

Psychoanalytic Psychotherapy of
the Narcissistic Personality Disorder (Closet):
A Developmental Self and Object Relations Approach

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A therapist baffled by a therapeutic impasse with a “borderline” patient asks for a consultation and gives a good description of the patient’s clinical picture: depression, difficulty with self-assertion, clinging in relationships and with the therapist, difficulties with anger and impulse control, an inadequate sense of self, and denial of self-destructive behavior.

The diagnosis of borderline personality disorder of the self seemed correct, and the therapist used the appropriate therapeutic intervention of confrontation. However, the patient, rather than integrating the confrontations to develop a therapeutic alliance, instead responded either by attacking the therapist and becoming more and more resistant, or by seeming to integrate the confrontations, but without a change in affect or the developing of a therapeutic alliance.

The therapist felt more and more frustrated and defeated, and the pressure to blame the borderline patient’s stubbornness or intransigence for this turn of events became irresistible as the therapist began to think, “These difficult-to-treat borderline patients ...” How many papers on the borderline begin with this phrase?

This therapist unfortunately had fallen prey to the most common diagnostic error with the personality disorders. He had mistaken a closet narcissistic disorder of the self for a borderline disorder of the self.

The first important reason why this happens is that the revised third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-R) makes no provision for the closet narcissistic personality disorder. Therefore, the clinician’s alertness to the presence of the disorder is dulled.

The second important reason is that the clinical picture of the closet narcissistic disorder of the self mimics the borderline personality disorder, but also, less commonly, the schizoid personality disorder. The developmental self and object relations theory pierces the clinical confusion and enables the therapist to identify the diagnosis by the underlying intrapsychic structure and select the effective therapeutic approach.

The closet narcissistic disorder of the self has a consistent underlying intrapsychic structure and an equally consistent defensive theme: idealization or devaluation of the omnipotent object to regulate the grandiose sense of self. The principal emotional investment is in the object, not the self. Despite this, the clinical picture, like a chameleon, can take on the colors of other disorders. There are a number of symptomatic themes that reflect the patient's initial complaints and presentation.

Clinical Themes

The impaired self can be consciously experienced as bad, inadequate, ugly, incompetent, shameful, or weak, or as falling apart. A prominent complaint is difficulties with intimacy or a close relationship. A real, healthy close relationship would interrupt the patient's narcissistic defenses and expose the patient to his or her impaired self and abandonment depression, and so the patient must form relationships based on narcissistic defense. The permutations and combinations of these relationships are endless. The complaint can vary, for a patient with a detachment defense, from having no or few relationships, to a lack of responsiveness on the part of a partner (failure to mirror perfectly), to being attracted to people who are not in reality available -- for example, having an affair with a married person or with someone who lives far away or travels a lot, with the distance providing the necessary defensive protection.

A seemingly inconsistent picture appears with persons with devaluing narcissistic disorders, who seem to be devoted either to partners whom they consistently attack and devalue or to partners who attack or devalue them. They undergo recurrent experiences of instantly "falling in love" based on sexual attraction, and then being disappointed and falling out of love as the relationship matures. Also, attracted by the other person's money, power, beauty, or sexual appearance (narcissistic supplies), they may evince a genuine feeling for the person that quickly leads to disappointment when the quality that attracted them disappears. Narcissistic rage emerges at the partner's failure to meet entitlement needs without awareness of the entitlement.

Problems with sexual functioning arise that derive not from a specific sexual conflict, but from the need to defend against the anxiety and depression produced by the emotional pressure for intimacy that occurs in a sexual relationship. They can be sexually competent with a partner with whom they are not involved, but when they are involved, they have to detach affect to function sexually.

The difficulties with real-self-activation also vary widely, from the patient's not knowing what he or she wants to do to the patient's being

able to identify it but not being able to initiate it, or being able to initiate it but not being able to follow through. Or the patient is able to activate only through a relationship with an idealized other, without whom self activation deteriorates.

The difficulty with self-activation also causes patients to take jobs in which they can function quite successfully, but where they feel no sense of meaning or satisfaction for example, a lawyer who really wants to be an artist. Or they may initiate a career based on their latent talent and being able to identify what they want (real-selfactivation), but find that success so frustrates their closet defenses, thus bringing them onto center stage, that it exposes them to such severe anxiety that they have to avoid following through in order to relieve the anxiety. Often the need to relieve the anxiety can lead to alcoholism or drug addiction. Workaholism as a defense against intimacy and/or the anxiety associated with self activation is common. The structure of the work partakes of their emotional investment in the idealized object, and while they work long hours, they feel an emotional equilibrium, and the loneliness, isolation, and burnout involved are denied. This difficulty with real-self-activation can extend to difficulties in taking good care of personal needs, such as diet, weight control, exercise, rest, and proper grooming. On the other hand, some patients can spend inordinate time on taking care of themselves.

There can be problems with affect regulation, with either detachment and too little affect or too much affect and outbursts of narcissistic rage. Unlike with the exhibitionist, there is a constant repetitive experience of the disorders-of-the-self triad: self activation leads to anxiety and depression, which leads to defense. Under separation stress, the depression is full blown and the patient may become suicidal. Otherwise the depression is better defended against and of a lower grade.

