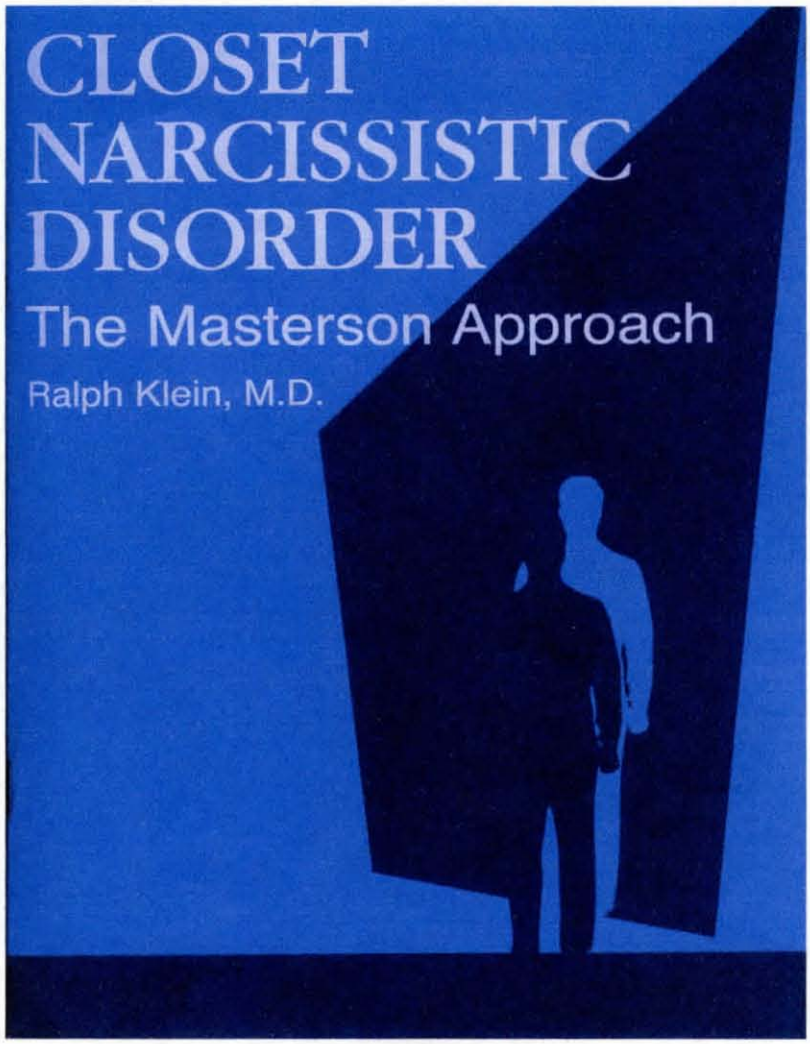
Klein, R. (1995) Closet narcissistic disorder



Klein, 1995,s.1
More often than not they defy the precise symptomatology of the DSM and elude the clinician's best efforts at treatment.

a form of narcissistic disorder not yet codified in the DSM the Closet Narcissistic Disorder

Klein, 1995,s.2
the Masterson Approach and describes in detail the specific form of developmental arrest experienced by the closet narcissist.

Klein, 1995,s.3
Clinicians who viewed these disorders as mild forms of psychosis emphasized supportive counseling. Those who saw these disorders as severe psychoneurosis attempted interpretations within a classical analytical framework. For the most part, these interventions failed because they did not address the patient's **developmental arrest**.

The Masterson Approach does this by:

1) identifying the developmental arrest;

2) linking the particular developmental arrest to a specific category of personality disorder and underlying intrapsychic structure; and

3) correlating specific personality disorders (or "disorders of the self' as Masterson refers to them) with specific therapeutic interventions.

The appeal of the DSM system is that it focuses on the most readily identifiable and most easily replicated phenomena: symptoms. The weakness of this system is that symptomatology is episodic and transitory [forbigående]. Another shortcoming of the DSM is that it emphasizes lower-level borderline and narcissistic patients who have difficulty functioning and tends to overlook higherlevel patients who tend to function better.

Klein, 1995,s.4
the DSM ..... does not include "closet narcissistic disorder"-the topic of this video and manual-an obvious handicap for evaluating and treating this type of personality disorder.

the intrapsychic structure-the patient's template [mal] for self-expression

the Masterson Approach reorganizes the many categories of personality disorder identified in the DSM-IV into four basic divisions: borderline, narcissistic, schizoid, and antisocial. Each diagnostic category of personality disorder within the Masterson Approach corresponds to a unique intrapsychic structure which reflects a specific developmental arrest that occurred during the patient's toddler years and impeded [hindre] normal maturation from that point on.

