Disorders of the Self – and Transactional Analysis

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Notes taken from "Split Self Split Objects" by Philip Manfield – I found this a terrific book which describes in depth the defensive systems found in disorders of the self, the diagnostic categories and treatment of clients with these disorders all in a way which is easily used within a TA psychotherapists frame of reference and treatment approach. A significant aspect of the book is Mansfield's critique of the various approaches used to diagnose and treat these clients from the well known authors; Kohut, Masterson and others.

I prefer the use of the words hidden/protective self and projected self to real / false self – however in these notes I use the terms the authors use.

Kohut 1978 used the term disorders of the self to describe the disorders involving patients who difficulty in connecting to their own inner self. This impairs the ability to reference his/her own values, preferences, thoughts, and feelings in order to make life choices, develop intimate relationships and to resolve tension and conflicts. Each disorder involves a distortion in the persons view of themselves, others and relationships which significantly impairs their ability to function in life:

A neurotic client will be preoccupied with conflict within, asking why do I do what I do? The goal is release from the harsh controlling internal observer, and the uncovering of deep unconscious motives for questionable behaviours feelings and thoughts.

The client with a disorder of the self lacks a genuine sense of their "self" and as a consequence has an impairment of self regulating abilities. Instead of looking with themselves to locate feelings or to make decisions they look outside of themselves for evaluations, directions, rules or opinions. As a result, they identify themselves with a false / defensive self which was created to deal with the hostile / withholding / absent / attacking world. In order to protect themselves they developed the splitting mechanism and split the world and people into good / bad objects. This enables the child whose mother is abusive to preserve an image of the mother as loving by splitting off the abusive aspects of her hostile world. This mechanism is used by infants to preserve their all loving mothers and loving environment however as the infant develop the defensive splitting is relinquished as the infant learns to hold both the good and bad aspects of their mother in a co-existing realistic view of her. People with disorders of the self have not relinquished this defence and it is maintained as their primary and primitive defence mechanism enabling them to survive.

This creates shallowness in relationships as people and relationships and the environment are not seen realistically. This creates great difficulty in psychotherapeutic work as the therapist reaches out to the inner self the client does not recognise the psychotherapist as a whole and splits them into good / bad objects. The therapist is perceived as shifting rapidly from caring and sensitive to withholding, unfeeling and critical. A neurotic client experiencing such a shift would be curious and wonder what has happened, the client with a disorder of the self is not curious, whatever his current world view is the reality and he does not question it as this would entail relinquishing the splitting defensive structure.

Mansfield notes that in fact everyone uses splitting to manage their internal conflicts to some degree however the level to which this splitting is manifest is an indicator of the disturbance the client is experiencing.

The creation of the false self takes many forms, however it always defends the hidden angry, scared, isolated, sad and hurt inner self. The false self can be charming, co-operative, self confident, intelligent, seeking or avoiding others, the most important thing for the person with the disorder of the self is their façade is maintained and not threatened as this would result in them experiencing all the hurts, scare and anger of the inner self and that is perceived as too dangerous.

For people with a disorder of the self many self regulating functions which the neurotic will do "naturally and automatically" will be extremely difficult for them… these include impulse control, limit setting, self affirming, self soothing, self comforting and self empathy. An important aspect in psychotherapy is for the psychotherapist to provide these roles as an external substitute when needed by the client until they learn this function themselves. This in turn means that techniques which work well with neurotic clients will not work with people with disorders of the self. For example, a person who presents as depressed and is neurotic will be in touch with their sadness and sense of hopelessness and will respond to the relational presence of the psychotherapist. The person with a disorder of the self will be detached from their inner feelings including sadness. They are not open to the relationship with the psychotherapist as they do not allow themselves to engage in the therapeutic relationship and relate to the therapist through splitting processes and finds it hard to separate the projected fantasy from the reality of the psychotherapist meaning they cannot evaluate effectively their feelings and relationship.

Masterson: "The neurotic thinks the therapist is helping with their problems while the borderline thinks their therapist is the problem."

Borderline: A patient who experiences himself as lovable when complying and adapting and bad when he acts autonomously which then generates high levels of anxiety is borderline. Masterson describes how a therapist is likely to be seduced into doing things with the client that they would rather not do.

