

# Depression and Narcissistic Pathologies of the Self

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## Abstract

The manic phase of Bipolar I Disorder is often misdiagnosed as Narcissistic Personality Disorder (NPD). Narcissists mourn the loss of narcissistic supply; they grieve over vanished sources of supply; they bemoan the injustice and discrimination that they suffer at the hands of their inferiors. Narcissists are often in a bad mood, anhedonic, dysphoric, and outright depressed. The narcissist's mood swings are self-destructive and self-defeating.

**Keywords:** Culture Bipolar Disorder •Narcissistic Personality Disorder •Narcissism •Drugs

## Introduction

The manic phase of Bipolar I Disorder is often misdiagnosed as Narcissistic Personality Disorder (NPD).

Bipolar patients in the manic phase exhibit many of the signs and symptoms of pathological narcissism: hyperactivity, self-centeredness, lack of empathy, and control freakery. During this recurring chapter of the disease, the patient is euphoric, has grandiose fantasies, spins unrealistic schemes, and has frequent rage attacks (is irritable) if her or his wishes and plans are (inevitably) frustrated.

The manic phases of the bipolar disorder, however, are limited in time. NPD is not. Furthermore, the mania is followed by usually protracted depressive episodes. The narcissist is also frequently dysphoric. But whereas the bipolar sinks into deep self-deprecation, self-devaluation, unbounded pessimism, all-pervasive guilt and anhedonia, the narcissist, even when depressed, never forgoes his narcissism: his grandiosity, sense of entitlement, haughtiness, and lack of empathy [1-5].

Narcissistic dysphorias are much shorter and reactive; they constitute a response to the Grandiosity Gap. In plain words, the narcissist is dejected when confronted with the abyss between his inflated self-image and grandiose fantasies and the drab reality of his life: his failures, lack of accomplishments, disintegrating interpersonal relationships, and low status. Yet, one dose of Narcissistic Supply is enough to elevate the narcissists from the depth of misery to the heights of manic euphoria [5-13].

Not so with the bipolar. The source of her or his mood swings is assumed to be brain biochemistry, not the availability of Narcissistic Supply. Whereas the narcissist is in full control of his faculties, even when maximally agitated, the bipolar often feels that s/he has lost control of his/her brain ("flight of ideas"), his/her speech, his/her attention span (distractibility), and his/her motor functions.

The bipolar is prone to reckless behaviors and substance abuse only during the manic phase. The narcissist does drugs, drinks, gambles, shops on credit, indulges in unsafe sex or in other compulsive behaviors both when elated and when deflated.

As a rule, the bipolar's manic phase interferes with his/her social and occupational functioning. Many narcissists, in contrast, reach the highest rungs of their community, church, firm, or voluntary organization. Most of the time, they function flawlessly, though the inevitable blowups and the grating extortion of Narcissistic Supply usually put an end to the narcissist's career and social liaisons.

The manic phase of bipolar sometimes requires hospitalization and more frequently than admitted involves psychotic features. Narcissists

are never hospitalized as the risk for self-harm is minute. Moreover, psychotic microepisodes in narcissism are decompensatory in nature and appear only under unendurable stress (e.g., in intensive therapy).

The bipolar's mania provokes discomfort in both strangers and in the patient's nearest and dearest. His/her constant cheer and compulsive insistence on interpersonal, sexual, and occupational, or professional interactions engenders unease and repulsion. Her/his lability of mood rapidly shifts between uncontrollable rage and unnatural good spirits, is downright intimidating. The narcissist's gregariousness, by comparison, is calculated, "cold", controlled, and goal-orientated (the extraction of Narcissistic Supply). His cycles of mood and affect are far less pronounced and less rapid.

The bipolar's swollen self-esteem, overstated self-confidence, obvious grandiosity, and delusional fantasies are akin to the narcissist's and are the source of the diagnostic confusion. Both types of patients purport to give advice, carry out an assignment, accomplish a mission, or embark on an enterprise for which they are uniquely unqualified and lack the talents, skills, knowledge, or experience required.

But the bipolar's bombast is far more delusional than the narcissist's. Ideas of reference and magical thinking are common and, in this sense, the bipolar is closer to the schizotypal than to the narcissistic.

There are other differentiating symptoms:

Sleep disorders, notably acute insomnia, are common in the manic phase of bipolar and uncommon in narcissism. So is "manic speech" – pressured, uninterruptible, loud, rapid, dramatic (includes singing and humorous asides), sometimes incomprehensible, incoherent, chaotic, and lasts for hours. It reflects the bipolar's inner turmoil and his/her inability to control his/her racing and kaleidoscopic thoughts [13-17].

