

THE NARCISSISTIC INVESTMENT IN PATHOLOGICAL CHARACTER TRAITS AND THE NARCISSISTIC DEPRESSION: SOME IMPLICATIONS FOR TREATMENT

RUTH F. LAX, NEW YORK

Character neurosis, as has already been pointed out by Waelder (1930), represents in large measure a malformation of the ego, resulting from compromise formations attempted to accommodate conflicting demands impinging upon the individual from reality, the superego, the drives, and the repetition compulsion. However, specific characteristics of particular compromise formations depend on the relative strength of these conflicting demands, the level of psychic maturity, the type of former identifications with a significant object or the need to dis-identify. Additionally, the hierarchical layering of past conflict resolutions which were adaptive during earlier psychosexual phases may subsequently lead to conflict, the resolution of which may or may not be adaptive (Schafer, 1968; Sandler, 1983). All these divergent psychic factors are reflected in the child's internalized object relations (Kernberg, 1976).

Processes leading to character formation and to the development of the superego are intimately connected since each is formed to a large extent, at least initially, in relation to parental demands and standards and as a solution to intrapsychic conflict evoked by this pressure. The types of identification formed by the child and the motives for their formation are important contributing factors which will significantly impact on the development and nature of the ego ideal. Character, however, develops not only in response to the demanding and

prohibiting forces in the environment, i.e. the 'thou shalt and shalt not', but also because of the child's wishes to be like and live up to the idealized aspects of parents, the child's significant objects, and personal heroes. All these factors may lead to a harmonious configuration or may, at odds with each other, stimulate conflicts requiring further compromise formations. The type of object relations and the manner in which parental authority is imparted will also be of great significance, as will the child's affect at the time these become internalized. Thus, a seductive manner, brutalization, being shamed, 'reasoned with', ignored, smothered, to name just a few possibilities, will lead to different intrapsychic resolutions.

With these sketchy introductory remarks as a background, I shall focus my discussion on the narcissistic¹ investment in pathological character traits and on some of the reasons we encounter such great difficulties in dealing with them analytically. These traits, as is well known, are not only ego-syntonic but frequently regarded by the patient as assets. This becomes understandable when their origins are considered, namely, that the trait or traits represent an unconsciously evolved solution to the dilemmas the child confronted (Baudry, 1984). Considered from this point of view, character traits are highly complex structures which developed as a dynamic accommodation between intrapsychic constellations fuelled by instinctual energies and

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¹ The terms narcissism and narcissistic are used throughout this paper as suggested by Hartmann (1950), namely, to indicate a libidinal investment in the self or an aspect of the self.

by parental demands (e.g. reality factors). Frequently the unconscious 'selection' by the child of a particular 'way of being' (e.g. character trait or constellation) is the child's only way to maintain an object tie, hold on to parental love, gain attention, feel accepted, etc.

Implied in 'being' what the parent wishes (e.g. a clean child) and not only doing what the parent demands (i.e. washing) is an identification with the aggressor (A. Freud, 1936; Sandler with A. Freud, 1985). In this process a partial 'surrender' of an aspect of the self takes place. Conflicting consequences usually follow. Such an identification may, as its corollary, involve a modification of the child's ego ideal² into which become introjected the idealized parental values and the aggressive valence. It is likely that aspects of the child's aggression become fused with this introject. Subsequent aggressive self-righteousness may in part originate from such a merger (Lax, 1975).

Intrapsychically, the child's 'surrender' usually becomes 'rewarded' by the superego and thus consciously experienced with a sense of well-being. Simultaneously, however, aggressive and hostile feelings surreptitiously increase in the child and must therefore continuously be repressed. This aggressivity is related to the child's sacrifice of his wilful, oppositional, and autonomous tendencies necessitated by compliance with parental demands and the identification with them. The type and intensity of the child's repressed aggressivity will also depend on the psychosexual phase during which the character trait originated, since drive constellations and psychic structure formation differ from phase to phase. However, the child's repression of this aggression is never total or lasting. A contributing factor to the maintenance of this repression is the narcissistically rewarding nature of external and/or internal 'praise' for being 'good'—whatever 'good' may mean.