- **Kohut** describes that with respect to creative self expression and their motives for achievement the borderline client will express satisfaction with success however it will be associated with increased levels of anxiety which means that a borderline rarely is successful in the world and does not appear to function well.
- With respect to love relationships the borderline derives comfort and relief by being taken care of, in exchange for this dependence the borderline compliantly subordinates his/her own needs to those of their partner and sacrifices self expression

- **Masterson** describes how the borderline was prevented as an infant from experiencing independence and self exploration. Instead of encouragement they experienced withdrawal or an excessive clinging by mother. Consequently, the borderline has difficulty in expressing / asserting her/his own needs, acting independently or being separate from others. Therefore, the borderline often appears like the frightened child that has never grown up and is constantly searching for the good mother.

- Life becomes a constant battle between the inner split of real self that desires independence and to grow up and the defensive self that feels anxious at any move towards independence. Without the love of the sought for good mother – often projected onto the therapist the client's self image moves from "good" to "bad" The borderline holds the contradictory worlds of good and bad simultaneously by only allowing themselves to experience and to be aware of one at a time. Therefore, the client will have difficulty in making decisions which involve self interest, thinking for themselves. They often have many friends acting as care taker or through manipulation and by acting as a helpless child invites others to take core of them. Friendships however are often short lived because of the fear of abandonment the borderline rejects the friend if there is any discord. Alternatively, borderlines often end in relationships which are openly abusive towards them as they fear desertion and independence. Often this is also reflected in other relationships such as professional relationships.

- As an infant the splitting defence is a healthy attempt to keep the good mother upon whom the infant's survival is dependant. The negative aspects of the care giver are split off and projected on to another so preserving the good mother.

- **Masterson – The borderline Triad:** Masterson described the following sequence: Self activation > painful feelings associated with childhood separation and individuation > defences against feelings. Being aware of this process is important for the psychotherapist as they manage the ongoing psychotherapeutic relationship. The goal is to interrupt the defensive acting out by bringing the triad process into the client's awareness and to invite the borderline into the real relationship and awareness of their actions and the consequences. "the client borrows the healthy ego function of the therapist and gradually develops their own". The therapist has to use their own healthy observing ego to do the work which is absent in the client's - the therapist asks the self regulatory questions the client is not asking… What is painful in this process for you? Why do this? What are the consequences? The therapist has to be the good mother that offers the symbiotic breast and celebrates as the child is weaned and becomes independent.

- **Kohut** describes how the client uses "transmuting internalisations" = a process of internalising the therapists healthy ego functions. The therapist uses soothing interventions and interpretations that enable the client to maintain their internal organisation. In order to do this he uses mirroring in which the client feels seen and understood and appreciated. Rather than confront the client like Masterson would Kohut sooths and this leads to the client feeling safe enough to drop the defences and to experience the inner self.

- From a TA point of view both models fit well and can be used. With therapist holding both sides of the split, and staying connected in the here and now with the client. Bringing the process into awareness can be compared to Bringing the process into Adult awareness and over time in the psychotherapeutic relationship the client can work through the trauma associated with their self activation though the process of deconfusion, introjecting the therapist as a healthy new parent figure leading to 3rd degree impasse resolution.

- In order to do this work the therapist must be able to rely on is / her own internal feelings for wellbeing and self esteem, he must work through the countertransference in order to facilitate the client's move through dependence to independence and all the difficulties and struggle this entails.

Schizoid: A patient who perceives relationships in terms of master / slave and does not believe he can expect or find any better way forward is schizoid. Masterson said that the therapist does things for the client when they would rather not do them… because the client will never do them for themselves! Because of the nature of their defensive structure they are unlikely to seek psychotherapy.

- **Kohut** describes that with respect to creative self expression their motives for achievement is associated with decreasing levels of anxiety. The schizoid will feel self sufficient so avoiding dependency and vulnerability. The schizoid is also often successful in the world, especially if they can tolerate superficial social interaction. Their success is usually in a quiet way with little public recognition, that is because they are very self controlled and also are very focussed on controlling their environment. The schizoid feels safe in the controlled environment.
- The schizoid yearns for intimacy however they cannot tolerate it because of the horror of their own vulnerability. They split off from their desperation, their feelings of fear and hopelessness. Despite their yearning for closeness their fear often prevents them from forming relationships and often if they do enter relationships it is as a slave to a master believing that this may save him/ her from abandonment and attack.
- **The schizoid dilemma:** they are constantly walking a fine line between two devastating dangers; If too distant from people they fear disintegration and oblivion, if too close then they will be co-opted, used, devoured and totally lost in the other. The schizoids silence is because they are too afraid to talk of what they know and feel.
- **Guntrip:** describes how the schizoid disorder develops as a result of infantile deprivation, an unresponsive caregiver and environment. The infants needs physical and emotional are not responded to and remain unmet.