As opposed to narcissists, bipolar in the manic phase are often distracted by the slightest stimuli, are unable to focus on relevant data, or to maintain the thread of conversation. They are "all over the place" simultaneously initiating numerous business ventures, joining a myriad organization, writing umpteen letters, contacting hundreds of friends and perfect strangers, acting in a domineering, demanding, and intrusive manner, totally disregarding the needs and emotions of the unfortunate recipients of their unwanted attentions. They rarely follow up on their projects.

The transformation is so marked that the bipolar is often described by his/her closest as "not himself/herself". Indeed, some bipolars relocate, change name and appearance, and lose contact with their "former life". Antisocial or even criminal behavior is not uncommon and aggression is marked, directed at both others (assault) and oneself (suicide). Some bipolars describe an acuteness of the senses, akin to experiences recounted by drug users: smells, sounds, and sights are accentuated and

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attain an unearthly quality.

As opposed to narcissists, bipolars regret their misdeeds following the manic phase and try to atone for their actions. They realize and accept that "something is wrong with them" and seek help. During the depressive phase they are ego-dystonic and their defenses are autoplasmic (they blame themselves for their defeats, failures, and mishaps).

Finally, pathological narcissism is already discernible in early adolescence. The full-fledged bipolar disorder including a manic phase rarely occurs before the age of 20. The narcissist is consistent in his pathology not so the bipolar. The onset of the manic episode is fast and furious and results in a conspicuous metamorphosis of the patient.

Many scholars consider pathological narcissism to be a form of depressive illness. This is the position of the authoritative magazine "Psychology Today". The life of the typical narcissist is, indeed, punctuated with recurrent bouts of dysphoria (ubiquitous sadness and hopelessness), anhedonia (loss of the ability to feel pleasure), and clinical forms of depression (cyclothymic, dysthymic, or other). This picture is further obfuscated by the frequent presence of mood disorders, such as Bipolar I (co-morbidity) [18-20]

While the distinction between reactive (exogenous) and endogenous depression is obsolete, it is still useful in the context of narcissism. Narcissists react with depression not only to life crises but to fluctuations in Narcissistic Supply and to a circumstantial inability to express their dominant psychosexual type (cerebral or somatic).

The narcissist's personality is disorganised and precariously balanced. He regulates his sense of self-worth by consuming Narcissistic Supply from others. Any threat to the uninterrupted flow of said supply compromises his psychological integrity and his ability to function. It is perceived by the narcissist as life threatening.

Indeed, depression can be conceptualized as a reaction to the systemic failure of hitherto trustworthy and efficacious coping strategies, either owing to a seismic change in circumstances and the environment, or because of overwhelming new information.

### Loss Induced Dysphoria

This is the narcissist's depressive reaction to the loss of one or more Sources of Narcissistic Supply – or to the disintegration of a Pathological Narcissistic Space (PN Space, his stalking or hunting grounds, the social unit whose members lavish him with attention).

### Deficiency Induced Dysphoria

Deep and acute depression which follows the aforementioned losses of Supply Sources or a PN Space. Having mourned these losses, the narcissist now grieves their inevitable outcome – the absence or deficiency of Narcissistic Supply. Paradoxically, this dysphoria energises the narcissist and moves him to find new Sources of Supply to replenish his dilapidated stock (thus initiating a Narcissistic Cycle).

### Self-Worth Dysregulation Dysphoria

The narcissist reacts with depression to criticism or disagreement, especially from a trusted and long-term Source of Narcissistic Supply. He fears the imminent loss of the source and the damage to his own, fragile, mental balance. The narcissist also resents his vulnerability and his extreme dependence on feedback from others. This type of depressive reaction is, therefore, a mutation of self-directed aggression.

### Grandiosity Gap Dysphoria

The narcissist's firmly, though counterfactually, perceives himself as omnipotent, omniscient, omnipresent, brilliant, accomplished, irresistible, immune, and invincible. Any data to the contrary is usually filtered, altered, or discarded altogether. Still, sometimes reality intrudes and creates a Grandiosity Gap. The narcissist is forced to face his mortality, limitations,

ignorance, and relative inferiority. He sulks and sinks into an incapacitating but short-lived dysphoria.

### Self-Punishing Dysphoria

Deep inside, the narcissist hates himself and doubts his own worth. He deplores his desperate addiction to Narcissistic Supply. He judges his actions and intentions harshly and sadistically. He may be unaware of these dynamics – but they are at the heart of the narcissistic disorder and the reason the narcissist had to resort to narcissism as a defence mechanism in the first place.

