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The Disorders of the Self and their Treatment: An Outline

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It is the aim of this survey to provide a summary of the concepts and theories of the psychoanalytic psychology of the self and of the clinical (diagnostic and therapeutic) formulations that are correlated to them. Although we wanted to be comprehensive and to convey a sense of the complexity of our subject matter, we tried to keep our presentation as brief as possible. While this goal needs no excuse, it may require a cautionary comment. In view of the fact that we had to keep our definitions terse and our formulations brief, we could not often indulge in the luxury of introducing qualifying statements. This is as we think it should be within the framework of a summarizing outline. It must be emphasized, however, that the paucity of restricting and modifying clauses does not imply any conviction on our part that we are presenting a finished or definitive system of thought. On the contrary, this survey should be considered to be a progress report about the present state of a step in the evolution of psychoanalysis that is itself only in its very beginning.

Why then a summary at such an early point? The answer to this question is simple. It is the very unsettledness of the state of scientific knowledge during a new developmental move that makes it advisable to take stock by dispassionately spelling out, simply and straight-forwardly, the clinical discoveries that have been made and the theoretical constructions that have been formed. This stock-taking must, however, not lead to a hardening of our convictions. It should rather assist us in separating the wheat from the chaff—enable us to recognize those areas in which our investigations have been successful and those where they have so far failed. But let us now go to the heart of the matter and describe how the new psychology of the self came into being.

1. THE EMERGENCE OF A PSYCHOLOGY OF THE SELF

During recent years the psychoanalytic investigation of certain frequently encountered patients led to the recognition of a definable syndrome which at first appeared to be related to the psychoneuroses and neurotic character disorders. It was clear from the outset that these patients are characterized by a specific vulnerability: their self-esteem is unusually labile and, in particular, they are extremely sensitive to failures, disappointments and slights. It was, however, not the scrutiny of the symptomatology but the process of treatment that illuminated the nature of the disturbance of these patients. The analysis of the psychic conflicts of these patients did not result in either the expected amelioration of suffering or the hoped-for cessation of undesirable behaviour; the discovery, however, that these patients reactivated certain specific narcissistic needs in the psychoanalytic situation, i.e. that they established 'narcissistic transferences', made effective psychoanalytic treatment possible. The psychopathological syndrome from which these patients suffer was designated as *narcissistic personality disorder*. The narcissistic transferences which are pathognomonic for these syndromes were subdivided into two types: (1) the *mirror transference* in which an insufficiently or faultily responded to childhood need for a source of accepting-confirming 'mirroring' is revived in the treatment situation, and (2) the *idealizing transference* in which a need for merger with a source of 'idealized' strength and calmness is similarly revived. As the understanding of the symptomatology, core psychopathology, and treatment of the narcissistic personality disorders increased, in particular via the investigation of the narcissistic transferences, it became clear that the essence of the disturbance

from which these patients suffered could not be adequately explained within the framework of classical drive-and-defence psychology. In view of the fact that it is a weakened or defective self that lies in the centre of the disorder, explanations that focused on conflicts concerning either the libidinal or the aggressive impulses of these patients could illuminate neither psychopathology nor treatment process. Some progress was made by expanding the classical libido theory and by revising the classical theory of aggression. Specifically, the weakness of the self was conceptualized in terms of its underlibidinization—as a cathectic deficit, to speak in the terms of Freudian metapsychology—and the intense aggressions encountered in the narcissistic personality disorders were recognized as the responses of the vulnerable self to a variety of injuries. The decisive steps forward in the understanding of these disorders, however, were made through the introduction of the concept of the selfobject and via the increasing understanding of the self in depth-psychological terms. *Selfobjects* are objects which we experience as part of our self; the expected control over them is, therefore, closer to the concept of the control which a grown-up expects to have over his own body and mind than to the concept of the control which he expects to have over others. There are two kinds of selfobjects: those who respond to and confirm the child's innate sense of vigour, greatness and perfection; and those to whom the child can look up and with whom he can merge as an image of calmness, infallibility and omnipotence. The first type is referred to as the mirroring selfobject, the second as the idealized parent imago. The *self*, the core of our personality, has various constituents which we acquire in the interplay with those persons in our earliest childhood environment whom we experience as selfobjects. A firm self, resulting from the optimal interactions between the child and his selfobjects is made up of three major constituents: (1) one pole from which emanate the basic strivings for power and success; (2) another pole that harbours the basic idealized goals; and (3) an intermediate area of basic talents and skills that are activated by the tension-arc that establishes itself between ambitions and ideals.

Faulty interaction between the child and his selfobjects result in a damaged self—either a diffusely damaged self or a self that is seriously damaged in one or the other of its constituents. If a patient whose self has been damaged enters psychoanalytic treatment, he reactivates the specific needs that had remained unresponded to by the specific faulty interactions between the nascent self and the selfobjects of early life—a selfobject transference is established.