The Masterson Approach: The Theoretical Framework

The theoretical framework of the Masterson Approach is founded on the premise that **the psychological development which occurs from birth through three years of age is especially critical to an understanding of both normal development of the self, and the developmental arrest of the self which produces a personality disorder.**

Failures in the developmental process result in an impaired real self. To deal with the painful affects associated with the impaired real self (what Masterson has termed the "abandonment depression"), the patient develops a "false self."

Klein, 1995,s.5
The "real self' is the sum total of the individual's intrapsychic images of the self and of significant others, as well as the feelings associated with those images.

The self can be seen as the "operational arm" of the ego, though it is more than that. The ego can be seen as the "executant arm" of the self (through reality testing, impulse control, and other ego functions and "defenses").

While the clinician is concerned with ego functions (reality testing, frustration tolerance, impulse control) and object relations (the interpersonal world of the patient), the focus is on the self as it must act in the world (self-acknowledging, self-activating, committing, and creating).

The ingredients or building blocks of the real self consist of the biologic and genetic endowment, evolving maturational processes... , and the interactions of the developing self with a caring object (i.e., a mother or other primary caregiver) who can acknowledge and respond with support to the unique emerging self.

too each of us begins life with different genetic potentials that will direct our psychological capacities.

Klein, 1995,s.6
Caracteristics of the real self.

Spontaneity-Aliveness of Affect
The capacity to experience affect deeply with liveliness, joy, vigor, excitement, and spontaneity.

Self-Entitlement
From early experiences of mastery, coupled with parental acknowledgment and support for the emerging self, the person develops a sense that he/she is entitled to appropriate experiences of mastery and pleasure, as well as to the environmental input necessary to achieve these objectives. This sense is sorely deficient in patients with a borderline disorder of the self, and pathologically inflated in those with a narcissistic disorder.

Self-Activation and Assertion [hevdelse]
The capacity to identify one's unique wishes and to autonomously take initiative and use assertive modes of behavior to express those wishes in the external world, and to support and defend them when under attack.

Acknowledgment of Self-Activation and Maintenance of Self-Esteem
To identify and acknowledge to oneself that one has coped with an affective state and/or an environmental demand in a positive, adaptive

manner. This ability is a prerequisite for autonomously maintaining self-esteem.

Soothing of Painful Affects
The capacity to autonomously limit, minimize, and soothe [berolige] painful affects.

Continuity of Self
The recognition and acknowledgment that the "I" of one experience is continuous over time and related to the "I" of another experience.

Commitment
To commit the self to an objective or a relationship and to persevere despite obstacles.

Creativity
To use the self to change old, familiar patterns into new, unique, and different patterns.

Intimacy
The capacity to express the self fully in a close relationship with minimal fear of abandonment or engulfment [oppslukthet]

Klein, 1995,s.7
(1) The separation of internalized self representations from internalized object representations.

The child must learn that his or her needs, feelings, and thoughts are distinct and separate from what he imagines to be the needs, feelings, and thoughts of others.

The child thinks of himself and his mother as a single emotional unit. Masterson calls this a state of "like-mindedness" from the child's perspective.

(2) The integration of contradictory, opposite, affect states.

In early development, the child uses the defensive operation of "splitting," keeping apart contradictory affect states, with their associated self and object representations-memories and fantasies about what the self and others are like. The toddler tends to perceive or categorize experiences along global dimensions of good or bad, all or nothing, black or white. It is a developmental achievement to be able to perceive people, experiences, or the self as good and bad (at the same time), as neither all nor nothing, and as multi-colored (neither all white nor all black) (Mahler, 1975).

(3) The unfolding of the capacities of the emerging, individuated self.

The child, through experimentation and reinforcement, learns that the emerging self can and should primarily be creative and spontaneous and self-acknowledging, and not primarily reactive and compliant with the wishes and expectations of others.

Object Relations Theory
This developmental process described above is driven by a combination of fate, the push of the innate developmental forces, and an adequate nurturing environment. Crucial to the process is the mother's (or primary caretaker's) ability to foster and support the unique, individuative aspects of the child's emerging self. The parent supports the child's self-activation, reinforcing separation and the emergence of the child's real self.

Object relations theory is the psychoanalytically based study of the internalization of early interactions between child and parents.

Klein, 1995,s.8
What Is the Abandonment Depression?

A basic assumption of the Masterson Approach is that the developmental arrest of the real self stems from the failure of the combined forces of nature, nurture, and fate and results in a disorder of the self. **Individuals with disorders of the self present to themselves and to the world what Masterson terms a "false self."**

It is the function of the false self to come to the rescue and create a shield of distortion and pleasure for the embattled, impaired real self. It is the role of the false self to save the individual from knowing the truth

about the impaired real self, from penetrating the deeper causes of unhappiness, and from seeing the self as it really is: vulnerable, afraid, and unable to let the real self emerge.

The false self defends against a range of painful affects-including anxiety, depression, panic, rage, guilt, helplessness and hopelessness, and emptiness and void-which are known collectively, in the Masterson Approach, as the "abandonment depression."

