressed inner impulse world because these impulses are not congenial to their conscious self-definition. Winnicott, however, argues that there is a spectrum of non-psychotic people **who are not yet persons** i.e. autonomous individuals with an integrated sense of identity, a substantive internal world and a capacity to relate to others as independent people. For the latter category of people the typical anxiety does not concern the issue of integrating egodystonic impulses into their self-definition, but rather the **partial or total lack of self-definition altogether**. The neurotic's anxiety concerns the fear of owning alien aspects of being, but the anxiety of self-pathology is the very real question and threat of **non-being**, either in the form of temporary ego boundary dissolution or a denuded inner world. [6] These people go through the motions of everyday interaction with others, seeming to adapt relatively well to social tasks and responsibilities. However, they are never fully engaged with life, they cannot establish mutually fulfilling intimate relations with others, they lack depth and density, often feeling empty, disconnected or disembodied. (Although Winnicott never uses a clear-cut differential diagnostic taxonomy it is clear that he is referring to narcissistic, schizoid and borderline pathology.)

The question that arises is: if these people have no substantive sense of self then how can they adapt to normal vocational and social demands? Winnicott's answer is that the person's relations

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[6] The former is the typical borderline anxiety while the latter is more characteristic of the narcissist. Both, however, indicate the lack of an integrated and substantive sense of self.

with the external world are regulated by a psychic subsytem that emerges in infancy as an adaptive response to external (maternal and social) demands. Winnicott calls this subsytem the **false self** because it is not the spontaneous product and expression of the infant's instinctual being but rather a compliant conformity to the needs of the other. To the extent that it expresses a compromise between the demands of our instinctual life and the demands of society, the false self is a normal and necessary development without which socialization would not be possible. In addition to social adaptation the false self performs a second vital function: protecting the vulnerable hidden inner core of identity from contact with the external world. This inner core Winnicott calls the **true self**, the matrix and locus of authentic selfhood:

> "I suggest that this core never communicates with the world of perceived objects, and that the individual person knows that it must never be communicated with or be influenced by external reality...Although healthy persons communicate and enjoy communicating, the other fact is equally true, that each individual is an isolate, permanently non-communicating, permanently unknown, in fact unfound...and this is sacred and most worthy of preservation." (Winnicott 1965 pg 187)

Winnicott, always unsystematic and cryptic, is never more so than when he obliquely discusses the true self. One gets the feeling that Winnicott resists a comprehensive theoretical formulation of the true self deliberately in order to protect it from conceptual probings that would impinge on its secrecy and thus violate it. At one point he says that there is no point in formulating an accurate idea of the true self "because it does no more than collect together the details of the experience of aliveness." (1965 pg 148) He also contradicts himself, at one point equating the true self with the Freudian id and at another describing it as the ego capacity to make an id impulse a personal experience. Winnicott's use of the word ego is ambiguous and different from

its meaning in classical psychoanalysis. He uses the words self and ego interchangeably to refer to the organizational center whereby the infant acquires a personal psychosomatic reality. However, the following points can be made about the true self:

1. It is experienced immediately as bodily aliveness and as the center of "I-ness" i.e. the locus of individual identity. It is the source of "the spontaneous gesture and the personal idea." (1965 pg 148)

2. It is a pre-objectal structure - it is not the product of the internal world and in fact preceeds the formation of internal objects:

> "...the concept of an individual inner reality of objects applies to a stage later than does...the True Self. The True Self appears as soon as there is any mental organization at all, and it means little more than a summation of sensori-motor aliveness." (1965 pg 149)

3. It emerges in response to a good-enough maternal environment in which the mother intuitively and lovingly recognizes and meets her infant's **hallucinatory omnipotence** (which results from the primary narcissistic lack of differentiation between self and other) rather than destroying the infant's grandiose illusions by imposing her own needs on the infant. The earliest impingement on the true self occurs when the mother does not meet and mirror the infant's spontaneous gesture but instead substitutes a gesture of her own, unconsciously demanding a compliant response from the infant in order to satisfy her own needs rather than the infant's. Under optimal conditions the normal infantile omnipotence, if invited and mirrored by mother, is gradually relinquished and becomes the source of creative play, symbol formation and spiritual/religious experience.

4. The true self is protected from impingement by the external world by the "caretaker" false self which adapts compliantly to external demands while preserving the pristine integrity of the hidden and incomunicado true self.

Normal true self/false self development presupposes a containing and "holding" maternal environment. Where this is absent or deficient, however, the normal split between true and false self becomes a schism. The true self is not nourished and enriched because the mother's impingement or lack of intuitive responsiveness to the infant's needs threatens and violates the embryonic core of selfhood. The anxiety associated with either **non-recognotion** or **exploitation (impingement)** of the true self is intense, a real fear of **psychic annihilation.** The true self, atrophied and threatened retreats behind the shield of the false self facade, which becomes prematurely compliant and attuned to the demands of others:

> "...the infant gets seduced into a compliance, and a compliant False Self reacts to environmental demands and the infant seems to accept them. Through this False Self the infant builds up a false set of relationships, and by means of introjections **even attains a show of being real...**" (Winnicott 1965 pg 146).

In this case the the child identifies with the false self and loses touch with his/her spontaneous needs and gestures. Having sacrificed his/her own needs the child adaptively becomes the parental image of him/her:

> "...in the extreme of such a case the word **being** has no relevance. In order to be and so have the feeling that one is, one must have a predominance of impulse-doing over reactive doing." (Winnicott quoted in Davis and Wallbridge 1981 pg 114)

The resultant character structure becomes phenomenologically evident in some or other disorder of selfhood where the person

feels unreal, insubstantial, disembodied, two-dimensional, lacking vitality and an internal sense of self-worth. Laing (1982) explains this as follows:

> "If the individual delegates all transactions between himself and the other to a sytem within his being which is not him (the personal), then the world is experienced as unreal, and all that belongs to this system is felt to be false, futile and meaningless."

The caretaker false self often adapts so successfully to social demands that even psychotherapists may mistake its compliance and attunement to the therapist's expectations as therapeutic progress. However, what happens is that therapy proceeds at the surface level with the false self's associations, anxieties and defenses, leaving the true self untouched and unrecognized:

> "It is as if in looking at narcissistic illness the clinician is liable to be caught up with the absorbed, or internalized, environment, and to mistake this (unless well prepared) for the real individual, who in fact is hidden and is secretly loved and cared for by the self within the self. It is the true individual that is hidden." (Winnicott 1965 pg 127)

Many therapies with self-pathology disorders fail because the therapists treat these patients as neurotics. True therapy can only begin once the therapist recognizes and acknowledges not the patient's existence, but rather his/her non-existence i.e. impoverished sense of self and interiority. Only by understanding that very often the totality of the personality is a defense against a primitive anxiety can therapeutic interaction with the true self begin. This already difficuilt process is exacerbated by highly intelligent patients who see (as many narcissistic patients do) psychotherapy as an intellectual task directed towards self-insight:

> "When a False Self becomes organized in an individual who has a high intellectual potential there is a very strong tendency for the mind to become the location of the False Self, and in this case there develops a dissociation between intellectual activity and psychosomatic existence." (Winnicott 1965 pg 144)

Winnicott's seminal contribution to our understanding of the genesis and truncation of selfhood is his concept of **transitional space** and its related phenomena. Transitional space designates an intermediate area of experience between the infantile pre-object state characterized by a lack of self-other differentiation, and that of **object-permanence**, where the boundaries between self and other are clearly demarcated. Prior to this stage, which Winnicott locates at about six months of age, the infant has not yet been born psychologically i.e. is not yet a seperate person with an awareness of inside and outside. " Personalization", as Winnicott refers to this process, is a developmental accomplishment which is not guaranteed, but rather contingent on the quality of the infant's experience in the intermediate area of **illusion**. Winnicott uses the word illusion to capture the nature of the contact between the infant's hallucinatory omnipotence ("The world is an extension of me and will do what my fantasy commands") and the world of external reality which gradually makes the infant's omnipotence increasingly untenable. For a while the infant needs the illusion of his/her omnipotent creation of the external world. This illusion is held and sustained by a mother who intuitively understands and respects the infant's grandiosity. Premature rupture of this illusion fractures the infant's nascent self and eventuates in self-pathology. There is a paradox here that needs to be sustained and not challenged if the infant's omnipotence is to crystallize into a core of personal identity. The paradox is this: the area of illusion is also the area of the infant's first not-me i.e. object experience. The infant thus both **creates** the object through hallucinatory omnipotence and **discovers** it, in which case

s/he could not have created it. Between the narcissistic phantasy of seamless union with the world and the reality perception of seperation from the world lies the area of transitional space which Winnicott also called **potential space**. He uses this term because in reality there is not yet literal space i.e. differentiation between self and object. On the other hand, there is no longer complete fusion and identification with the object. Certain physical objects or sounds stand for i.e. represent, the maternal object in her absence. This is the famous transitional object which both is (in phantasy) and yet is not mother. This potential space is the matrix of symbolism, play, creativity and spirituality, where the metaphorical triumphs over the literal. It culminates, optimally, in a situation where self and object are mediated by a third entity, the symbol. However, where the development of transitional space is disrupted or prevented by the absence of good-enough-mothering, the attainment of object constancy i.e. clear differentiation between self and object, is simply not possible. If, owing to maternal **privation** this occurs at the beginning of infancy then not even partial differentiation is possible. The result is psychosis, with its characteristic absence of ego boundaries expressed as hallucinations and delusions. If, however, the infant does receive adequate mothering prior to but not during the transitional stage, then **partial** self-object differentiation ensues, sufficient to prevent psychotic fusion of self and object but not sufficient to attain complete object constancy and a consolidated ego. The latter situation is typical of borderline pathology where a degree of self-other differentiation has occurred but yet the person, lacking a substantive sense of self only feels real when in the presence of others by adopting their moods and personalities. The literal absence of others is experienced as **psychic death**, not only because of a fragmented internal world populated by abandoning archaic part-objects, but also because the borderline lacks the capacity for **symbolization**. Because self and object are not mediated by symbols people disappear when they are not

literally present, hurtful words are experienced as physical attacks, and the therapist, rather than resembling parental objects (as in neurosis), literally becomes them in the borderline's eyes. Borderline pathology is very clearly a disturbance of transitional space, but what about narcissistic disorders? I would argue that narcissistic character pathology too is a transitional space disorder. This is not as evident in the narcissistic personality as it is in the borderline because the narcissist clearly has a cohesive and relatively stable self-representation. However, the composition of the self-representation it reveals a **fusion of self and idealized object representations**, rather than differentiation of the latter. (This will become clear in the section on Kernberg later in this chapter.) This accounts for the primitive defenses that the narcissist employs e.g. projective identification, denial, idealization etc. Sohn (1984) quotes Rosenfield (1964):

"In narcissistic object relations defences against any recognition of seperateness between self and object play a prominant part." (pg 202) Sohn, developing Rosenfield's argument, contends that narcissism involves the introjection of an idealized object and then identification with that object:

"When the object is omnipotently incorporated the self becomes so identified with the incorporated object, that all seperate identity, or any boundary, between self and object is denied." (1985 pg 202) I cite the above authors in support of my argument. Although they do not employ Winnicott's concepts it is clear that the narcissist's tendency to see other people as extensions of his/her self reflects the disruption of transitional space. Whereas this disruption functions in the borderline to **avoid independence**, in the narcissist the self-other identification functions to **avoid** dependence on the object. (This point will be taken up later.) The narcissist's grandiose false self thus serves the dual purpose of protecting the true self and avoiding dependency relations with external objects.

Winnicott delineates four categories of false self organization according to the severity of the split between true and false self and the extent to which the false self becomes identified as the totality of the person:

1. The first organization is that of healthy normality in which the false self is represented by social etiquette and conformity to rules and norms of conduct. The person has relinquished childhood omnipotence and primary process functioning in order to fit into society.

2. The second organization, still closer to health than serious pathology, occurs when the false self comprises actual identifications of significant others, thereby incorporating their ideals, attitudes etc. Presumably this is where neurosis begins as a tension or contradiction between internalized parental values and attitudes on the one hand, and spontaneous impulse life deriving from the true self influence on the other.

3. At the third level of organization significantly more severe pathology is evident. The false self is concerned with searching for conditions in which the true self can emerge or, failing that, reorganizing a new defense against exploitation of the true self. Sometimes, says Winnicott, suicide becomes the last defense: "Suicide in this context is the destruction of the total self in avoidance of annihilation of the True Self." (1965 pg 143)

4. At the fourth level the true self "is acknowledged as a potential and is allowed a secret life.: (1965 pg 143) This secret life is expressed indirectly through symptomatology which, ironically, serves the positive function of letting the person know that s/he does in fact have an inner life even though s/he might feel dessicated or dead inside.

5. At all of the above levels of organization the true self does find some or other expression in the person's life. But at this extreme "The false self sets up as real and it is this that observers tend to think is the real person." (Winnicott 1965 pg 143) Even though at this level there is no tension between between true and false self functioning, in close relationships the false self begins to fail because it becomes evident that something essential is missing from the personality. Even at this extreme, however, Winnicott sees the potential for access to the true self.

Although Winnicott does not provide diagnostic or rigorous clinical descriptions of the forms of pathology expressed by various levels of false self organization It may be argued that both narcissistic and borderline disorders fall largely into the last category. To this end the concepts of egosyntonicity and dystonicity may prove useful as criteria for evaluating the severity of the schism between true and false self. Where personality symptomatology is integrated, with little conflict or anxiety, into the overall character structure (egosyntonicity), then any residual true self functioning becomes eroded and totally entombed behind a wall of impregnable false self defenses. This situation would justify a sixth category of false self organization, in addition to Winnicott's original five. Into this category the author would place antisocial personalities as well as severely schizoid, paranoid and narcissistic personalities. These people are therapeutically inaccessible because they cannot acknowledge or even feel true self possibilities behind the false self character armour. However, even a slight tension (egodystonicity) between symptoms and character structure speaks of a residual true self life and a potentially hopeful therapeutic prognosis.

At this point the similarities between Balint's and Winnicott's formulations are evident:

1. Both theorists propose that there is a split within the personality between an external shell (Balint) or false self (Winnicott), and a vulnerable inner core of selfhood sheltered from contact with the external world. This split becomes the primary dynamic focus in self-pathology.

2. For both theorists these equivalent defensive structures serve an identical function: to protect the real or true self from damaging contact with the world while adapting compliantly to external demands. For both theorists the symptomatic result is the same: not feeling real or substantial, alive, spontaneous or in intimate contact with either oneself or others.

3. Both theorists locate the cause of this schism in the maternal lack of empathic adaptation to the infant's ego needs. This engenders a surface compliance with maternal expectations and, at a deeper level, a fundamental mistrust in the nurturant capacities of the external world. This mistrust is evidenced by the submergence of the real self behind the false self facade.

4. Both argue that effective therapy cannot begin until the patient feels safe enough to shed the false self carapace and regress to the level of the developmental lesion and the traumatic primary object relationship. Only the symbolic re-experience of adequate maternal provision in therapy can palliate the destructive impact of that first relationship and modify the damaged self- and object-representations.

5. At the level of technique both Balint and Winnicott emphasize non-interpretative interventions, the therapist's contribution to making a safe regressive space. The therapist needs to survive both the patient's loving and hating, the destructive fantasies and transference attacks. Both believe that benign regression, if managed correctly, can result in a new experience of aliveness,

individuality and qualitatively improved object relations.

As is the case with Balint there are serious conceptual flaws, ommissions and inconsistencies in Winnicott's account of false self pathology. This is partly due to Winnicott's unsystematic approach, partly to the fact that he was exploring new areas of pathology without a pre-existing theoretical map of pre-oedipal psychic territory, and partly because, for political reasons, he was trying to maintain a sense of continuity with and loyalty to the work of Freud and Klein. The above notwithstanding, the author believes that Winnicott's concepts of the false self and transitional space are valuable theoretical tools for understanding narcissistic dysfunction.

4.4 Heinz Kohut's model of narcissistic pathology

Balint and Winnicott, though pioneering theorists in their own right, did not deal comprehensively with the specific dynamics of narcissistic character pathology. They were more generally concerned with mapping out the broad domain of pre-oedipal pathology and devising general theoretical constructs to describe what they saw. The basic fault and false self are thus non-specific constructs encompassing a wide range of self-pathologies. The next generation of psychoanalytic theorists had the task of making finer diagnostic and conceptual discriminations in order to explain the particular dynamics of narcissistic pathology. Two pre-eminent figures stand out in this regard. Perhaps the most celebrated and controversial of these was Heinz Kohut, a Viennese neurologist who emmigrated to America after the war to train as an orthodox analyst. (He was even elected as president of the American Psychoanalytic Association.)

The remainder of his professional career, however, was concerned with transcending classical psychoanalytic theory by outlining a new theoretical model adequate to the task of understanding narcissistic disorders. In his 1971 publication The Analysis of the Self, Kohut admits to having "presented my findings concerning the psychology of the self mainly in the language of classical drive theory." (1977 pg 13) But in his second book The Restoration of the Self (1977) He clearly distances himself from classical theory with the central point of departure being the **clinical and conceptual status of the self**. He says there are two psychoanalytic approaches or positions in this regard:

> "A psychology in which the self is seen as the center of the psychological universe, and a psychology in which the self is seen as a content of a mental apparatus." (1977 pg 15)

While not discrediting the latter Kohut firmly identifies himself with the former. It would be more accurate to say that Kohut does not so much transcend classical drive theory as he does restrict its application to specifically neurotic disorders. At the level of oedipal pathology classical theory, with its focus on drives and defenses against these, is conceptually adequate. But at the pre-oedipal level of self-pathology a new explanatory system is necessary to account for the dynamics and etiology of the deficient self-structure that Kohut posits as the central feature in narcissistic disorders:

> "In view of the fact that it is a weakened or defective self that lies in the center of the disorder, explanations that focused on conflicts concerning either the libidinal or aggressive impulses of these patients could illuminate neither psychopathology nor treatment process." (Kohut and Wolf 1978 pg 414)

It is for this reason that I call his a split-level psychoanalytic model. By arguing that classical psychoanalysis and his "psychology of the self" are complementary and applicable

to different levels of pathology he is attempting to preserve rather than supplant the drive/structure model. But Kohut allocates developmental primacy to the growth of a cohesive self which is a precondition for the later oedipal issues documented by the classical theory. Oedipal pathology, moreover, is becoming historically eclipsed by narcissistic disorder as the malaise of our time. In his words "Tragic man", the individual preoccupied with a depleted sense of self, today largely replaces "Guilty man", the individual preoccupied with avoiding oedipal guilt, as the focal psychological problem.

Kohut does acknowledge that periods of self-doubt and loss of self-esteem are aspects of both normal and neurotic functioning. However, he labels these as **secondary self disturbances:**

> "The experiential and behavioural manifestations of the secondary disturbances of the self are the reactions of a structurally undamaged self to the vicissitudes of life." (Kohut and Wolf 1978 pg 414)

His specific interest lies in the **primary disturbances of the self**, a category he divides into the following subgroups according to the descending level of severity of the self-disturbance: (1) the psychoses, (2) the borderline states, (3) the schizoid and paranoid personalities, and (4) the narcissistic behaviour and personality disorders.
Only the latter category, says Kohut, have a favourable therapeutic prognosis because only these disorders:

> "are capable of tolerating the frustrations of the reactivated narcissistic needs of their vulnerable self to which the working-through process in analysis exposes them without a protracted fragmentation or depletion of the self." (1978 pg 416)

The self in narcissistic character pathology, though vulnerable and often fragile, is more cohesive and less prone to regressive

fragmentation than in the other self-pathologies. It is this that makes the narcissist amenable to therapeutic intervention.

Kohut is strongly opposed to the psychiatric emphasis on seeing disorders as disease entities defined by specific symptomatic criteria. For this reason he does not systematically outline a symptom profile indicative of NPD. [1] His primary criterion is not based on presenting symptomatology or life history, but rather on the **specific quality of the emerging transference.** Kohut noticed the following typical transference phenomena emerging in his analysis of narcissistic patients:

Firstly, narcissists tend not to relate empathically to their therapists (and other people generally) as seperate, autonomous individuals with unique needs, perceptions, feelings etc. Rather, they tend to relate to them as parts or extensions of themselves. This, argues Kohut, is because, owing to a structural lesion or deficit in the narcissist's self-system, the external object is required to **execute vital psychological functions that the narcissist's own weakened self is incapable of.** Next to maintaining a sense of cohesion and continuity the most important function performed by the self is that of self-esteem regulation i.e. preserving a positively flavoured self-representation and sense of self-worth [2] It is the developmental arrest of this second function that leads to narcissistic character pathology. Kohut noted that beneath the narcissist's grandiose facade was a

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[1] Hence his exclusion from the diagnostic systems presented in the first chapter. However, the behavioural descriptions that emerge in his clinical vignettes tally well with the symptom criteria of both Kernberg and Akhtar and Thomson.