There may be a host of neurotic symptoms, from anxiety to phobias, compulsions, and hysterical symptoms. Somatic symptoms are particularly common as the patient experiences the impaired real self as "the body's falling apart." In some patients, acting-out symptoms arise, with sexual promiscuity, alcoholism, or drug addiction. In others, the symptomatic picture can be that of an eating disorder, most commonly bulimia, but also anorexia nervosa. For the adult patient, there may also be a current, ongoing enmeshed relationship with the mother or father, or both, with the patient feeling caught up in the role of psychological caretaker and unable to free himself or herself from the role.

Separation stresses commonly precipitate a clinical syndrome: separation from the idealized or devalued object and/or a loss of narcissistic supplies, such as power, money, beauty, or appearance, or a failure of the idealized object to provide perfect empathy.

Summary

The diversity of the clinical picture -- difficulties with self-image, with affect, with relationships with others, with overt symptoms, with impulse control, as well as workaholism and alcoholism -- seem to defy organization, and therefore, the development of a carefully thought-through and considered therapeutic approach. The advantage of the developmental self and object relations perspective, is that it sifts through this clinical diversity to reach the underlying, enduring, unchanging intrapsychic structure. It allows the therapist to organize the clinical material according to this structure, which then informs the therapist as to what is on the center stage of treatment and how it must be dealt with, and also how to evaluate the results of the efforts to deal with it. In other words, it provides not only a point of view, but also a tool with which to conduct an ongoing evaluation of that point of view.

Etiology

The etiology consists of two facets: neurobiological and psychological.

Neurobiological

Recent neurobiologic research has made clear that the mother's role is as vital neurologically as it was found to be psychologically. The brain at birth is immature, and in the first year of post-natal life, increases in size 2-1/2 times. Most of this increase is in the cortex. At birth a child is practically without a cortex. The cortex provides an inhibiting function on lower centers so that the mother provides this function until the child's own cortex develops, i.e., she regulates the child's affect. "The mother is the major source of the environmental stimulation that facilitates (or inhibits) the experience dependent maturation of the child's developing neurologic structure. Her essential role as the psychologic regulator of the child's immature psychophysiologic systems directly influences the child's biochemical growth processes which support the genesis of new structures."

The neurologic development of the brain is not continuous, but occurs in spurts and in critical phases when environmental input is vital for the successful completion of that critical phase of development. Schore theorizes from this neurobiologic evidence that a critical phase for the emergence of self-regulation of affect occurs in the right prefrontal cortex at 10 to 12 months of age, and a second one at 14 to 16 months of age. It is crucial that the mother's interaction be appropriate and supportive helping the child to regulate his or her affect for the appropriate wiring to occur.

Genetics are responsible for the existence of the neuronal structures, but interaction with the maternal environment is crucial to the wiring of those neurons that will form the neurologic basis for a sense of self. We no longer speak of nature or nurture but of nature and nurture. One does not occur without the other. The mother's role is as vital neurologically as psychologically. From this perspective the closet narcissistic patient suffers from a neurologic wiring deficit that leads to a psychological developmental arrest of self, ego, and object relations. However, evidence is accumulating that this wiring defect can be healed by psychotherapy.

Psychological

Some of the mothers of patients with narcissistic disorders are themselves narcissistic and emotionally detached. They ignore their children's need for emotional support of the emerging real self in order to mold them into objects that will justify their own perfection ratio, emotional needs. The child's real self suffers as the child resonates with the mother's idealizing projections. The child must be perfect for the mother, rather than be his or her own real self. The identification with the mother's idealization leads to preservation of the grandiose self, which defends against the perception of both the mother's failure to support the real self and the child's associated feelings of abandonment depression.

The developmental dynamics of the closet narcissistic personality disorder show some variations on the theme. Often both parents have narcissistic disorders of the self, the father exhibitionistic, the mother closet. Neither parent supports the child's real self. The mother idealizes the father, who is the narcissistic center of the family, and the child's only recourse is to identify with the mother's closet narcissism. To identify with the father's exhibitionism would threaten the father's position and expose the child's vulnerability. In other cases, the child emerges from separation-individuation as an exhibitionist, but later in childhood, trauma to the exhibitionistic self impels the child to "go underground" -- that is, to shift the dominant investment in the grandiose self to idealizing the omnipotent object, which thereby becomes a closet narcissistic disorder of the self.

Intrapsychic Structure

Closet Narcissistic Disorder of Self (Figure 1)

The underlying intrapsychic structure is the same as for the exhibitionistic disorder: It consists of two part units, a defensive libidinal fused part unit and an aggressive fused part unit that are kept apart by the splitting defense mechanisms. There are also primitive ego functions and defense mechanisms.

The defensive or libidinal grandiose-self-omnipotent-object relations fused unit of the closet narcissistic disorder consists of an omnipotent-object representation that contains all power, perfection, direction, supplies, and so on. The grandiose-selfrepresentation is one of being superior, elite, with an affect of feeling perfect, special, unique, adored, admired. The underlying aggressive object relations fused unit consists of a fused object representation that is harsh, punitive, and attacking and a self-representation of being humiliated, attacked, empty, and linked by the affect of the abandonment depression that is experienced more as the self fragmenting or falling apart than as the loss of the object described by the borderline personality disorder.