Experiencing these vicissitudes is to some extent inherent in a child's normal process of socialization. The development of pathological character traits or constellations is likely when identification with the aggressor and surrender of aspects of the self involve profound and painful renunciations. This occurs, to mention

most frequent patterns, when the child is exposed to severe regimentation in feeding, toilet training, and cleanliness; when parental anxiety precludes the possibilities of autonomous development during the separation-individuation subphases; when there is crippling identification with a depressed parent; when object loss occurs (Lax, 1986); when the child is physically or psychologically abused; when withdrawal of love or threats of abandonment are used to coerce required behaviour, etc.

The following vignette will illustrate genetic factors leading to the development of a pathological ego ideal and pathological character traits in which both adaptive and reactive aspects were present.

Pat entered analysis because she feared she would never get married. She was in her late twenties and this fear had made her desperate. Each of her relationships had ended in bitter quarrels. Men accused her of being destructive and castrating. The reasons for this eluded her. Pat felt she 'did no wrong'. She always acted responsibly, was orderly and put things away; she was loyal, fulfilled her commitments, was punctual, thoughtful, etc. She felt the men were terribly unfair. They were the ones who did not live up to their promises. It therefore was justified and even mandated for her to point this out to them. Though pretty and well-built, Pat struck me as prim and grim, forever frowning, with closed narrow lips and a measured gait. She always greeted me with a perfunctory smile—a mere automatic 'politeness'. Pat would 'settle' on the couch and after some silence start with the list of her latest grievances. These were contrasted with examples of her responsible and correct behaviour. Pat depicted herself as a paragon of always appropriate virtues. It was incomprehensible to Pat that others criticized her and did not seek her friendship. Pat was completely oblivious to her haughtiness, covert aggression, and vengefulness. Her complaints had the unspoken message: 'Look how good and virtuous I am. See what I do. I am better than...' followed by the silent, angry demand, 'Why the hell don't you praise me?'

Pat was born while her father was away in the army. During the first 20 months of Pat's

² My formulations regarding the development of the pathological ego ideal, the pathological ideal-self-image, and

the relationship of these substructures to each other are derived from the theories of Jacobson (1954, 1964, 1971).

life, mother centred and lavished all her attention on the little girl, establishing an overly close and intense relationship with her. Pat felt she was 'most important' for mother. This situation changed abruptly when father returned. Mother's happiness and mother's love for father made Pat feel pushed out of mother's orbit, displaced and rejected. It was a shock experienced as a severe emotional object loss (Haynal, 1985). It evoked despair and fury. Pat's sense of deprivation, unresolved longing, and anger was unending. The consequences of this trauma which occurred during the rapprochement subphase, combined with the phase-specific conflicts, interfered with Pat's capacity to develop an appropriate, loving relationship with father and to accept her changed status in the relationship with mother. Pat was about 3 when her sister was born.

Pat describes sister as sickly, forever crying, and forever carried by mother. Pat wished to silence sister—Pat wanted mother to hold her. She remembered squeezing sister hard, 'out of love', and mother screaming, 'You'll choke her'. Pat reported with tears of anger that mother blamed her for all of sister's illnesses. Pat remembers pushing sister when she started walking. Pat made her fall. Mother saw it, spanked Pat, and told her that 'she was a bad girl and would be sent to nursery...' Pat recalled weeping and begging mother not to send her away. She promised over and over to be 'good'. Pat indeed did become 'good'; she became mother's helper.

Subsequently, Pat was praised by her parents, teachers, and other authority figures for being responsible, dutiful, helpful, diligent, and kind, etc., i.e. 'a paragon of virtue'. Pat cherished this praise and approval and strove for it since to her it was a proof of love and acceptance. Pat developed rigid, high standards and a strict and exacting superego. She had a constant need to be reassured by praise. All these factors helped Pat keep her despair, murderous wishes, rage, and extreme penis envy unconscious. Pat lived for the rewards of fulfilled 'duty'; her spontaneity and creativity became inhibited.

Pat's childhood adaptive psychic conflict resolutions eventuated in her currently maladaptive characteristics. Pat was unaware of the extent to which her inflexible manner of doing 'the right thing' expressed her unconscious sense

of grandiosity, entitlement, aggression, and her wish to be acknowledged as 'better than...' Pat likewise did not realize that her self-righteous attitudes and behaviour provoked hostility in others. Pat prided herself for 'living up to her standards', by always being responsible and dutiful, which meant to her: doing 'what one should'. Though Pat acknowledged having angry feelings, she considered these to have been provoked by the 'unfair way in which she had been treated'. Pat had no insight into the real unconscious causes or the magnitude of her anger and envy.