[2] Where the developmental dysfunction involves a deficit in the primary ontogenetic task of gaining **self-cohesion** after an initial unintegrated state, the resultant pathology is not narcissistic but borderline. Narcissistic dysfunction is thus a **higher level** pathology that involves damage to self-worth rather than self-integration.

chronic sense of inferiority and lack of self-esteem. Lacking this internalized self-function the narcissist depends on others to provide constant supplies of attention, praise, affirmation etc. Because the object is called upon to perform a function that in normal circumstances is performed by the self Kohut calls the narcissist's external objects **selfobjects**. This explains why the narcissist's relationships are so shallow. The other person is not seen as a seperate individual with whom to relate, but simply as an impersonal source of positive affirmation necessary to buttress the narcissist's precarious self-esteem.

The second important transference phenomenon that Kohut noted is that narcissists not only relate to their therapists as selfobjects, but also that these selfobject transferences typically fall into two specific modes of object relating. The first he calls the **mirror** transference and the second the **idealizing** transference.

The **mirror transference** expresses the narcissist's attempts to experience a substantive self and feeling of positive self-regard by having the selfobject reflect (mirror) and hence affirm his/her compensatory grandiosity and exhibitionism. The unconscious logic of this is as follows: "I feel very small, inferior and insubstantial. In order to avoid the anxiety of this realization I need to deceive myself by pretending to be bigger, stronger and more self-confident than I in fact feel. But I can't do this alone, I need other people to see my act, to praise me and respect me so that by basking in their admiration I can confirm and identify with this protective facade. I need other people to admire me and to thus embody my own missing self-esteem." The problem, however, is that people often experience this behaviour as shallow, egotistical and exasperatingly insensitive. When they fail to mirror his/her defensive grandiosity and instead become critical or indifferent, the narcissist feels hurt, insecure and angry. This is expressed as

overt rage, disparagement or cold hostility directed toward the offending object; or alternatively, as self-related feelings of emptiness, invisibility, ugliness, alienation, inferiority etc.

The idealizing transference also concerns inflated perceptions of grandiosity, power, success etc; but instead of self-perceptions, as in the mirror transference, the idealization involves **object perceptions**. Kohut defines this transference as the "therapeutic activation of the omnipotent object (the idealized parent imago..." (1971 pg 37). One of the ironies of this pathology is that the hypercritical, cynical and contemptuous narcissist often becomes infatuated with certain people, seeing them as being unambiguously good, strong, wise, exciting etc. This manifests in the transference as unrealistic perceptions of the therapist as omniscient, omnipotent, perfectly wise, understanding and caring. Whereas the mirror transference functions directly to preserve the narcissist's grandiose self-representation the idealizing transference performs the same function indirectly through **vicarious identification** with the idealized selfobject. The unconscious logic of this is as follows: "I feel small, inferior and unlovable. If I can identify or merge with certain other people who I see as powerful, knowledgeable, attractive etc then I can vicariously share those qualities and so conceal my negative self-representations from both others and myself." A narcissistic patient of mine would watch a lot of movies and find himself identifying completely with certain heroic characters in these films and actually living out these movie personae in his everyday life. He would also adopt the characteristic mannerisms, speech patterns and gestures of acquaintances he admired, thus illustrating the structure and function of the idealizing transference. (This attempt to vicariously participate in the qualities of the idealized other in order to raise self-esteem should not be confused with the borderline tendency to fuse with the other in order to prevent fragmentation and annihilation. Thus, although the borderline and the narcissist may both show

the same symptomatology i.e. object devaluation and idealization, the functional purpose of this is different in the respective pathologies.)

Kohut refers to the "mirror-hungry" and "ideal-hungry" modes of object relating as representing distinct personality styles. However, narcissistic people may exhibit both modes of relating toward the same selfobject at different times:

> "Swings from the therapeutic activation of the idealized parent imago (idealizing transference) to a transient hypercathexis of the grandiose self are...common occurrences in the analysis of narcissistic personalities." (Kohut 1971 pg 67)

The function of these two different modalities is the same - to create and protect, by means of selfobjects, a precarious sense of self-worth that cannot be maintained by resilient **internal self-structures.**

These two selfobject transference modalities indicate, says Kohut, developmental arrest of normal self-development prior to the internalization and transformation of archaic selfobjects into internal self-structures.

Although Kohut calls his work "self psychology" and defines narcissism as a developmental self-deficiency he never defines the term self exactly. Nor is he apologetic for not doing so:

> "My investigation contains hundreds of pages dealing with the psychology of the self - yet it never explains how the essence of the self should be defined. The self...as the center of the the individual's psychological universe, is...not knowable in its essence. " (Kohut 1977 pg 310)

He does, however, describe the nuclear self in the following terms:

> "This structure is the basis for our sense of being an independent center of initiative and perception, integrated with our most central ambitions and ideals and with our experience that our body and mind form a unit in space and a continuum in time." (1977 pg 177)

This nuclear self, which begins to emerge in infancy, has a **bipolar structure** comprising two distinct but intimately related components. The first of these derives from the infant's natural grandiosity and exhibitionism. Kohut, like Winnicott, attributes great developmental importance to the infantile omnipotence that emerges as a consequence of the interaction between the infant's lack of differentiation between self and maternal object (hence the term selfobject) on the one hand, and rapidly developing motor skills on the other. The child takes exhibitionistic delight in showing off its burgeoning developmental skills to an admiring selfobject (First mother and later father and other people.) If the primary selfobject spontaneously delights in the child's grandiose gestures and expresses unambiguous admiration and encouragement then the child experiences him/herself as "the gleam in the mother's eye." The admiring selfobject mirrors the child's grandiosity and so makes him/her feel special, competent and loveable. What then happens is that, through a process of gradual disillusionment resulting from the realistic limits of maternal devotion, the admiring selfobject is internalized and transformed into a nuclear self-structure. [3] This structure comprises both feelings of self-esteem and competence and realistic ambitions of success and mastery. Kohut calls this process **transmuting internalization** because the role previously performed by a selfobject is now performed by an internal self-structure which provides internal resources of self-esteem and

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[3] Kohut's understanding of this process is almost identical to that of Winnicott who understands ego differentiation and growth as resulting from the benign failure (optimal frustration) of the good enough mother to perfectly meet every infantile need.

hence positive self-representations. When this self-structure is consolidated and stable the person's ongoing self-esteem is not dependent on a constant supply of external praise and admiration and s/he does not need to behave in a grandiose or exhibitionistic way. This is not to say that the healthy adult does not need recognition and respect. We do need periodic affirmation from others, particularly when feeling uncertain or despondent about ourselves. However, our self-representations remain largely positive in flavour and fairly resilient to life's vicissitudes. But if for some reason the selfobject fails to admire or mirror the child's grandiosity then transmuting internalization cannot occur and the appropriate self-structure fails to develop. The child becomes fixated at this developmental juncture and remains chronically dependent on constant external supplies of admiration in order to feel appreciated, loveable and worthwhile. The self-representation becomes predominantly negative and the child uses the defense of splitting to externalize i.e. project this "bad" self-image and compensate for his/her consequent hollow psychic interior by grandiose fantasies of power, wealth, knowledge etc. Life revolves around a constant greedy search for selfobjects to bolster one's chronic self-deficiency against the omnipresent threat of split-off negative self-perceptions. The latter are projected onto others, resulting in the narcissist's perception of others as being weak, inferior, stupid, boring etc.

The second component of this nuclear bipolar structure derives from the infantile need to not only be admired by a mirroring selfobject, but also to **idealize and identify with a selfobject perceived as omnipotent**, good, perfectly nurturant etc. This idealized parental imago is experienced as gratifying, soothing and containing. The idealized imago is gradually modified through experience of parental limitations and becomes internalized as the nucleus of an embryonic superego. This in turn matures into a system of moral ideals, values and a sense of conscience. If,

however, infantile object-idealization becomes traumatically deflated then the idealized parental imago cannot be internalized. Consequently a mature superego structure cannot evolve. This results in the narcissist's exploitativeness and conspicuous absence of moral values and conscience. It also accounts for the phenomenon whereby some narcissists experience accute guilt and shame. This occurs because the punitive archaic superego precursors have not been tempered and modified by an idealized parental imago and real experiences with affectionate selfobjects:

> "Unconsciously fixated on an idealized self-object for which they continue to yearn, and deprived of a sufficiently idealized superego, such persons are forever searching for external omnipotent powers from whose support and approval they attempt to derive strength." (Kohut 1971 pg 84)

The selfobject mirroring pole and the idealized selfobject pole constitute the two nuclear self-structures around which the embryonic personality consolidates. Kohut posits that a "tension arc" exists between the nuclei of ambitions (derivative of early grandiosity) and ideals (derivative of early object idealization). This tension mobilizes and directs the child's emerging skills and talents, performing a catalytic and guiding function. Healthy adults are thus driven by their ambitions and led by their ideals. Kohut further contends that if one of these two self-constituents is retarded by a deficient selfobject the resulting effect can be compensated for by the other constituent:

> "...if the exhibitionistic component of the nuclear self (the child's self-esteem insofar as it is related to his ambitions) cannot become consolidated, then its voyeuristic component (the child's self-esteem insofar as it is related to the child's ideals) may yet give it enduring form and structure." (Kohut 1977 pg 187)

In other words a child whose mother failed his/her need for

mirroring is not automatically destined for narcissistic pathology according to Kohut. The damage may be ameliorated by an empathic and caring father who is adequately internalized as an idealized parental imago. When narcissistic pathology does result, whichever self-constituent is deficient will determine the specific nature of the narcissistic phenomenology i.e. whether the deficit is expressed as a predominantly mirror-hungry or ideal-hungry personality style.

Whatever the specific developmental failure, Kohut clearly locates narcissistic etiology in deficient parental provision:

> "Similarly to Winnicott, disorders of the self in general are understood as environmental deficiency diseases; the caretakers have failed to allow the child to establish and slowly dissolve the requisite selfobject configurations which, through transmuting internalization, generate healthy structures within the self." (Greenberg and Mitchell pg 356)

The healthy bipolar self maintains its cohesiveness in two ways: firstly, from support derived from internalized selfobjects which provide ambitions, assertiveness and internal reserves of self-esteem (having been loved by external others one is now loved by internal objects); and secondly, from affirmative people who revive infantile memory traces of mirroring, soothing or guiding archaic selfobjects.

Kohut's model is one of the most detailed, comprehensive and influential object relations accounts of narcissistic pathology. His contribution, moreover, has not just been theoretical. He provides clinical accounts of his own therapeutic approach and reccommends, as does Winnicott, technical modification of the traditional interpretative technique. Because narcissistic pathology involves developmental arrest of the nuclear bipolar self psychotherapy is directed towards restoring the growth of the retarded self-structures. This is not effected primarily

through cognitive interpretation but rather by allowing the regressive selfobject transference to form and flourish. In this way, as in normal childhood development, the therapist allows him/herself to be internalized as the selfobject nucleus for self-structuralization. If successful, this benign regression in the service of structuralization culminates in healthy internal resources of self-esteem and the capacity to relate to people as others rather than as archaic selfobjects.

What Kohut has done is to formulate a developmental model that accounts for the process of self-structuralization and its pathogenesis in the form of narcissistic disorders. Furthermore, at the level of self-pathology he breaks entirely from classical instinct theory, not only in declaring the self to be the center of the psychological universe but also by undercutting the role played by sexuality and aggression in normal and pathological development. The notion of healthy selfobject relations acting in the service of self-structuralization replaces libidinal homeostasis as the fundamental objective of human life. Where sexuality and aggression emerge, in either childhood or adulthood, as apparently primary motivational determinants, they do so really as pathological "**disintegration products**" of frustrated self-development:

> "...initially the self does not seek tension reduction or instinctual expression but relatedness, attachment, connection to others. If there is a severe injury to the self and its relations, these primary constellations break down and there is deterioration to pure pleasure-seeking and rage. Thus, classical theory has made the result of severe psychopathology the building-blocks of its developmental psychology." (Greenberg and Mitchell pg 361)

It has been argued that this makes his dual-level model conceptually untenable, particularly with his increasing distance from classical drive theory. Kohut has been criticized by purist object relations authors (and classical theorists) for his

metatheoretical position. However, his cogent elucidation of the dynamics and treatment of narcissistic pathology remains impressive and influential. Although his work is clearly in the tradition of Balint and Winnicott, he has focused, refined and developed what was often only inchoate in their thought and extended it to provide a comprehensive formulation of self-development and deficiency without employing traditional metapsychology.

4.5 Otto Kernberg's model of narcissistic pathology

Kernberg has undoubtedly been the most systematic and prolific psychoanalytic author to write on the topic of self-pathology, specifically on narcissistic and borderline conditions. His theoretical position is rather unique. Like Kohut he believes that classical psychoanalytic theory is invaluable and should be retained. But unlike Kohut he does not want to restrict classical theory's application to neurotic disorders only. He believes that the classical model has relevance to our understanding of self-pathology as well. He is no Freudian however, his work is a conceptual hybrid of the traditional drive model and object relations theory. The latter, purged of Freudian metapsychology, does not provide a complete model of psychic functioning, argues Kernberg. Whereas Kohut restricts the application of classical theory Kernberg does the same to object relations theory by defining it as:

> "...a more restricted approach within psychoanalytic metapsychology stressing the build up of dyadic or bipolar intrapsychic representations (self- and objectimages) as reflections of the original infant-mother relationship and its later development into dyadic, triangular, and multiple internal and external interpersonal relationships..." (1976 pg 57)

Kernberg thus retains the concepts of drive, the topographic model, constitutional aggression etc. while integrating object relations developmental theory in order to account for narcissistic pathology. Kernberg describes the primary feature of narcissistic people as a "disturbance of their self-regard in connection with specific disturbances in their object relationships." This is clearly similar to Kohut's understanding but, unlike Kohut, Kernberg gives a very specific diagnostic profile of the narcissistic personality. (See chapter one). He describes them as being grandiose, egocentric,

emotionally shallow, envious, prone to idealization and depreciation, exploitative, volatile, cold, resentful and incapable of feeling any real sadness or depression. He also notes that although, on the surface, there seems to be a lack of object relationships, on a deeper level there exist very intense, primitive and frightening internal object relations. Comparing the structure of narcissistic pathology to that of borderline disorders he says

> "The defensive organization of these patients is quite similar to that of the borderline personality organization in general. They represent a predominance of primitive defensive mechanisms such as splitting, denial, projective identification, omnipotence and primitive idealization. They also show the intense, primitive quality of oral-aggressive conflicts characteristic of borderline patients. What distinguishes...narcissistic personalities from the usual borderline patient is their relatively good social functioning, their better impulse control, and what may be described as a pseudosublimatory...capacity for active, consistent work in some areas which permits them partially to fulfill their ambitions of greatness and of obtaining admiration from others. (1975 pg 215)

Like Kohut, Kernberg understands narcissistic pathology in terms of deficient self-development stemming from the child's inability to metabolize pathogenic internal object relations, and hence consolidate a stable nuclear self-structure. He defines the self as the "**sum total of self-representations in intimate connection with the sum total of object-representations.**" (1982 pg 900)

The development of the self begins in the following way. Early infantile development consists of the internalization and differentiation of rudimentary dyadic object relations units, each of which comprises three interrelated components:
The first of these is a **self-representation/image**. Because self-representations are formed only in relation to external objects the second component is the **object-representation/image**. The self- and object-representations are connected by a third

component, an **affective charge or "valence"** which is essentially a drive-derivative and hence either libidinal or aggressive in flavour. The prototypical object relations which form the building blocks of subsequent personality development are thus **semi-autonomous bipolar introjects** consisting of self- and object-images derived from contact with primary care-givers and connected by a positive or negative emotional charge. These simple object relations units are formed through the defensive process of splitting, whereby good and bad self and object-representations are kept apart. The infant's experiences with a single external object are thus split into antagonistic self-object units, each with a different affective valence depending on whether the experience felt gratifying (good) or frustrating (bad). Introjections taking place under the positive valence of libidinal gratification fuse and become organized into the **good internal object**. Introjections taking place under the negative valence of aggressive drive derivatives merge with similar negative introjects to constellate the **bad internal object**.

Introjection is later replaced by a higher level internalization mechanism, **identification**, which incorporates the role-related aspects of interpersonal relations e.g., a young boy does not simply internalize his emotional experience of his father, he also identifies with social aspects of his father's masculine role. This involves a clearer differentiation of self from other and a more differentiated, less intense emotional colouring. Although identifications begin towards the end of the infant's first year they only become fully developed during the second year of life.

The third and last stage in the organization of internalization processes, says Kernberg, is the level of **ego identity**, which refers to "the overall organization of identifications and introjections under...the synthetic function of the ego." (pg 362) This implies, firstly, consolidation of those ego structures

related to a sense of **self-continuity**, where self is understood to be the total organization of self-image components of introjections and identifications. Secondly, in addition to a stable organization of self-related internal structures there must be a complementary sense of a **stable object world** derived from the organization of the object-image components of introjections and identifications. This experience of one's object world as consistent and dependable in relation to oneself is vital for the acquisition of ego identity. A third prerequisite for ego identity is confirmation and affirmation of the child's characteristic interactions with his/her environment by care-givers.

The developmental outcome of normal identity formation is a sense of **stable ego boundaries** i.e. a high degree of self-other differentiation, a **rich internal world** comprising the depersonified internal presence of objects who were loved and admired in a realistic way, and the experience of the external world as an **inviting space** populated by people who are (potentially) trustworthy, caring and consistent.

In narcissistic disorders and all forms of self-pathology a stable sense of ego identity has never been consolidated because of a preponderance of pathological splitting, destructive internal objects and resulting poor self-other differentiation. "The persistence", says Kernberg, "of non-metabolized early introjections is the outcome of a pathological fixation of severely disturbed, early object relations." (pg 365)
Because introjections are the developmental precipitants around which ego nuclei constellate, their role in identity formation is crucial. The process of splitting, whereby bad introjects comprising self- and object-images are defensively seperated from the good introjects and projected outwards, is gradually given up in normal development, culminating in the "depressive position" which Klein outlined so well. In narcissism, however, although

fairly stable ego boundaries have formed, the presence of severely destructive bad objects and the relative absence of good objects means that the predominantly bad introjects have to be continually split off and projected. The result is a relatively empty, impoverished internal world where self-representations are unconsciously organized around negative self-images derived from destructive external object relations. Self-esteem is consequently very low and the narcissist's underlying self-experience is that of being small, weak, ugly, bad, empty, hateful etc. At this point the specifically narcissistic defensive configuration comes into existence. Whereas normal infantile development is characterized by progressive differentiation of self- and object-representations, narcissistic development involves a process of:

> "...**refusion of the self and object images**...at a level of development at which ego boundaries have already become stable. At this point there is a fusion of ideal self, ideal object, and actual self images as a defense against an intolerable reality in the interpersonal realm, with a concomitant devaluation and destruction of object images as well as of external objects." (Kernberg 1975 pg 216)

The unconscious rationale for identifying oneself with one's own ideal self and ideal object-images is to avoid or deny **dependency** on external objects or the internalized representations of these objects. The narcissist's unconscious logic is as follows: "I do not feel loveable for myself alone. The person who cares for me and whom I idealize will only love me if I am not small, vulnerable and needy. In order to avoid the threat of rejection I will become my ideal self (strong, attractive, independent etc). Not only will I identify with my ideal self but I will also identify with that idealized other person. In this way I can become completely self-sufficient and not need anyone."

The narcissist's grandiosity thus derives from an inflated self-

concept produced by the **defensive conflation of real self (the specialness of the child reinforced by some good early experience), ideal self (fantasies of perfection that compensate for the experience of oral frustration), and idealized object (fantasy of a perfectly nurturant mother in contrast to real experience of deficient nurturance) representations.** Furthermore, the unacceptable "bad" self-representations are split off and projected onto external objects who the narcissist then devalues.

A further consequence of this pathological conflation is that mature superego development is retarded. The normal superego comprises the internalized demands and prohibitions of objects as well as gratifying rewards and encouragement if these are adhered to. In this way the ego-ideal and the idealized object are integrated into an internalized and valued system of personalized ethics and standards. The primitive and punitive superego forerunners (the projection of infantile aggression onto the "bad" frustrating parent) are tempered and modulated by real experiences with nurturant parental figures. With the narcissist, however, the fusion of real self, ideal self and ideal object eradicates any tension between the real self (ego)and the ideal self and object (superego) and thus prevents superego maturation. Moreover, the punitive superego forerunners are not modified by contact with realistically good parents and thus remain projected onto external objects:

> "Although some superego components are internalized, such as prohibitive parental demands, they preserve a distorted, primitive, aggressive quality because they are not integrated with the loving aspects of the superego which are normally drawn from the ideal self and object images..." (Kernberg 1975 pg 217)

This explains the narcissist's typical moral corruptability, lack of conscience and generally paranoid fear of being harmed, humiliated or rejected by those who have power over him/her. (These characteristics are most pronounced in antisocial

personalities, the most severe category of narcissistic disorder.)