The patient projects the omnipotent object on others and regulates the grandiosity of the self by “basking in the glow” of the idealized object. (2) The closet narcissistic patient does not have the capacity consistently to maintain the continuity of defense and therefore, is prone to experience depression and to present the same clinical sequence as the borderline disorder (i.e., self-activation-depression-defense).

When this defensive alliance does not prove adequate, the patient massively projects the underlying attacking object with its associated rage and depression on the external object; feels attacked from without; feels humiliated, shamed, vulnerable, and inadequate; and either attacks back or withdraws, feeling fragmented -- having lost the organization of the sense of self.

Disorders of the Self Triad

Empathy failures of the idealized object and/or efforts at self activation precipitate the harsh, aggressive unit with its abandonment depression which triggers defense. Identifying and tracking the clinical vicissitudes of this triad sets the framework for the treatment.

The Therapeutic Task:

Establishing Trust in the Therapeutic Relationship

Therapeutic Alliance, Transference, and Transference Acting Out

Crucial to an understanding of the psychoanalytic psychotherapy of the closet narcissistic disorder of the self is an understanding of the differences between therapeutic alliance, transference, and transference acting out. Failure to understand this difference probably has been responsible for much of the confusion about treatment of this disorder.

Therapeutic alliance is a real-object relationship in which the therapist and patient agree to work together to help the patient improve through better understanding and control. As a real-object relationship, it depends on the capacities of both the patient and therapist to see each other as they

are in reality, both good and bad at the same time. In other words, both must have the capacity for whole-object relations.

Transference is not a real-object relationship, but one in which the therapist serves as a target upon whom infantile conflicts and affects are projected. The capacity for a transference, however, also requires the capacity for a therapeutic alliance, that is, to see the therapist as he or she is in reality, both good and bad simultaneously. This forms the reality screen against which the patient's transference projections are identified and measured and worked through. How can a patient tell that he or she is projecting without also being able to see at the same time the screen upon which he or she is projecting?

The closet narcissistic patient relates by transference acting out, which consists of the projection of the omnipotent object representation upon the therapist without any awareness of the therapist's independent existence at the time of the projection. To understand the dynamics of the transference acting out, we can go back to an article by Freud. He did not have the term "acting out," so he had to coin his own term, "repeating what is forgotten in behavior." The patient remembers nothing; he or she repeats it in behavior. Narcissistic patients seem to have a poor memory. However, it is not that their memory is really poor, but that there is nothing to remember, as it is being discharged in their acting out. The proof of this is found when the transference acting out is overcome, and the patient develops an extremely acute memory. The function then of the transference acting-out is to defend against both feeling and remembering.

At the same time, the patient's capacity to establish a therapeutic alliance is fragile and brittle at best because of the developmental arrest. This developmental arrest also has other consequences, such as a difficulty with boundaries, a difficulty in using an observing ego to distinguish between infantile and mature aspects of mental life, and a difficulty in tolerating frustration.

The fact that the patient has a fragile therapeutic alliance and is relating through massive projection and transference acting out without awareness of the independent existence of the therapist indicates the goal of the psychotherapy. This initial and continuing goal is to establish, maintain, and strengthen the therapeutic alliance, which nevertheless, under the influence of the disorder-of-the-self triad, will break down routinely, inevitably, and inexorably under the self activation stress created by the treatment itself. However, proper management of these breakdowns can lead the patient to mastery of the closet narcissistic problem.

To define the therapeutic goal more clearly, it is to help the patient convert transference acting out into transference and therapeutic alliance

by the therapeutic technique of mirroring interpretation of narcissistic vulnerability.

Mirroring Interpretations of Narcissistic Vulnerability

The patient begins psychotherapy unable to trust the therapist or to face the painful affect. Therapists who start by urging patients to trust them not only are wasting their time, but are overlooking the essential nature of the first testing phase of the psychotherapy. Even if the patient did not have an intrapsychic problem of trust, why should he or she trust the therapist at the beginning? The patient does not know the therapist at all, even though the recommendation is good and the therapist's reputation is good. Perhaps this otherwise reputable therapist is currently caught up in an intractable countertransference, or develops one with this patient. When my patients tell me at the beginning that they don't trust me, I reply that that makes sense to me. Trust is something that has to be earned.

The therapist earns trust and helps the patient to establish a therapeutic alliance by the way he or she handles the patient's early testing maneuvers. I think that many patients drop out of therapy early because these maneuvers have not been identified or handled properly. The patient begins therapy by focusing more on defense than on conflict and painful affect. The appropriate handling of the patient's defenses leads him or her to the underlying painful affect and conflict and establishes trust.

Therapeutic neutrality is vital. The therapist must maintain the neutrality of the therapeutic frame and expect the patient to identify his or her feeling states and report them. The therapist must not be personally involved with the patient, and must maintain this neutral position without resonating with either the patient's wish to be admired or feeling of being attacked. The function of transference acting out is to defend against both feeling and memory. The patient externalizes and acts out on the therapist in the present problems from the past without realizing it. The neutral therapeutic frame is vital protection against the treatment's being inundated by the patient's transference acted-out projections and the therapist's countertransference. It forms the essential framework within which these projections will be interpreted.