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

Once the self has crystallized in the interplay of inherited and environmental factors, it aims towards the realization of its own specific programme of action—a programme that is determined by the specific intrinsic pattern of its constituent ambitions, goals, skills and talents, and by the tensions that arise between these constituents. The patterns of ambitions, skills and goals; the tensions between them; the programme of action that they create; and the activities that strive towards the realization of this programme are all experienced as continuous in space and time—they are the self, an independent centre of initiative, an independent recipient of impressions.

2. THE SECONDARY AND THE PRIMARY DISTURBANCES OF THE SELF

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. A strong self allows us to tolerate even wide swings of self-esteem in response to victory or defeat, success or failure. And

various emotions—triumph, joy; despair, rage—accompany these changes in the state of the self. If our self is firmly established, we shall neither be afraid of the dejection that may follow a failure nor of the expansive fantasies that may follow a success—reactions that would endanger those with a more precariously established self.

Among the secondary disturbances belong also the reactions of the self to physical illness or to the incapacities of a structural neurosis, e.g. the dejection or the anger experienced when incurable muscular paralysis or chronic neurotic anxiety inhibit a person from pursuing his central self-enhancing goals. And even certain reactions of relatively undamaged layers of the self to the consequences of its own primary disturbances—such as dejection over the fact that a damaged self's vulnerability has led to social isolation—should be counted among the secondary disturbances of the self.

The *primary disturbances of the self* can be divided into several subgroups, depending on the extent, severity, nature and distribution of the disturbance. If serious damage to the self is either permanent or protracted, and if no defensive structures cover the defect, the experiential and behavioural manifestations are those that are traditionally referred to as *the psychoses*. The nuclear self may have remained non-cohesive (schizophrenia) either because of an inherent biological tendency, or because its totality and continuity were not responded to with even minimally effective mirroring in early life, or because of the interplay between or convergence of biological and environmental factors. It may have obtained a degree of cohesion but because of the interaction of inherent organic factors and a serious lack of joyful responses to its existence and assertiveness, it will be massively depleted of self-esteem and vitality ('empty' depression). It may have been almost totally deprived during the crucial periods of its formation of the repeated wholesome experience of participating in the calmness of an idealized adult (i.e. of a merger with an idealized selfobject), with the result, again decisively influenced by inherent biological factors, that an uncurbed tendency toward the spreading of unrealistically heightened self-acceptance (mania) or self-rejection and self-blame ('guilt'-depression) remains as a serious central weak spot in its organization.

A second subgroup of primary disorders of the self are the *borderline states*. Here the break-up, the enfeeblement, or the functional chaos of the nuclear self are also permanent or protracted, but, in contrast to the psychoses, the experiential and behavioural manifestations of the central defect are covered by complex defences. Although it is in general not advisable for the therapist to tamper with these protective devices, it is sometimes possible to make the patient's use of them more flexible by reconstructing the genesis of both the central vulnerability and of the chronic characterological defence. It may, for example, be helpful to the patient to understand the sequence of events, repeated on innumerable occasions, when as a child his need to establish an autonomous self was thwarted by the intrusions of the parental selfobject. At the very point, in other words, when the nascent self of the child required the accepting mirroring of its independence, the selfobject, because of its own incompleteness and fragmentation fears, insisted on maintaining an archaic merger.*1*

1 Dr Nathaniel J. London has questioned the 'writing style' of our paper. He thinks our language often suggests an anthropomorphization of the concept 'self', in the same way that 'ego' used to be anthropomorphized. To illustrate his position he rewrote the two sentences in our essay that precede the number in the text which leads to this note. Here is his version.

'It may, for example, be helpful to the patient to understand the sequence of events, repeated on innumerable occasions, when as a child his need to establish an autonomous self was thwarted by an intrusive mother. At the very point, in other words, when the child required an accepting mirroring of his independence for the formation of his nascent self, his mother, because of her own incompleteness and fragmentation fears, insistently tried to achieve an archaic merger. Instead of serving as the source of a usable selfobject to the child, the mother provided an unmanageable and tyrannical selfobject which, among other ill-effects for development, left the child with an insatiable yearning for something that would allow him to feel whole and complete—something that he could only begin to define for himself in the non-intrusive atmosphere of the treatment situation.'

We fully agree with the spirit of Dr London's critique—it is similar to Schafer's **(1973)** —and believe that it should be implemented, even in predominantly clinical communications, whenever such conceptual exactness can be adhered to without introducing undue stylistic complexity. But not at all cost, as an expression of a variant of that specific purity-of-thought-and-language morality of which Karl Kraus **(see Janik & Toulmin, 1973, esp. pp. 67–91)** was the most famous protagonist in our century. Since Dr London can so easily

grasp our meaning and translate it into more exact scientific language, we trust that others, too, will realize that the reifications of our language are not a manifestation of conceptual confusion but in the service of evocativeness and conciseness.