As this vignette illustrates, the childhood resolution of psychic conflicts in which identification with the aggressor plays a decisive role also leads to the formation of a pathological ideal-self-image modelled on the pathological ego ideal which contains the introject of the aggressor. In these cases subsequent identifications facilitate the unconscious perpetuation of unmodulated wishful infantile fantasies of merger and fusion which entail participation in parental grandiosity, power, and omnipotence. This whole unconscious complex of internalized object relations may be expressed via the enactment of pathological character traits or configurations which express unconscious compliance with the pathological ego ideal and simultaneously a sharing in the powers of the internalized parental representations (Kernberg, 1980, chapter 9).

The pathological ideal-self-image as an intrasystemic standard of aspiration furthers the reactive patterns manifested in a variety of pathological character traits and constellations. These traits which originated, as has been indicated, at the behest of parental authority to repress forbidden drives and wishes, simultaneously served to assuage this authority. Thus in addition to their specific defensive function, these traits initially were also adaptive. The latter quality resulted in a sense of mastery which, combined with the internalized parental valuation, accounts for their intense narcissistic investment. The narcissistic significance of these traits in the psychic economy results also in the tenacity and rigidity with which they are perpetuated. They thus frequently become generalized attitudes (for instance, haughtiness, self-righteousness, overpoliteness, passivity, impudence, exaggeration, generosity, etc.) As

Fenichel (1945) and Gitelson (1963) suggested, some pathological character traits and constellations may even lead to the accrual of a degree of secondary gain. To these belong attempts at narcissistic overcompensation which have met with some partial success in reality (for instance, workaholics, 'good fellows', etc.).

Concomitant with the specific pathological character traits or constellations of a particular individual are personality attributes shared by all these patients which further impede the analytic work. Predominant among those are impaired flexibility, limited capacity for non-defensive self-observation, difficulties in tolerating frustration, shame, embarrassment, and frequently a general withholding attitude.

Analytic treatment of patients with pathological character traits and constellations presents many difficulties and complications. Fenichel (1954), familiar with these, recommends when treating such patients that their 'rigid attitudes' be remobilized into 'living conflicts'. To achieve this aim, the patient must be made aware of the peculiarities of his behaviour, of his being unable to act otherwise, of his need for this behaviour for purposes of defence, and eventually of the danger (or dangers) he fears and against which he defends. Fenichel further suggests that these tasks can be accomplished by making ego-syntonic characterological patterns dystonic and by helping the patient tolerate the anxiety this engenders. Fenichel notes that in these cases, though 'the analyst must see all three aspects of psychic phenomena and in the struggle between them remain neutral, essentially *he always begins to work with the ego* and only through the ego can he reach the id and the superego; in this sense he is *always closer* to the ego than to the other two' (1941, p. 70; *my italics*). Thus in treatment, the pathological character traits and constellations become initially the significant though *not* exclusive therapeutic focus.

Baudry (1984) maintains that in dealing with pathological character traits and constellations, there clearly are 'no hard and fast rules and the art rather than the science of psychoanalysis enters...' thus '...each practitioner will develop his personal style and approach'.

In the treatment of this type of patient the beginning phase is most difficult. It entails an

astute 'dosing' of the interventions necessary to interfere with and disrupt the ego-syntonicity of the pathological character traits. This eventually results in the disturbance of the neurotic equilibrium and the patient's increased accessibility to analysis. In principle, ego-syntonicity implies a closed, perpetually self-confirming system of basic principles which structure experience (Schafer, 1979). This is manifested by the narcissistically invested character traits and constellations which reflect the effects of pervasive unconscious internal precepts. Ego-syntonicity is a formidable obstacle to treatment and may result, when completely uniform, in a case that is not analysable. In practice, however, such a degree of homogeneity does not prevail. Some inconsistency is usually present, as well as some experiential diversity and ability to perceive contradictions. In all cases where ego-syntonicity is particularly persistent, the initial analytic task is to strengthen dystonic elements and to encourage curiosity.