The narcissist experiences his/her relationships with others as exploitative, characterized either by **greed** (other people have nourishing resources inside which need to be extracted) [1] or by **depreciation** (other people are seen as already emptied and therefore worthless). This complex defensive structure is an elaborate protection against a split-off and deeply buried self-image:

> "It is the image of a hungry, enraged, empty self, full of impotent anger at being frustrated, and fearful of a world which seems as hateful and revengeful as the patient himself." (Kernberg 1975 pg 219)

In terms of etiological considerations Kernberg is rather non-committal as to the respective roles of constitutional and environmental influences. However, he does identify a coldly aggressive or indifferent maternal figure as common in the backgrounds of these patients. This mother figure performs her maternal role with superficial competence "but with a degree of callousness, indifference and nonverbalized, spiteful aggression." (Kernberg 1975 pg 220) As a result the child experiences intense emotional hunger, anger, resentment and frustration which initiates a process of defensive self-reliance and grandiosity.

Kernberg isolates further specific etiological features characteristic of the narcissist's early relationships. These people are often realistically endowed with special features or

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[1] The author's experience with one narcissistic patient supports Kernberg's emphasis on the oral dynamics underlying narcissism. The male patient in question was preoccupied with oral sexual fantasies and experienced a persistently intense "sexual hunger" for women which he experienced in his stomach rather than his genitals. I understood this to represent the sexualization of a predominantly oral need.

aptitudes which parental figures unconsciously envy or resent. These features then become a refuge against feelings of being unloved, unaccepted and resented. A third possible environmental cause involves the child being used to vicariously satisfy the parents' own narcissistic needs through the former's brilliance, beauty, talents etc and at the expense of the child's own needs. The mother's narcissistic world creates a predisposition for the child's "specialness" around which fantasies of grandiosity crystallize.

Whatever the specific etiology in each case it is clear what purpose the narcissist's defensive structure serves: to **prevent dependency relations** and the attendant greedy hunger, frustration and exploitation of the vulnerable archaic self-structure:

> "Once the kind of mechanism mentioned - defensive fusion of ideal self, ideal object, and self-images- comes into operation, it is extremely effective in perpetuating a vicious circle of self-admiration, depreciation of others, and elimination of actual dependency. The greatest fear of these patients is to be dependent on anybody else because to depend means to hate, envy and expose themselves to the danger of being exploited, mistreated and frustrated." (Kernberg 1975 pg 220)

Even when the narcissist idealizes another person and is apparently dependent on him/her, the reality of the relationship is usually that there is no relationship at all because the admired other is experienced merely as an extension of the narcissist's own self. Narcissists thus often begin therapy after being rejected by someone. The resulting empty depression and despair is not part of the normal process of mourning a lost relationship, but is rather a consequence of losing oneself because the other was experienced as a mirror to, or extension of, oneself and not as an individual in his/her own right.

Unlike Kohut, Kernberg emphasises envy as an important dynamic in

narcissistic pathology. Because narcissist's experience their interior as empty or bad they are enviously attuned to the fullness and goodness of others. To experience this envy is painful because it emphasises their own inner desolation. Devaluation of others thus serves the defensive function of denying their own envy. This places narcissists in a double-bind: they desperately need so much from others to fill up their emptiness but cannot accept anything because it induces envy of others. This simply reinforces the defensive self-sufficiency and denial of dependency needs.

Kernberg's explanation of narcissistic pathology may be summarized as follows: In the late oral stage of development the infant, having experienced a period of relatively adequate maternal provision and hence attaining reasonable self-other differentiation, now experiences intense oral frustration. This frustration may be due to an inordinate amount of constitutional aggression or it may be the product of deficient maternal care. Whatever the etiology the result is the subjective experience of deprivation felt and expressed through the oral modality as aggression, hatred, greed and envy. The preponderance of these negative experiences results in excessive splitting of both object and ego and the projection of aggressive phantasies onto external objects. This excessive splitting and projection results in a denuded and impoverished internal world expressed in feelings of emptiness, loneliness, coldness, ugliness, chronic inferiority and envy of others. The specific defense against this chronic emptiness, inferiority and envy takes the form of a regressive fusion of real self, ideal self and ideal object after ego boundaries have become consolidated. This defensive fusion serves two primary purposes: firstly, it results in a compensatory grandiose self-representation that denies the underlying negative self-representation of hollowness, inadequacy, badness, envy, hunger etc. Secondly, it abolishes dependency on an object world perceived as depriving, rejecting,

hateful and unloving. The end result is a defensive grandiose and self-sufficient self-representation which hides an impoverished internal world ruled by chronic hunger, oral dependency, envy and rage. These underlying feelings are split off and projected onto external objects who are consequently depreciated.

Kernberg, more than Kohut, emphasises the subjective experience of emptiness that is a central feature of narcissism. Narcissist's often complain of emotional numbness, bored restlessness, blankness, hollowness, meaninglessness and the feeling of being only half alive. Kernberg attributes this to the narcissist's denuded internal world:

> "The subjective experience of emptiness represents a temporary or permanent loss of the normal relationship of the self with object representations, that is, with the world of inner objects...that constitutes a basic ingredient of ego identity...when there exists a lack of an integrated self and of normal relations of the self with integrated internal objects, a deep-seated, chronic sense of emptiness and meaninglessness...ensues. In narcissistic personalities, where the normal relations between an integrated self and integrated internal objects are replaced by a pathological grandiose self and a deterioration of internal objects, the experience of emptiness is most intense and almost constant." (Kernberg 1975 pg 220)

Although Kernberg and Kohut agree on the phenomenology of narcissism and the notion that the central feature is a deficient self-structure, they differ in the following important respects:

1. Firstly, Kohut defines narcissistic cathexis not in terms of its object (either self or other) but in terms of the nature of the ensuing transference which is either idealizing (the therapist serves as an idealized selfobject) or self-aggrandizing (the therapist serves as a mirror for the patient's grandiose self). Kernberg, in contrast, defines narcissistic cathexis specifically in terms of its object i.e. the grandiose self-

representation.

2. Secondly, while Kohut attributes narcissistic pathology to the developmental arrest of **normal** phase-specific narcissistic selfobject relations, Kernberg contends that narcissistic dysfunction represents an actively pathological distortion of psychic structures and object relations that is not part of normal development. Pathological adult narcissism and normal infantile narcissism are two entirely diffrent phenomena. Pathological narcissism involves a grandiose but deficient self-structure which is a defense against emptiness, rage and envy which are not typical features of normal child development.

3. Thirdly, whereas Kohut believes that narcissistic fixation may occur as late as pre-adolescence, after a period of normal development, Kernberg argues that narcissism has its genesis in the late oral stage of infantile development. This accounts for Kernberg's descriptive emphasis on oral metaphors in narcissistic functioning e.g. hunger, greed, oral aggression etc. Both theorists emphasize maternal deficiency as a primary etiological factor, although Kernberg entertains the notion that excessive constitutional aggression may play a causal role.

4. Kohut and Kernberg differ on the issue of classifying narcissistic pathology. Whereas Kohut makes a clear distinction between narcissistic personality disorder and borderline pathology Kernberg classifies NPD as a subtype of borderline disorder, distinguished from BPD by a fairly integrated, though pathological grandiose self. The narcissist employs borderline defenses such as splitting, idealization, devaluation, projective identification etc as well as sharing many borderline symptoms.

5. Kohut sees narcissistic aggression as a reactive product of environmental frustration and only a secondary feature in NPD. Kernberg, on the contrary, sees oral aggression/rage as a primary

feature of narcissism and understands this in terms of instinctual derivatives. The ghosts of Freud and Klein are constantly present in Kernberg's metapsychology but Kohut has, in the area of narcissistic disorder, exorcised practically all traditional metatheoretical residues.

6. At the level of clinical practice Kohut emphasises empathy rather than interpretation and the tolerant facilitation of selfobject transferences. He counsels clinicians to allow the idealizing and mirroring transferences to emerge and grow in order to foster the original transmuting internalization that was arrested at an early age. Kernberg, on the other hand, perceives these selfobject transferences not as normal (arrested) developmental phenomena but as pathological defenses against infantile rage, hatred and envy. The transference phenomena are thus impediments to therapeutic change and should be systematically interpreted in order to access the underlying oral aggression.

The debate between Kohut and Kernberg is not simply metatheoretical insofar as their respective conceptual frameworks, to an extent, determine not only what they see psychodynamically but also how they act as clinicians. Their basically irreconcilable conceptual models have both contributed significantly to our understanding of narcissism and have provided an arena for lively debate.

Chapter summary

This chapter was devoted to a selective literature review of object relations authors who have made significant contributions to our understanding and treatment of narcissistic disorders. We began by looking at the early contributions of Balint and Winnicott. The value of Balint's work centers on his metaphor of the basic fault, a rich description of the phenomenology of

narcissistic injury. It was then argued that, although the two theorists have much in common, Winnicott provides a more comprehensive theoretical model of self-pathology revolving around the cardinal concepts of transitional space and false self development. Although Winnicott and Balint were theoretical pioneers in the field of pre-oedipal pathology they had little to say about the specifics of narcissistic disorders. To this end we turned to Kohut and Kernberg, the two most influential modern experts on narcissism. Kohut's split-level model focused on the arrested development of the bipolar self and the resulting primary deficits in self-structuralization. This is expressed in self-aggrandizing or idealizing selfobject relationships where other people are needed to perform functions (particularly self-esteem regulation) that cannot be performed by the person's own underdeveloped self-structure. The remainder of the chapter concerned Kernberg's mixed model explanation of narcissistic dysfunction which centered on the defensive role played by the grandiose self-representation formed by the fusion of real self, ideal self and ideal object in order to deny object-dependency and chronic underlying feelings of emptiness, greed, rage and envy. The chapter concluded with a brief comparison of Kohut and Kernberg and the argument that their incommensurate theoretical paradigms have both advanced our understanding of narcissism.

CHAPTER FIVE

A PSYCHOTHERAPEUTIC CASE STUDY OF NARCISSISTIC DISORDER

5.1 Introduction

This chapter explores the phenomenology, structure and psychodynamics of narcissistic pathology, drawing on a single short-term depth psychotherapy conducted by the author while completing his clinical psychology internship at Rhodes University psychology clinic. It includes diagnostic considerations, highlights of the patient's history and the presentation of significant extracts from each session. Detailed discussion of the therapeutic material is not included here but appears in the discussion chapter (chapter six).

5.2 Identifying data

Dianna (a pseudonym) was a twenty-six year old university student who returned to Grahamstown a number of years after completing a BA degree in order to pursue graduate studies in journalism. She had spent the last few years working in commerce. Although successful in this field she felt unfulfilled. Although uncertain about an alternative career choice she intended studying nature conservation after completing her journalism diploma, a qualification she believed would have practical use in a conservation career. She lived alone, was unmarried and not involved in a sexual relationship at the time.

5.3 Presenting problem

On her clinic application form the patient cited her problem as follows:

> "I have been suppressing something from an early age which has subtle but distinct ramifications in every area of my life and undermines me. I have built up a wall against it which I am tired of papering. I would like assistance to identify and confront it and put it behind me. I have tried alone but ultimately end up papering cracks again. I've experienced this for as long as I can remember, although conscious awareness of it has been intermittent since the age of sixteen."

Elaborating on this during the assessment session she described experiencing "**a parting of the vale and seeing something scary but not knowing what it is.**" She added that it was something "**which I'm subliminally aware of, something deeper than the normal surface crises.**" She felt that it related to the issue of self-confidence, to a dim but tangible awareness that her self-image had been seriously undermined at some early age. She said she was becoming increasingly aware of "**a fragility, an insubstantiality underlying my surface confidence.**" She wondered whether the fact that she had been sexually molested by a family friend at the age of three or four was not the source of her presenting problem.

She added that in situations in which she felt vulnerable she would adopt an attitude of superiority, "**a brittle dogmatic confidence**" that she was increasingly coming to recognize as a front. She was very sensitive to criticism and did not deal with it well because criticism made her painfully aware of her underlying fragility. Her usual response to criticism was either to lash out or withdraw resentfully from the encounter. It was particularly confrontational situations that alerted her to this fragility. An innocuous comment by an acquaintance on her rather spartan living conditions (she had very few material posessions and liked to feel that she could pack everything she owned in her car and leave at a moment's notice) had an unusually strong impact on her. Her spartan life-style suddenly felt like a "failure" on her part for which she felt guilty. She wasn't sure

what her guilt was about but felt that it had something to do with a vague feeling of "**having in some way failed myself.**"

Another aspect of her presenting problem was that "**I seem to be perennially sarcastic in response to surface compliments. Compliments about external appearences are not important, I need to have compliments about my self.**"

As can be seen from the above her presenting problem was rather vague and shadowy. She did not feel depressed or anxious and did not exhibit any of the usual neurotic symptomatic indicators.

5.4 Personality

"**How much time do I have?**", she laughed in response to my question of how she sees herself. "**I'm a funny mixture of the gregarious and the solitary. I enjoy my own company because it places no demands on me. Others think me eccentric. I don't fit in with going trends, I don't run with the pack.**"
She was very outdoors-oriented and said she was happiest when she was out alone in the bush. She would frequently grab some camping gear, jump on her motorcycle and just take off at a moment's notice for anywhere, hiking and sleeping alone in the veld. Sometimes, frustrated by Grahamstown's lack of stimulation, she would drive miles out of town at night and, after parking her car in a deserted spot, turn up the volume of her car sound system and dance alone outside her car.

She claimed to be " **excited by little things - new leaves, rays of sunshine.**" She said she had "**a very dry sense of humour that verges on caustic.**" She had always felt herself to be rather unique and felt ostracized by other kids at school because "**they could never understand what I had to say.**" Her mother, however, attributed her lack of belonging to a "**haughty attitude.**" She said that although she had the highest IQ in her class she never

lived up to her intellectual potential potential, much to the exasperation of her teachers.

She always had the feeling that she never really fitted into things, that she was somehow left out. She never had many friends although she always ensured that she had one friend at any one time. For as long as she can remember she had always been very self-sufficient, relying on herself for everything.

She described herself as being " **a sympathetic person, although that's not as noble as it sounds. I would always find people with hang-ups and want to fix them. I guess I needed to be needed- its an ego thing**"
In spite of her apparent confidence she said she had always had a sense of "incompleteness" which she found strange because of her extraordinary self-reliance.

She described moments of intense happiness or excitement and was aware of a secretive inner essence which she called "**the silent passion.**" It was silent because it did not have an outlet and she felt afraid of it being exposed and ostracized. Its only expression was in the poetry she wrote. She said it was passion in its purest form - that of intense feeling.

5.5 Personal impressions

The tone and style of her clinic application told me that Dianna was an unusual person. Her appearance and manner confirmed this impression. She was an imposing presence. She was a very tall, long-limbed and attractive woman who dressed very casually and wore her hair long. She didn't walk but rather sauntered into my office with a studied nonchalance, draped herself languidly over the chair and stretched out her legs without any sign of anxiety or tension. She leaned back in her chair, gazed slowly and appraisingly around my office with an ironical half-smile on her

lips and commented critically on the "**perceptual pollution**" of the sound-proofed walls and the curious taste evident in my choice of pictures. "**They're very childish, not the sort of pictures I would hang on my walls**", she said condescendingly. Taking her time she collected her thoughts and began to speak in a slow, lazy American drawl. She sighed dramatically, laughed lightly and spoke in an almost bored tone, choosing her words with a thoughtful and articulate precision from an impressive vocabulary. I felt like a member of an audience about to watch a theatrical performance by a celebrated actress. From the start it was clear that she was directing the interview. I had to hastily thrust my questions into the infrequent pauses in her impressive verbal flow. I felt small, self-conscious and vulnerable as she responded to my questions with an expression of wry and often surprised amusement. I chose my words carefully while she processed them, gazing steadily at me without blinking. She asked me a lot of personal questions and laughed at my evasiveness. I was aware that she was assessing me at the same time as I was assessing her. She began our second session by asking whether we could do therapy in the botanical gardens which my office overlooked. When I said no she asked whether she could sit in my chair for a change. I felt that she was testing me, tring to see to what extent she could control or influence me. At the end of our first session she inquired whether I was suffering from a hangover as I looked "**all pale and wan.**" In spite of her critical, taunting and condescending attitude a degree of idealization was present from the start: "**I came to the clinic because I'd heard so much about you personally.**" She requested, if accepted, to see me personally because, by the end of the interview she claimed to trust me more than she would be able to trust another therapist.

5.6 <u>Highlights of personal history</u>

Rather than listing purely factual details of the patient's life

I will present a number of anecdotes that capture the atmosphere of her life and her family relations.

Dianna is one of three children, the only daughter in the family. She has a younger and older brother. Her parents are divorced and both are remarried.

She was a solitary child who always felt that she was rather special. Her father only wanted a girl and wouldn't even go to the hospital to see his first child because it was a boy. "I was my daddy's pride and joy." She described her father as being "a clown, rather immature and not very strong, although he had a good sense of humour."

She described her mother as being a "matriarch", strong and domineering. She is a frustrated but talented artist who was pushed by her family into an architecture career and who has held down two concurrent full-time jobs for the past fifteen years. Dianna says that the children "are the reason for my mother's existence and she's made a lot of sacrifices for us." The world presented to Dianna through her mother's eyes was one of perpetual strife. She remembers her mother constantly telling her: "You must fight your own battles because you're on your own and no-one will fight them for you." Although devoted to her children Dianna experiences her mother as remarkably insensitive: "Although there is still that atavistic bond I can't trust her with my feelings." This feeling was so strong that she still recoils if her mother tries to hug her. Her mother had always accused Dianna of being too dreamy and oversensitive. She had ambitious fantasies about her daughter one day becoming a great writer and making lots of money for the family. Dianna, however, felt that "I was not able to express something because my mother dismissed a lot of what I said as being oversensitive, the product of a wild imagination."

Dianna remembers being caught in the middle of a fierce marital quarrel one day. Her mother called Dianna's brothers to her and Dianna was left standing between her parents. Her mother told her to come to her and Dianna realized that if she did the whole family would be standing against her father. She felt torn but eventually went to her father's side. Out of gratitude he bought her a large chocolate easter egg. When she brought it home her mother smashed it against the wall and Dianna recalls her and her father picking up the chocolate fragments.

The marriage was conflict-ridden and she says she was born with the insight that there was a lack of bonding between her parents, that they did not marry for love.

Dianna said that when she was a child she lived in "**a mist of dreams and books**" which she used as a form of escape. At the age of five, while taking her younger brother to nursery school, "**I suddenly felt sad and realized that my childhood was over.**"

She fought a lot with her brothers and defended herself against their superior physical strength with her verbal aggression. One day, in a moment of malice, she decided to start a fire in her brother's toy box beneath his bed. Having done so she left the room and carried on reading. The room caught fire and the fire brigade was called in. Dianne felt no remorse and remembers "**enjoying the high drama of it all.**"

Her parents were divorced when she was thirteen years old and both remarried within six weeks of each other. Dianna stayed with her mother and so inherited three step-siblings who she did not get along with. Nor did she have a good relationship with her step-father: "**He used to play psychological mind games with me.**" She coped with her unhappiness by withdrawing and overeating, something she still does periodically.

Between the ages of sixteen and twenty-two she went through a long period of "solid depression". She was moved from a school where she feels she would have been made head-girl to an up-market convent where she felt very alienated. During this period her mother would tell Dianna about all her problems and Dianna became her mother's only confidante.

After leaving school she came to university to study law. It was a traumatic time for her: she became involved with a notorious campus political reactionary who was extremely disturbed. When she tried to extricate herself from the relationship "**he set out to systematically destroy** me." During this stressful period her mother got divorced for the second time. She says that all that kept her going during this time was her Christian faith and a very close male friend, both of which her mother vigorously attacked. It was in this year that she lost her virginity. This horrified her because her mother had told her that she was the only virgin left in the family and therefore responsible for upholding the family honour. Feeling that she'd betrayed her mother she experienced severe guilt for a period of three years. One night the accumulated stress got too much:
" **I started to go numb. I felt I was in a grey cotton cloud, seperated from other people. I felt guilty, laden and responsible. I was unable to get angry.**"

During her third year at university she got engaged to a man who went overseas and who she did not see for the next eighteen months. She eventually realized that she did not want to get married and ended the relationship. During this period, she says, " **I started to build myself up again.**" Her life after this until the present has been relatively stable except for the continual effect of her presenting problem.