- **Tantalising refusal….** Refusal to meet the infants need for love.
- **Impingement…** by a hostile and aggressive environment / object creating the fear of an overwhelming / overpowering outer world which evokes a flight into the inner safety of the inner world.

Rejection and neglect… none recognition by desertion and by deficiency in the outer world. The infant experiences hunger to be life threatening. When the breast is withdrawn nthe infant feels completely cut off and when it is finally offered again the impulse and desire is to devour it completely for fear of losing it again. This leads to a fear of destroying the desired object if it comes too close and so the fear of what they most desire. The schizoids compromise is to find the position of being neither in nor out of relationship.

Treatment of the schizoid process: Ralph Klein: describes how the most important ongoing need for the psychotherapeutic work is for the client to experience being understood and in order to achieve this they need safety and so creation of the safe therapeutic environment and relationship is central to the work.

The Masterson Triad: With the schizoid the movement is towards expression of feelings, closeness or spontaneity will lead to the experience of extreme fear leading to the withdrawal of the client into their hidden inner world.

Splitting: for the schizoid there is no positive internal object relationships (object relations unit)… There is a negative internal object relations unit consisting of a sadistic, depriving, intrusive attacking object and a self that is vacant and exiled linked to feelings of fear and aloneness and alienation.

Countertransference: As the therapist accepts the projection of the master / slave unit then there is a risk of the therapist becoming impatient and attempting to move the client along, which is experienced as an attempt to control the client. Work with these clients therefore is extremely slow as the need to manage their need for safety in the relationship and the therapist needs attunement and attendance to the clients expression of needs.

Narcisstic: A patient has an inflated view of himself at the centre of the universe and he tries to preserve that impression whatever the cost, he avoids situations which he would experience as demeaning which would put him in touch with his sense of worthlessness which is humiliating. Masterson said that the therapist will do things for the client in the hope of impressing the client.

- **Kohut** describes that like the schizoid client in respect to creative self expression their motives for achievement is associated with decreasing levels of anxiety. The narcissist will feel excited and inflated, this in turn leads to them seeking achievements and a narcissist often appears to be functioning well in the world which rewards his / her success.
- **Kohut** describes how in health through transmuting internalisations an infant develops a healthy relationship towards the world, however if this process fails it is because the disappointments the child experiences and the failures in relationships are so great that they overwhelm the child leading to insufficient internal structures to self sooth and to restore the sense of self worth. The child does not then develop a healthy adult narcissism and his development is arrested and remains infantile through adulthood. This infantile narcissism expects the world to revolve around them. The infant is omnipotent, invulnerable and believes that nothing can harm him. He hides from the true feelings of emptiness, shame and isolation by building the shield of grandiosity.
- With respect to love relationships the narcissist rejects dependency because of the vulnerability it would create would be unbearable. Therefore, the narcissist is self sufficient and independent, in their relationships they seek only fuel for the grandiosity: beauty, power, money, fame, perfection.

Exhibitionistic Narcissism: If the child is supported in his grandiosity by the environment that tells him he is superior while ignoring individuality, feelings, personal interests, he develops into an adult that coerces his environment into supporting his grandiosity, superiority and perfectionism. He flaunts his narcissistic process feeling entitled in the world.

Closet Narcissist: If the child's grandiosity is considered threatening and is forbidden the child will grow into an adult that secretly believes he is superior… but does not feel safe to allow others to see his superiority.

Idealising and Mirroring Selfobject Transferences: Kohut describes these transference like processes as being developed by narcisstic clients, however they are not strictly transference phenomena as the client experiences the impact of the relationship directly not only through its symbolic meaning in respect to historic parental figures. The narcisstic client is not able to develop a realistic therapeutic relationship and does not have a sufficient observing ego to explore the meanings of the projective transferential processes.