The following vignette depicts the beginning phase of treatment with this type of patient.

David, in his twenties, son of Holocaust survivors, complained in treatment about the general untrustworthiness of people, their lack of reliability, and occasionally, their dishonesty. These views applied to everyone, from business acquaintances to girlfriends. David told me stories to prove his point. I realized, after listening for some time, that David, motivated by an unconscious pervasive attitude of mistrust, unknowingly construed his interpersonal interactions in such a way as to prove his point.

David's attitude, not surprisingly, manifested itself also in the transference. He minutely examined the treatment situation and used any deviation on my part—some lateness, an occasional change in the schedule, etc.—as a basis for accusations. David maintained I lacked consistency, was flighty, and he therefore could not depend on me or trust me. David accused me of having a 'scheme' to manipulate him. Consequently, he could not believe I really had his interests at heart.

David criticized everything about me: my manner, my analytic interventions, and my silence. I came to realize that he mistrusted and suspected everything I did or did not do, though he did not know why. He was unaware that his

accusations were the outcome of his prevailing attitude. David believed, as he did in relation to everyone else, that his criticisms were justified by reality.

I told David I was puzzled by the apparent contradiction between his tremendous mistrust of me, suspiciousness, and criticism, and his staying in treatment in spite of it. I wondered what the real motive for all the fault-finding could be and suggested that his criticisms were just a ruse.³

These remarks startled David. He became curious and we began to explore the contradiction between David's attitude of suspiciousness and his staying in treatment. David, in this process, began to realize the discrepancy between the intensity of his critical feelings and the incidents which provoked them. Eventually David provided enough material to justify the interpretation that his accusations were an unconscious attempt to provoke an outburst of anger by me and thus compromise my 'analytic attitude'. Were he to succeed, David could prove once again that he was justified in not trusting anyone, even an analyst.

Continued analysis revealed that David's constant mistrust was his way of guarding against possible hurts and disappointments. This stance reflected parental attitudes and was strongly reinforced by them. It became apparent in the course of treatment that his unconscious vigilante posture was also narcissistically enhancing for David. By holding to it, David felt 'united' with his parents in their 'special strengths' which had enabled them to survive the Holocaust.

At a much later stage analysis revealed that on a deeper level David's mistrust was the consequence of devastatingly persistent and traumatic parental inconsistency during his childhood. This caused many painful events. David's credo: 'I shall never be hurt because I trusted' was the outcome of these childhood experiences. Most significantly, however, the pervasive mistrust was an unconscious enactment of the idealized parental introject and simultaneously expressed David's anger and devaluation of it.

Schafer (1979) emphasizes that the analyst's skill, patience, composure, sensitivity, imagina-

tion, and the 'goodness of fit' between patient and analyst might well make the decisive therapeutic difference in the treatment of patients with pathological character traits and constellations. The highlighting and exploration of contradictions (Kernberg, 1980, 1984; Schafer, 1982) is of utmost significance in the analysis of these patients since it enables them to become aware of ego-dystonic elements and therefore leads to the exploration of unconscious conflicts. However, even when the patient is motivated by a sense of unhappiness, seeks analysis—and even when a good therapeutic alliance prevails, consistent, though *not* exclusively so—tactful analytic attention to incongruities will evoke the patient's anger. The most immediate cause for the anger may be an awareness of a sense of 'unease' stemming from shifts in the unconscious defensive equilibrium. The patient may respond to a decrease in ego-syntonicity with a perception of the analyst as intentionally confusing. This is understandable since unconsciously there is an attempt to maintain the neurotic equilibrium which has been attained at great cost. The analyst at this time is usually accused of misunderstanding and of attacking the patient—of being overly critical, judgmental, guided by his own values, and worse still, of wishing to impose his value system on the patient. Such reactions occur irrespective of the specific content of the underlying unconscious fantasies and wishes.