The therapeutic task is to track the sequences of self-activation -- painful affect -defense and to use mirroring interpretations of narcissistic vulnerability to help the patient convert the transference acting out to transference and therapeutic alliance. This establishes trust in the relationship and brings to the center stage of the patient's awareness the painful affects associated with a focus on his or her self and selfactivation.

How does the therapist then gain entrance to this seemingly solipsistic defensive system? It is important to keep in mind what I like to call “narcissistic window” of entrance. In working with a narcissistic patient, the focus must be on the here and now in the interaction between the patient and the therapist. With a borderline patient, one gains entrance by confronting maladaptive behavior that often, but not always, takes place outside the session. This is not the pathway to take in working with the narcissistic disorder. One has to understand that anything outside a narcissistic window can be interpreted as a narcissistic wound by the patient.

The patient with a closet narcissistic disorder begins treatment projecting the fused omnipotent object representation on the therapist, idealizing the therapist to regulate the patient’s grandiose sense of self. The therapist then interprets to the patient that it is so painful for the patient to focus on himself or herself that he or she turns to the therapist in order to soothe the pain. Here, the key words are pain, self, and defense. This key interpretation helps the patient to feel “understood.” The beginning of the interpretation, “It’s so painful to focus on yourself,” is a way of joining the patient and empathizing with the patient’s pain, which is why we use the adjective *mirroring* with the word *interpretation*. The purpose of the mirroring is to open the defensive door in order to point out the affect and defense. One of my patients described the way it works in this way: “I don’t know how you do this, but somehow you slip in the back door and the next thing I know I’m thinking about something that makes me uncomfortable that I really don’t want to think about.”

Repetitive interpretation of the patient’s idealizing of the therapist as a way of dealing with narcissistic vulnerability gradually produces a consensus between patient and therapist that the patient is exquisitely sensitive to the therapist and easily disappointed in failures of idealization. At this point, the consensus leads to the idea that this operation is defensive against the patient’s feelings about himself or herself, which then opens the door to the exploration of the abandonment depression associated with self-activation.

Shorter-Term Therapy

The term “shorter” is used to distinguish this therapy from short-term therapy, which usually takes a matter of weeks. This psychotherapy can last months or years, with the patient being seen once a week. The goal could be called ego repair with an increase in adaptation. It is indicated primarily for lower-level patients who have difficulty functioning and not enough ego strength to work through the abandonment depression. It can also benefit high-level patients, but they have the alternative of intensive

analytic treatment. The patient's need for narcissistic defense lessens, as does his or her denial of reality, so that he or she is able to function realistically and effectively. One of my exhibitionistic patients described it as follows: "I was like a prince closeted behind my castle walls with the bridge over the moat drawn up. The treatment has helped me to come down out of the castle, lower the bridge, cross the moat, emerge from the castle, and put on the clothes of a commoner and mingle with them."

Therapeutic technique consists of mirroring interpretations of narcissistic vulnerability that focus mostly on the here and now in the relationship and not on genetic interpretations. These interventions will lead to affect and memory, which can then be used more to shed light on current narcissistic problems than to work through the genetic elements of the abandonment depression. One limitation is that the therapist should avoid pushing for fantasy, dreams, and the depression, since all of these draw the patient deeper into the depression, and the structure of the therapy does not provide for working through the depression. If the patient needs to talk about these issues, the therapist allows it, but does not take them up for systematic investigation.

The length of treatment varies greatly, from a few months to years. The average length would be from a year to 18 months. However, much longer periods are justified, in my view, as long as the therapist does not collude with regression.

At the end of treatment, the real self has been strengthened and narcissistic vulnerability decreased; however, the developmental arrest has not been changed, so the patient remains vulnerable to separation stress. Should the stress be strong enough, the patient will become symptomatic again and return. In order to regress and become symptomatic, the patient has to give up previously learned insight, but when the patient returns to therapy, it takes far less time to restore the insight and overcome the symptomatic state.

Intensive Psychoanalytic Psychotherapy

The patient most often is seen three times a week with the goal of overcoming the narcissistic defenses and working through the underlying depression, which frees the real self to emerge and resume its developmental pathway through the oedipal stage and beyond.

There are two dividends of this treatment that strongly recommend that it be tried where possible: (1) It removes the vulnerability to separation stress, and there is separation stress in all of our lives all the time. (2) As the anchor of the abandonment depression is lifted and the real self is freed, a flowering of self-activation occurs. The patient experiences it as being reborn, becoming a new person. But what has

happened is that all those talents and capacities of the real self that had been blocked by the developmental arrest now are free to emerge.

It is difficult to set a duration for this treatment, but it can be thought of as taking the same amount of time as a classical analysis -- three to five years. However, it could be either longer or shorter.

The best candidates are high-level patients, but many middle-level patients are good candidates. The key is that the patient must have sufficient ego strength to contain the depression when the defenses are overcome so that the abandonment depression can be worked through.