Everyone with a disorder of the self experiences (or, rather, defends against experiencing) each of these painful feelings to some degree. They are the feelings which inevitably accompanied the child's experience of not having the emerging real self acknowledged, supported, and affirmed by significant caretakers.

The patient with a disorder of the self experiences life as the endless repetition of this vicious cycle.

Klein, 1995,s.9

The Borderline Disorder of the Self

In the DSM-IV, the borderline personality disorder is characterized by these criteria:

- interpersonal chaos,
- identity diffusion,
- affective instability (anger, emptiness),
- impulsivity (including suicidal preoccupation), and
- fear of abandonment.

This describes the most severe type of borderline disorder of the self. **To understand the entire spectrum of the borderline disorder of the self, the clinician must focus on the developmental arrest and associated intrapsychic structures.**

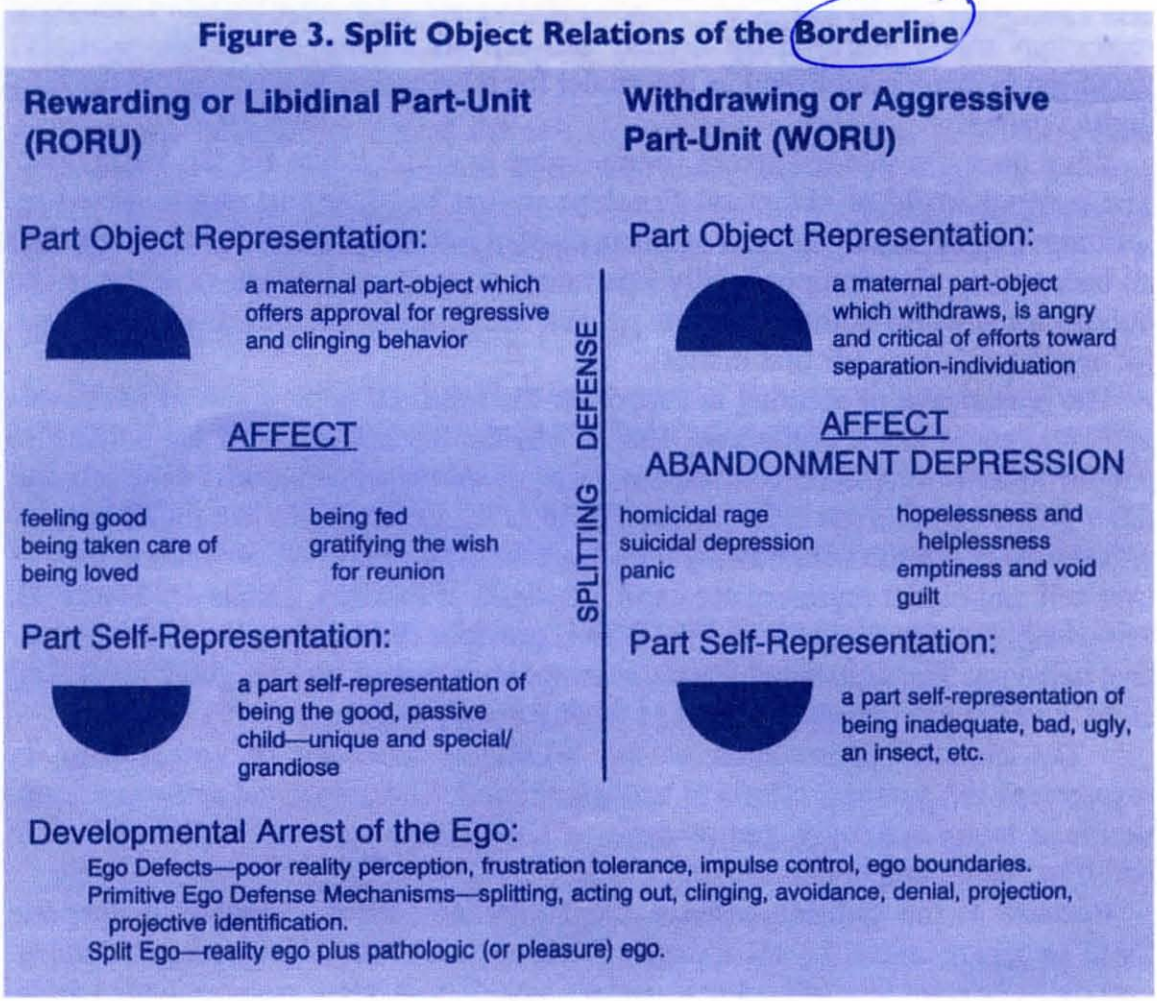
In the borderline disorder of the self, the necessary support for healthy self-activation was not available. Rather than emotional reward for healthy self-activation and discouragement of infantile, regressive behavior found in normal development, in the borderline patient's developmental history we find the opposite: reward for regression and withdrawal for healthy self-

activation. This pathologic relational form became established as the model for relationship in the mind of the borderline patient.