The patient's anger contains many elements which have to be addressed and analysed. I shall explore only those which I consider most important. Foremost among these is repressed aggression specifically engendered during childhood in the process of identification with the aggressor (Abraham, 1921). It is important to note that aggression evoked by this identification was not the primary motive for the development of a specific reactive defence (i.e. overly solicitous attitudes covering up murderous wishes). Analysis reveals that the child's hostility evoked by submission to the parent manifests itself during this phase of treatment and becomes displaced upon the analyst. This is understandable since the analyst, both as a transference figure and in the reality of the analytic situation, by invoking

³ My conviction was in part due to countertransference feelings in which anger played a part.

analytic rules makes demands, unconsciously experienced by the patient as analogous to the parental demands during childhood. The patient experiences the analyst's probing of his pathological traits as a request to give up what he, the patient, values: a surrender, once again, of a part of himself. This is perceived as a painful and infuriating repetition of the past.

The analyst's exploration of the pathological traits and constellations also evokes anger because the patient wants to hold on to their pleasurable quality, which stems from the adaptive aspect of these childhood compromise formations. Thus, though the formation of the conflict resolution may have been prompted by desperation, analytic exploration is resisted because it is experienced as threatening to the gratifying component.

The analytic process of unravelling contradictions frequently stimulates the patient to re-experience specific aspects of his childhood, such as power struggles and threats that love would be withheld for disobedience, etc. It is thus of utmost importance that the analyst scrutinize his countertransference feelings and avoid behaviour which patients could correctly interpret as corresponding to parental punishment (i.e. retaliatory silence).

Since the pathological traits and constellations originated to preserve the parent-child object relationship threatened by loss of parental love, the patient experiences the analyst's interventions as an attack on what he values. Namely, an assault on the parental introject, incorporated in the ego ideal, with which aspects of the patient's self representation are fused. This intrapsychic amalgam is only partly depersonified, even though frequently expressed by 'lofty' values. The analyst's attitude of empathy and understanding for the patient's struggle and anger can help the patient tolerate his pain during this period. Especially important is the analyst's regard for these patients' extreme sensitivity to shame and/or humiliation.

The patient, nonetheless, even in an optimal analytic atmosphere, will react to the analyst's consistent (though not exclusive) attention to

contradictions with a feeling that the analyst wishes to 'show him up'. This reaction occurs because pointing out disparities leads to the analysis of traits whose unconscious motivation contains elements the patient wishes to hide since they were and are forbidden and/or shameful. The patient thus responds to this analytic process with a growing awareness and sense of the pretence and disguise inherent in the pathological character traits and constellations which retain their defensive, frequently reactive function.⁴ The patient's resistance at this time may increase because of attempts to ward off these painful revelations. This was illustrated by one of my sophisticated patients, whose excessive generosity and submissiveness took years to analyse and work through. He said during the termination phase: 'I know I was complaining that nothing was happening and the analysis was going nowhere...I didn't want it to go anywhere...I experienced everything you said as either patronizing or as a criticism...and when I finally let myself know what was going on inside of me I formulated the rule: the worst about myself, and that which I really didn't want to know, *is* the truth about me. When the so-called moral coating goes, what remains I would rather not see!'

To minimize provoking profound narcissistic mortifications which only intensify defensiveness, it is helpful for the analyst to highlight the contradictions and simultaneously express his puzzlement about them. This attitude, when genuine, elicits the patient's curiosity. Identification with the analyst's attitude of empathic inquiry leads to the formation of a split in the ego.⁵ Such a split, and possibly also a transference-motivated need to please the analyst, may account for the patient's wish to discover the unconscious factors which lead to the formation of contradictions. Optimally, under these circumstances, the patient may even experience some narcissistic gratification from the exploration of contradictions, and this may serve to mitigate the injury to his narcissism caused by his discoveries. Nonetheless, during this very painful period of the analysis, in-

⁴ In contrast to structures of secondary autonomy which are predominantly fuelled by neutralized energy even though they may continue to be triggered by the drives (Hartmann,

1939, 1950, 1952, 1955).

⁵ Analogous, though not identical, with the split into the observing and experiencing ego.

terventions should be couched to bring the patient relief, preferably in the context of the transference, by helping the patient understand the nature of his suffering. The use of reconstructions is frequently indicated.