The therapeutic technique is the same as in shorter-term therapy: mirroring interpretation of narcissistic vulnerability. This is what overcomes the defenses and establishes a therapeutic alliance. Once the depression emerges, genetic interpretations can be added. In the final phase of treatment, as the real self starts to flower, an intervention that I call communicative matching must be added. I mean by this that as the patient reports new interests and activities, the therapist should discuss the reality aspects of these interests with the patient. I do not mean discussing the therapist's personal life, but just the patient's new interests. This refuels the real self. In the last or separation phase, the patient must work through the transference fantasy that the therapist is the object that he or she always wished for to acknowledge his or her real self; that is, this phase marks the separation from the therapist.

The analytic therapy consists of three stages: testing, working through, and separation. In the testing stage, a therapeutic alliance is formed in analytic therapy, just as in shorter-term therapy, by mirroring interpretations of narcissistic vulnerability. When the therapeutic alliance and transference are established, the patient's abandonment depression takes center stage through memories, dreams, fantasies, and transference. It is of great importance that the patient's access to historical and genetic material come spontaneously from the patient and not from the therapist. When affect and memories lead the content of sessions, working through has been established. It now becomes possible to make genetic interpretations. The therapy gradually deepens until the patient hits the bottom of the abandonment depression where all six affects are present and expressed as "if I separate, I will die and my mother will die."

When this stage has been worked through, the real self begins to emerge and must be responded to by the therapist with communicative matching -- by discussing the patient's new interests and activities. The patient then enters the final or separation stage.

Treatment

Case History

Ms. A., tall, slender, blond, 40-year-old homosexual woman, was a successful businesswoman and the divorced mother of two children. She complained of difficulties in interpersonal relationships.

History of Present Illness

The patient had had her first homosexual relationship while in college. Later, she fell in love with a man, married, and in so doing “lost her sense of self”. She became “all things to her husband and children.” She was married for 10 years, during which time there were no homosexual relationships.

She reported: “After 10 years, I realized I had no self, nor did I have any intimacy with my husband. I started to drink; I had a low tolerance for alcohol and became an alcoholic. I had blackouts. I drank for three years until last year, when I joined AA and started an affair with a woman. During the three years that I was drinking, I had three relationships with women and one with a man. All of the relationships were difficult and conflictual. I tended to sell out to women who were attracted to me.

“I then met another woman, an older woman who reminds me somewhat of my mother, and I have been having a relationship with her for the past year. I find her very distant. I find myself giving and then pulling back and we have a lot of conflict.”

“I have great difficulty acknowledging myself. I feel that I have no self. I have trouble asserting myself. On the other hand, I have this idea that I can get away with anything. At one point, I took Prozac but put on 35 pounds.”

Personal History

“Mother was domineering, paranoid, a will of iron, angry, attacking, stingy, a monster who never let me alone. Mother was also a very successful career woman. Father was a rather inadequate, kind, and distant man, who was never available and who did not help me with my mother.”

The patient was the oldest of three children, with sisters five years younger and seven years younger. She had to take care of the sisters, who also had serious problems in relationships.

The patient did well in high school, college, and business school. She had friends and did not become aware of her homosexual impulses until college. She has a son in high school and a daughter in graduate school.

She had had prior treatment with a therapist once a week for several years when she was contemplating divorce, but she felt that this treatment had not been of much help.

Clinical Impression and Intrapsychic Structure

The patient appeared to have a closet narcissistic disorder with a history of alcohol abuse.

Intrapsychic Structure

The omnipotent-object-grandiose-self fused unit consisted of an idealized, omnipotent object representation that provided admiration for perfect performance and compliance. The grandiose-self-representation was one of being unique and special when performing for and in compliance with the object. The aggressive fused unit consisted of a blatant, draconian, domineering, harsh object representation that monolithically and harshly attacked every aspect of a failure to be perfect and any effort at self activation. The impaired-self-representation, the target of the attacker, was of being frozen, numb, paralyzed, nothing, dead, nonexistent. "A disembodied heart that couldn't contract." The abandonment depression was seen mostly in the aggressive attacks of the object representation. The depressive element was held in check by the detachment defense.

The disorder-of-the-self triad operated as follows: If she were not perfect in the eyes of the object, or if she attempted real-self-activation, the harsh attacking object was triggered and experienced as a harsh voice in the head. She defended against this by focusing on the omnipotent idealized object, not on the self. The psychotherapy began by interpreting and investigating both of these defenses against self-activation: the focus on the omnipotent idealized object and the intensive attacking attitude of the object.

Psychotherapy

The patient began psychotherapy once a week talking about how she cheats on her lover. "If I can't get her full time, I feel rejected and go out and look for others and then lie to her, but then, when she calls, I come running. Nothing comes from me; there's a void. Mother told me everything I do is wrong, so she had to tell me what to do. She yelled at everything, I felt hurt, not appreciated, not important. I have a voice in my head which attacks me whenever I make a mistake."