This inexhaustible well of ill will, self-chastisement, self-doubt, and self-directed aggression yields numerous self-defeating and self-destructive behaviours – from reckless driving and substance abuse to suicidal ideation and constant depression.

It is the narcissist's ability to confabulate that saves him from himself. His grandiose fantasies remove him from reality and prevent recurrent narcissistic injuries. Many narcissists end up delusional, schizoid, or paranoid. To avoid agonising and gnawing depression, they give up on life itself [20-26].

## Anchoring

One therapeutic technique would be "anchoring": re-orienting the narcissist towards self-supply. Rather than resort to fickle and ephemeral external sources of narcissistic supply, the narcissist is taught and encouraged to resort to himself for same: to look forward with excited anticipation to the structured pursuit of hobbies, vocation, traits, skills, and reward-eliciting behaviors. This approach leverages the narcissist's grandiose solipsism and fantasy of omnipotence to render him emotionally self-sufficient.

There is no necessary connection between these two clinical conditions: depressive illness and pathological narcissism. In other words, there is no proven high correlation between suffering from Narcissistic Personality Disorder (NPD, or even a milder form of narcissism) and enduring bouts of depression.

Depression is a form of aggression. Transformed, this aggression is directed at the depressed person rather than at his environment. This regime of repressed and mutated aggression is a characteristic of both narcissism and depression. Indeed, narcissism is sometimes described as a form of "low-intensity" depression.

Originally, the narcissist experiences "forbidden" thoughts and urges (sometimes to the point of an obsession). His mind is full of "dirty" words, curses, the remnants of magical thinking ("If I think or wish something it just might happen") as well as denigrating and malicious cerebrations concerned with authority figures (mostly parents or teachers). These are all proscribed by the Superego (the "conscience".) This is doubly true if the individual possesses a sadistic, capricious Superego (a result of the wrong kind of parenting). These thoughts and wishes do not fully surface. The individual is only aware of them in passing and vaguely. But they are sufficient to provoke intense guilt feelings and to set in motion a chain of self-flagellation and self-punishment. Amplified by an abnormally strict, sadistic, and punitive Superego, they result in a constant feeling of imminent threat. This is what we call anxiety: it has no discernible external triggers and, therefore, it is not fear. It is the echo of a battle between one part of the personality, which viciously wishes to destroy the individual through excessive punishment and his or her instinct of self-preservation. Anxiety is not – as some scholars have it – an irrational reaction to internal dynamics involving imaginary threats. Actually, anxiety is more rational than many fears. The powers unleashed by the Superego are so enormous, its intentions so fatal, the self-loathing and self-degradation that it brings with it so intense that the threat is real. Overly-strict Superegos are usually coupled with weaknesses and vulnerabilities in all other dimensions of the personality. Thus, there is

no psychological structure which is capable of fighting back, of taking the side of the depressed person. Small wonder that depressives have constant suicidal ideation: they toy with ideas of self-mutilation and suicide, or worse, commit them. Confronted with such a horrible internal enemy, lacking in defences, falling apart at the seams, depleted by previous attacks, devoid of energy of life – depressed people wish to die. Their anxiety is about survival, the alternatives being, usually, self-torment or self-annihilation. Depression is how this kind of patient experiences his overflowing reservoir of aggression. He is a volcano, which is about to erupt and bury him under his own ashes. Anxiety is how he experiences the war raging inside him, his inner conflict. Sadness is the name that he assigns to the resulting wariness, to the knowledge that the battle is lost and personal doom is at hand. Depression is the acknowledgement by the depressed individual that something is so fundamentally wrong that there is no way he can win. The individual is depressed because he is fatalistic. As long as he believes that there is a chance – however slim – to better his position, he moves in and out of depressive episodes. True, anxiety disorders and depression (mood disorders) do not belong in the same diagnostic category. But they are very often comorbid. In many cases, the patient tries to exorcise his depressive demons by adopting ever more bizarre rituals. These are the compulsions, which – by diverting energy and attention away from the "bad" content in more or less symbolic (though totally arbitrary) ways – bring temporary relief and an easing of the anxiety. It is very common to meet all four: a mood disorder, an anxiety disorder, an obsessive-compulsive disorder and a personality disorder in one patient. Depression is the most varied of all psychological illnesses. It assumes a myriad guises and disguises. Many people are chronically depressed without even knowing it and without discernible corresponding cognitive or affective content. Some depressive episodes are part of a cycle of ups and downs (bipolar disorder and a milder form, the cyclothymic disorder). Other forms of depression are "built into" the characters and the personalities of the patients (for instance: dysthymic disorder, or what used to be known as depressive neurosis). One type of depression is even seasonal and can be cured by photo-therapy (gradual exposure to carefully timed artificial lighting). We all experience "adjustment disorders with depressed mood" (used to be called reactive depression, which occurs after a stressful life event and as a direct and time-limited reaction to it). These poisoned garden varieties are all-pervasive. Not a single aspect of the human condition escapes them, not one element of human behaviour avoids their grip. It is not wise (has no predictive or explanatory value) to differentiate "good" or "normal" classes of depression from "pathological" ones. There are no "good" depressions: whether provoked by misfortune or endogenously (from the inside), whether during childhood or later in life they are all one and the same. A depression is a depression no matter what its precipitating causes are or in which stage in life it occurs. The only valid distinction seems to be phenomenological: some depressive patients slow down (psychomotor retardation), their appetite, sex life (libido) and sleep (known together as the vegetative functions) are notably perturbed. Behaviour patterns change or disappear altogether. These patients feel dead: they are anhedonic (find pleasure or excitement in nothing) and dysphoric (sad).