The following vignette illustrates some of these points:

Pat frequently complained that her helpful (but unsolicited) suggestions to friends about ways in which they decorate their homes met with thinly disguised hostility. Pat justified her behaviour by saying that 'real friendship required honesty and helpfulness' and her advice, sometimes acted out, stemmed from her wish to share her excellent aesthetic taste. She reminded me that mother always admonished her 'to share'. She had to share her knowledge with sister and teach her when sister had exams. Pat was totally unaware that her so-called helpful behaviour expressed aggression and was experienced as haughty, domineering, and controlling. When I acknowledged Pat's painful disappointment at the reactions of her friends and conveyed my puzzlement at her persistence in such unrewarding behaviour, Pat burst out in a barrage of self-righteous indignation. She accused me of advocating hypocrisy, being duplicitous, and misunderstanding the nature of real friendship. She was ready to suffer in the service of duty; it was Right to point out what was Wrong. Pat was hurt by my lack of appreciation and praise for her high standards, her wish to be helpful, and her perseverance in doing the 'right thing'. Driven by an unconscious compulsion, Pat vowed to continue her behaviour irrespective of consequences.

Pat became quite depressed while considering issues involved in her relationships. She questioned whether being a 'true' friend was worthwhile. She spoke about 'real' criteria of friendship—complained she had no 'real' friends and wished she had a friend who would do for her what she did for others. During this stormy period Pat reported the following dream fragment: she 'shoved food down the throat of a small, hungry dog'. Pat added in a whisper: 'quite unmercifully'.

After ruminations and associations, Pat blurted out that she likewise 'shoved information down her sister's throat' when she helped her prepare for exams. She added, 'She had to do well or else mother would have blamed me'.

During the subsequent long period of analysis, it became evident that derivatives of compromise formations arrived at as means of resolving childhood conflicts manifested themselves in Pat's compulsive helpfulness and generosity—in her insistence on the Right way of doing things and her perseverance in these tasks. The pseudo-altruistic sharing of her aesthetic sensibility was but one of the many different ways in which this constellation of her pathological traits manifested itself.

Since the therapeutic process leads to increased reality testing, the patient gradually develops a growing awareness that sought-for goals were not achieved by enactment of pathological traits and constellations. Further, the patient also becomes increasingly aware of the unacceptable unconscious motives connected with these traits. The patient now not only suffers from a transient loss of self-esteem, he also experiences more permanent injuries to his self-image. At this stage of treatment patients frequently manifest extreme resistances which may lead to the disruption of the analysis. It is likely that these resistances are manifestations of an unconscious desperate strategy to produce a stalemate and avoid the feared, excruciating narcissistic mortification anticipated by the patient unconsciously, were the painful facts and feelings faced.

In my experience, when this stage is reached in the treatment process, patients with the best prognosis develop a depression.⁶ It is caused (Bibring, 1953) by a breakdown of the mechanisms⁷ which contributed to the establishment of the patient's self-esteem. The patient consequently experiences a narcissistic injury to his self-image. He becomes acutely aware of real and/or imaginary helplessness, and of an incapacity to live up to both conscious and unconscious goals. This painful discovery is exacerbated further by the recognition of the

⁶ This coincides with Kernberg's finding (1975, chapter 8). I differ with Kernberg, however, regarding the aetiology of this type of depression since I do not consider that guilt

plays a significant role in this phase of analysis with this type of patient.

⁷ I.e. the pathological traits and constellations.

discrepancy between goals, aspirations, and the realization of the unacceptable nature of the underlying unconscious motives. Whereas the patient previously may have felt good and righteous, he now feels bad and considers himself unlovable.

Intersystemic tensions between the ego and ego ideal (aspect of the superego) and intrasystemic tensions within the ego are experienced as a narcissistic depression. This phrase, as far as I know, has not been used in the literature.⁸ It is implicit, however, in the work of Bibring (1953) and Jacobson (1971). In a narcissistic depression, feelings of shame and humiliation, rather than guilt, predominate. A patient, in the course of analysing aspects of his pathological ideal self, may experience intense feelings of forlornness, abandonment, and helplessness. His goals may not have changed, but he now sees them as so exalted he no longer hopes ever to attain them. The loss of a sense of mastery evokes feelings of humiliation and shame. Conversely, the goals may now be changed and the patient, when middle-aged, may despair about wasted years and misdirected energy. This phenomenon is especially poignant in women who for a variety of reasons did not want to have children and in their early forties, having analysed their psychic obstacles to motherhood, despair they may never have a child. A patient may also experience a lack of inner-directedness. At such a time, long-held standards no longer seem meaningful and the patient may experience a transient feeling of loss of identity and despondency. This may be accompanied by a wish to 'do nothing', to be cared for, possibly a regressive appeal for help in the transference.