She then shifted to describing the difficulties she had disciplining her son. At which point I made the first mirroring interpretation of narcissistic vulnerability as follows: It's so painful to focus on yourself and the attacks in your head that you protect yourself by talking about your lover and your son. The patient replied "whenever I do anything wrong, the voice ends up attacking me the way my mother attacked me. She then went back again to defense talking about her lover. Near the end of the session I reinterpreted that it was so painful to focus on herself and

the attacks in her head, that she protected herself by focusing on her lover at which point she turned to me and said “what should I do?” I then interpreted that again it was painful to focus on yourself so that in order to protect herself she was focusing on me.

The next session was dominated by defense. The next session she reported not being able to discipline and set limits to her son. I pointed out that she kept taking over for him, by reminding him to do things rather than disciplining him. She replied “I feel I am wrong to activate myself and set limits.” At this point I interpreted again, it’s painful for you to focus on yourself and set limits so the way you protect yourself is to avoid it and take over for your son.

She replied, “I was never taught to trust my own feelings. I feel cheated, angry at my mother, and sorry for myself.” She looked depressed and started to tear. She continued: “Mother’s brutal tirades -- I couldn’t please her. She was so cheap.” (She was now beginning to face the painful affects of the impaired self and its relationship to the attacking object in her head.)

In the next session she continued the theme suggesting that the interpretation was beginning to be integrated: “I don’t focus on myself because it brings on Mother’s attacks; that’s it, but where do I go with it?” I responded: “Focusing on yourself facing the issue in your head seems to impel you to feel helpless -- I wonder why.” (The first intervention that focuses on the impaired self is often responded to by helplessness and hopelessness.)

Some history then emerged as an elaboration of the interpretation: “As a kid, I was punished for being a kid. Mother ruled with an iron hand.” She went on to elaborate many examples. In the next session affect again emerged in parallel with some selfactivation. “I went to a movie and cried about never having had a loving mother. I was angry and envious of those in the movie, but I am starting to do things for myself more. I started to play bridge, I’m starting to light a few fires just for me. I was able to be alone and walk around the city with no difficulty. I feel almost cried out about mother. But, I feel so alone.” I interpreted that it was so painful to focus on herself and the aloneness, that focusing on the mother in her head was to help to soothe those feelings about being alone. She ignored this interpretation and reported “When I screw up, I don’t attack myself as I used to. I’m also now more able to empathize with other people’s pain.”

She then went on again to talk about her lover which I interpreted as a defense against focusing on herself she came back to the impaired self. “I never felt loved. I always cried. Mother threatened to put me out of the car and leave me alone on the road if I didn’t comply.”

The integration of the interpretation was demonstrated as she returned in the next session with a dream: "Mother is working, needing money, and I told her I would support her." *Free association*: "I don't want to let go of my mother. I feel nobody cares; I'm absolutely alone, crying. I felt broken by mother. She attacked everybody I was close to." She then elaborated further on the conflict with her mother.

The affects of the abandonment depression slowly began to emerge, but also there was more release of self activation: "I'm feeling better about myself. I'm going to AA more. I used to be very detached in my work. I'm now feeling empathy for others. I feel I make more flexible efforts at asserting myself, and I can do it without lying or manipulating."

In the next session, the patient returned to the defensive part of the triad. She reported feeling depressed, thinking mostly about her lover, "my addiction." But instead of calling her lover or drinking, she contained the feelings and called her AA sponsor, and then found herself stealing a pair of sunglasses: "I knew what to do about it but I had to call the sponsor to tell me. My week had been good." I interpreted the disorder-of-the-self triad that she had activated herself, had done well, and then had become anxious and depressed, and to soothe these feelings she had to steal and then call in another person to take over for her. "It keeps me alive," confirming the interpretation, "as if I don't exist if I am alone." I then interpreted that this behavior was a protection against the depression anxiety she felt if she focused on herself. She replied, "I know who I am as a parent and at work but not when alone, but I've grown; I don't feel desperate and panicky and not alive. I'm ahead in the search for me, what I want to do today. I'm trying to get a better job, I felt more like a mother with my children, and I resumed my relationship with my lover. I'm also trying to paint and play bridge.

In the next session she said she felt my attention vacillating, it annoyed her but she made a joke of it. I interpreted that she seemed to feel the need to have my attention intensely at all times as she focused on me and if the attention vacillated, she felt disappointed and angry, vulnerable and exposed, and had to make a joke in order to get me back, to reassure herself; in other words, she was focusing more on me than on herself. She replied, "If I don't do that, I feel I don't exist and I am dead."

Comment

After five months the patient had overcome the defensive part of the triad, was contained and focusing on the impaired self and the abandonment depression in the interviews, and then slowly returned to defensive acting-out, probably to deal with the emerging depression and the childhood memories of the mother. The relationship with the lover is

a specific acting-out defense. She reenacts in the present to defend against feeling and remembering from the past.

In the next session, her serious difficulties with intimacy emerged in bold relief. She had a liaison with a new woman to whom she was attracted and had a very good time, but then felt extremely anxious and uncomfortable: "It was too close, and I wanted to get away. I wanted to shrink up and shrivel away and I have a terrible headache. I'm angry that I started it. I interpreted that it seemed to me the relationship exposed her vulnerability and that she protected herself by pulling away and detaching feelings. There was a long silence and she said "is it my mother? I feel very sad now."