What does the internal world (intrapsychic map) look like for the borderline? **The internal world of object relationships is first and foremost characterized by splitting; experience of self and others is divided into rigid categories of all good or all bad, totally gratifying or totally frustrating. Everything is black or white in the interpersonal world of the borderline patient. There are no emotional shades of gray (or any other colors, for that matter).**

The persistence of splitting in support of the false self is the focus of the developmental arrest in the borderline. That is why the internal world of the borderline patient consists of split object relations units, or split representations of the self and other people. Masterson has described these as the Rewarding Object Relations part-Unit (RORU) and the Withdrawing Object Relations part-Unit (WORU), each with its own self and object representation and linking, or associated, affect (see Figure 3).

Figure 3. Split Object Relations of the Borderline



• The object representation of the RORU provides reward or approval for regressive behavior. The associated self-representation is that of being a good, compliant child, and the linking affect is that of feeling good.

• The object representation of the WORU is attacking or withdrawing in response to the person's efforts to activate the self. The associated self-representation is of being bad, ugly, and inadequate, and the linking affect is that of feeling bad (the abandonment depression).

Because of the splitting defense, the borderline patient is unable to integrate these two part-units (the all-approving caretaker and the all-rejecting caretaker, each with its attendant self-representations and affects) into a more realistic whole.

Klein, 1995,s.10

The defense of splitting combined with the paradigm of reward for regression and withdrawal for genuine self-activation leads to the disorders-of-the-self triad described above: self-activation leads to anxiety and depression, which leads to defense. Genuine self-activation (not just compliantly submitting to one's parents' wishes and expectations) leads to the painful feeling of abandonment (loss of the object or the approval of the object), which leads the child/patient to try to defend against this potentially traumatic, painful situation.

The patient can defend against these painful feelings by allying with (acting out in behavior with) the rewarding part-unit or the withdrawing part-unit. There is no other choice. Genuine, healthy self-activation only leads to more pain. The patient must defend. This means that the patient must ally himself with one or the other of the distorted part-units.

Usually, the patient will try to activate the rewarding part-unit. While the patient must behave in a regressive or compliant maladaptive fashion, his affective state is one of feeling good or taken care of, and the patient is able to deny the maladaptive behavior.

If the patient is frustrated in his efforts at being rewarded for this behavior, the withdrawing part-unit will be activated because of the splitting defense. When the withdrawing part-unit is activated, the other or "object" is, as described above,

Klein, 1995,s.11

experienced as withdrawing or attacking, the self is experienced as "bad" and "inadequate," and the associated affect is the abandonment depression. This state of affairs cannot be permitted to persist. Guided by the disorders-of-the-self triad, the patient must quickly defend. **The patient denies his own bad feelings, projecting them instead onto the object, and attacks the object as cold, inadequate, uncaring, or bad. In this fashion, the patient at the very least expresses his rage and feels in control.** Better still, the expression of the rage effectively coerces or manipulates the object into rewarding the patient for his regressive behavior (the object steps into, and reactivates, the RORU). The borderline patient is caught in a terrible bind! **If he (or she) acts in a healthy, adaptive fashion, he will (owing to the now internalized model of withdrawal for healthy self-**

activation) feel terrible and threatened with the loss of the significant object. If, on the other hand, he acts in a regressed, maladaptive fashion, he will feel better, albeit at a tremendous cost in terms of healthy adaptation.

This is the clinical situation confronting the therapist called upon to treat the borderline patient. **The split object relations part-units of the borderline are the legacy of the patient's past.** The patient creates endless reproductions of this dilemma from this original template.

The Narcissistic Disorder of the Self

The narcissistic disorder of the self can be differentiated into two distinct subtypes, the exhibitionistic and the closet. As alluded to above, the DSM-IV contains a description of only one of these two subtypes: the exhibitionistic. The diagnostic criteria include:

- a grandiose sense of self-importance,
- fantasies of perfection,
- a sense of entitlement,
- hypersensitivity to criticism, and
- a lack of empathy for others.

These symptoms listed in the DSM-IV are the exhibitionistic narcissist's calling card and must be evaluated first. As with the borderline disorder, to understand the narcissistic disorder of the self the clinician must first turn his or her attention to the developmental arrest and then to the intrapsychic structure. **The pictures for both are quite different from that of the borderline disorder of the self. As in the developmental history of the borderline, the history of the narcissist reveals a failure to receive the support necessary for the emergence of the real self. However, the nature of the failure is different. In the case of the exhibitionistic narcissist, the parent (caretaker) idealizes the child to shape the child to his/her own needs. The child defends against the painful affects associated with the experience of lack of support for the real self by identifying with the parent's idealization. The child emerges from this early period of life with an inflated or grandiose sense of self which requires constant shoring up; he feels unique, admired, and adored through the pursuit of "perfect mirroring" of his grandiosity and perfection by others.**

Klein, 1995,s.12

Where the borderline struggles to find a way to feel connected to the object (to get the object onto the same emotional roller coaster, if you will), the narcissist, by contrast, feels 'fused" with the object; he experiences no separation between himself and the object. His thoughts, needs, and feelings, are, he believes, identical to those of the object, and, furthermore must be.