5.7 Preliminary diagnosis

At the end of the assessment session I felt relatively certain that Dianna's problem was essentially narcissistic. My reasons for suspecting this were as follows:

1. The presenting problem involved an inner fragility, incompleteness and insubstantiality underlying a rather grandiose exterior. Her extraordinary self-sufficiency concealed a chronic lack of self-confidence. This, as the literature suggests, is the leitmotif of narcissistic pathology.

2. Her hypersensitivity to criticism and tendency to lash out or withdraw in response is another characteristic narcissistic feature.

3. For all her life she has experienced herself as being special, unique and more intelligent than those around her. This "haughtiness" alienated her from other people and clearly affected her interpersonal functioning.

4. The biting quality of her self-confessed sarcasm indicated a veiled aggression. The extent of this aggression was hinted at by her deliberately setting fire to her brother's toy box. Her pleasure in the "high drama" of this occasion, together with the absence of any guilt suggested deficient superego functioning characteristic of narcissistic disturbance.

5. Her behaviour in the initial interview had a definite narcissistic quality to it. She was subtley critical, taunting, controlling, condescending and exhibitionistic. At the same time elements of idealization were present.

6. My countertransference response to her was unusual for me and possibly diagnostically meaningful. I felt small, vulnerable, defensive and evasive. These are often shadow qualities of the narcissistic person and I wondered if I was registering her own

underlying self-representation.

After the interview the above features, together with the long-standing duration of the problem, pointed toward a diagnosis of narcissistic personality disorder. No other diagnosis appeared to warrant serious consideration.

In spite of the fact that short-term depth psychotherapy with narcissistic patients is contraindicated I decided to accept her as a therapy patient, even though therapy would end after only four months owing to both patient and therapist leaving town. My reasons for accepting her were as follows:

Firstly, in spite of her grandiosity and self-sufficiency she was consciously in touch with her underlying vulnerability and insubstantiality. The felt tension between her external facade and her internal experience, together with her desire to understand the meaning of this tension rather than simply abolish it, were healthy prognostic indicators.

Secondly, she'd attempted for many years to master these egodystonic feelings by herself. Now she was acknowledging that she was not after all completely self-sufficient, that she could only be healed with the aid of another person. This partial surrender of narcissistic independence was another healthy indicator.

My third reason for accepting her is less easily articulated. It had to do with the quality of our contact. What struck me most about my previous limited experience with narcissistic patients was their coldness or indifference and my experience of them as emotionally unavailable and far away. Dianna was rather different. She brought with her a tangible energy, an aliveness and vitality that, even though narcissistic in expression, made her feel somehow substantial and three-dimensional. Instead of

the typical narcissist's solipsistic withdrawal from external relationship, I experienced a very definite and strong sense of contact, of being in relationship with her. Interpersonal style or, more accurately, the atmosphere or feeling tone created by a patient, is often a more reliable diagnostic indicator than the presenting symptom profile. Although Dianna's symptomatology and dynamics appeared expressly narcissistic she was clearly not a typical case of narcissistic personality disorder. I found this anomaly both intruiging and hopeful even though it presented an immediate diagnostic dilemma. I felt that any clear-cut diagnosis would be ex post facto, emerging only as the therapy unfolded.

Her expectations of therapy were modest - she wanted help in exploring this other side of herself which she'd pushed aside for so long. All the above suggested that she could possibly benefit from psychotherapy, even in the short-term.

5.8 Psychotherapy

Sessions two and three

Psychotherapy began with a very definite focus, the disturbed relationship between Dianna and her mother. This was hardly surprising. Dianna's description of her mother in the assessment interview had made me feel horrified, angry and sad even though Dianna described her and their relationship in an unemotional and matter-of-fact way. I felt tears in my eyes when Dianna described the episode of her mother shattering the chocolate easter egg. When I questioned the detached manner in which she described the event Dianna shrugged and said she'd come to terms with it. I realized, though, that this destructive dyadic relationship would inevitably be the crux of Dianna's difficuilties and that my horror, anger and sadness would need to become her own at some point in the course of therapy. At the end of the assessment session I already knew a lot about her mother, who had

immediately become a very real presence for me, arousing a lot of strong negative emotion that Dianna did not apparently feel. My early impressions of Dianna's mother may be summed up as follows: Firstly, she is clearly a very powerful and domineering figure who was the source of authority in the family. Father, being a weak and childish man was not able to check or counteract her influence - the family system was clearly matriarchal. Secondly, mother is also a talented and creative person whose artistic potential has been frustrated by a career (architecture) into which she was pushed rather than guided. Thirdly, in Dianna's words, the children were the reason for her mother's existence and she'd made many sacrifices for them, holding down two full-time jobs in order to see to their material comfort. This apparent maternal devotion emerges as extremely pathological in the light of her fantasy of Dianna one day becoming a great writer and making lots of money for the family. This fantasy, together with the belief that the family honour depended on Dianna's virginity suggests that Dianna was the vechile for her mother's own grandiose and frustrated ambitions and values and that she hoped to vicariously satisfy her own unrealized needs through the life of her intelligent and talented daughter. This, together with her insensitivity, volatility, destructive anger and domineering presence is the characteristic profile of a narcissistic personality.
Fourthly, mother's narcissistic committment and devotion to her children would probably have masked her destructiveness, thereby making it hard for Dianna to get angry with her without feeling considerable guilt.

These were my initial impressions of Dianna's mother and it didn't surprise me when Dianna began therapy by saying that although she wanted to tell her mother about herself and about starting therapy but couldn't because she felt that her mother would be hurt, take this as criticism and respond in her typical way by lashing out rather than listening. Dianna's mother was

leaving shortly on an overseas trip and Dianna said: "**Air travel isn't as safe as it was. If anything happens I want to have sorted this out.**" The unconscious derivative I heard in this communication was the repressed phantasy or wish that her mother would come to harm. I did not articulate this and Dianna carried on to relate an incident that had happened when she was a child of six. For some reason unknown to her she felt that there was going to be a drought and that she needed to collect water. When she went to her mother to ask for bottles her mother had laughed at her, leaving Dianne feeling very hurt. I understood this to be a symbolic communication that **the child had felt insecure about her mother's love and feared that her already meager supplies of nurturant affection might dry up or be withdrawn, leaving her internal world parched and barren.** Instead of taking the child seriously Dianna's mother had laughed at her, thus confirming her phantasies. I did not interpret this either but instead picked up on the theme of destructiveness by asking whether Dianna felt somehow afraid of harming her mother. She confirmed this and said "**my huge indomitable mother has become much weaker since her children left and she no longer has anything to defend.**" Later on she asked whether I, as a therapist, found myself affected by absorbing my patients' "negative vibes." Making the connection between an earlier statement of hers about wondering whether anyone would be there to catch her if she fell, and the present phantasy of hurting her mother, I interpreted her fear that I might not be strong enough to handle her destructive feelings or hear the underlying frustrated plea for genuine caring which her mother had ignored. "Yes", she said, "its a question of trust."

Session four

Dianna began session four by saying that the previous session had not been very productive. She felt she had to find the incidents in her past responsible for the way she was feeling. But, she said, she'd already analyzed her past on her own and rationalized

the various events. There was nothing she did not understand, so why was she still not in control of her life? What more could she possibly do? Her intellect was even more formidable than I'd originally suspected. She generated theories and hypotheses about her life, expecting praise or at least encouragement for her efforts. To her intense frustration I did not provide any. She would arrive at each session with a handful of type-written notes she'd taken between sessions. The notes contained intellectual ruminations and "promising" clues to unconscious childhood memories she felt sure she must have repressed. She got annoyed with me when I suggested that **for her therapy would be about not knowing and not understanding.** I had noticed that periodically, when a "hot" topic arose her eyes would become moist. Her response on these occasions would be a manic flurry of intellectual associations to the topic broached. When I pointed this out to her she said "**I don't cry in front of other people. I should be able to sort this out by myself.**" When I interpreted her need for intellectual control and independence she said this was very necessary because "**I can't expect anyone to catch me. That's too much to expect and, besides, I don't know anyone strong enough.**" It occurred to her that right throughout her life she had always needed to have someone to protect in some way. This, she felt had something to do with her fear of being out of control. It emerged that as long as she was protecting someone else's vulnerabilities she could feel less vulnerable herself and thus more in control.

Session five

Session five began with her recalling an incident that happened when she was at Rhodes for the first time. She was staying with a friend and feeling rather fragile at the time. When the friend hugged her she felt "a dam burst" and she sobbed uncontrollably. After that incident her friend had remained distant. Dianna felt she must be thinking "**You're not the person I thought you were.**"

I made the interpretation that although she was feeling fragile she could not let go for fear that I might not hold her, but rather withdraw because she wasn't as strong as the image she presented. "Yes", she said, "I don't know what I can expect and what I have a right to expect from you if that happens again...What happens if I break down five minutes before closing time. Will you kick me out? Do I have to time my break-down to fit in with the limits of therapy?"

This session was significant because, for the first time, her neediness and dependence on me had become apparent. Up until now Dianna had used me simply as an audience for her intellectualized attempts to gain mastery over her life. She had previously referred to her perception of my role by saying "I need you because two brains are better than one." Now, however, I was no longer merely a cerebral assistant but someone she wanted to care for her, to hold her and not reject her if her brittle shell of competence cracked. Although she felt that I, because of my professional training, might do a better job than her friend had done, she feared that I might just try to console her with psychological platitudes.

She added that although she trusted me instinctually, "all I have to go on on an intellectual level is that you have a crochette-hook mind." To trust me completely, she said, she would need to feel that I was her friend and not just doing a job.

She concluded the session with a powerful and evocative metaphor: "I feel like a broken limb that has healed but hasn't set properly. I need to have it broken again - but then I'll need a crutch."

Session six

By this time my initial impressions of Dianna had to be considerably revised. As detailed in the previous chapter the hallmark of narcissistic object relating is the attempt to avoid any intimate relationship with the object in order to deny

the dangerously intense underlying dependency needs and maintain the grandiose self-representation. In Dianna's case, however, the initial narcissistic self-reliance and avoidance of dependency on me had rapidly dissipated to reveal an intense desire for intimacy and support. I was surprised by how quickly this had happened and felt apprehensive about the extent and nature of her demands. In order to preserve the therapeutic frame I could not become her friend or give her extra time if she became very upset towards the end of a session. I knew that in this sense I would inevitably have to fail her. Because of my own unresolved personal issues in this regard I felt uncomfortable and guilty about the necessary limitations on what I could offer her. I also felt afraid of her anger. I took Dianna's emerging apprehension of her own destructiveness very seriously and questioned my ability to withstand it. The fantasy I had was of being cut up or lacerated. This rather extreme countertransference response was puzzling. Was the fantasy more the product of something unresolved in myself or was I picking up on a surface derivative of an underlying sadistic rage expressed obliquely through Dianna's cutting sarcasm? Even though the vulnerability could be glimpsed with increasing frequency beneath the tough facade, there were occasional moments when her cruel cynicism made me flinch inwardly.

Dianna arrived for session six saying that she'd recently had a dream which had left her feeling angry, disappointed and betrayed. It was an unusually vivid dream and she'd woken up with her body completely rigid. The dream was as follows:

> "I'm in a large enclosure with fences around it. There is a caravan in the corner and the enclosure has the feeling of a temporary settlement - like a building site. I'm there with a man I've contacted before but who I don't know very well. He used to be a chef and is telling me about his experiences. I've come to him to talk about a problem. We leave the corner where there is something like a beerstube going on. We walk to the end of the enclosure and sit beneath a small tree that

> doesn't give much shade. The trunk is gnarled and twisted and it doesn't have many leaves. I'm busy telling him my problem when suddenly he puts his arms around me and kisses me. I'm very surprised but not displeased. Just then a male acquaintance of the chef arives and begins telling him about a woman who has been giving him a hard time. I realize that the chef knows the woman and has had something to do with her in the past. This man leaves. Then a short, dark, heavily made-up woman arrives. I realize that this is the woman they were talking about. She starts telling the chef about a problem when suddenly he leans over and kisses her just as he did to me. He tells me that he kissed her simply in order to help her. Then yet another woman arrives and I leave through a door which closes behind me. I try not to imagine what the chef is doing with the woman behind the door. I feel angry and betrayed by his infidelity. I thought that his kiss indicated some personal caring but now realize that it was just a meaningless gesture."

This dream was very meaningful in the context of the previous session in which she'd felt frustrated by her feeling that my professional role set limits and called into question whether she could really trust me, given the fact that our relationship was a professional one. In her dream she comes to a chef for help. A chef's professional role is to feed and nourish people - an oral metaphor for the therapist's provision of symbolic nourishment. But Dianna sees him in a temporary enclosure which will soon be dismantled. This is an obvious reference to thr transience of the therapeutic space and our relationship. Together they walk to a gnarled tree. The latter reminded me of something she'd alluded to in the last session - she'd felt like a limb that had been broken and set crookedly, needing to be broken again in order to heal properly. The twisted tree in this instance was a possible reference to the narcissistic injury she'd suffered and hence her negative self-representation. At first she interprets the chef's kiss as an affectionate, caring gesture. But when she sees him kissing other women in order to help them - a reference to my seeing other patients - she feels betrayed, hurt and angry. My apparent tenderness and caring is not sincere but just a

technique, a stategy to make patients feel better. My interpretation of this dream left her feeling shaken. She said she was very scared of becoming dependent on me. All her life she'd been extremely independent, cultivating relationships in which others were dependent on her. She concluded the session by saying that she'd recently had the strange thought that **she needed to protect me from herself.** I felt deeply moved and close to her in her vulnerability.

Session seven

The dream of the previous session was distinctly erotic in flavour and indicated the emergence of a sexualized transference. Dianna began the seventh session by openly discussing this. She said she felt attracted to me on a "personal" level but that this was interfering with therapy because she was starting to have spontaneous erotic fantasies about me between sessions. She said she'd decided to "**split you into a person, on the one hand, and a professional on the other, and to push the personal part away in order to relate only to the professional.**" I interpreted this as a defensive strategy to avoid the frightening and perhaps uncontrollable needs that might emerge if she related to me as a person rather than a professional. Her reply to this was: "**I found out that you're seriously involved with someone, and I don't go around stealing other women's men.**"

Session eight

Session eight was devoted to working on two dreams which she'd had after last session. The dreams were as follows:

> Dream one:
>
> "I'm going on a trip back to Grahamstown on my motorbike. For some reason I'm taking along a cat and a white rabbit. (The rabbit will one day grow big and the idea is that I'll be able to use it for transport.) For

some reason I don't take the usual road but go straight up the side of a mountain that is very steep and rocky. Night is falling and I realize that I won't make it to Grahamstown before dark. I find some sort of building and go inside. I take out the cat and the rabbit. They have completely opposite personalities. The cat is friendly and affectionate but the rabbit is very scared and nervous and is looking for a place to hide. I find a place to put the scared rabbit and look outside. Way below me I see the road I should have taken. Now I have to go all the way back again in order to get onto the easier road."

Dream two

"I've been away from Grahamstown for quite a few years and have come back. I'm living in a flat with a nice garden. I meet you again and you come to my flat to give me therapy. You look older and weatherbeaten like the man in the Camel advertisement, sort of travelled and macho. You arrive with a bag of Africana. What catches my eye are two African-looking ornamental knives. You feel quite aloof and distant. The crossed knife blades somehow add to your air of aloofness. We sit down to do therapy but keep getting interrupted, first by a group of black urchins and later by a group of old men. You get irritated and say something about not being able to do therapy like this and leave. You come back later in a better mood, but instead of therapy we sit down together and start doing a cross-word puzzle from a women's magazine.

Both these dreams are rather complex. The following aspects, however, stand out:

Dream one:

The therapeutic journey is perhaps represented by the steep and rocky path up the mountain. The two animals are both probably aspects of herself that are presently unlived possibilities, not yet fully integrated into her life. The rabbit is particularly interesting as it symbolizes the weak, frightened, inadequate self-representation manifest in her presenting problem - that side of herself hidden behind the grandiose persona. Although the

rabbit needs to be hidden at present, it will one day grow big and become a means of transport i.e. psychic growth and movement. This shows Dianna's unconscious realization that therapeutic growth will emerge from her underlying vulnerabilty rather than from her egoic strength. However, the dream ends with Dianna abandoning the difficuilt mountain route in favour of a more familiar and easier road. Did this mean that, at some level, she was not prepared to see therapy through because it was proving too difficuilt?

Dream two

The second dream did not make the first one any clearer. Here I am represented as an older, experienced and Africanized masculine figure. In spite of my aloofness the impression created is of earthiness, rootedness. My attempts to help her are interrupted by poor black children and old men. Although I respond with irritation and leave, I return later in a better frame of mind. But instead of resuming therapy we start doing a cross-word puzzle.

Dianna had few associations to these dreams. The endings of both dreams concerned me as both seemed to refer to the abandonment of the therapeutic venture. In the first dream the difficult therapeutic journey is foresaken in favour of another easier route. In the second dream therapy becomes a word game. However, in a supervision consultation Dr Vera Buhrman cautioned me not to underate the significance of the cross-word puzzle. She felt it referred to the serious task of articulating, piecing together and sorting out the puzzle of her life.

Session nine

She began by saying that she'd felt very depressed over the weekend. Lying on her bed she had kept "telling myself how

wonderful I am" in order to ward off a pervasive feeling of inadequacy and emptiness. In her depression she'd also felt anger which was directed at me. In the session she criticized me in a tone of cold hostility for what she perceived as my lack of personal involvement:

> "You're very good at what you do. You're a good listener, you have a fine memory and a crochette-hook mind that doesn't miss a stitch. But you sit on the side-lines and watch with a morbid kind of clinical interest. If I had to break down I think you would just sit there and think to yourself "Mm, this is interesting" and then just kick me out at closing time. They could invent a computer to take yor place - there wouldn't be much difference!"

Her attack made quite an impact on me and I felt trapped: on one level I felt quite hurt by her criticism and anxiously wondered whether there was an element of transference-free truth in her words. On another level I felt she was provoking me, trying to manipulate me into modifying the therapeutic frame. Internally I felt a pressure to demonstrate some non-professional caring. Her frustrated need for intimacy and emotional responsiveness clearly expressed the relationship with her mother who, although seeming to perform the role of mother adequately, did so with a narcissistic coldness and insensitivity to her daughter's emotional needs. In the transference I had become the cold, witholding, robotic mother.

Session ten

She began session ten by saying that she'd thought about last session and had realized that she'd been trying to control me, although she didn't know why. She went on to say that she needed to get to the bottom of her problem quickly because "**otherwise I'll end up doing what I always do - papering cracks.**" I told her that she was like a trench digger, desperately digging away in order to get as deep as possible without staying with the

feelings she unearthed in the process. I pointed out how, on a number of occasions she had been almost tearful but, instead of staying with her feelings she'd pushed them aside in order to proceed with her manic archaeology. By doing so she was avoiding experience and also controlling the pace of therapy. Her therapy had less to do with digging deeper into herself (another attempt at self-control) than it had with staying with and exploring the the relational in-between, her feelings and fantasies about me and the relationship. Dianna construed therapy to be a desperate and inward historical pursuit of a hermeneutic key, a single biographical event that would unlock her past, dissolve the "**fine plastic mist**" that shrouded her and break her "**hard and brittle shell of illusion**". Therapy represented a process of working towards self-mastery by uncovering a determinate childhood fact that she could intellectually grasp. She was tuned perpetually inward, constantly listening for the echo of this discrete subteranean event. She desperately wanted to be self-sufficient in this pursuit and not have to rely on me. She was offended when I called her a trench digger. She felt frustrated when I constantly called her away from a distant internal past and persistently relocated her in the interpersonal present where dangerously strong feelings for me threatened her equilibrium and her defensive self-reliance. She would get resentful when I didn't co-operate. She felt constrained, stuck and anxious when I seemed disinterested in her past and more interested in dwelling on the details of images and nuances of feelings, when I focused on the texture of the interpersonal rather than the interior.

Session eleven

For the first time she arrived ten minutes late, without her usual sheaf of notes. She said she felt a "**calm sense of self-awareness and control.**" She felt aware of something very fragile inside of her: "**Its like I'm holding a fragile crystal bowl inside of me.**" She said she'd come to terms with "**the fact that**

you're not really committed to this therapy." In an earlier session I'd cautioned her that our therapy together was only preparatory work for more long-term therapy at some later date. This remark, she said, had convinced her that I didn't have much energy invested in our therapy and was just doing it because it was my job. She added that she was determined not to let my lack of committment interfere with her therapy, thus indicating a return of her defensive self-sufficiency. She went on to speak about a television programme on schizophrenia she'd seen the previous night. It was mentioned in the programme that hearing voices was a symptom of the disease. This had worried her because occasionally she would hear a shrill, inhuman voice inside her ear calling her name. I did not know what to make of this but simply interpreted her fear of being crazy or more disturbed than was apparent.