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

Closely related to the narcissistic behaviour disorders are the *narcissistic personality disorders* where break-up, enfeeblement or serious distortion of the self are also only temporary but where the symptoms—e.g. hypochondria, depression, hypersensitivity to slights, lack of zest—concern not primarily the actions and interactions of the individual but rather his psychological state.

Of the patients who suffer from disorders of the self, only those with narcissistic behaviour and personality 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. In other words, of all the primary disorders of the self only narcissistic behaviour and personality disorders are analysable.

3. THE AETIOLOGY OF SELF-PATHOLOGY

In view of the fact that the disorders of the self are, by and large, the results of miscarriages in the normal development of the self, we shall first present an outline of the normal development of the self. It is difficult to pinpoint the age at which the baby or small child may be said to have acquired a self. To begin with, it seems safe to assume that, strictly speaking, the neonate is still without a self. The new-born infant arrives physiologically pre-adapted for a specific physical environment—the presence of oxygen, of food, of a certain range of temperature—outside of which he cannot survive. Similarly, psychological survival requires a specific psychological environment—the presence of responsive-empathic selfobjects. It is in the matrix of a particular selfobject environment that, via a specific process of psychological structure formation called *transmuting internalization*, the *nuclear self* of the child will crystallize. Without going into the details of this structure-building process, we can say (1) that it cannot occur without a previous stage in which the child's mirroring and idealizing needs had been sufficiently responded to; (2) that it takes place in consequence of the minor, non-traumatic failures in the responses of the mirroring and the idealized selfobjects; and (3) that these failures lead to the gradual replacement of the selfobjects and their functions by a self and its functions. And it must be added that while gross identifications with the selfobjects and their functions may temporarily and transitionally occur, the ultimate wholesome result, the autonomous self, is not a replica of the selfobject. The analogy of the intake of foreign protein in order to build up one's own protein is very serviceable here—even as regards the detail of the splitting up and rearrangement of the material that had been ingested.

If we keep in mind the processes by which the self is created, we realize that, however primitive by comparison with the self of the adult the nuclear self may be, it is already at its very inception a complex structure, arising at the end-point of a developmental process which may be said to have its virtual beginnings with the formation of specific hopes, dreams and expectations concerning the future child in the minds of the parents, especially the mother. When the baby is born, the encounter with the child's actual structural and functional biological equipment will, of course, influence the imagery about its future personality that had been formed by the parents. But the parental expectations will, from birth onward, exert a considerable influence on the baby's developing self. The self arises thus as the result of the interplay between the new-born's innate equipment and

the selective responses of the selfobjects through which certain potentialities are encouraged in their development while others remain unencouraged or are even actively discouraged. Out of this selective process there emerges, probably during the second year of life, a nuclear self, which, as stated earlier, is currently conceptualized as a bipolar structure; archaic nuclear ambitions form one pole, archaic nuclear ideals the other. The tension are between these two poles enhances the development of the child's nuclear skills and talents—rudimentary skills and talents that will gradually develop into those that the adult employs in the service of the productivity and creativity of his mature self.

The strength of these three major constituents of the self, the choice of their specific contents, the nature of their relationship—e.g. which one of them will ultimately predominate—and their progress towards maturity and potential fulfilment through creative actions, will be less influenced by those responses of the selfobjects that are shaped by their philosophy of child rearing than by those that express the state of their own nuclear self. In other words, it is not so much what the parents *do* that will influence the character of the child's self, but what the parents *are*. If the parents are at peace with their own needs to shine and to succeed insofar as these needs can be realistically gratified, if, in other words, the parents' self-confidence is secure, then the proud exhibitionism of the budding self of their child will be responded to acceptingly. However grave the blows may be to which the child's grandiosity is exposed by the realities of life, the proud smile of the parents will keep alive a bit of the original omnipotence, to be retained as the nucleus of the self-confidence and inner security about one's worth that sustain the healthy person throughout his life. And the same holds true with regard to our ideals. However great our disappointment as we discover the weaknesses and limitations of the idealized selfobjects of our early life, their self-confidence as they carried us when we were babies, their security when they allowed us to merge our anxious selves with their tranquillity—via their calm voices or via our closeness with their relaxed bodies as they held us—will be retained by us as the nucleus of the strength of our leading ideals and of the calmness we experience as we live our lives under the guidance of our inner goals.