Masterson has explicated this experience of fusion in terms of "one-mindedness" or "like-mindedness." **The narcissist expects the other to be "on the same page," so to speak, as he is with regard to feelings, perceptions, and agendas; in other words, he expects the object to feel the same way, perceive and understand reality in the same fashion, and share the same concerns, with the same sense of urgency and priority. Only the experience of "perfect mirroring" or matching of his beliefs, concerns, and needs will support this defense.**

The persistence of the need for perfect mirroring in support of the grandiose self is the focus of the developmental arrest in the patient with a narcissistic disorder. **The nature of the developmental arrest in the narcissist results in an intrapsychic structure that is different from that of the borderline in both form and content.**

Form

The intrapsychic structure of the borderline, as described above, consists of split object relations units or split representations of the self and other people. **The intrapsychic structure of the narcissist, by contrast, consists of fused object relations units. Masterson has described these as the defensive fused object relations partunit and the aggressive fused object relations part-unit (see Figure 4).**

Content

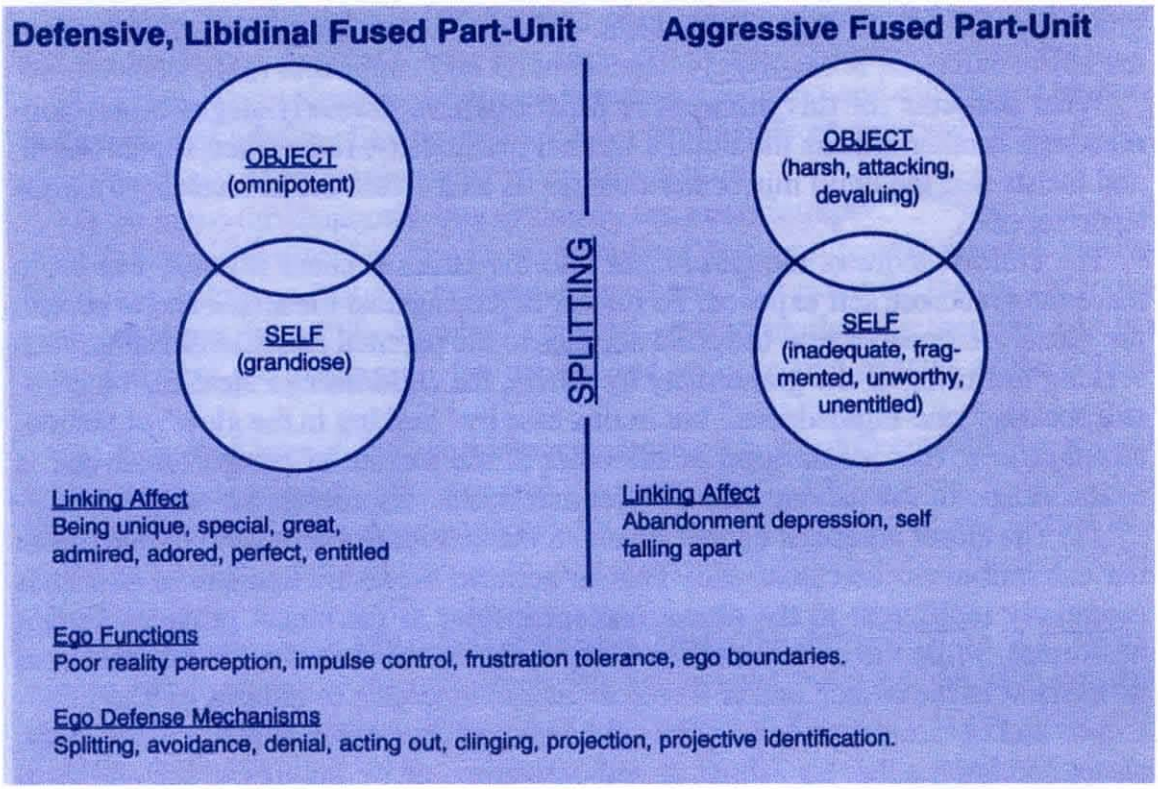
The defensive fused part-unit consists of an omnipotent object representation that contains all power, perfection, direction, and "narcissistic supplies" (or mirroring capabilities); a grandiose self-representation (the self is experienced as being superior, elite, deserving of special entitlements, and so on); and a linking affect of feeling perfect, special, adored, and admired. The exhibitionistic narcissist projects the grandiose self, exhibits entitlement, and expects perfect mirroring of the grandiosity and perfection by others.