Session twelve

She apologized for being angry with me. She realized that her anger had to do with me not acknowledging or being taken in by her strong competent facade. She also understood now why she resents superficial compliments - because her facade is identified as the real her while her vulnerable, small, incompetent real self goes unrecognized. She said she wanted to talk about food - her tendency to binge when she feels bored or stressed. She felt this had to do with not taking responsibility for her life. Eating made her feel tired, lazy and sleepy, thus preventing her from sorting her life out and realizing her true potential. She remembered being told by a teacher that she had the highest IQ in the class and yet never actualized her intellectual capacity. At this point she made a meaningful slip of the tongue. She meant to say "My teachers at school..." but instead said "My pupils...", thus indicating how much the desire

for power and control is central to her life. She said she'd previously been hampered by the facade of being competent and in control but now she was actually attempting to gain real control by setting high goals and doing everything possible to attain them. In an earlier session she'd mentioned that she could not diet beyond a certain point without feeling inexplicably anxious. Connecting this to her binging I said that overeating may be a way of remaining physically big to counteract a feeling of internal smallness and vulnerability. The issue of control had shifted from her attempts to control me to an intense effort to control herself on both a bodily and emotional level. I asked her what it was that was so scary, so threatening that she needed to control it so desperately? An image came to her mind: "I'm falling into a black void!" At this point she became anxious and couldn't hold the image, saying "I feel the mists closing in." The issue of control moved on many different levels. She was desperately trying to identify her psychic lesion and give it a name. She felt that by naming it she could control it. For some reason I commented that although her image had to do with falling, another metaphor that came to mind was that of not being held. She became very sad and said that when she experienced me as aloof, distant and disinterested that was exactly what came to mind - that I wouldn't hold her. She remembered that, in the presence of her mother, if she became upset her mother would grab her and hug her. But this was an ambivalent experience because, although it was comforting she also felt vulnerable and afraid because her mother was in control. As a child she remembers her mother crying because of something she'd done. She felt obliged to go and comfort her but at the same time felt terribly resentful.

Session thirteen

Dianna arrived saying that she'd "hit a brick wall" and had nothing to say. "Its as though I'm enveloped in a thick mist and

can't see any further." She said she was hoping to find a significant event in her childhood responsible for her present condition, but now felt stuck. When I asked her for an image of her stuckness she described going into an empty room with a low ceiling and no furniture. The room was cold, had a marble floor and was antiseptically clean. There was a door in the room and as she looked through it she saw countless other identical rooms. "**These are the rooms of my mind**", she said. She went on to say that she'd had a lot of recurring negative images lately. As a child she often had vivid fantasies of monsters and rapists. She'd forced these fantasies out but recently felt that they were starting to invade her again. The most vivid fantasy was as follows:

> "I'm sitting in a room with my back to the wall, facing the window. Outside, looking in, is the head of a large wolf. The wolf is staring at me intensely with unblinking bulbous green eyes - its staring at me with malicious intent."

At first she wasn't able to say why the wolf was staring at her. I explored the meaning that wolves had for her. Her associations were: they're vicious predators that can survive in harsh conditions and hunt in packs, although this wolf is solitary. This reminded me of something she'd said in our first session. She'd described herself as someone "**who never runs with the pack.**" I reminded her of this. At first she brushed it aside but then said that perhaps the wolf was a self-image and did embody part of her. I asked about the wolf's intent. She said that if she went near the window the wolf would savage her. I asked her to carry on the fantasy and see what would happen if she did approach the wolf. She found herself on the other side of the glass. The wolf sprang at her, ripping her face with its claws, tearing her flesh to tatters. (this vivid fantasy left us both feeling shaken and horrified.) When I asked why the wolf had only

attacked her face she said it had something to do with a feeling "**that I've spent the whole of my life wearing a mask.**" Perhaps, I said, the wolf was tearing the mask of her face in order to discover who she really was, what she really looked like. She said she feared that maybe **she didn't have a face beneath the mask but just nothing, like an endless succession of empty rooms.** She was now aware that she'd never felt real, that she'd always made or fashioned a face for herself. Now she was afraid and unsure of what, if anything, lay beneath the facade.

Session fourteen

This session focused on a dream she'd brought:

> "Its a futuristic dream that takes place in a post-apocalyptic world after a nuclear war has destroyed civilization as we know it. I'm living in a beautiful green valley, in the remnants of a two-storey building. There are no windows, the walls have been destroyed and a lot of the building reduced to rubble. The building has merged with the mountain side as a result of a landslide. It is a reversion to a primitive age. I live in the building with another woman. We are dressed in animal skins and carry slings and bows and arrows as weapons. The other woman is very tall, flambuoyant, beautiful, strong and athletic. Every morning she gets up and goes running for miles over the hills. She is also very promiscuous, although the men she has sex with are very shadowy figures who seem to exist only for her pleasure before disappearing again. During sex it is she who lies on top of them, rather than the other way around. I feel I want to show my affection for her. To do this I lie on top of her. As I'm doing so another woman arrives and accuses me of being promiscuous. (It is not a sexual act although it could be misinterpreted as such). This third person is the other woman's sister but she is much smaller and doesn't have her sisters qualities or personality-she's like a shadow of her sister. Just then we are attacked by a neighbouring tribe carrying long spears. They come swarming down the mountain and into our building. A fierce battle ensues. We fight very hard, taking our opponents' weapons to use against them. I remember running a spear through one man and him saying "I've never experienced anything so painful." When he

> wouldn't die I tore out his throat with his own knife. At this point I decided to run and leave the other two. Soon I came to a big swimming pool, which seemed out of place given the primitive environment. In the pool were a number of animals. One was a rabbit or a squirrel and I guided it out of the pool. The other was my landlady's stupid dog Aztec who was standing on the bottom of the pool looking up at me with huge, soulful eyes. I got him out of the pool and then realized I was close to a large suburban center. With some sadness I realized that that this beautiful primitive world was just a fantasy within a dream. The dream ends with me being caught by the neighbouring tribe. I knew it was them because I recognized an elderly, squat, dark-haired woman who glared at me malevolently."

Dianna related the dream to something she'd been doing the previous night. She'd been conducting a dialogue between two parts of herself. She remembered that, as a child, she'd liked her name very much. Dianna was an exotic name that made her feel special and unique in a way that the name Dianne didn't. Dianne was conventional and ordinary. The name Dianna evoked fantasies of her being an exeptional person - strong, intelligent, articulate and totally self-reliant, a superhuman being. She needed this fantasy because from an early age she'd felt that her real self wasn't good enough and that she needed to be special. This real self, which she called Dianne, was unexciting, average and unexceptional.

The dream obviously referred to the discrepancy which Dianna experienced between her real self which was ordinary and unexceptional - and hence unacceptable; and her ideal self which was powerful, beautiful and self-sufficient (represented in the dream by the Amazonian woman.) I believe that Dianna's lying on top of this woman in her dream represented the attempt to fuse or merge with this omnipotent ideal self representation. The third woman is Dianne (the real self), the plain, unexeptional one who does not in fact possess any of the remarkable qualities of her grandiose sister. In the dream they are attacked by another tribe. This, I think, symbolizes the breach of her narcissistic defenses by the therapy process. Dianna, like the mythical

Narcissus, finds herself gazing at a beautiful pool. But instead of a narcissistically perfect self-reflection gazing back at her, she sees two helpless and vulnerable animals, depicting aspects of her own underlying self-representation which, significantly, she rescues. The dream ends with the realization that her primeval eden is only a fantasy that cannot be sustained any longer. Psychotherapy has confronted her with the shared, mundane world of suburban reality. Significantly, her dream ends in a confrontation with her dark, squat, aggressive negative self-representation from whom she has been fleeing. This dream clearly indicated Dianna's unconscious realization that her narcissistic fantasies were no longer an adequate defense against psychotherapy's attempts to confront her with split-off aspects of her real self which she had previously kept at bay through identification with her ideal self representation.

Dianna accepted this interpretation and said that the previous night she'd heard Dianne mocking the omnipotent Dianna for not being real.

Session fifteen

The previous session had left her feeling very vulnerable. Over a period I had noticed a qualitative change in her presence. She was no longer so critical, sarcastic and intellectually verbose. She felt softer and more receptive. But, she said, she equated vulnerability with being "**completely stripped, broken and destroyed as a person.**" For the first time in therapy she started crying. The session ended with her saying "**Well, aren't I a good girl - I finally managed to cry in front of Mister Ivey.**" Her tone was sarcastic and I suddenly realized that she'd been feeling that my caring was conditional on her living up to "my" expectation that she should be vulnerable and fragile, that she could not meet my needs and earn my approval unless she became vulnerable. Earlier on in the session she'd mentioned that she'd

always felt that her mother's love had to be earned, that it was not unconditional. In the transference I had clearly become the mother who would only love her if she lived up to my expectations.

Session sixteen

She began this session by presenting a dream:

> "I'm jumping on a trampoline with an acquaintance, a girl who is unattractive and lonely but also arrogant and opinionated. I'm trying to have a conversation with her while I'm jumping but I feel unstable and frightened of falling, not knowing where I'm going to land. Then I suddenly find myself on a university campus. The buildings are old and Oxfordian, with rolling green lawns and a river running down towards the sea. I walk and turn right when I get to the river. I end up walking through two large white doors. I see a sign saying "This way to happiness." It leads to a scenic spot with ponds and boats."

She felt this was a positive dream that referred somehow to her future. The first part clearly indicates the therapeutic dialogue between the two previously diconnected aspects of Dianna's self-representation i.e. the overt narcissistic self-image and the underlying lonely, unattractive negative self-representation. Interesting to note is that they are no longer split but have become aspects of the same person. This dialogue, however, is unsettling. She no longer has the (quasi-) secure footing of her narcissistic self-representation to negotiate her world. Acknowledging her vulnerable, inferior and unattractive self has destabilized her, made her balance precarious and her psychological destination uncertain. The second part of the dream is perhaps an answer to the first part. At first I considered it a rather defensive narcissistic attempt to assuage the anxiety of the threat to Dianna's egoic equilibrium: a beautiful edenic world promising happiness without conflict, compromise or sacrifice. My supervisor, however, emphasised an alternative

teleological interpretation that focused on the positive psychic possibility of a new and fertile world that might emerge from the healing integration of the negative self-representation. He felt that this dream expressed a feeling of being held.

We played with the dream for a while but then, after a period of silence, Dianna spoke of how uncomfortable she felt sitting in silence. Her associations led to a feeling that she would be letting me down unless she brought something to talk about. She said she felt she had to "earn" whatever benefit she got from therapy. I reminded her that she'd used the word "earn" last session to refer to having to earn her mother's love. I connected this to my feeling in the last session that she felt she had to meet my expectations in order to earn my approval. She said yes, she remembers being very competitive toward her siblings for her mother's attention which wasn't simply forthcoming but had to be worked for. I suspected that her anxiety about silence was more complex than this, that it had another component. The first component was clearly an interpersonal one that concerned her perception of my (and in the transference, her mother's) expectations of her and her belief that she needed to earn love and recognition. But I felt there was a second component which was more intrapsychic than interpersonal. This anxiety about silence, I suspected, had to do with her own hollow interior. I felt that words for her were a way of filling up silence which symbolically represented the absence and emptiness which she experienced at the core of her being. I did not make this interpretation to her but simply asked her if any images arose from the silence. "Only that of falling, or rather, being suspended motionless over a bottomless black pit", she said. She then added "I guess I talk to fill up the spaces, I talk in order to be", thus confirming my unspoken interpretation. Linking this to her earlier fear that if she became vulnerable she would be "destroyed as a person" I made the following interpretation: "Perhaps your deepest anxiety concerns not the question of what

to be but, rather, at some deep level **whether you are** or whether there is only a bottomless empty space at the center of your being that threatens to swallow you. Perhaps yours is a fear of non-being." She became tearful and said that this was exactly how she'd felt when she lost her virginity and, in so doing, betrayed her mother's expectation that she remain a virgin and uphold the family honour. She'd felt that she'd ceased to exist.

Session seventeen

She began this session by talking about success and her need to achieve. When I asked what success meant to her she said: "**Saving the world - being very busy working on committees for environmental concern, alerting people to the dangers of pollution...**" One of the first words she'd used when we first met was pollution and it had often cropped up since then in her speech. Certain words and themes struck me as highly significant. Pollution, in a general sense, means **contaminating, poisoning or making something bad**. Her reference to "saving" meant reparing or preventing damage done by pollution. Melanie Klein has written extensively about how infantile aggression is often expressed in fantasies of poisoning or contaminating the interior of the hated maternal object with urine, faeces etc. Dianna's concern with pollution and its prevention, I suspected, had a lot to do with such unconscious destructive phantasies and reparative urges to undo the damage done by her poisonous phantasies. I did not make this interpretation to her but rather asked how her interest in pollution and ecology had come about. She related how, as a girl, she'd grown up in a small suburban house next to a veld. In the middle of the veld was a copse of trees. Inside the copse was lush green grass, a stream and a little waterfall. This was a secret and very special space to Dianna. One day she went there, only to find that her special place had been been destroyed, with a town-house development being built in its place. This was a traumatic event for her. When I asked what the place had meant to

her she replied: "It was a place where I could be accepted without anything being expected of me. It didn't expect me to love it even though I did. All that green grass filled up the empty spaces inside of me."

This confirmed my earlier impressions. Her preoccupation with ecology and pollution, at least at one level, symbolically depicted an externalization of her own internal ecology, the fate of her own psychic interior. The dynamics of this, I suspected, were as follows. The baby Dianna had internalized a destructive maternal object, founded realistically on her experience with her narcissistic mother. In order to defend herself against this bad introject she probably had phantasies of poisoning it with every resource at her body's disposal. (Dianna's "caustic" i.e. corrosive humour could be a residue of this childhood phantasy.) However, she would have feared retaliation from this introject in the form of contamination (pollution) and poisoning of her own internal world. She also felt sufficiently ambivalent towards her mother to feel guilty for her phantasized poisoning of her mother's body. This was expressed in the transference as her concern that I might be harmed by her "negative vibes" (see session one) and her feeling that for some reason she needed to defend me from herself. The reparative urges she felt in response to her destructive phantasies were expressed in her enthusiastic concern for ecology - "saving the world", as she phrased it. This understanding also made sense of the dream she'd had in the previous session. The lush, green university campus with ponds and streams suggested the possibility that her internal world was not just empty and polluted but potentially green and fertile.
While making sense of her experience at one level, what this interpretation risked doing was pathologizing and hence invalidating Dianna's committment to environmetal preservation. I told her this and emphasized the authentic and praiseworthy dimension of her ecological concern, without attempting to reduce it to an interior event.(The external world is, after all, not

simply an externalization of an internal world. It is being contaminated and destroyed, irrespective of the psychodynamics of phantasy life.)
My interpretation, however, was very meaningful to her. She admitted that she was no longer in control of therapy, that her intellect and logic could no longer make sense of her experience. She said she'd finally put her trust in me and allowed herself to become dependent on me, although she felt very vulnerable doing so.

Session eighteen

Dianna began the session by saying that, as a young schoolgirl, she occasionally suffered from anxiety attacks that were not precipitated by any obvious events or circumstances. She has had a number of these since, usually when involved in a conflict situation. She said that recently she'd started having these attacks again. Picking up on the connection she'd made between conflict and anxiety I commented that a lot of her relationships were conflictual ones. She said that, for some reason, a lot of people took exception to her. (Given her aloofness, condescending air of superiority and verbal aggressiveness this was hardly surprising). She said that she'd always been aware of a powerful energy force within herself that she could call on. When young she remembers thinking that if ever she was crippled she could cure herself through the sheer power of her will alone. (This is a good example of narcissistic omnipotence and self-sufficiency). Lately, she said, she'd been afraid of entertaining negative thoughts about other people because of a conviction that these thoughts carry energy. This energy enters the atmosphere and might harm others and perhaps even herself. Linking the topic of destructive fantasies to her anxiety I said that she seemed frightened that her own aggression was so powerful that, if it were unleashed in therapy, it might harm me (the good object) and possibly even her as well. I asked her if any image came to mind

when she thought of her destructiveness. "**Just that big, black, square hole**", she said. I commented that the hole was no longer just a void, an absence, but also a presence, although it seemed that what was present was a lot of anger and aggression. She said yes, but she felt scared of confronting it because she had no idea where to put it or what to do with it, given that therapy was almost over. (Clearly the adaptive context for her anger had to do with termination and my "abandoning" her at the point when she was most vulnerable and dependent. She acknowledged this but did not become angry with me.) At this point a memory suddenly sprang to mind. When Dianna was a little girl the family maid had a baby. One day while Dianna was present in the room she heard a sickening thud and then screaming. She turned to see that the baby had fallen off the bed. A few days later the child died and Dianna felt that she had somehow killed it. This, I think can be understood in the context of the generalization of Dianna's childhood destructive phantasies, from the original target of the bad maternal introject to other objects in the child's external world. As a result she must have felt convinced of her omnipotent destructiveness. This phantasy had persisted and now she clearly felt concerned about possibly destroying me and, in transference, her unloving and insensitive mother - the original object of her aggression.

Session nineteen

She arrived saying that she felt very vulnerable. A friend of hers, small in stature and emotionally insecure, had accused her of "**just wanting to make friends with little people in order to make yourself look big.**" At this point Dianna suddenly started sobbing. She said that she'd suddenly felt that there "**is something bad or destructive in me that is harmful to other people.**" I related this to her depressive transference fears/fantasies of hurting me for ending therapy just at a point when she was able to start trusting and depending on me. This

interpretation relieved her. She said that, although she felt very weak and vulnerable, her vulnerability has had a marked positive impact on her interpersonal relations. She felt much more receptive and open towards people, more able to empathize with them. She realized, in retrospect, that although she used to pride herself on being able to intellectually analyze other people, she was in fact not emotionally in touch with them.

Session twenty

I felt concerned about how rushed our termination had been. Therapy had ended just at the point when Dianna's most significant transference feelings were emerging. There had been no time to work through these, let alone the usual termination issues. We spoke about these. Dianna felt very fragile but said she could not revert back to her old way of being. She felt that enough had happened to ensure a permanent change in her life. She also felt determined to go back into therapy at some later date in order to work through the issues that had emerged. She said that, in the light of her new understanding of the meaning of ecology in her life, she no longer felt sure about pursuing a career in that field. Although this left her feeling up in the air she claimed to feel more at peace with herself.

While writing this thesis I received a letter from her, thanking me for the therapeutic experience. She said her initially strong feelings for me had mellowed into fondness and warm respect. She had been accepted to study environmental science and felt enthusiastic about her future.

CHAPTER SIX

DISCUSSION OF CASE STUDY

6.1 Diagnostic considerations

A personality disorder is more than an aggregate of long-standing symptoms detrimental to the individual's personal and social functioning. It is better described as a chronic maladaptive mode or style of object-relating that is not transient or situation-dependent but rather continuous over time and context. This definition shifts the focus from the presenting symptoms to the individual's characteristic style of interpersonal functioning. Obviously, obtaining a detailed a symptom profile is a necessary feature of any psychological assessment. However, many personality disorders either (a) do not initially present with overt florid symptomatology, (b) present with features of a polysymptomatic neurotic condition, or (c) present with certain features of a personality disorder syndrome but not enough to warrant a personality disorder diagnosis according to DSM-3 criteria. This situation is complicated by the diagnostic pressure to identify the patient according to mutually exclusive nosological categories e.g. either the person is neurotic or personality disordered. Many personality disorders are consequently misdiagnosed because of the emphasis on the presenting symptoms rather than the nature of the underlying object relations. It is only in the unfolding context of the transference relationship - insofar as this reveals disturbances in the person's external and internal object worlds - that the psychodynamic structure of the personality disorder reliably emerges.