It is only in the light of our appreciation of the crucial influence exerted on the development of the self by the personality of the selfobjects of childhood, that we are able to trace the genetic roots of the disorders of the self. Psychoanalytic case histories tended to emphasize certain dramatic incidents, certain grossly traumatic events—from the child's witnessing the 'primal scene' to the loss of a parent in childhood. But we have come to incline to the opinion that such traumatic events may be no more than clues that point to the truly pathogenic factors, the unwholesome atmosphere to which the child was exposed during the years when his self was established. Taken by themselves, in other words, these events leave fewer serious disturbances in their wake than the chronic ambience created by the deep-rooted attitudes of the selfobjects, since even the still vulnerable self, in the process of formation, can cope with serious traumata if it is embedded in a healthily supportive milieu. The essence of the healthy matrix for the growing self of the child is a mature, cohesive parental self that is in tune with the changing needs of the child. It can, with a glow of shared joy, mirror the child's grandiose display one minute, yet, perhaps a minute later, should the child become anxious and over-stimulated by its exhibitionism, it will curb the display by adopting a realistic attitude *vis-à-vis* the child's limitations. Such optimal frustrations of the child's need to be mirrored and to merge into an idealized selfobject, hand in hand with optimal gratifications, generate the appropriate growth-facilitating matrix for the self.

Some parents, however, are not adequately sensitive to the needs of the child but will instead respond to the needs of their own insecurely established self. Here are two characteristic illustrations of pathogenic selfobject failures. They concern typical events that emerge frequently during the analysis of patients with narcissistic personality disorders during the transference repetitions of those childhood experiences that interfered with the normal development of the self. We must add here that the episodes depicted in the following vignettes are indicative of a pathogenic childhood environment only if they form part of the selfobjects'

chronic attitude. Put differently, they would not emerge at crucial junctures of a selfobject transference if they had occurred as the consequence of a parent's unavoidable *occasional* failure.

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

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

4. PSYCHOPATHOLOGY AND SYMPTOMATOLOGY

In the following we will present some syndromes of self-pathology, arising in consequence of the developmental failures described in the preceding section. It is clear that in many if not in most instances the various forms of self-disturbance which we separate from each other in the following classification will not be clearly identifiable in specific patients. Mixtures of the experiences characteristic of different types will often be present and, even more frequently, one and the same patient will experience the one or the other of the pathological states of the self at different times, often even in close proximity. The following descriptions should, however, be clinically helpful because they point out frequently occurring clusters of experience.

The *understimulated self*. This is a chronic or recurrent condition of the self, the propensity to which arises in consequence of prolonged lack of stimulating responsiveness from the side of the selfobjects in childhood. Such personalities are lacking in vitality. They experience themselves as boring and apathetic, and they are experienced by others in the same way. Individuals whose nascent selves have been insufficiently responded to will use any available stimuli to create a pseudo-excitement in order to ward off the painful feeling of deadness that tends to overtake them. Children employ the resources appropriate to their developmental phase—such as headbanging among toddlers, compulsive masturbation in later childhood, daredevil activities in adolescence. Adults have at their disposal an even wider armamentarium of self-stimulation—in particular, in the sexual sphere, addictive promiscuous activities and various perversions, and, in the non-sexual sphere, such activities as gambling, drug and alcohol-induced excitement, and a life style characterized by hypersociability. If the analyst is able to penetrate beneath the defensive façade presented by these activities, he will invariably find empty depression. Prototypical is the compulsive masturbation of lonely, 'un-mirrored' children. It is not healthy drive-pressure that leads to the endlessly repeated masturbation, but the attempt to substitute pleasurable sensations in *parts* of the body (erogenous zones) when the joy provided by the exhibition of the *total* self is unavailable.

The *fragmenting self*. This is a chronic or recurrent condition of the self, the propensity to which arises in consequence of the lack of integrating responses to the nascent self in its totality from the side of the selfobjects in childhood. Occasionally occurring fragmentation states of minor degree and short duration are ubiquitous. They occur in all of us when our self-esteem has been taxed for prolonged periods and when no replenishing sustenance has presented itself. We all may walk home after a day in which we suffered a series of self-esteem-shaking failures, feeling at sixes and sevens within ourselves. Our gait and posture will be less than graceful at such times, our movements will tend to be clumsy, and even our mental functions will show signs of discoordination. Our patients with narcissistic personality disorders will not only be more inclined to react with such fragmentation symptoms to even minor disappointments, but their symptoms will tend to be more severe. If a normally tastefully dressed patient arrives in our office in a dishevelled attire, if his tie is grossly mismatched, and the colour of his socks does not go with that of his shoes, we shall usually not go wrong if we begin to search our memory with the question whether we had been unempathic in the last session, whether we had failed to recognize a narcissistic need. Still more serious degrees of fragmentation will finally be encountered during the

psychoanalytic treatment of the most severely disturbed patients with narcissistic personality disorders. Here a patient