The underlying aggressive object relations unit consists of a fused object representation that is harsh, punitive, and attacking; a self-representation of being humiliated, attacked, and empty; and a linking affect of abandonment depression. For the patient with a narcissistic disorder of the self, the abandonment depression can be precipitated either by efforts at true self-activation (i.e., the pursuit of realistic self-expressive goals as opposed to the narcissistic goals of perfection, adoration, money, power, beauty, and so on) or by the perception of the object's failure to provide perfect mirroring; self-activation or the absence of mirroring leads to abandonment depression, which leads to defense. **The narcissistic patient experiences the abandonment depression as the self fragmenting or falling apart (rather than as the loss of the object experienced by the borderline).**

Klein, 1995,s.13

To defend against the abandonment depression, the patient with an exhibitionistic narcissistic defense projects his grandiosity and seeks mirroring from the "perfect object." The failure to receive such mirroring or "like-mindedness" results in the narcissist's devaluing, avoiding, or writing off those who fail to supply the needed narcissistic supplies. The projection of grandiosity and the dismissal of those who don't share the narcissist's views is the narcissist's basic modus operandi. The operation of this defensive unit is so uniqe and airtight that it effectively conceals from the casual observer the underlying pathological or aggressive fused unit.

Fig.4



Klein, 1995,s.14

The Closet Narcissistic Disorder of the Self

There is much confusion among clinicians about the diagnosis and psychotherapy of the closet narcissistic disorder of the self. It is a common clinical experience for a therapist to feel baffled by a therapeutic impasse with a so-called "borderline" patient. The patient's clinical picture looks borderline:

- **depression,**
- **difficulty with self-assertim,**
- **apparent clinging in relationships,**
- **difficulties with anger,**
- **an inadequate sense of self, and**
- **denial of destructive behavior.**

The therapist uses the therapeutic interventions indicated for the borderline patient, but rather than leading to therapeutic progress, the therapist experiences only growing frustration as the patient responds by either

increasing attack and resistance or by seeming to respond, but without a change in affect or therapeutic relationship.

The problem is that the patient who looks like a "borderline" but doesn't act like a borderline may well in fact have a "closet" narcissistic disorder of the self. Unfortunately, as of the latest revision to the DSM, there is still no provision for the closet narcissistic disorder of the self.

The intrapsychic structure of the closet narcissistic disorder is the same as that of the exhibitionistic narcissistic disorder (review Figure 4). There are, however, two key differences between them:

(1) There is an emotional investment in the omnipotent object, rather than in the grandiose self. While the exhibitionistic narcissist seems impervious to the object, the closet narcissist is exquisitely dependent on and vulnerable to the object.

What accounts for this difference? **Most often, in the early stages of development, the mother attacks the child's normal grandiosity, rather than supporting it, and insists that the child mirror her own needs as a condition of receiving "narcissistic supplies."**

The child withdraws the narcissism into the closet because it is too painful to leave the grandiose self exposed. To further defend against the attack and to protect the grandiose sense of self, the child accedes to the parental conditions. Rather than seeking mirroring of the grandiosity by others, the child instead idealizes others still seeking "one-mindedness," but in this case by "basking in the glow" of the idealized object. This idealization of the other in the service of the grandiose self is characteristic of the patient with a closet narcissistic disorder of the self.

(2) The closet narcissist cannot maintain the continuous activation of defense as the exhibitionistic narcissist can. This is because the exhibitionistic narcissist is essentially indifferent to the object (except insofar as the object provides perfect mirroring), while the closet narcissist has, as described above, made an emotional investment in the object, and is therefore more vulnerable to failures of like-mindedness and ensuing depression. The abandonment depression is precipitated in

the closet narcissist either by efforts at self-activation, or by failures in the ability to

Klein, 1995,s.15
idealize the other and so bask in the reflected glow.

The disorders-of-the-self triad (self-activation depression defense), seen so readily in patients with a borderline disorder of the self but only seen in exhibitionistic narcissistic patients later in treatment when the defenses have been consistently breached, is also readily apparent in closet narcissistic patients at the start of treatment.

These key differences between the exhibitionistic and the closet narcissistic disorders help to clarify why closet narcissistic patients have not been identified as narcissistic.

In addition, as noted above, the clinical picture looks borderline. There are three main sources of this confusion:

(1) The idealizing defense of the false self of the patient with a closet narcissistic disorder may be confused with the clinging defense of the borderline disorder. Both seem to need the object desperately (albeit for different reasons).

(2) The closet narcissist is much more likely to present with a depressed, deflated, inadequate self rather than with a grandiose, inflated false self. Like the borderline patient, the closet narcissist is also more likely to be conscious of associated feelings of helplessness, hopelessness, emptiness, and void.