Some of these vicissitudes could be seen in Pat's reactions to learning that her pseudo-altruistic behaviour was actually motivated by hostile wishes to control and dominate others. Pat at that time became quite depressed and complained she no longer felt like the 'good and helpful person' she always believed she was. She thought she now knew what her friends meant when they said, 'She was too good to be true'.

It meant the opposite, namely that 'her goodness was untrue'. She decided it was best 'not to do anything' since in that way she 'would not impose on anyone'. Further analysis revealed that she harboured the secret hope that her inaction would induce her friends to turn to her for help. It expressed a spiteful wish: 'Just you wait and see how much you'll miss me'. It eventually was possible for Pat to recognize that the extremes of her behaviour corresponded to the polarities of her ambivalence.

The patient's unconscious fantasied participation in parental grandiosity, power, and omnipotence is yet another aspect of the pathological ideal self which requires analysis. The patient's painful awareness of his limitations highlights the illusion of this fantasied participation, leads to its childhood sources, and eventually in a de-idealization of the fantasied parental imago. While this occurs, the narcissistic depression takes on some of the features of mourning. The process by which the parental introject becomes devalued may be fraught with anger and despair, optimally expressed in the transference, though that is not always the case. When successful, this process leads to a more realistic psychic representation of each parent and improved reality testing.

The analyst, according to Balint (1968), must sincerely accept the patient's complaints, re-creations, and resentments and allow ample time for the patient to change these re-creations into regrets. This sequence, when successfully traversed, promotes an intrapsychic separation from the pathogenic introject. If the patient internalized during this process the analytic attitudes of empathy and tolerance, such a separation results in a modulation of the pathological ego ideal. The noxious internal imagos become decathected. This leads to the development of a more mature and realistic wishful self-image (in Jacobson's sense, 1954, 1964).

The patient's mourning, which at this time may intensify, is for the fantasied grandiose, omnipotent, and protective parent, as well as for the fantasied infantile self-image in which gran-

⁸ From my study of the self-psychology literature and a discussion with Drs Anna and Paul Ornstein, it appears that within the Kohutian schema the experiencing of a depression caused by narcissistic pain is due to a sense of *self-defect*. I, however, am examining the narcissistic injury to one's self-image due to the discovery of the unacceptable unconscious

motives for character traits that were narcissistically invested and lead to the subsequent corruption of the goals of the ego ideal. The consequence of such an analytic investigation is a blow to one's grandiosity and fantasied omnipotence. Continued analysis eventually leads to the discovery of the underlying unconscious conflict.

diosity, omnipotence, and the belief in the capacity to control the environment played a predominant part. The patient must be given time to experience, mourn, and master these losses. The capacity for grieving implies that the narcissistic pain related to the acceptance of one's shortcomings can be tolerated, and also that the imperfections of the libidinal object have now become acceptable. Increased acknowledgment of more realistic limitations is a relative achievement, fragile and always subject to regressive pull.

The pain of mourning which accompanies the renunciation of one's fantasied perfect self eventually paves the way for a 'coming to terms' (*sich damit abfinden*) with the self that is. When this occurs, the patient has developed the capacity for empathy with himself and for adaptation (in Hartmann's sense, 1939).

In patients with a character neurosis, after this analytic work has been accomplished, though narcissistic issues will continue to play a part throughout their analysis, the emphasis will shift. In the subsequent phase of treatment, the patients will become concerned with the task of analysing the danger situations and conflicts which eventuated in the compromise formations expressed via the pathological traits and constellations. At this stage of the analysis, the anxiety described by Fenichel (1954) shall become the predominant affect experienced by the patients. Analytic work will eventually lead to another depressive period during which exploration of conscious and unconscious guilt will predominate and the analysis of the harsh and punitive superego shall become the central focus.

SUMMARY

The developmental history of pathological traits and constellations, specifically their origin in the context of the parent-child relationship, their initially adaptive nature derived from parental valuations as well as the role of identification with the aggressor, has been described. The narcissistic investment of these traits is accounted for by these factors.