might respond to even minor rebuffs, whether from the side of the analyst or in his daily life, with a deep loss of the sense of the continuity of his self in time and of its cohesiveness in space—a psychic condition that produces profound anxiety. The feeling, in particular, that various body parts are beginning not to be held together anymore by a strong, healthy awareness of the totality of the body-self, leads to apprehensive brooding concerning the fragments of the body, often expressed by the patient in the form of hypochondriacal worry concerning his health. Unlike the chronic hypochondriacal preoccupations encountered in some psychoses, however, even the most severe and quasi-delusional analogous worries in the narcissistic personality disorders are the direct consequence of some specific, identifiable narcissistic injury, and they disappear, often with dramatic speed, as soon as a bridge of empathy with an understanding selfobject has been built. A frequently occurring sequence of events during the analysis of patients who have established a mirror transference will demonstrate this point. When the mirror transference is in balance, the patient, sensing the analyst's empathic attention, feels whole and self-accepting. Subsequent to an erroneous interpretation, however—e.g. following a session in which the analyst had addressed himself to some *detail* of the patient's psychic life when, in fact (after some progress in treatment, for example, or after some external success), the patient had offered his *total* self for approval—the patient's feeling of wholeness which had been maintained via the transference disappears. It is re-established when the analyst restores the empathic tie to the selfobject by correctly interpreting the sequence of events that had led to its disruption.

The *overstimulated self*. The propensity towards recurrent states during which the self is overstimulated arises in consequence of unempathically excessive or phase-inappropriate responses from the side of the selfobjects of childhood, either *vis-à-vis* the activities of the grandiose-exhibitionistic pole of the child's nascent self or *vis-à-vis* the activities of the pole that harbours the guiding ideals, or both.

If it was the grandiose-exhibitionistic pole of a person's self that had been exposed to unempathic overstimulation in childhood, then no healthy glow of enjoyment can be obtained by him from external success. On the contrary, since these people are subject to being flooded by unrealistic, archaic greatness fantasies which produce painful tension and anxiety, they will try to avoid situations in which they could become the centre of attention. In some such individuals creativity may be unimpaired so long as no exhibition of the *body* -self is involved, directly or indirectly. In most of them, however, the creative-productive potential will be diminished because their intense ambitions which had remained tied to unmodified grandiose fantasies will frighten them. In view of the fact, furthermore, that the selfobjects' responses had focused prematurely and unrealistically on the fantasied performance or the fantasied products of the self but had failed to respond appropriately to the exhibitionism of the nascent nuclear self of the child as the initiator of the performance and as the shaper of products, the self will, throughout life, be experienced as separate from its own actions and weak in comparison with them. Such people will tend to shy away from giving themselves over to creative activities because their self is in danger of destruction by being siphoned into its own performance or into the product it is shaping.

If it is predominantly the pole that harbours the ideals that had been overstimulated—e.g. by the unempathically intense and prolonged display of a parental selfobject in need of admiration—then it will be the persisting, intense need for the merger with an external ideal that will threaten the equilibrium of the self. Since contact with the idealized selfobject is, therefore, experienced as a danger and must be avoided, the healthy capacity for enthusiasm will be lost—the enthusiasm for goals and ideals which people with a firm self can experience *vis-à-vis* the admired great who are their guide and example or with regard to the idealized goals that they pursue.

Closely related to the overstimulated self is the *overburdened self*. But while the over-stimulated self is a self whose ambitions and ideals had been unempathically responded to in isolation, without sufficient regard for the

self *in toto*, the overburdened self is a self that had not been provided with the opportunity to merge with the calmness of an omnipotent selfobject. The overburdened self, in other words, is a self

that had suffered the trauma of unshared emotionality. The result of this specific empathic failure from the side of the selfobject is the absence of the self-soothing capacity that protects the normal individual from being traumatized by the spreading of his emotions, especially by the spreading of anxiety. A world that lacks such soothing selfobjects is an inimical, a dangerous world. No wonder, then, that a self that had been exposed in early life to states of 'overburdenedness' because of the lack of soothing selfobjects, will under certain circumstances experience its environment as hostile. During states of 'overburdenedness' in adult life—e.g. after the therapist had been unempathic, in particular by failing to give to his patient the right interpretation with regard to his emotional state, or by pouring too much insight into him all at once, oblivious to the fact that the absorption of the new understanding confronts the patient with an excessive task—a patient might dream that he lives in a poisoned atmosphere or that he is surrounded by swarms of dangerous hornets; and, in his wakeful awareness, he will tend to respond to otherwise hardly noticeable stimuli as if they were attacks on his sensibilities. He will, for example, complain of the noises in the therapist's office, of unpleasant odours, etc. These reactions of patients with narcissistic personality disorders, especially when they involve an overall attitude of irritability and suspiciousness, may at times strike us as alarmingly close to those we encounter in the psychoses, in particular of course in paranoia. Unlike the more or less systematized, chronic suspiciousness and counter-hostility of the paranoiac, however, these manifestations of the overburdened state of the self appear, like the analogous hypochondriacal preoccupations in states of self-fragmentation, always as the direct consequence of a specific narcissistic injury, as a consequence of the unempathic, overburdening response of a selfobject. They disappear speedily when an empathic bond with the selfobject has been re-established, i.e. in therapy, when a correct interpretation has been made.