(3) The closet narcissist may seem to respond to confrontation, the intervention of choice with borderlines. However, the fact that

there is no consequent change in affect or in the therapeutic alliance reveals that the response is not genuine, but a result of a defensive wish to please the therapist.

Differential Diagnosis

How then can the therapist distinguish between the closet narcissistic disorder and the borderline disorder? Four key areas differentiate one from the other:

(1) There is a qualitative difference between idealizing and clinging. The borderline patient who is clinging will accept a few words of approval, whereas the closet narcissist seeks perfect admiration all the time.

(2) To make the diagnosis, one evaluates the same intrapsychic structures as in the exhibitionistic disorder; that is, the grandiose self-omnipotent object defensive fused unit and the underlying aggressive fused unit. For example, the patient looks to the therapist for a "like-minded" response, assuming that the therapist has the same thoughts and feelings as the patient and will respond exactly as the patient needs.

(3) Key elements of the abandonment depression are different for the patient with a closet narcissistic disorder and the patient with a borderline disorder. The closet narcissist's depression is marked by feelings of humiliation and shame and of the self falling apart, in contrast to the borderline's experience of the loss of the object.

(4) In those cases in which it is difficult to make the differentiation, it is necessary to decide on one or the other diagnosis and to implement that decision through the therapeutic stance taken. The patient's responses to the interventions must confirm the diagnosis.

Klein, 1995,s.21
The Closet Narcissistic Disorder of the Self

This patient begins treatment idealizing the therapist. The therapist then interprets the projection: "It is so painful for you to focus on yourself that you turn to me in order to defend against, or soothe, the pain." Here the key words are pain, self, and defense. This key interpretation helps the patient to feel "understood."

interpretation of narcissistic vulnerability.

Klein, 1995,s.22
the patient is exquisitely sensitive to the therapist and easily disappointed by failures of idealization (experienced as separateness, not being "on the same page," and failures in one-mindedness).

It is important to stress that the therapist cannot confront the projections of the narcissistic patient because that would trigger the underlying aggressive unit and the patient would see the therapist's action as an attack and respond with projection, devaluation, or avoidance.

Again, one does not confront a defense as with the borderline patient, but rather interprets it as a defense against narcissistic pain. For example, one might confront a borderline patient who is late for a session by pointing out that this is destructive to his objective; that he is depriving himself of time to do the work. In contrast, with a patient with a narcissistic disorder, one would interpret it as follows: "It must be very painful for you to talk about yourself here, and you must have felt the need to withdraw to soothe that pain."

Klein, 1995,s.29
Developmental History

Throughout his childhood, he felt that the family revolved around his father, an overbearing, strict disciplinarian who felt that it was important to teach his son how to be "a real man" and his sisters "real women, like their mother." Essentially, this meant to be "on call" for the father. He remembered most vividly his mother telling the children not to disturb their father and to obey him, rules she herself followed.

He recalled feeling that what he wanted was never important. "I had no agenda that was my own. I felt that I had to please Mom and Dad. That was my agenda, and I was only concerned to do it well."

Although he worked hard to please them, he remembered that he never felt that he was "good enough" for his father, and though he felt close to his mother, "she always seemed down, depressed .... I wondered if she

was disappointed in me. It made me just try harder to help her, to make her feel better."

Thoughout high school and college, the patient's life was generally uneventful, though feelings of depression and unhappiness seemed to hover.

Though never especially popular, he had always had at least one very close friend, though different ones at different periods in his life: one in grade school, one in high school, and one in college.

Klein, 1995,s.30

there was no readily identifiable "illness" which could and should be medicated and alleviated.

Rather, David C. presented very much with the kind of vague, diffuse, pervasive, and disturbing symptoms typical of a disorder of the self.

Klein, 1995,s.51

Abandonment Depression

A complex of painful affects (including anxiety, depression, panic, rage, guilt, helplessness and hopelessness, emptiness and void), which are known collectively in the Masterson Approach as the "abandonment depression," and are associated with failures of support for the child's real self in early development, not with literal abandonment.

Confrontation

A therapeutic intervention designed to empathically bring to a patient's attention the destructive or maladaptive aspects of a particular defensive behavior. Confrontations may take the form of a question or statement pointing out the contradiction in a patient's statements or between the patient's actions and feelings. **Confrontation is the intervention of choice with a borderline patient.**

Defense

Defense-any one of several maneuvers (i.e., avoidance, denial, projection) used to keep feelings that would otherwise be too painful or overwhelming at bay.

Idealizing defense
The idealization of another person in order to obtain "narcissistic supplies" by "basking in the other's glow" (characteristic of the closet narcissist).

Grandiosity defense
The pursuit of adoration or perfect mirroring of one's uniqueness or specialness as a defense against feelings of vulnerability (characteristic of the exhibitionistic narcissist).