My patient is an interesting case in point. Her symptom profile and style of relating in the early stages of therapy bore many of the hallmarks of a narcissistic personality disorder e.g.

grandiosity (with underlying sense of inferiority and emptiness) , exhibitionism, self-sufficiency, sarcasm, argumentativeness hypersensitivity to criticism etc. However, after a short period of time the quality of her relationship with me invalidated NPD as an appropriate diagnosis. The evidence was as follows:

a) In spite of her desire for control and self-sufficiency Dianna quickly developed **strong dependency needs** that expressed the desire for sexual contact, emotional intimacy and maternal holding. One of the primary diagnostic and dynamic features of NPD is the (surface) absence of object-need. This serves the purpose of denying rapacious underlying dependency needs, envy, inferiority, anger etc. The fast and intense emergence of her dependency needs suggested that, whatever narcissistic features she exhibited, these were not characteristic of NPD. Moreover, Dianna was primarily interested in understanding these needs rather than simply gratifying them. She could acknowledge, respect and use the limitations of the therapeutic frame without becoming unreasonably demanding or destructive.

b) Dianna's **communication style was primarily symbolic** - the latent meanings of her words carried deeper meanings which indirectly - through metaphor and symbol - conveyed unconscious feelings and wishes. In NPD, however, words are not primarily symbolic vehicles of unconscious communication. Words, rather, are used to destroy authentic communication in order to avoid a meaningful relationship with the object. (Langs 1983 pg 599)
Dianna's dreams were also rich, textured purveyors of unconscious meaning, portrayed by animals, humans and inanimate objects. The dreams of NPD patients tend to be autistic, flat, impoverished and two-dimensional.

c) No matter how much her (transference) experience of me was influenced by her pathological maternal relationship Dianna always related to me as a whole rather than a part-object. I was

never merely a narcissistic extension of herself. Furthermore, Dianna's **concern that I (and others) may have been harmed by her destructive impulses** is uncharacteristic of NPD patients whose anxiety is more paranoid than depressive in character.
She was also able to take **and hold interpretations**, which NPD cannot do because it would be allowing the therapist inside of them i.e. establishing intimate contact with him/her and thus deflating their defensive self-sufficiency. Not only was she able to internalize my interpretations during the sessions, **I was also a very real presence for her between sessions** - she would have silent dialogues with me, look forward to sessions and wonder how I would respond to some event, feeling or thought. Once again, this is totally uncharacteristic of NPD object-relating. For the latter patients the therapist tends to disappear between sessions and is not easily internalized as a real affective presence.

d) The qualitative change in Dianna's presence - from aggressive self-sufficiency, arrogance etc to vulnerability, neediness, mature dependence and improved receptivity to others would not have happened so quickly in the case of NPD. (I do not think that this was a defensive "flight into health". Dianna's life was not magically transformed and she was well aware of how much work still needed to be done.)

All of the above provide strong evidence to suggest that Dianna's was not a typical case of NPD.

A related problem to that of symptomatic diagnostic model is that of the psychodynamic diagnosis of object relations theory. Melanie Klein classified all functional psychopathology according to its psychodynamic location in either of two well-known developmental positions: the paranoid-schizoid position or the depressive position. In the **paranoid-schizoid** position the infant's immature psyche protects the infant from anxiety through the use of the primitive defense mechanisms of splitting,

projective identification, denial, idealization etc. In this way good and bad self- and object-representations are kept apart in order to protect the good internal objects from attack by the bad objects. If excessive frustration (endogenous or environmental) occurs at this point the paranoid-schizoid position cannot be successfully negotiated and personality development becomes arrested at this point. The ensuing adult psychopathology (ranging in severity from psychosis to affective and personality disorders) reflects this developmental arrest through the preponderance of splitting and other primitive defenses, as well as interpersonal functioning characterized by **part-object relating.** Borderline and narcissistic personality disorders traditionally fall into this category.

If, however, infantile anxiety/frustration does not give rise to excessive splitting in the paranoid-schizoid position, then the infant matures to a point at which the good and bad self- and object-representations are recognized as being different aspects of a composite, differentiated self and object. Klein called this the **depressive position.** The primary anxiety here concerns the fear that the object (no longer a part-object) will be harmed by the infant's aggressive phantasies. This results in concern for the object, guilt and depression centered on remorse for having hurt or destroyed the unified object. Adult pathology arising from this later developmental juncture is typically neurotic in structure, characterized primarily by the higher level defense of repression (rather than splitting) and **whole object relating.**

Although not entirely true to her original theory, Klein's paranoid-schizoid/depressive position dichotomy is often used interchangeably with the categories pre-oedipal/oedipal and dyadic/triadic pathology to describe characteristic object relations and psychodynamic operations resulting from the given level/position of developmental arrest.

Klein's explanation of psychopathology in terms of developmental positions has proved extremely useful. However, in terms of diagnostic exclusivity it poses a similar problem to that presented by the symptomatic diagnostic model. Because narcissistic pathology, according to this formulation, invariably has a pre-depressive (position) pathogenesis, it makes little sense to speak of a neurotic whose dynamics are primarily narcissistic. **Neurotics, by definition, have successfully negotiated the developmental position in which narcissitic dysfunction has its etiology.** One can speak of a narcissistic character structure even though a full narcissistic symptom profile is not overtly manifest. (This is frequently the case with seemingly neurotic patients who, in the course of treatment, prove to have an underlying narcissistic personality structure). However, in terms of this developmental model, it is difficuilt to explain the case of a narcissistic patient who proves to have a neurotic i.e. depressive character structure. My patient, I would argue, is just such a case.
The following evidence is strongly suggestive of depressive dynamics and object-relating:

1) Firstly, Dianna's **primary defense was repression rather than splitting.** She was able to make use of my interpretations, emotionally access the underlying material and integrate this into a progressively evolving complex self-representation.

2) Secondly, she was **able to hold and contain ambivalent feelings** towards both me and her mother, something which would have proven impossible if she was employing primitive narcissistic defenses.

3) Thirdly, her transference anxiety about harming me represented a **depressive capacity for concern** that is unavailable to typical narcissistic patients whose anxieties are paranoid-schizoid in nature i.e. more concerned with being harmed than harming others.

In spite of the narcissistic presenting profile and the long-standing duration of her symptoms I have argued that Dianna could not be diagnosed as a typical case of narcissistic personality disorder. Yet the central issue in her life was expressly narcissistic - **a shell or facade of grandiose self-reliance erected as a defense against underlying feelings of inferiority, emptiness and destructiveness.** But because (a) this underlying negative self-representation was repressed rather than split off, (b) this repression was effected in the interpersonal context of whole object-relating, and (c) the anxiety was depressive rather than paranoid-schizoid, I would use the term **narcissistic neurosis** (not in Freud's original sense) to describe Dianna's case i.e. narcissistic symptomatology within a predominantly neurotic character structure.

6.2 Psychodynamics

Although, in the previous chapter, most of the psychodynamic processes were mentioned as they arose in therapy, this section provides a more comprehensive dynamic formulation in dialogue with the relevant theorists discussed.

Dianna may be best decribed as a neurotic with a narcissistic injury or "lesion" genetically explicable in terms of a pathogenic early relationship with a narcissistic mother. In order to adapt defensively to her mother's destructive influence Dianna had unconsciously to renounce her childhood dependency needs and hide her vulnerability behind a facade of grandiose self-sufficiency, superiority and intellectual control of her world. Underlying her surface self-representation of specialness, intelligence, independence and omnipotent strength was the negative self-representation of a needy, empty, vulnerable, unloved and angry child. It was this repressed self-representation that emerged indirectly in her presenting problem.

The latter, it may be recalled, included a sense of fragility, vulnerability, insubstantiality and lack of confidence accompanied by aggressive sarcasm and a hypersensitivity to criticism.

Her defensive facade was narcissistic in Stolorow's (1980) terms because it served the functional purpose of maintaining the integrity, continuity and positive emotional valence of the conscious self-representation against the threat of the negative unconscious self-image. In terms of Stolorow's categorization Dianna's would be described as a case of mild narcissistic disturbance because, although her underlying self-representation was decidedly negative, it retained its structural cohesiveness and continuity over time. (Hence the absence of severe chronic identity diffusion).

Her defensive facade became a habitual egosyntonic component of her character structure. However, instead of employing the typical narcissistic defenses of splitting and projective identification to rid herself of the negative self-representation and thereby control it, Dianna used the **higher order defense of repression** to force the "bad" self-representation out of awareness. Because repression is a much less primitive and severe defense than splitting, the negative self-representation was more accessible than is usually the case in severe narcissistic disorders.

The absence of splitting also meant that her symptomatology was less severe and that her mode of (whole) object-relating was neurotic rather than schizoid. This accounts for my initial feeling that, in spite of her narcissism, I had made contact with Dianna and established a relationship with her.

The preponderance of splitting over more primitive defenses was evident in the symbolic nature of her communications which

conveyed hidden meaning rather than destroying meaning in order to avoid relationship.

The composition of her narcissistic self-representation is revealed in the "post-apocalyptic" dream (session fourteen in the previous chapter). The dream featured three people: herself, a beautiful, powerful and athletic huntress-warrior, and the latter's sister - smaller, ordinary and totally unlike her extraordinary sister. I understood these figures to represent her real self, ideal self and/or ideal object, and negative underlying self-representation. This interpretation was confirmed by her associations to the dream. Although, as a child, Dianna had felt very plain and unexceptional she'd fantasized about being strong, beautiful and self-reliant. She needed this fantasy because of her conviction that she had to be a very special and exceptional person in order to earn her mother's love. It was not good enough to be herself, she had to be something better. Otto Kernberg considered the primary feature of pathological narcissism to be a stable grandiose self resulting from the regressive identification of real self, ideal self and ideal object once object constancy had been attained. It is interesting to note that, in Dianna's case, although there is the wish to merge with the ideal self symbolized by the huntress-warrior (by lying on top of her) the fusion is never effected. For Dianna the narcissistic identification with her ideal self remains a **wish** rather than a successfully enacted phantasy - **real self and ideal self remain differentiated**, which is not the case with more severe narcissistic disorders. The degree of differentiation between the real self and ideal self, I would argue, is a valuable prognostic indicator in narcissistic pathology. **A lower degree of differentiation would be expressed symptomatically by a higher degree of grandiosity and a poorer therapeutic prognosis.** The inverse would apply - as it does in this case - with a high degree of real self/ideal self differentiation. It is easier to work with someone who wishes to be her ideal self than it is with

someone who believes she is her ideal self. [1]

Another significant point is that Dianna's negative self-representation is present in the dream, embodied firstly by the plain, unremarkable sister of the huntress-warrior and later by the dark, squat and aggressive woman from the invading tribe. Both figures depict different aspects of the repressed self-representation. The significance of their dream presence lies in the relative accessibility of the underlying self - another good prognostic indicator which could prove useful in assessing the therapeutic suitability of narcissistic patients.

The structure of Dianna's grandiose self has already been discussed. We turn now to a closer consideration of the repressed negative self-representation. It is a fairly complex entity, comprising at least three aspects or components:

Firstly, there is the mundane, ordinary and unexeptional child who desperately needs her mother's recognition and love but feels this has to be earned by meeting narcissistic maternal expectations. Because Dianna intuited the message that she was not to be naughty, needy or childish these aspects of herself could not be expressed and had to be repressed. To be needy or vulnerable at the hands of an insensitive and witholding mother must have been a very threatening experience - hence Dianna's belief that she could not trust her mother with her feelings. She thus renounced her childish dependency needs, becoming prematurely independent and intellectually mature. Biographical evidence for this is suggested by the realization she felt at the age of five that her childhood was over. In order to compensate for the mundane, unremarkable - and hence unloveable - self-

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[1]. It should be borne in mind that the huntress-warrior may not just symbolize the ideal self, but also might be an amalgam of the ideal self and the ideal object, integrated into a single image.

representation Dianna fantasized about being strong, beautiful, flamboyant and self-sufficient. This fantasy protected her from the unacceptable reality of her ordinaryness.

The second aspect of Dianna's repressed self-representation is vividly expressed in her wolf fantasy (session thirteen). Wolves for her were ravenous, vicious predators - wild and aggressive. This image symbolically depicts her own oral aggression, expressed indirectly by her biting sarcasm and tendency to give those who crossed her a "tongue-lashing". The genetic origin of this underlying self-representation can be inferred from Dianna's relationship with her mother. The latter was experienced as insensitive and witholding. Unconditional love and affection were in short supply and Dianna remembers having to compete seriously with her siblings for her mother's attention. (This emerged in the transference as the jealousy and anger she felt toward me in the chef dream (session six) for seeing other patients and not caring sincerely for her). The resulting childhood frustration must have given rise to extreme anger and aggression which could not be openly expressed but was instead displaced onto her siblings. (The incident in which she set fire to her brothers' toy box illustrates the destructive intensity of her anger). At times the destructive phantasies accompanying her frustrated anger - almost certainly directed towards her witholding mother- could not be so effectively repressed. Although these did not emerge into consciousness their threshold activation gave rise to the anxiety attacks that she felt as a child and still does in certain conflict situations. Her transference feeling that she needed to protect me from herself indirectly revealed the anxiety she felt about the repressed destructive anger she felt towards her mother. The oral origins and derivatives of her frustrated aggression - her "ravenous carnivore" association to wolves- supports Kernberg's claim that narcissism has its etiological locus in the experience of oral deprivation and subsequent angry hunger. Dianna's childhood conviction that there was going to be

a drought and that she needed to collect water in preparation was clearly a symbolic reference to a mother whose limited love and affection was threatening to dry up completely, leaving her daughter parched and thirsty for emotional sustenance. In therapy the unconscious choice of the wolf image and her association that wolves are "hardy animals that can survive in harsh conditions" reflects the cold, bleak and harsh maternal environment in which Dianna greedily hunted and fought for nurturance and recognition. The following quotation from Kernberg is remarkably relevant to Dianna's case:

> "The narcissistic character defenses protect the patient not only against the intensity of his narcissistic rage, but also against his deep convictions of unworthiness, his frightening image of the world as being devoid of food and love, and his self-concept of the hungry wolf out to kill, eat and survive." (Kernberg 1975 pg 276)

The third aspect of the patient's underlying self-representation is dramatically illustrated by two of the images that emerged in therapy: the bottomless black pit or void (session twelve) and the endless empty and sterile rooms (session thirteen). The self-representation here is what I would call the hollow self. This refers to Dianna's anxiety that her psychic interior was an arid, drought-stricken, denuded and empty space, unpopulated by sustaining internal objects. This is illustrated by Dianna's fear that if the wolf ripped away her mask there might in fact be nothing behind it - behind her narcissistic defenses she might be hollow and faceless. For this reason the prospect of silence in therapy was very threatening. Silence symbolized her internal experience of hollowness and words served to partially fill up the empty space. Kernberg explains the subjective experience of emptiness in terms of "loss of the normal relationship of the self with ...the world of inner objects." (1975 pg 220) A sense of inner "fullness" and self-worth comes from the internalization of a good maternal object which forms the nucleus

for a positive self-representation. Dianna, however, must have internalized a destructive maternal object, experienced as ungiving, callous, insensitive and rejecting. Dianna could not depend on this destructive internal object for gratification and so severed ties with it by becoming (in phantasy) omnipotent and self-reliant. But, as Kernberg points out, the psychodynamic consequence of disrupted contact with internal objects is a feeling of emptiness. The symptomatic result in Dianna's case was the underlying feeling of hollowness and insubstantiality.

Accompanying the subjective experience of emptiness was the phantasy of destructive psychic contamination. The psychodynamics of this can be fruitfully argued in terms of Kleinian theory. In phantasy the malignant maternal introject polluted her internal world. Klein's work revealed that infantile aggression is often expressed in phantasies of poisoning, burning or contaminating the interior of the hated bad object's body with urine or faeces. The child imagines that the object will retaliate in like fashion and thus fears contamination of its own interior by the punitive object. Evidence for this is suggested by Dianna's preoccupation with the threat of pollution and her desire to "save the world" from being poisoned. (See session seventeen in the previous chapter). At one level the poisoned world referred to might well be the world of her own psychological interior. The dynamics behind this may have been either oral (drinking contaminated milk from the bad breast) or anal/urethral (being poisoned by the bad mother's faeces or urine). Whatever the organ modality behind this phantasy the result was the threat a polluted internal world and the need to defend herself against this possibility. Dianna, I believe, defended herself by attacking the bad maternal introject with similar phantasies of poisoning and pollution. But in Dianna's case the maternal introject was not completely bad. In spite of her mother's narcissism Dianna had already experienced a degree of adequate mothering which had allowed her to mature beyond the paranoid-schizoid position to a point where

she felt ambivalently towards a relatively integrated whole internal object, comprising images of both good and bad aspects of maternal care. It was this integration and the consequent replacement of splitting by more mature defenses that saved Dianna from much more severe narcissistic pathology. She had in other words reached the depressive position and her anxiety was not primarily the paranoid fear of destruction by the bad object but rather the fear of harming the sufficiently integrated, ambivalently loved and hated whole object. Her destructive phantasies of polluting and destroying the inside of her mother's body mobilized guilt and reparative concern. This was expressed biographically by her desire to save the (object) world from the threat of pollution, and transferentially by her fear of harming me and the need to protect me from herself. Further evidence for this thesis was her statement (session nineteen) that there was something bad or destructive in her that was harmful to other people. The incident in which she felt responsible for the death of the family maid's baby is another indication of her pervasive sense of destructiveness and her need to protect others from this.

As implied above, Dianna's internal world was certainly not all bad. This was apparent from the initial assessment session when she mentioned the internal presence of a secretive inner essence which she called the "silent passion". This, she said, was a center and source of intense feeling which had no outlet and which was afraid of being exposed and ostracized. Reading this description one realizes that Dianna has provided a more accurate and evocative description of Winnicott's true self concept than even Winnicott himself has done! It may be recalled that Winnicott described the true self as the intensely private core of psychosomatic identity, vitality and spontaneous action which has no traffic with the external world and which requires protection from external impingement. Dianna's "silent passion" and Winnicott's true self correspond exactly. What strikes one is

the aliveness and immediacy of Dianna's contact with her true self. The hallmark of severe narcissistic pathology is the almost total lack of contact with the true self owing to the latter's intense fear of traumatic exploitation by a hostile object world. The result is the typical narcissistic feeling of deadness, emotional blunting, hollowness and lack of spontanaiety. Although Dianna did at times feel hollow and insubstantial she did not experience the chronic emptiness, deadness and depersonalization that invariably accompanies severe narcissistic disturbances. She did, however, experience the fear of true self impingement. This was manifest in her equating vulnerability with being "completely stripped, broken and destroyed as a person". The presence of her true self and its vulnerability was vividly illustrated at a point in therapy when she started to relinquish her narcissistic defensiveness, by the image of holding a fragile crystal bowl inside of her. Her fear of true self violation clearly had its developmental origin in her relationship with a narcissistic mother. Even as a child Dianna had felt that she could not express an essential part of herself because of her mother's insensitive dismissal of her attempted communications. (The incident in which her mother smashed her easter egg - even if we ignore the heavy symbolism - illustrates the extent of her destructive insensitivity). This essential part was her true self which, lacking adequate maternal recognition, required the formation of a rigid false self defensive structure to protect it from impingement. This false self, manifest as Dianna's narcissistic facade, became identified with the real Dianna. This identification, though, was not complete as her true self was allowed a secret life which took the form of moments of intense excitement, childhood fantasy and poetry writing. A powerful childhood symbol of her true self was the "secret place" she used to visit (see session seventeen) where the green grass filled up her "empty spaces" and where she was unconditionally accepted without any expectations of her. The destruction of this place by builders, even on its own terms a painful event, had an added

traumatic impact by virtue of its personal symbolic status - a reminder of the violation Dianna's true self had already experienced at the hands of an insensitive mother.
Interestingly, Dianna's dream (session sixteen) of finding herself in a scenic place with green lawns, rivers and ponds promises the mature resurrection of her secret childhood space and fertile possibilities for renewed true self functioning.

The remarkable resiliance and vibrancy of Dianna's true self, however, meant that she never fully identified with her narcissistic false self. For this reason she was, after a short period in therapy, able to recognize this false self as being a "mask" and a "hard, brittle shell of illusion". Her fantasy of being attacked by a wolf (session thirteen) cannot be simply understood in terms of an aggressive underlying self-representation. Added meaning is gained from interpreting this as the necessary therapeutic destruction of her false self facade or "mask", as she called it, in order to discover the real face of her true self possibilities hidden beneath. Fortunately for Dianna she had a reach internal world, unlike the truncated and atrophied interiors of more severely disturbed narcissists. Her narcissism, moreover, was not the product of transitional space pathology, hence her capacity for symbolic communication, imagination and creativity.

The nature of Dianna's narcissistic injury raises an interesting question concerning the conceptual applicability of Balint's basic fault formulation to her dynamics. The phenomenology of her presenting problem strikes one as a classic example of such a fault. Dianna emerges as a true philobat who, as a consequence of having been failed by her mother, wears a protective shell of grandiose self-sufficiency to protect a structural flaw. This flaw or fault is expressed symptomatically as a vague feeling of internal deficiency and insubstantiality, of having been somehow undermined at an early age. An evocative metaphor that Dianna

later used was that of a broken limb which had set crookedly and needed to be broken again in order to heal properly. Another powerful symbol was that of the gaping black whole over which she was suspended. Dianna's problem had all the structural characteristics of basic fault pathology. It was experienced as an internal deficiency rather than a conflict and the interpersonal context was clearly dyadic, the developmental product of deficient maternal care.
But in the context of our therapeutic interaction Dianna did not exhibit three fundamental features of basic fault pathology:

Firstly, the question of shared language and meaning was never really an issue. Dianna's narcissistic lesion could be languaged quite adequately with a conventional, though creatively colourful, lexicon of shared meanings.
Secondly, although interpretation was my primary form of intervention Dianna did not experience interpretations as attacks, intrusions or failures in empathy. Instead she usually felt met by these interpretations and was able to use them remarkably well.
Thirdly, although her symptoms could be understood in terms of a structural deficit rather than a repressed impulse, neurotic conflict over ambivalent feelings was a significant psychodynamic feature.