In a later session she reported: "I realize when I had a good weekend (when she supported herself) I developed an enormous craving for my lover." I interpreted the Disorders of the Self Triad -- when she supports herself she begins to experience a negative voice of her mother and her dead self, which she had mentioned earlier and in order to soothe them she reaches out for her mother in the environment. It's better to have a mother outside the head, then to face the one inside. She replied: "My lover is just like my mother. She tells me how wrong I am, and on the other hand she is loving towards me -- all the time she is putting me down. However, I am now being more direct with everybody. I could never do that before, and I can spend time alone without going crazy." She began to tear and fell silent. "I'm thinking about how sad I was as a child. I was alone over the weekend. I put on my mother's ring for the first time in a long time. When I felt bad I had this fantasy of calling my lover, but I called my AA sponsor instead. I felt lonely, unloved and uncared for. However, I knew what to do about it, and then I got angry.

"Although I can accept rejection better I feel very sorry for myself. I am symbolically eating mother's candy to hold on to her, but on the other hand I don't want to have anything to do with her. If she were here I couldn't fight with her, I couldn't win, it hurts. Where's the me? I sold myself out. It's so easy to make mother and my ex-husband the focus."

This led to a series of sessions expressing the rage at her mother, recalling many childhood memories of the mother's rejection, and at the same time having a severe headache. For example, "I think I hated my mother but my impatience and hostility were directed to myself. In the third grade I thought the dentist had made a pass at me, but I couldn't tell my mother, I had no rights with the dentist like with my mother -- there was nothing I could do. I'm having great trouble getting in touch with my feelings and anger with my mother -- she was cheap, she was a manipulating bitch, I'm so used to being fucked over by her -- my grandmother was my only positive influence until I was thirteen."

“I’m preoccupied by people committing suicide -- the suicide of myself to my mother. She was never honest.”

The patient then reported: “I visited my mother’s grave, and I sobbed, and said you made it so hard. Then I said to her, I forgive you. I felt wholer, I felt right, not resentful, envious, expecting things. I feel clearer, more direct and accepting with other people.”

In the next session, the patient continued to focus more on her mother and did not defend, but now she developed a severe pounding headache as she came to the session. She said: “I feel angry -- angry at myself and my mother. She pushed me to relate to my father. He explained that I had to behave because of her. I remember her rages. My anger went into being negative toward myself.”

This is followed by “I’m having terrible trouble getting in touch with my feelings about my mother, and the headache continues. She was cheap, and I’m just as cheap as she was. I emulate her, but then I feel guilty. I’m cheap with myself. As a child, I saved my babysitting money to give her a gift, and then she attacked me. The will was being beaten out of me. “I’m preoccupied by people committing suicide. The suicide of myself to my mother. She was never honest. I wanted to go to one college, and she coerced me into another. The only one who let me know I was okay in the family was my aunt.”

Later the patient said: “I recalled my mother’s dying and I have thoughts about my own death. I’ve run up against a wall about Mother. When I was alone, I was afraid of death. Being alone was like being dead. I couldn’t be alone.” (The patient seemed to have gotten through a superficial level of the conflict with the mother and had come up against severe resistance to going deeper).

In the next session she began to realize more about her mother: “What she did was awful. Mother wrote my applications to college. She felt I couldn’t do it without her. I was terrified about being told that I was doing the wrong thing. I hate her. She was so abusive. I feel upset when I leave here. I feel sad. I feel so protected with you. Father was there, but really not there. In high school, my father wrote to me: ‘I’m glad you were born’. However, my parents cherished boys -- girls are ordinary.”

In the next session, the patient reported trying to get her anger at the mother out by throwing eggs at a tree in the backyard. She then teared, talked about feeling deprived, growing up in such a hostile environment: “My mother got her ideas across through attacking other people, no love, or warm feelings, didn’t know what love meant; the anger is threatening. I put away Mother’s pictures. I’m going to put away her dishes. I was always told I was wrong. Nobody said I was okay, plus any complaint, I was wrong. My father, my sister, and I were hostages. When did I cut off and lose my sense of self? My difficulty facing my mother in the past is

complicated by my difficulty facing what I did to my own children as a mother.”

Some sessions later: She woke up in the middle of the night with a fantasy of (a disembodied heart trying to contract, but it couldn't because it was solid inside! *Free association*: “I felt scared, like I was losing my mind, afraid I wouldn't be able to find myself. There's nothing there. However, the rest of this last week I was more at ease with myself.”

She then elaborated on how better she is able to activate herself; does not feel so guilty if she makes an error or mistake; and is trying to separate herself more clearly from her son, not waiting on him, making her own plans and expecting him to make his own plans.

Summary

In 16 months, at once-a-week sessions, the patient has begun to explore the aggressive fused unit and its relationship with her impaired self, which has given her greater access to and use of her real self, and this has produced definite clinical improvement.

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A Response to James Masterson *James Hillman*

One of the values of this conference is that the opportunity of being with people of such enormously diverse viewpoints and schools and ways of behaving and practicing and thinking about the work. Dr. Masterson and I are friendly companions on the road but we have different lunch baskets and different knapsacks. We carry even different guidebooks probably. So what I thought I would do was ask myself not to discuss the paper from the inside of which I'm incompetent to do, meaning from within what he has presented which I thought was marvelously presented, the integration of how he practices with how he constructs the thought of what he is practicing. In other words, the structure of his thought and the structure of his work are integrated. You can see how the thought leads to

the way he behaves and how the behavior is based on a psychodynamic theory.