With character neurotics, in the first phase of treatment, the analysis of contradictions brings about a state of psychic disequilibrium. The patient, in this process, experiences a loss of self-

esteem. This is related to the discovery of the nature of his unconscious motivations, to the painful awareness of his limitations, and the recognition that participation in parental omnipotence is an illusion. These insights result in a temporary narcissistic depression.

Intrapsychic separation from the pathogenic introject, combined with the internalization of the analytic attitudes of empathy and tolerance, leads to the modulation of the pathological ego ideal.

Mourning, which accompanies the renunciation of one's fantasied grandiose self, eventuates in the development, by the patient, of a capacity of empathy with himself and the formation of a more mature and realistic wishful self-image.

TRANSLATIONS OF SUMMARY

L'auteur décrit l'histoire du développement de traits et de constellations pathologiques, notamment leur origine dans le contexte des relations parent-enfant, leur nature au départ adaptative à partir des valeurs parentales, ainsi que le rôle de l'identification à l'agresseur. Ces facteurs rendent compte de l'investissement narcissique de ces traits.

Au cours d'une première phase, l'analyse des contradictions fait apparaître un état de déséquilibre psychique. Le patient, au cours de ce processus, vit une perte de l'estime de soi due à la conscience douloureuse de ses limites et de l'illusion de sa participation à l'omnipotence parentale. Il s'ensuit une dépression narcissique.

La séparation intrapsychique de l'introjecté pathogène, combinée à l'internalisation des attitudes analytiques d'empathie et de tolérance, conduit à la modulation du moi idéal pathologique.

Le deuil, qui accompagne la renonciation au soi grandiose fantasmé, conduit au développement par le patient d'une capacité à éprouver de l'empathie pour lui-même, à la formation d'une image de soi plus mature et plus réaliste dans ses désirs.

Die Entwicklungsgeschichte von pathologischen Charakterzügen und Konstellationen, besonders ihr Ursprung im Kontext der Eltern-Kindbeziehung, ihr anfänglich anpassendes, von elterlichen Werturteilen abgeleitetes Wesen sowie die Identifikation mit dem Aggressor ist beschrieben worden. Die narzisstische Investition dieser Charakterzüge wird durch diese Faktoren erklärt.

In der ersten Phase erzeugt die Analyse von Widersprüchen einen Zustand von psychischen Disequilibrium. Der Patient erfährt in diesem Prozess einen Verlust an Selbstrespekt, der mit dem schmerzlichen Bewußtsein seiner Begrenzungen zusammenhängt, sowie der Illusion der Teilnahme an der elterlichen Omnipotenz. Es folgt eine narzisstische Depression.

Intrapsychische Trennung vom pathogenen Introjekt, verbunden mit der Verinnerlichung der analytischen Haltungen von Mitgefühl und Toleranz, führt zur Modulation des pathologischen Ich-Ideals.

Der Trauerprozess, der die Aufgabe des eigenen fantasiierten, grandiosen Selbst begleitet, führt zur Entwicklung der Fähigkeit Mitgefühl mit sich selbst zu haben und zur

Entstehung eines reiferen und realistischeren Wunschselbstbildes.

Este artículo describe la historia evolutiva de rasgos y constelaciones patológicas, específicamente su origen en el contexto de la relación entre los padres y el niño, su carácter que en un principio es adaptador y derivado de la evaluación de los padres, y el papel de identificación con el agresor. La inversión narcisista de estos rasgos queda explicada por los factores anteriores.

En la primera fase el análisis de contradicciones produce un estado de desequilibrio psíquico. El paciente, durante este

proceso, experimenta una pérdida de estima propia relacionada con la dolorosa consciencia de sus limitaciones y de la ilusión de su participación en la omnipotencia paterna. A ello sigue una depresión narcisista.

La separación intrapsíquica del introyecto patógeno, combinada con la internalización de las actitudes analíticas de empatía y tolerancia, lleva a la modulación del yo ideal patológico.

El duelo, que acompaña a la renunciación del yo gradioso de la fantasía, culmina en el desarrollo por parte del paciente de la capacidad de empatía consigo mismo y la formación de una imagen del yo deseado más madura y realista.

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