Splitting defense
A defense which keeps contradictory affect states separated from one another; the effect of this defense (characteristic of the borderline) is that experiences of self and others are either all good or all bad.

Disorder of the Self
Masterson's term for "personality disorder," denoting deficits in the ability to perceive reality without self-protective distortions, and to deal with problems in the real world assertively and creatively.

Klein, 1995,s.52
Disorders of the self derive from failures in early childhood to receive support for the emerging real self. The individual with a disorder of the self presents to the world what is called a "false self' to defend against feelings of vulnerability associated with the "impaired real self." (See definitions under "self' below).

Disorders-of-the-Self Triad
According to Masterson, attempts at self-activation (see below) or other events involving exposure of the real self lead to one or more of the affects associated with the abandonment depression (anxiety, depression, etc.), which, in turn, leads to further defense. The patient with a disorder of the self experiences life as the endless repetition of this cycle.

Fusion or "One-Mindedness" 7, 11-13
This refers to an experience of self and others as fused or identical. **The individual with a narcissistic disorder of the self fails to appreciate (in**

any way other than intellectually) that others are indeed distinct-having needs, wishes, thoughts, and feelings separate from his own. Masterson has described this as the narcissist's need for "one-mindedness" or for "being on the same page" as the other.

Interpretation-a therapeutic intervention designed to heighten the patient's awareness of unconscious defenses, including devaluation, avoidance, and projection.

Mirroring Interpretation of Narcissistic Vulnerability A therapeutic intervention that combines mirroring of the patient's pain with interpretation of the defense designed to ward off that pain. A mirroring interpretation of narcissistic vulnerability is the intervention of choice with narcissists of the exhibitionistic as well as the closet variety.

Linking Affect-an affect associated with a particular representation of self and others.

Object Relations Theory
A psychoanalytic theory to account for how the child's early interactions with the mother or other primary caretaker become internalized, resulting in images of the self and others (self and object representations) and expectations (whether realistic or distorted) about what can be expected in relationships.

Object Relations Unit
An object relations unit consists of a particular self-representation, a particular object representation, and a linking affect associated with those internalized images.

Klein, 1995,s.53
Object Relations Part-Unit-Failures of support for the child's emerging self result in both an impaired real self (see below) and a "false" or defensive self, each with its associated object relations units, which are referred to as "part-units."

Part-Units of the Borderline

The two part-units of the borderline are the rewarding unit and the withdrawing unit.

Part-Units of the Narcissist

The two part-units of the narcissist are the aggressive fused unit and the defensive fused unit.

Projection

A defense mechanism whereby the individual projects an internal image of the self or other onto the external world.

Self

False Self

The "false self' is the defensive structure which protects the individual from painful affects associated with lack of support for the developing real self. The purpose of this defensive shield is not to deal with reality, but to defend against pain.

Impaired Self

The "impaired self' is a deficit state that derives from a combined failure of nature, nurture, and fate to provide adequate support for healthy development of the real self. The person with an impaired real self lacks a sense that the self is adequate and worthy of support, and compensates for that deficit with various defenses.

Real Self

The "real self' refers to the self that can see "reality" without distortion and act autonomously to support the self in the external world, soothing painful affects without distorting reality to accomplish that, pursuing goals in the face of obstacles, and so on. The development of the real self is, according to Masterson, a developmental achievement, not a maturational given. Characteristics of the real self are outlined in Figure 1 of this manual (on page 6).

Self-Activation

A key concept in the Masterson Approach, this refers to the ability to identify one's genuine wishes and to take autonomous action both to express those wishes in the world, and to defend them when under attack. The ability to self-activate is impaired in individuals with disor-

Klein, 1995,s.54

ders of the self, owing to the child's having been either punished for attempts at genuine self-activation, or inappropriately idealized for fulfilling the caretaker's needs rather than the child's own needs.

Therapeutic Alliance

A relationship in which the patient sees the therapist as he or she really is, both good and bad at the same time; it is what Masterson calls a "real object relationship." The development of a therapeutic alliance is one of the initial goals of therapy with patients with disorders of the self.

Therapeutic Neutrality

A cornerstone of the Masterson Approach, therapeutic neutrality refers to the neutral stance of the therapist to support the patient's attempts at self-activation without becoming personally involved in the patient's life. It is a respectful stance aimed at promoting the therapeutic conditions which will enable the patient to see his or her defenses, and overcome them.

Transference

In a transference relationship, the patient projects his (or her) fantasies about who the therapist is, but is also aware that he is projecting. A transference relationship, therefore, presupposes the capacity for a "real object relationship" with the therapist, i.e., a therapeutic alliance.

Transference Acting Out

In contrast to transference, transference acting out is characterized by the projection of internal images onto the therapist with no awareness of the reality existence of the therapist.