So I ask myself, “What would a classic Jungian therapy be with this same patient?” Of course this is all a fantasy because I don’t know the patient. I’m just working with what we see. There are several things that I want to emphasize. One is clearly the archetypal figure of the bad mother is constellated. That comes all through the case. So that’s one of the essential aspects of the case. The archetypal figure of the bad mother. What does that archetypal bad mother want with this person? Is it only to destroy the person? Or is there a challenge in what the bad mother is doing, the voices in the patient’s head of some sort? And what else is there in the bad mother?

The second part of what would go on in a classical Jungian therapy would be to take a sense of this complaint of being lonely. She declares herself being alone was like being dead. I couldn’t be alone, that this disembodied heart was solid inside in the dream, that there is a monolithic sense of self whereas in a Jungian therapy from day one, one asks about the dreams. One asks about the fantasies. One asks about other ... In other words, to explore the self beyond the person.

Can you follow me there? In others words, to inquire into what else is there besides ... what else? What does she dream of? What does her ambitions go towards? What peculiar events in childhood still remain as markstones besides the constant reference to the one, that is the mother? It isn’t to neglect the mother, repress all that, but to invite a great deal more into the sense of being a self so that it doesn’t feel lonely and void. She said that not only being alone was like being dead it’s ... See in a Jungian view you are never alone. You are living in only one room of your house and that’s why you feel lonely. There are other rooms in the house of visitations of other figures from dreams, from memories. Now you can say here memories were blocked and held off completely by the dominant figure at the gateway of the mother, but the invitation from session one to ask, “What did you dream before you came here today?” or “Do you remember any dreams recently or any dreams that keep coming back?” or “Any dreams from childhood that you still remember?” To explore the other figures who live in the house so that when one is alone one isn’t alone. There’s an internal communication invited. There’s another place where I think she says, “Nothing comes from me. There’s a void.” I think that this, “Nothing comes from me. There’s a void.” is also perhaps, I wonder if you’d think so too, is a defensive move against the possibility of things coming from her. And that they way you skillfully open that more can be self-active. I would call upon the other figures who I don’t think belong to her. I think they’re part of the imagination, part of a wider sense of the collective soul and that these figures can speak to her

in dreams and elsewhere so that she is never really alone in the way we ... See we're alone when we're wrapped in our own person, in our own ego, in our own self reflective system. So I want to know more about beyond her personality structure so that her self begins to be imagined beyond what she thinks is herself.

Then as far as her history goes I have to say I think in Jungian therapy her sexual life would not be the main or the first focus whether she's homosexual or not homosexual, whether she had homosexual behavior early in her life or still has or so on. But this is not necessarily a primary concern.

Diagnostically, I was trying to think what would my Jungian colleagues say about what we've seen so far. I suppose they would use the language that Jung uses about the ominous of the mother. In other words, what this woman is haunted by is the mother's negative, critical, accusatory, harsh, unloving, iron fisted, ruling, rejecting, in Jung's language, male voice, which also made this mother, according to the daughter's report a very effective woman in her career and her profession. This demand of that ominous, the patient herself is challenged to meet that demand in some way. Because one has to ask, "What's the intention of this vicious mother's voice? Is it only destructive?" This is where the idea of the archetype comes in because in Jung's idea of the archetype there are always two sides to it. It's multi-faceted. So if the negative is coming in so strongly what is it's function? What else is it wanting? One thing it's done it's brought her to therapy.

Another thing it seems to have wanted is some kind of act ... She's being prodded constantly into activity. But because there's no other resources, that is, there are no other figures to compensate her, to fill out the void of the woman, she alone isn't up to the task. That's why I think it's important from the Jungian point of view to invite as much else into the sense of self than the restricted notion of self as me. I'm using the metaphor of the house with many rooms. I think in a Jungian case like this we would not be hearing the mother's voice, only the way the patient hears the mother's voice. We would be trying to hear what it could be intending beyond destruction.

Also from a Jungian viewpoint, the diagnostic would be that her own ominous is trapped in her mother. That is, her own possibilities of action, thought, activity, determination, vision is trapped in her mothers. In the sixteen months of therapy you see how she eventually extracts through the therapeutic skill this potential for self activation is extracted from the mother. Then the mother, in a sense, dies because she goes to the grave of the mother. But still there is a heart that is monolithic. In other words, a singleness of feeling. What I'm trying to get at is how do you expand the heart to have many chambers? How do you get the multiplicity of the

personality back in? By inviting, as I say, the figures from dreams, the imagination from fantasies, the wishes from childhood, from peculiar events that have been neglected because of the monofocus of the patient from the mother.

That's really only to make this contrast from outside. It's not a response from within the field. It's a response from another position. And this other position is not a negative critique of what we've just heard. It is simply another way of looking at this case, which of course is second and third hand, but still opens the opportunity to give another perspective which, I think, is what we're supposed to do here at this conference. Thank you.