5. BEHAVIOURAL PATTERNS AND THE INJURED SELF

It is with a good deal of reluctance that the psychoanalyst undertakes to present a typology of behaviour, even if he has been able to correlate his descriptions of frequently occurring clusters of specific surface manifestations with specific underlying dynamic constellations or with specific foci of genetic experience. The best efforts of the past—Freud's **(1908)**, **(1910)**, **(1916)**, **(1931)**; Abraham's **(1921)**, **(1924)**, **(1925)** —are no exception to the rule that the simplified correlation of specific patterns of manifest behaviour with universally present psychological conditions which of necessity forms part of any such typology will, in the long run, impede scientific progress. Why then, do we persist in the attempt to devise characterologies? The answer is that such classifications, even though we must be aware of the fact that they may eventually limit our thinking and stand in our way, can for a while be valuable guides in psychological territory in which we feel not yet at home. There is no question, for example, about the fact that an analyst who adheres strictly to the thought patterns so beautifully laid out by Abraham in 1921, will be hampered in his ability to understand some of his patients. Had Mr W.'s 'obsessional' description of the contents of his trouser pocket **(Kohut, 1977, pp. 164–9)** been seen unquestioningly as a manifestation of his 'anal character', the crucial significance of his behaviour, in the service of the maintenance of his endangered self, would not have been understood and the crucial genetic data would not have come to light. But does that mean that it would have been better for analysis if Abraham had never given us his typology? Decidedly not. It was of the greatest help to generations of analysts and, so long as we are aware of the limitations of its applicability, continues to be of limited service even today.

But although we therefore feel that the setting up of typologies is justified, it behooves us to be explicit about the shortcomings inherent in any such attempt. We have no doubt, for example, about the fact that the concept of a 'mirror-hungry personality', to be sketched out shortly, will be helpful as an orientating device within the framework of the psychology of the self, just as Abraham's 'anal character' was helpful within the framework of drive-psychology. But we must immediately say that there are some mirror-hungry individuals whose personality structure is different from the one which, according to our

dynamic interpretation, is correlated to their mirror-hungry behaviour—it is different because it was not formed as the result of the specific traumata in childhood which, according to our genetic reconstruction, are the responsible agents. Mr X.'s behaviour **(Kohut, 1977, pp. 199–219)** might well be characterized as that of a mirror-hungry personality. Yet his insistent claims for attention and praise, his arrogant superiority, were not manifestations of the specific personality structure—characterized by simple deficiencies due to insufficient mirroring attention in childhood—that we should expect to encounter on the basis of our description of '*the*' mirror-hungry person. His mirror-hungry behaviour was embedded in a much more complexly organized pathological personality. His behaviour was the manifestation of a sector of his personality that was isolated from his nuclear self by a 'vertical split'—a split that had come about not because of a *lack* of mirroring attention in childhood but because of a specific *fault* in his mother's responses to him. While, to state it more exactly, her approval of him had indeed been excessive, the focus of her mirroring had not been selected in accordance with *his* needs—namely, to develop an independent and vigorous self—but in accordance with *hers* —namely, to keep him dependent on her, indeed to retain him within her own personality organization, in order to brace up her own, precariously constituted self.

There are many cases, however, where our brief explanation of the 'mirror-hungry personality' is more nearly correct. Miss F., for example **(Kohut, 1971, pp. 283–93)**, became indeed 'mirror-hungry'—i.e. self-righteously demanding exclusive attention and reassuring praise—because her phase-appropriate needs for mirroring had not been met by her self-absorbed mother. But even in these cases the patients' demandingness is not simply the present-day expression of normal, self-assertive needs of childhood that have persisted because they had not been appropriately responded to in the past. Because of the intensity of these needs and, *par excellence*, because of these patients' conviction that they will not find an echo of understanding empathy, they arouse deep shame which, in turn, leads to their suppression, manifested by depressed and hopeless withdrawal—the latter behaviour sometimes, in particular in the narcissistic behaviour disorders, alternating with bursts of enragedly expressed but not effectively pursued demands that the wrong that had been done be set right.

Having in the foregoing given voice to some of the arguments that speak for and against psychoanalytic characterologies in general and to some of the pros and cons regarding a classification of behavioural syndromes in the area of the disturbed self in particular, we will now throw further caution to the winds and outline some frequently encountered narcissistic personality types.