- **Idealising**: the client maintains an idealising view of the therapist by doing so the client enhances her view of herself, she can then borrow from the (object) therapist the strength needed to maintain an internal sense of cohesion enabling her to tolerate frustration. Kohut compared this process to the client looking into the mothers eyes and seeing the gleam in the mothers eye.
- **Mirroring:** Kohut described the process in which the client impresses the therapist and the therapist then reflects back to the client their success, accomplishments and grandeur, the clients sense of wellbeing and internal cohesion is maintained by eliciting admiration from others.
    - **There are three types:**
        - **Merger** – in whch the client sees the therapist as merely an extension of themselves and does not differentiate between themselves and the other. The client expects perfect resonance. Any miss attunement will be seen as a breach and the client is likely to withdraw.
        - **Twinship (Alter ego) –** in which the therapist is seen as "just like me"
        - **Mirror Transference –** Kohut called the third level of mirror transferences simple the mirror transference, the therapist is recognised as a separate individual but the client does not have care or appreciation about the other person as a unique and separate person… the person is not seen as a "real person"… only in their function serving the needs of the narcissist.

Splitting The narcissist defends against feelings of worthlessness and isolation and at the same time – (splitting) believes there is nothing in him that needs curing. In the therapeutic setting when the client is experiencing wounding than it is important to address this disturbance and distress. In order to do this acceptance, stroking and recognition are essential as a part of the idealising and mirroring transferences the narcissist needs.

Antisocial: "is not addressed because of a lack of possible treatment methods." Masterson suggests the therapist will do things for these clients as they are afraid of the consequences of not doing them for the client. That is because the other has no meaning or value other than as a means of achieving the anti socials own ends. The anti social might well be very successful in the world as they use and manipulate others for their own success.

Each disorder involves defensive mechanisms:

Splitting: Characterises people with disorders of the self: The person has a distorted view of reality and especially of relationships. Essentially the patient splits the other and himself into two parts: All positive (good) and All negative (bad). There is no middle ground and therefore makes his experience of himself / his emotions and relationships very different from other people's experiences often causing misunderstandings and miss attunements in psychotherapy.

Transference acting out and externalisation: Classical transference in which the client projects onto the therapist an historical figure then reacts as if the therapist is that figure.

Clinging defences: the person clings to others as a distraction or comfort and does not deal with their underlying depression and loneliness which is never satisfied by the clinging relationships. This can lead a client into the therapeutic relationship however eventually it must be addressed.

Compliance: Attempting to please those around in order to avoid the painful feelings associated with being autonomous and independent.

Projection: Projecting onto others feelings that are actually your own… this is a way of externalising and distancing from the disturbing feelings.

Avoidance: Knowingly sidestepping uncomfortable issue and this must be addressed early in the therapeutic work.

Denial: Unconscious process which is the same as avoidance – only the client is not aware of their avoidance. The person has created an alternative reality and splits off from the painful experience.

Intellectualisation: A common defence in which the client will explore intellectually the issues rather than actually feel the painful feelings and deal with the problem.

Projective Identification: A complicated version of projection – "projection with a twist or with bells on"… The client projects onto the therapist a part of him/herself which is too painful / threatening / precious and the therapist unconsciously takes on the projected role and starts feeling / acting as if they are the part the client has projected on to them. Usually this is because the client will exert pressure by enacting the role of the parent of the client which led the client to develop their experience in the first place. This is a hugely significant process in psychotherapy as the client observes how the therapist metabolizes and deals with their feelings the client learns new ways of managing their experiences and can re-internalize their own projection and manage it in a new way.

Withdrawal: The client is overwhelmed and protects themselves by pulling back behind their defensive wall. This is a more general pulling back and shutting down than avoidance or denial is.

Narcissistic Defences: common to everyone – not only the narcissistic disorder.

Grandiose Defence: An inflated sense of the self is preserved by defending against perceived attacks which would reveal the clients vulnerabilities and their feelings of powerlessness, inferiority and emptiness. A front of omnipotence and wonderfulness is presented to the world.

Devaluation: The client devalues the therapist = saying you have not helped me and so putting their sense of misery onto the other.

Self Sufficiency defence: As a defence self sufficiency is used to avoid the feelings associated with vulnerability which comes with a sense of relatedness.

Manic defence: Getting busy rather than facing the vulnerability and feelings associated with it.