The above highlights a problem already mentioned in the first part of this chapter - the tendency of object relations theorists to divide psychopathology into mutually exclusive categories according to the presumed level of developmental arrest. In classical theory a patient was either neurotic or psychotic. Research on borderline and narcissistic pathology made this simple dichotomy untenable and it was replaced by another binary opposition - the distinction between paranoid-schizoid and depressive pathology. The former's psychodynamics were termed broadly psychotic while the latter's were considered neurotic.

This conceptualization has been questioned by modern theorists such as Andre Green (1986) who contend that deep analysis of neurotics reveals a psychotic kernel to their pathology. In a similar way this case study challenges Balint's rigid distinction between neurotic and basic fault pathology. My patient clearly exhibited the phenomenology of basic fault pathology in the context of primarily neurotic defenses and object relations. This paradox cannot be adequately conceptualized in terms of the simple object relations model of heirarchically structured developmental levels. Psychodynamic contradictions flourish in the murky world between these familiar conceptual co-ordinates with little respect for the self-consistency of theoretical models.

6.3 Etiology

Because etiology and psychodynamics are closely interwoven the previous section includes a number of speculations concerning the genetic origin of the patient's narcissism. This section will draw together and argue the causal factors posited in the case study chapter and the above section on psychodynamics.

In spite of the considerable differences in the psychodynamic formulations of narcissism presented by various influential theorists there is remarkably close concordance on the issue of the causal factors involved. All the authors cited in the literature review adopt an **environmentalist** stance - they argue that pathological narcissism is a (mal)adaptive response to deficient parental care at formative stages in the child's psychogenesis. Balint contends that at the developmental point when symbiotic union with the mother ("primary love") ends, the child's awareness of seperateness and dependence renders him/her perticularly vulnerable to deficient maternal care. If this care is not adequate the child deals with the resulting anxiety either **ocnophilically** - becoming excessively clinging and dependent - or

philobatically - withdrawing from people and becoming excessively independent. The latter defensive strategy is clearly narcissistic in character. According to Winnicott self-pathology results from the absence of good-enough-mothering in the early months of infancy prior to the attainment of object constancy. Either through impingement or non-recognition the mother fails to meet and mirror her infant's spontaneous omnipotent gestures. This retards the process of ego differentiation and development, resulting in the retreat of the true self behind the rigid defensive facade of the false self structure which forms the nucleus of the grandiose self-representation.

In Kohut's model the arrested self-structuralization results from the parental selfobjects' failure to mirror the child's phase-appropriate grandiosity and to invite the child's idealization. As a result transmuting internalization of the selfobject is prevented and the internal structures for self-esteem regulation cannot develop. Compensatory narcissistic selfobject relationships are consequently necessary to bolster the chronically fragile sense of self-worth.

According to Kernberg a coldly aggressive, resentful or indifferent mother results in the infant's experience of oral deprivation and subsequent hunger, greed and rage. The consequent excessive splitting results in feelings of emptiness and inferiority which are defended against by the grandiose self formed by the fusion of real self, ideal self and ideal object. Kernberg isolates another causal factor in the parents' attempts to vicariously satisfy their own narcissistic needs vicariously through the lives of their children while not recognizing the latter's own needs.

In various degrees all of the above positions are supported by evidence from this case study. Dianna's narcissism can clearly be traced to her childhood relationship with a pathogenic mother. Available information suggests that Dianna's mother was narcissistically disturbed. She appears to have been a

superficially hard, powerful, domineering matriarch who was so devoted to her children that she made considerable sacrifices for them. Her sacrifices, however, were narcissistic attempts to realize vicariously her own frustrated needs through their accomplishments e.g. her fantasy of Dianna one day becoming a great writer and making the family wealthy. Dianna, in other words, functioned as a selfobject for her mother. In spite of her apparent devotion to her family she was cruelly insensitive to Dianna's needs for love and recognition, awarding these only when Dianna earned them by meeting her mother's expectations of appropriate behaviour. Her mother, moreover, was easily hurt and angered when Dianna did not live up to these maternal expectations. Dianna, her dependency needs for love and recognition frustrated by her selfishly insensitive mother, renounced these needs. An omnipotent, invulnerable false self structure emerged to deal with her destructive maternal environment. She became prematurely self-reliant and withdrew into a private world of fantasies and books. By the age of five she was no longer a child but a miniature adult. But underlying her haughty, superior, self-sufficient exterior was a hungry, empty, vulnerable, dependent and angry little girl who resented her lack of nurturance and wished her mother harm. Destructive phantasies coexisted with guilt and reparative urges.

A comprehensive outline of the ensuing psychodynamic details is included in the previous section and need not be repeated here. What stands out clearly is that Dianna's narcissism was a defensive adaption to a narcissistic mother who not only failed to meet her daughter's dependency needs but also unconsciously expected Dianna to gratify her own frustrated needs. Deeply frustrated, unhappy and resentful she sought vicarious satisfaction through the life of her daughter. Dianna felt burdened, angry and guilty and retreated behind a narcissistic mask, repressing both her anger and her frustrated need for love.

One author who, more than most, emphasises the narcissistic mother as the primary etiological determinant is Alice Miller (1987):

> "What these mothers had once failed to find in their own mothers they were able to find in their children: someone at their disposal who can be used as an echo, who can be controlled, is completely centered on them, will never desert them, and offers full attention and admiration". (Miller 1987 pg 53)

The truth of this in Dianna's case is illustrated by the fact that her "huge, indomitable mother" became weaker and insecure when the children left home - losing her selfobjects meant confronting her own narcissistic emptiness and inadequacy.

Dianna intuitively realized the fragility and insecurity that lay beneath her mother's narcissistic character defenses. This was evident in her tendency to search out emotionally disturbed people in order to heal them: "**I would always find people with hang-ups and want to fix them. I guess I needed to be needed**". These were displaced reparative attempts to heal her narcissistic mother. Harold Searles is fond of emphasising that the extent of his patients' pathology is determined by the extent to which their therapeutic strivings to heal their disturbed parents were frustrated. The child wishes to heal his disturbed mother in order that she might function as an adequate parent to him. This introduces an added perspective to the traditional Kleinian notion of reparative urges. In this case Dianna's therapeutic strivings made her resentment and anger even more difficuilt to accept.

The question that emerges is not why Dianna became narcissistically disturbed but why, given her history, she was not more disturbed? The answer, I believe, lies in her relationship with her father. Although he was clearly a weak man

the fact that Dianna was "his pride and joy" meant that she must have received sufficient devotion and mirroring from him to compensate for her deficient maternal care. This probably amelierated the malignant influence of her mother by providing adequate mirroring and the subsequent transmuting internalization of a good paternal introject.

6.4 Psychotherapy

Details of the therapeutic interaction are included in the case study chapter. This section will therefore simply provide a summary of the course of Dianna's treatment and offer a few observations on therapeutic strategy with less severely disordered narcissistic patients.

Dianna approached psychotherapy as an exercise in intellectual excavation. She wanted to uncover the cause of her problem by analyzing clues and integrating them within a sophisticated water-tight conceptual framework that would allow her total mastery and control over her world. My dual role was to be that of intellectual accomplice and admiring observer of her conceptual and verbal skills. I realized that a therapeutic priority was that of creating a space in which Dianna could feel safe enough to relax her intellectualizing defences and search for cognitive control sufficiently to experience her narcissistic injury and its biographical context. The focus, given her life history, would inevitably be her relationship with her narcissistic mother.

Stage one: sessions two to five

The first stage of therapy began with the implicit question of whether I, the transference mother, was strong enough to hold and contain Dianna's destructive feelings without being destroyed or rejecting her repressed dependency needs for love and

recognition. Her need to be held competed with her defensive need for self-sufficiency and emotional control. The question of trust was central. Dianna needed to know that I was not just professionally interested in her but that I really cared for her on a personal level, thus echoing the childhood insecurity she felt that her superficially competent mother was discharging her maternal duties without authentic care and affection. Although narcissistic qualities were present her relational style and defenses began to emerge as primarily neurotic.

Stage two: sessions six to eleven

The second stage of therapy was characterised by a rapid intensification of mixed transference feelings revealed primarily through dream material. Almost all the work during this period involved working with dream imagery because of the richness, depth and emotional charge of the dream content. Dianna was very frustrated by the restrictions imposed by the therapeutic frame. She was asking for nourishment and holding but the transience and professional nature of our relationship meant that I would inevitably fail her. She felt angry, hurt, jealous and betrayed by the fact that I had other patients and was not simply there for her alone. Furthermore, she felt that my apparent caring for her was not sincere but rather an impersonal therapeutic strategy. This announced the renewed emergence of depressive fears that I might be harmed by her destructive feelings and that she needed to protect me from herself. Increasing anxiety about becoming dependent on this uncaring therapist-mother anticipated the emergence of sexualized feelings which she dealt with by splitting me into the personal and the professional, pushing away the former in order to relate only to the latter. Interpretation of her narcissistic defenses resulted in feelings of depression and inadequacy. There was an atmosphere of anxious expectancy as she felt the approach of a nebulous but imminent emotional collapse. She made various attempts to control me and manipulate

me into modifying the therapeutic frame. At this point her resentment became anger and she experienced me as the cold, witholding, uncommitted therapist-mother who related to her mechanically without any real feeling or concern. Her response was a temporary return to defensive self-sufficiency of earlier. I experienced various strong countertransference feelings during this stage ranging from fear of her destructiveness to anxiety and guilt that I could not give her more, that I was incarnating her coldly ungiving mother.

Stage three

This stage began with the insight that her anger resulted from me not being deceived by and identifying her with the false self she presented. Although this made her vulnerable it also meant that her underlying weak and vulnerable real self felt recognized. She no longer attempted to control me but instead tried to use intellectualization to exercise self-control on increasingly finer levels to avoid falling into a black internal void. At this point she needed to feel held without her vulnerability being exploited as it had originally been exploited by her narcissistic mother. The descent into the emptiness confronted her with the realization that her narcissistic facade had been a mask and that there was a possibility that there might be nothing behind the mask, that she might in fact be hollow. This marked a distinct turning point in therapy, with Dianna recalling the childhood narcissistic fantasies of identifying with her ideal self in order to assuage the pain of not being loved for her real self alone. Her narcissistic fantasies were now no longer an adequate defense against the therapeutic confrontation with her repressed negative self-representation. She sadly acknowleged the untenability of identification with her ideal self and anxiously turned to face the world without the protection of her narcissism. She felt extremely vulnerable, fearing that without her narcissistic exoskeleton I might destroy or injure her like

her mother had done before. I became the transference mother who would not love her unless she met my expectations and subjected herself to my narcissistic power. Then began a period of dialogue with the aspects of Dianna's previously repressed negative self-representation and the tentative possibility that the integration of the latter might herald fertile possibilities for true self functioning without the hollow pseudo-security of a narcissistic false self structure. But the gravity of her emptiness drew her back to the hollow self and the possibility of non-existence. What emerged, however, was not nothingness but a polluted internal world contaminated by a malignant maternal introject which threatened the life of her good objects and the secret pockets of true self residues. Renewed and intensified depressive anxiety arose at this point with Dianna's fantasy that her aggressive destructiveness might harm the ambivalently loved and hated maternal object and all those (especially me) who came close to her.

Therapy ended prematurely at a point when Dianna felt raw, vulnerable and frightened, not only by her fragility but also by the aggression which we had only just begun to uncover. In spite of our short time together, however, she had undergone considerable change. She was warmer, less aggressive, more accessible and receptive. Her personal relationships had improved as a consequence and she found herself really listening to and empathising with people rather than intellectually analyzing their words and arguing for exhibitionistic effect.
Although she feared the return of her old narcissistic facade I do not think this is likely to happen. I am optimistic that her narcissistic false self structure has been sufficiently modified to allow more flexible and meaningful contact both with other people and with her own real self. Clearly, however, many issues were uncovered without being sufficiently worked through. At the time of termination Dianna was enthusiastic about entering long-term therapy at a later date. In spite of its many limitations I

consider our psychotherapy to have been reasonably successful. This is less attributable to my interventions than it is to her remarkable resources and capacities. Foremost in this regard was a rich internal internal world that, in spite of her subjective feelings of emptiness, proved to be a rather full and textured space. A second quality that stands out was her imaginative capacity for spontaneous fantasy. I discovered this in my efforts to side-step her formidable intellectualizing defenses. Dianna tried to make therapy a process of intrapsychic intellectual analysis rather than an interpersonal emotional experience. My detailed analysis of her intrapsychic dynamics gives a misleading impression of the therapy, which was very interpersonal in nature and focused on the spontaneous emergence of feelings in the immediate context of our relationship. In order to shift Dianna's defensive focus from the intellectual analysis of intrapsychic events and past incidents I would often ask if any images or fantasies emerged from the fleeting feeling states that she so desperately tried to intellectualize out of existence. To my surprise a vibrant and evocative world of spontaneous imagery opened up. The rest of our time together was spent almost exclusively working on fantasy and dream imagery, with specific emphasis on the transference context in which these images arose. Dianna, more than any other patient, has taught me about the therapeutic power of spontaneous imagery in accessing and working with deep unconscious material.

6.5 An explanatory model of narcissistic neurosis

This case study demonstrates that certain categories of less severe narcissistic disorders may respond favourably to short-term depth psychotherapy. The term **narcissistic neurosis**, purged of its Freudian connotations, suggests itself as the logical and most appropriate diagnostic label for the category I have in mind. I would define narcissistic neurosis as a form of

psychopathology in which a primarily neurotic character structure presents with a distinctly narcissistic symptom profile.
I use the term neurosis to refer to a syndrome in which egodystonic self-representations, occuring in a relatively cohesive self-structure, result in anxiety, the meaning of which is covertly expressed through symptom formation but actively denied conscious expression through the use of high level defenses.

The obvious question to ask is why a neurotic would present with narcissistic symptomatology? This case study, I believe, provides a plausible answer: **the defensive self-sufficiency and grandiosity of the person's false self structure emerges as a compensatory response to an internalized negative self-other relational unit resulting from a particular mode of deficient mothering.**

On the basis of this case study and my reading of the object relations literature I have formulated a rough explanatory model which attempts to outline the psychodynamic development of narcissistic neurosis. ([2]) The stages in the formation of narcissistic neurosis, I would argue, are as follows:

1) Stage one in the pathogenesis of narcissistic neurosis probably occurs after a period of adequate maternal provision has insured the successful negotiation of the paranoid-schizoid position, the capacity for play in the transitional space, and the attainment of object constancy. If this period of adequate mothering is initially absent in the first few months of life developmental arrest will occur within the configuration of paranoid-schizoid psychodynamics. In this eventuality severe self-pathology (NPD, BPD, schizotypal personality disorder or

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[2] Because my model derives from a single case study I do not make claims for its universal application in other similar cases. Its use is purely heuristic.

even psychosis) rather than neurosis will occur. Adequate mothering during this critical period explains why narcissism emerges in the context of a neurotic rather than a personality disorder character structure. However, at this point the quality of maternal care fails the stage-dependent needs of the child. The nature of these needs is most comprehensively presented in Margaret Mahler's (1979) model of infantile psychic development. Details of this model will not be presented here. Suffice it to say that between the the ages of fifteen and eighteen months the toddler experiences a crisis (the "rapprochement crisis") arising out of a developmental tension between contradictory emotional needs. On the hand there is the developmental need for independence, differentiation and separation from mother. The consequent exploratory forays from the maternal orbit, however, result in seperation anxiety, vulnerability and the regressive longing for symbiotic (re)fusion with the maternal object. The resulting tension between these opposing needs leads to considerable anxiety and frustration. The mother at this point is required to intuitively recognize the child's dilemma and to affirm his need for autonomy while accepting the periodic periods of regressive dependency and clinging. If the mother is threatened by the child's impending seperation from her only the regressive dependency needs are rewarded. This, I would argue, is the origin of borderline pathology, which is characterised by excessive dependency and seperation anxiety: "If I become a seperate person mother will abandon me. I will surrender my independent selfhood rather than risk rejection". The narcissistic mother, I believe, is threatened by her child's dependency needs, probably because her own frustrated dependency needs were never met by her own mother. She thus needs her child to become prematurely mature and renounce his dependency needs in order that he might gratify her own unmet needs. Through her selfobject identification with him she can vicariously live out her frustrated needs through his life: "Unless I stop being a child and grow up quickly in order to meet mother's needs and

expectations she will cease to love me". (My patient's relationship with her narcissistic mother supports this hypothesis). On these grounds I propose the following: **Borderline and narcissistic pathologies result from opposite defensive strategies to the threat of the maternal withdrawal of love. The borderline child employs the adaptive strategy of pathological dependence whereas the narcissistic child employs the strategy of premature pathological independence.**

Because at this stage identification has not yet replaced introjection as the primary internalization mechanism the negative child-mother interaction is internalized as a relational unit (I have in mind Kernberg's self-affect-object model of the introject structure). The object pole of this introject/unit is a demanding, insensitive maternal object who places conditions on her love, unconsciously demands that the target child gratify her own unmet needs, and who lives out her frustrated ambitions/ideals through the accomplishments of the target child. The self pole of this relational introject - initiated by the negative experience of self in relation to primary other - is a needy, hungry, angry, unrecognized, vulnerable and empty child who does not feel held or met by mother.

2. Stage two occurs simultaneously on two different levels: (a) **intrapsychically**, with the repression of this negative self-representation and its replacement by a defensively grandiose, omnipotent surface self-representation, and (b) **interpersonally**, by severing dependency relations with the destructive object by becoming prematurely independent and self-sufficient.

3. Stage three occurs when, owing to some specific precipitating event or general life context, symptoms emerge as symbolic expressions of the activated egodystonic bipolar introjects. Because of the nature of the repressed self-representation the presenting symptoms would probably involve feelings of emptiness,

inadequacy, loneliness, fragility, depression, abandonment etc even though the patient's interpersonal style may be expressly narcissistic - perhaps even more so than usual in order to combat the underlying negative self-representation with intensified narcissistic defenses.

6.6 Suggestions concerning assessment criteria for short-term psychotherapy with narcissistic neurotics

Because severe narcissistic disorders are notoriously difficuilt to treat and those with a favourable prognosis respond only to long-term intensive psychotherapy it is imperative that careful assessment criteria are employed to distinguish narcissistic neurosis from NPD. Data from this case study suggests that the following differential diagnostic criteria may prove useful in this regard:

(a) The symptomatology in NPD is more severe and long-standing than in narcissistic neurosis. This refers not only to the presenting problem as defined by the patient but also other narcissistic symptoms elicited during the assessment session. A qualitatively different premorbid profile is more likely in narcissistic neurosis. Furthermore, NPD symptoms are more likely to effect occupational and social functioning than is the case with narcissistic neurosis.

(b) In narcissistic neurosis the symptoms are likely to be more egodystonic than is the case in NPD. This means that the neurotic narcissist is more likely to experience and admit to feeling anxiety, depression and other feelings of subjective distress than is the NPD patient. This not only means a healthy motivation for change, it also indicates that the negative self-representation is closer to consciousness and thus more therapeutically accessible.

(c) In the case of neurotic narcissists a clearly defined therapeutic focus is more likely to emerge than with personality disordered narcissists who often present with multiple diffuse and non-specific complaints and issues. For example, in spite of the vagueness of my patient's presenting problem the troubled relationship with her mother quickly emerged as a useful focal issue.

(d) Narcissistic neurosis is characterized by the use of higher order defense mechanisms (primarily repression) than NPD where lower order defenses such as splitting, denial, projective identification etc predominate. The preponderance of these lower order defenses is an indication that paranoid-schizoid dynamics are dominant.

(e) The objective relations of neurotic narcissists are qualitatively better than those characteristic of NPD. The former are far more likely to have relatively intimate and enduring friendships and sexual relationships than are the latter. Neurotic narcissists are far more likely to relate to others as seperate people rather than as selfobjects and to appreciate them as a complex admixture of good and bad qualities (i.e. whole objects) rather than all good or all bad - an indication of part-object relating. Self-descriptions in narcissistic neuroses are also more likely to be three-dimensional, complex, textured and characterized by a mixture of positive and negative qualities.

(f) Neurotic narcissists are less likely to evidence identity diffusion/confusion than are people with NPD. Gender confusion, homo- or bisexuality and lack of vocational direction are common indicators of identity diffusion.

(g) In narcissistic neurosis there is more evidence of reasonable superego functioning manifest as feelings of conscience, guilt and a valued set of personal ethics, than is the case in NPD.

(h) Neurotic narcissists have a broader and more differentiated affective range than NPDs. The capacity for mild depression, sadness, warmth, empathy and vulnerability are good indications that depressive rather than paranoid dynamics are operant.