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

Ideal-hungry personalities are forever in search of others whom they can admire for their prestige, power, beauty, intelligence, or moral stature. They can experience themselves as worthwhile only so long as they can relate to selfobjects to whom they can look up. Again, in some instances, such relationships last a long time and are genuinely sustaining to both individuals involved. In most cases, however, the inner void cannot forever be filled by these means. The ideal-hungry feels the persistence of the structural defect and, as a consequence of this awareness, he begins to look for—and, of course, he inevitably finds—some realistic defects in his God. The search for new idealizable selfobjects is then continued, always with the hope that the next great figure to whom the ideal-hungry attaches himself will not disappoint him.

Alter-ego-personalities need a relationship with a selfobject that by conforming to the self's appearance, opinions, and values confirms the

existence, the reality of the self. At times the alter-ego-hungry personalities, too, may be able to form lasting friendships—relationships in which each of the partners experiences the feelings of the other as if they had been experienced by himself. 'If thou sorrow, he will weep; if thou wake, he cannot sleep; thus of every grief in heart he with thee doth bear a part' (Shakespeare, *The Passionate Pilgrim*). But again, in most instances, the inner void cannot be filled permanently by the twinship. The alter-ego-hungry discovers that the other is not himself and, as a consequence of this discovery, begins to feel estranged from him. It is thus characteristic for most of these relationships to be short-lived. Like the mirror- and ideal-hungry, the alter-ego-hungry is prone to look restlessly for one replacement after another.

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

Merger-hungry personalities will impress us by their need to control their selfobjects in an enactment of the need for structure. Here, in contrast to the types sketched out before, it is the need for merger that dominates the picture, the specific type of merger, however—whether with a mirroring or an idealized selfobject or with an alter ego—is less important in determining the individual's behaviour. Because the self of these individuals is seriously defective or enfeebled, they need selfobjects in lieu of self-structure. Their manifest personality features and their behaviour are thus dominated by the fact that the fluidity of the boundaries between them and others interferes with their ability to discriminate their own thoughts, wishes and intentions from those of the selfobject. Because they experience the other as their own self, they feel intolerant of his independence: they are very sensitive to separations from him and they demand—indeed they expect without question—the selfobject's continuous presence.

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

6. THE TREATMENT OF THE NARCISSISTIC BEHAVIOUR AND PERSONALITY DISORDERS

The essential therapeutic goal of depth-psychology is the extensive amelioration or cure of the central disturbance, not the suppression of symptoms by persuasion or education, however benevolently applied. Since the central pathology in the narcissistic behaviour and personality disorders is the defective or weakened condition of the self, the goal of therapy is the rehabilitation of this structure. True, to external inspection, the clusters of symptoms and personality features that characterize the narcissistic behaviour disorders on the one hand, and the narcissistic personality disorders, on the other hand, are completely different: the self-assertive

claims of the first group appear to be too strong, those of the second not strong enough. But depth-psychological investigation demonstrates that the psychopathological basis of both disorders—the disease of the self—is, in essence, the same.

With regard to those patients with self-pathology, those with narcissistic behaviour disorders, who make overly loud narcissistic claims, and whose behaviour appears to be overly self-assertive, the therapist might be tempted to

persuade them to relinquish their demands and to accept the limitations imposed by the realities of adult life. But doing this is like trying to persuade a patient who suffers from a structural neurosis to give up his phobia, his hysterical paralysis, his compulsive ritual. The overtly expressed excessive narcissistic demands of these patients and what appears to be their overtly displayed excessive self-assertiveness are a set of characterologically embedded symptoms—they are not the manifestations of an archaic narcissism that had not been tamed in early life and that must now be tamed belatedly. On the contrary, it is the essence of the disease of these patients that the access to their childhood narcissism is barred. The unfulfilled narcissistic needs of their childhood with which they must learn to get in touch, which they must learn to accept, which they must learn to express, lie deeply buried beneath their clamorous assertiveness, guarded by a wall of shame and vulnerability. If, on the basis of a therapeutic maturity-or reality-morality, the therapist concentrates on censuring the patient's manifest narcissism, he will drive the repressed narcissistic needs more deeply into repression—or he will increase the depth of the split in the personality that separates the sector of the psyche that contains the unresponded-to autonomous self from the noisily assertive one that lacks autonomy—and he will block the unfolding of the narcissistic transference. These considerations apply whether the patient's overt narcissistic demands are expressed via quietly persistent pressure, via attacks of scathing narcissistic rage, or via emotional means that lie between these two extremes. We all know people who annoy us by asking us again and again to repeat our favourable comments concerning some successful performance of theirs. And we all also know others who, throughout their life, go from one selfishly demanding rage attack to another, seemingly oblivious to the rights and feelings of those toward whom their demands are directed. If the analyst responds to these demands by exhortations concerning realism and emotional maturity or, worse still, if he blamefully interprets them as the expression of their insatiable oral drive that needs to be tamed or of a primary destructiveness that needs to be neutralized and bound by aggression-curbing psychic structures, then, as we said, the development of the narcissistic transference will be blocked. But if he can show to the patient who demands praise that, despite the availability of average external responses, he must continue to 'fish for compliments' because the hopeless need of the unmirrored child in him remains unassuaged, and if he can show to the raging patient the helplessness and hopelessness that lie behind his rages, can show him that, indeed his rage is the direct consequence of the fact that he cannot assert his demands effectively, then the old needs will slowly begin to make their appearance more openly as the patient becomes more empathic with himself. And when the repressions are thus ultimately relinquished—or when the split maintained via disavowal is bridged—and the narcissistic demands of childhood are beginning to make their first shy appearance, the danger is not that they will now run to extremes, but that they will again go into hiding at the first rebuff or at the first unempathic response. Experience teaches us, in other words, that the therapist's major effort must be concentrated on the task of keeping the old needs mobilized. If he succeeds in this, then they will gradually—and spontaneously—be transformed into normal self-assertiveness and normal devotion to ideals.

The foregoing conclusions hold also with regard to those individuals with self-pathology, those with narcissistic personality disturbances, who are overtly shy, unassertive and socially isolated, but whose conscious and preconscious fantasies—'The Secret Life of Walter Mitty'—are grandiose. If the therapist believes that the patient's timidity, shyness and social isolation are due to the persistence of archaic illusions, specifically that they are due to the persistence of his untamed childhood grandiosity as manifested in the form of his grandiose fantasies, then he will feel justified in the attempt, through the application of educational and moral pressure, to persuade the patient to relinquish these fantasies. But neither the patient's fantasies nor his social isolation are

the cause of his illness. On the contrary, together they constitute a psychological unit which, as a protective device, attempts to maintain the patient's precariously established self by preventing its dangerous exposure to rebuff and ridicule. If the therapist is educational rather than analytic, if he restricts

his approach to the attempt to persuade the patient to give up his fantasied grandiosity, then the distance between the patient's defective self, on the one hand, and the therapist as the hoped-for empathic responder to the patient's narcissistic needs, on the other hand, will increase and the spontaneously arising movement towards the first significant breach in the wall of sensitivity and suspicion, the establishment of a narcissistic transference, will be halted. If, however, the therapist can explain without censure the protective function of the grandiose fantasies and the social isolation and thus demonstrate that he is in tune with the patient's disintegration anxiety and shame concerning his precariously established self, then he will not interfere with the spontaneously arising transference mobilization of the old narcissistic needs. Despite disintegration fears and shame, the patient will then be enabled, cautiously at first, later increasingly more openly, to re-experience the need for the selfobject's joyful acceptance of his childhood grandiosity and for an omnipotent surrounding—healthy needs that had not been responded to in early life. And again, as in the case of the narcissistic behaviour disorders, the re-mobilized needs will gradually—and spontaneously—be transformed into normal self-assertiveness and normal devotion to ideals.

In the foregoing we demonstrated that the therapeutic principles which we enunciated and the therapeutic strategy correlated to them are based on the understanding of the central psychopathology of the analysable disorders of the self and that they have as their aim the amelioration and cure of this central psychopathology. Since the psychopathology of both major types of analysable disorders is identical, it follows that despite their divergent symptomatology—noisy demands and intense activity in the social field in the narcissistic behaviour disorders; shame and social isolation in the narcissistic personality disorders—the process of treatment also is identical in its essence. And the same, of course, holds for the nature of the wholesome result that is achieved by the treatment: it is the firming of the formerly enfeebled self, both in the pole that carries the patient's self-confidently held ambitions and in the pole that carries his idealized goals. It only needs to be added now that the patient's revitalized self-confidence and the revitalized enthusiasm for his goals will ultimately make it possible for him, whether he suffered from a narcissistic behaviour disorder or a narcissistic personality disorder, to take up again the pursuit of the action-poised programme arched in the energic field that established itself between his nuclear ambitions and ideals, will make it possible for him to lead a fulfilling, creative-productive life.

With the preceding remarks about some clinical lessons, derived from the application of the psychology of the self to the therapeutic situation, our survey of the psychology of the self has reached its end. Since it would serve no good purpose if we now made the attempt to summarize an essay which, in itself, is in its essence a summary of the results of previous investigations, we shall restrict our final statement to emphasizing once more that the brevity of our presentation does not imply any conviction on our part that we were offering the outline of a finished system of thought. We simply tried to describe briefly the current state of a new development in psychoanalysis—a development, it must be added, which not only has by no means come to its end but which, on the contrary, appears to have lost none of its initial momentum. The foregoing pages should, therefore, be considered as a survey of the current state of the psychoanalytic psychology of the self—a survey that should assist us in planning the further investigation of an as yet incompletely explored psychological field.

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