(i) Transference and countertransference phenomena, as well as communication style in the assessment period are extremely valuable differential diagnostic indicators. Firstly, in the case of NPD idealization, disparagement, envy, avoidance of personal contact, grandiosity and exhibitionism are far more likely to be more overt and intense. Secondly, countertransference feelings of anger, boredom, sleepiness, lack of empathy and non-relatedness are common with cases of NPD. With narcissistic neurosis the clinician is more likely to feel empathy, warmth and a sense of relationship. Thirdly, response to interpretation is an important differential criterion - With NPDs interpretations are often ignored, criticized or do not deepen rapport. Narcissistic neurotics are more likely to respond to accurate interpretations with anxiety, relief and deepened rapport. Fourthly, narcissistic neurotics are also far more likely to think about and respond emotionally between sessions to the events of the previous session(s). NPDs, on the other hand, are often emotionally unaffected and frequently do not think about therapy between sessions. Fifthly, the communications and dreams of narcissistic neurotics are far more likely to have the quality of symbolically conveying hidden meaning. NPD communication is often flat and meaningless with no sense of multiple layers or symbolically disguised messages.

As illustrated by this case study a narcissistic presenting profile does not automatically warrant a diagnosis of NPD. Careful and patient assessment may reveal a neurotic underlying structure which may respond favourably to brief psychotherapy.

6.7 Chapter summary

Discussion of the case study began with the issue of narcissistic diagnosis in the context of both the symptomatic and developmental object relations diagnostic perspectives. It was argued that both of the above result in mutually exclusive diagnostic categories that do not do justice to the complexities of the phenomena which straddle these conceptual divides.

The second section of the chapter was devoted to a detailed analysis of the patient's psychodynamics. The central psychodynamic structure to emerge was that of a narcissistic false self facade which served to defend the patient from a repressed negative self-representation comprising aspects of neediness, ordinariness, aggression and emptiness. Phantasies of a polluted internal world arising from the internalization of a bad maternal introject was a dominant feature. Also present were depressive anxities about harming the ambivalently loved and hated maternal object. Emphasis was placed on the ameliatory influence of vibrant true self functioning. This section concluded with the psychodynamic application of the basic fault concept and a critical discussion of certain paradoxes to emerge in this regard.

Part three considered popular hypotheses concerning etiological factors in narcissistic development. Evidence from the case study supported most of these theories. The specific etiological factor in this case appears to have been a narcissistic mother who used the patient for both direct and vicarious satisfaction of her own frustrated needs while not recognizing and meeting the needs of the patient. The patient's narcissism was an adaptive response to this uncongenial maternal environment.

Section four briefly discussed the the three stages of the therapeutic process and the factors presumed responsible for the therapy's relative success.

Section five was devoted to the definition and formulation of an explanatory model of narcissistic neurosis. It was argued that the narcissistic false self structure emerges after a period of adequate maternal provision ensures object constancy, psychic structuralization and the transition from primitive to more mature defenses. At this point a specific mode of deficient mothering results in the internalization of a negative self-object relational unit which necessitates the repression of this unit and the formation of a compensatory narcissistic self-representation to defend the psyche against the underlying deficient self- and object representations.

The chapter concluded with suggestions arising out of the case study concerning assessment criteria for short-term psychotherapy with narcissistic neurotics. It was emphasised that strict assessment criteria should be employed to differentiate narcissistic neurosis from narcissistic personality disorder as brief psychotherapy is contraindicated in the case of the latter.

CHAPTER SEVEN

CONCLUSIONS

This case study details the psychoanalytically-oriented brief psychotherapy of a female patient over a period of twenty twice-weekly sessions. The hermeneutic framework employed was that of the psychoanalytic object relations tradition. The author's understanding of the therapeutic dynamics was dialogued with the theories of narcissistic pathology provided by Balint, Winnicott, Kohut, Kernberg and Stolorow. The history of the concept of pathological narcissism in psychoanalysis was briefly reviewed and current diagnostic systems presented. Although the patient used for the case study initially presented as a case of narcissistic personality disorder certain anomalies in the course of treatment disconfirmed this initial impression and raised a number of diagnostic paradoxes. The data from this case study was used to advance the proposition that narcissistic symptomatology and psychodynamics may occur within a primarily neurotic character structure. Because diagnostic provision has not been made for this phenomenon in either the symptomatic or object relations developmental diagnostic models the author advocates the use of the term **narcissistic neurosis** to describe this disorder. Owing to the fact that object relations psychoanalytic theory has not provided an explanation for narcissistic neurosis the author formulated his own object relations explanatory model, drawing eclectically on the above mentioned object relations theorists, with the addition of Klein and Mahler. This model may be summarized in the following points:

1. The functional purpose of narcissistic pathology is the formation and maintenance of a grandiose, omnipotent and self-sufficient surface self-representation which protects the person against an underlying negative self-representation comprising feelings of emptiness, inadequacy, neediness and anger.

2. The (neurotic) narcissistic false self emerges at a developmental juncture when prior adequate maternal provision has insured the acquisition of object constancy, the relatively successful negotion of the paranoid-schizoid position and the replacement of primitive by more mature dynamics and defensive strategies. If this initial period of adequate mothering is absent development will be arrested at the paranoid-schizoid position. If specifically narcissistic pathology arises as a consequence it is more likely to assume the form of narcissistic personality disorder than the less severe narcissistic neurosis. The latter is less severe primarily due to the absence of splitting defenses which fragment the self and the object, resulting in part- rather than whole object relating and the predominance of paranoid anxieties.

3. Narcissistic neurosis may be structurally differentiated from NPD by the following: (a) The negative self-representation is repressed rather than split off, thereby making it potentially more accessible and recoverable, (b) the structural cohesion and temporal continuity of the self is not seriously threatened by decompensation, (c) whole rather than part-object relating and the increased capacity to see others as autonomous rather than merely selfobjects, (d) anxiety is depressive rather than paranoid i.e. anxiety relates to a fear of harming others rather than the developmentally earlier paranoid fear of being harmed by others.

4. The etiology of narcissistic neurosis results from the previously adequate mother's inability to meet the child's phase specific developmental needs due to her own unresolved conflicts concerning these needs. The specific need in this case concerns the recognition and gratification of the dependency, vulnerabilty, and need for holding that emerges in reaction to the child's increasing seperation from the maternal orbit.

(Frustration of the child's earlier need to have his grandiosity mirrored is more likely to result in NPD). The narcissistic mother demands that the child renounce his/her dependency needs and become prematurely adult in order to gratify the mother's own unmet needs and provide a means for the vicarious satisfaction of her frustrated ambitions/ideals.

5. The subsequent internalized self-object interactional unit comprises a demanding, insensitive and rejecting object-representation and a self-representation of a needy, hungry, empty and angry child.

6. In order to defend against this negative introject the child responds interpersonally by becoming prematurely self-sufficient, and intrapsychically by repressing the negative self-representation and replacing it with a defensively grandiose, omnipotent surface self-representation.

7. The advent of a specific precipitating event or general life context initiates the emergence of symptoms which symbolically express the nature of the repressed egodystonic self-representation.

Providing that careful discriminating assessment criteria are employed to diagnostically differentiate NPD from narcissistic neurosis the latter may be successfully treated with brief psychodynamic therapy.

Treatment of the patient focused intensively on the activation of the repressed negative self-representation in the context of an ambivalent maternal transference using dream imagery and spontaneous fantasy. In spite of the short duration of psychotherapy treatment was considered to be largely successful according to the criteria of significant modification of the narcissistic false self, greater self-insight and qualitatively improved interpersonal relations.

Appendix One: Ovid's Narcissus Myth, from Schwartz-Saland (1982)
pgs 73 - 76.

2 Ovid's Myth of Narcissus

The following translation of the myth is by Louise Vinge.[92] I include it here in its entirety because we shall be concerned with most of its elements. It begins with praise for the blind seer Tiresias:

> He, famed far and near through all the Boeotian towns, gave answers that none could censure to those who sought his aid. The first to make trial of his truth and assured utterances was the nymph, Liriope, who once the river-god, Cephisus, embraced in his winding stream and ravished, while imprisoned in his waters. When her time came the beauteous nymph brought forth a child, whom a nymph might love even as a child, and named him Narcissus. When asked whether this child would live to reach a well-ripened age, the seer replied: "If he ne'er knows himself." Long did the saying of the prophet seem but empty words. But what befell proved its truth – the event, the manner of his death, the strangeness of his infatuation. For Narcissus had reached his sixteenth year and might seem either boy or man. Many youths and many maidens sought his love; but in that slender form was pride so cold that no youth, no maiden touched his heart. Once as he was driving the frightened deer into his nets, a certain nymph of strange speech beheld him, resounding Echo, who could neither hold her peace when others spoke, nor yet begin to speak till others had addressed her.
>
> Up to this time Echo had form and was not a voice alone; and yet, though talkative, she had no other use of speech than now – only the power out of many words to repeat the last she heard. Juno had made her thus; for often when she might have surprised the nymphs in company with her lord upon the mountain sides, Echo would cunningly hold the goddess in long talk until the nymphs were fled. When Saturnia realized this, she said to her: "That tongue of thine, by which I have been tricked, shall have its power curtailed and enjoy the briefest use of speech." The event confirmed her threat. Nevertheless she does repeat the last phrases of a speech and returns the words she hears.
>
> Now when she saw Narcissus wandering through the fields, she was enflamed with love and followed him by stealth; and the more she followed, the more she burned by a nearer flame; as when quick-burning sulphur, smeared around the tops of torches, catches fire from another fire brought near. Oh, how often does she long to approach him with alluring words and make soft prayers to him! But her nature forbids this, nor does it permit her to begin; but as it allows, she is ready to await the sounds to which she may give back her own words.
>
> By chance the boy, separated from his faithful companions, had cried: "Is anyone here?" and "Here!" cried Echo back. Amazed, he looks around in all directions and with loud voice cries "Come!"; and "Come!" she calls him calling. He looks behind him and, seeing no one coming, calls again: "Why do you run from me?" and hears in answer his own words again. He stands still, deceived by the answering voice, and "Here let us meet," he cries. Echo, never to answer another sound more gladly, cries: "Let us meet"; and to help her own words she comes forth from the woods that she may throw her arms around the neck she longs to clasp. But he flees at her approach and, fleeing, says: "Hands off! Embrace me not! May I die before I give you power o'er me!" "I give you power o'er me!" she says, and nothing more.
>
> Thus spurned, she lurks in the woods, hides her shamed face among the foliage, and lives from that time on in lonely caves. But still, though spurned, her love remains and grows on grief; her sleepless cares waste away her wretched form; she becomes gaunt and wrinkled and all moisture fades from her body into the air. Only her voice and her bones remain; then, only voice; for they say that her bones were turned to stone. She hides in woods and is seen no more upon the mountainsides; but all may hear her, for voice, and voice alone, still lives in her.

Thus has Narcissus mocked her, thus has he mocked other nymphs of the waves or mountains; thus has he mocked the companies of men. At least one of these scorned youth, lifting up his hands to heaven, prayed: "So may he himself love, and not gain the thing he loves!" The goddess, Nemesis, heard his righteous prayer. There was a clear pool with silvery bright water, to which no shepherds ever came, or she-goats feeding on the mountain side or any other cattle; whose smooth surface neither bird nor beast nor falling bough ever ruffled. Grass grew all around its edge, fed by the water near, and a coppice that would never suffer the sun to warm the spot. Here the youth, worn by the chase and the heat, lies down, attracted thither by the appearance of the place and by the spring.

While he seeks to slake his thirst another thirst springs up, and while he drinks he is smitten by the sight of the beautiful form he sees. He loves an unsubstantial hope and thinks that substance which is only shadow. He looks in speechless wonder at himself and hangs there motionless in the same expression, like a statue carved from Parian marble. Prone on the ground, he gazes at his eyes, twin stars, and his locks, worthy of Bacchus, worthy of Apollo; on his smooth cheeks, his ivory neck, the glorious beauty of his face, the blush mingled with snowy white; all things, in short, he admires for which he is himself admired.

Unwittingly he desires himself; he praises, and is himself what he praises; and while he seeks, is sought; equally he kindles love and burns with love. How often did he offer vain kisses on the elusive pool? How often did he plunge his arms into the water seeking to clasp the neck he sees there, but did not clasp himself in them? What he sees he knows not; but that which he sees he burns for, and the same delusion mocks and allures his eyes. O fondly foolish boy, why vainly seek to clasp a fleeing image? What you seek is nowhere; but turn yourself away, and the object of your love will be no more. That which you behold is but the shadow of a reflected image and has no substance of its own. With you it comes, with you it stays, and it will go with you – if you can go.

No thought of food or rest can draw him from the spot; but, stretched on the shaded grass, he gazes on that false image with eyes that cannot look their fill and through his own eyes perishes. Raising himself a little, and stretching his arms to the trees, he cries: "Did anyone, O ye woods, ever love more cruelly than I? You know, for you have been the convenient haunts of many lovers. Do you in the ages past, for your life is one of centuries, remember anyone who has pined away like this? I am charmed and I see; but what I see and what charms me I cannot find – so great a delusion holds my love. And, to make me grieve the more, no mighty ocean separates us, no long road, no mountain ranges, no city walls with close-shut gates; by a thin barrier of water we are kept apart.

"He himself is eager to be embraced. For, often as I stretch my lips towards the lucent wave, so often with upturned face he strives to lift his lips to mine. You would think he could be touched – so small a thing it is that separates our loving hearts. Whoever you are, come forth hither! Why, O peerless youth, do you elude me? Or whither do you go when I strive to reach you? Surely my form and age are not such that you should shun them, and me too the nymphs have loved. Some ground for hope you offer with your friendly looks, and when I have stretched out my arms to you, you stretch yours too. When I have smiled, you smile back; and I have often seen tears, when I weep, on your cheeks. My becks you answer with your

nod; and I suspect from the movement of your sweet lips, you answer my words as well, but words which do not reach my ears.- Oh, I am he! I have felt it, I know now my own image, I burn with love of my own self; I both kindle the flames and suffer them. What shall I do? Shall I be wooed or woo? Why woo at all? What I desire, I have; the very abundance of my riches beggars me. Oh, that I might be parted from my own body! And, strange prayer for a lover, I would that what I love were absent from me! And now grief is sapping my strength; but a brief space of life remains to me and I am cut off in my life's prime. Death is nothing to me, for in death I shall leave my troubles; I would he that is loved might live longer; but as it is, we two shall die together in one breath."

He spoke and, half distraught, turned again to the same image. His tears ruffled the water, and dimly the image came back from the troubled pool. As he saw it thus depart, he cried: "Oh, whither do you flee? Stay here, and desert not him who loves thee, cruel one! Still may it be mine to gaze on what I may not touch, and by that gaze feel my unhappy passion."

While he thus grieves, he plucks away his tunic at its upper fold and beats his bare breast with pallid hands. His breast when it is struck takes on a delicate glow; just as apples sometimes, though white in part, flush red in the other part, or as grapes hanging in clusters take on a purple hue when not yet ripe. As soon as he sees this, when the water has become clear again, he can bear no more; but, as the yellow wax melts before a gentle heat, as hoar frost melts before the warm morning sun, so does he, wasted with love, pine away, and is slowly consumed by its hidden fire. No longer has he that ruddy colour mingling with the white, no longer that strength and vigour, and all that lately was so pleasing to behold; scarce does his form remain which once Echo had loved so well. But when she saw it, though still angry and unforgetful, she felt pity; and as often as the poor boy says "Alas!" and his hands beat his shoulders she gives back the same sounds of woe. His last words as he gazed into the familiar spring were these: "Alas, dear boy, vainly beloved!" and the place gave back his words. And when he said "Farewell!" "Farewell!" said Echo too.

He dropped his weary head on the green grass and death sealed the eyes that marveled at their master's beauty. And even when he had been received into the infernal abodes, he kept on gazing at his image in the Stygian pool. His naiad-sisters beat their breasts and shore their locks in sign of grief for their dead brother; the dryads, too, lamented, and Echo gave back their sounds of woe. And now they were preparing the funeral pyre, the brandished torches and the bier; but his body was nowhere to be found. In place of his body they find a flower, its yellow centre girt with white petals.

When this story was noised abroad it spread the well-deserved fame of the seer throughout the cities of Greece, and great was the name of Tiresias.

Appendix two: The Case-study Method. From Bromley (1986) pgs 25-27.

THE CONTENTS AND ORGANIZATION OF A CASE-STUDY

The basic rules and procedural steps above describe how a case-study should be conducted but do not specify the sorts of information to be included. The treatment of this issue in this book is rather different from that described in Bromley (1977, pp. 173–202), to which readers who are particularly interested in the content analysis of case-studies are referred.

The question of what information is to be included in (or excluded from) a case-report should be answered within the case-report itself. At the heart of the case-report should be a description and analysis of the central problem(s) that the case-study was set up to deal with, together with any recommendations based on the analysis. These central issues, however, are embedded in a wider context of relevant information and procedural considerations.

It will be helpful to review the many sorts of information that commonly find their way into case-reports and personality descriptions. These range from obvious routine statements of fact, through an assortment of commonsense particulars about the case, to technical matters of a scientific and professional nature. Consider the following list of categories based on a content analysis of personality descriptions.

(i) The identity of the Subject of the case-study: his or her name, age, address, physical appearance.
(ii) The life-history, present circumstances, and future prospects of the Subject, including his or her routine activities, material possessions, physical health, and any pertinent incidents or life-events.
(iii) The psychological attributes of the Subject, including his or her characteristic reactions, motivations, attitudes, expressive behaviour, abilities, morality, self-image, and 'life-story'.
(iv) The Subject's social life: his or her social position, role and status, social relationships, family and kin, friendships, and loyalties.
(v) The relationships between the Subject and the Investigator(s) carrying out the case-study.
(vi) The value judgments of the Subject's morals in terms of the ethical standards governing the case-study.

In view of the fact that we are pursuing a technical (scientific and professional) approach to the psychological study of individual cases, it might seem out of place to recommend a moral judgment as an element in a case-report. The reasons for including it are as follows. First, moral attitudes and judgments are virtually unavoidable when assessing people; so one may as well recognize the fact and state one's attitude explicitly (otherwise it might affect the way one handles a case without one's being aware of the fact). Second, moral judgments can be justified by rational argument and reference to empirical data—see Toulmin *et al.* (1979, pp. 309–337), and Chapters 9 and 11 of the present book. One can determine the extent to which a person's conduct matches up to an agreed moral code, i.e. the collective moral code of the community of interest represented by the person(s) carrying out the case-study. Third, in many instances it is the Subject's failure to match up to the moral code of the community to which he or she belongs that gives rise to the need for the case-study; hence it is essential that the ethical isues involved be made clear. Fourth, the moral attitude of the community to which the Subject belongs is an important factor governing the social environment to which the Subject has to adjust; therefore it must be taken into account in the analysis and in any recommendations about the course of action to be taken in the interests of all concerned.

In addition to the sorts of categories of information listed above, a case-report should contain the following items.

(vii) A statement of the central problem(s) under investigation giving the purpose(s) and terms of reference of the case-study together with its authorship and authority.
(viii) A detailed account of the evidence and arguments describing and analysing the issues in the case, bearing in mind its purpose(s) and terms of reference.
(ix) Where appropriate, a detailed technical (scientific and professional) account of any central issues in the case which fall outside the normal range of commonsense and ordinary language (or can be dealt with more effectively in technical terms).
(x) A statement of the findings in the case, i.e. conclusions or solutions, justifying the associated decisions and recommendations.

If the case-report is lengthy, it is advisable to incorporate reminders, reviews, and summaries, as follows:

(xi) A review of the evidence and arguments dealing with the central issues in the case in relation to the conclusions reached and recommendations made.
(xii) A summary of the methods used in carrying out the case-study; a reminder about the context of the case (the circumstances surrounding it, the conditions which gave rise to it, the factors affecting its future); any reservations, implications, or comments deemed appropriate in reporting and publicising the case.

A psychological case-study carried out in a scientific and professional way can be presented as a technical report—see Cooper (1964) and Tallent (1983). Such a report contains three further items.

(xiii) A title and an abstract; the abstract should give simply a brief statement of what the case-study is about.
(xiv) Summary and conclusions: a brief statement of the problem, the methods used to investigate the problem, the main findings, conclusions, recommendations, and forecasts.
(xv) References, sources, acknowledgements.

I emphasize that there is no standard format for psychological case-studies. They vary in length, content, purpose, and organization. Consequently, the information need not cover all of the first ten categories listed above. If the case-report is brief, or if some aspects of the case-report are brief, then the relevant information is simply assimilated to the most convenient category. The aim is to prepare a concise, well-organized account of the case which represents the facts well and is as comprehensible and as useful as possible.

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