The other type of depressive is psychomotorically active (at times, hyperactive). These are the patients that I described above: they report overwhelming guilt feelings, anxiety, even to the point of having delusions (delusional thinking, not grounded in reality but in a thwarted logic of an outlandish world).

The most severe cases (severity is also manifested physiologically, in the worsening of the above-mentioned symptoms) exhibit paranoia (persecutory delusions involving them in systematic conspiracies), and seriously entertain ideas of self-destruction and the destruction of others (nihilistic delusions). They hallucinate. Their hallucinations reveal their hidden contents: self-deprecation, the need to be (self-) punished, humiliation, "bad" or "cruel" or "permissive" thoughts about authority figures.

Depressives are almost never psychotic (psychotic depression does

not belong to this family, in my view). Depression does not necessarily entail a marked change in mood. "Masked depression" is, therefore, difficult to diagnose if we stick to the strict definition of depression as a "mood" disorder.

Depression can happen at any age, to anyone, with or without a preceding stressor (stressful event.) Its onset can be gradual or dramatic. The earlier in life it occurs, the more likely it is to recur. This apparently arbitrary and shifting nature of depression only enhances the guilt feelings of the patient. He refuses to accept that the source of his problems is beyond his control (at least as much as his aggression is concerned) and could be biochemical or genetic. The depressive patient blames himself, or events in his immediate past, or his environment.

This is a vicious and self-fulfilling prophetic cycle. The depressive feels worthless, doubts his future and his abilities, and feels guilty. This constant brooding alienates his dearest and nearest. His interpersonal relationships become dysfunctional and this, in turn, exacerbates his depression.

The patient finally finds it most convenient and rewarding to avoid social interactions altogether. He resigns from his job, shies away from social occasions, sexually abstains, and shuts out his few remaining friends and family members. Hostility, avoidance, histrionics all emerge and the existence of personality disorders only make matters worse.

Freud said that the depressive person had lost a love object (was deprived of a properly functioning parent). The psychic trauma suffered early on can be alleviated only by inflicting self-punishment (thus implicitly "penalizing" and devaluing the internalised version of the disappointing love object).

The development of the Ego is conditioned upon a successful resolution of the loss of the love objects (a phase all of us have to go through). When the love object fails the child is furious, revengeful, and aggressive. Unable to direct these negative emotions at the frustrating parent the child directs them at himself instead.

Narcissistic identification means that the child prefers to love himself (direct his libido at himself) than to love an unpredictable, abandoning parent (mother, in most cases). Thus, the child becomes his own parent – and directs his aggression at himself (at the parent that he has become). Throughout this wrenching process, the Ego feels helpless and this is another major source of depression.

When depressed, the patient becomes an artist of sorts. He tars his life, people around him, his experiences, places, and memories with a thick brush of schmaltzy, sentimental, and nostalgic longing. The depressive imbues everything with sadness: a tune, a sight, a colour, another person, a situation, a memory.

In this sense, the depressive is cognitively distorted. He interprets his experiences, evaluates his self and assesses the future totally negatively. He behaves as though constantly disenchanting, disillusioned, and hurting (dysphoric affect) and this helps to sustain the distorted perceptions.

No success, accomplishment, or support can break through this cycle because it is so self-contained and self-enhancing. Dysphoric affect supports distorted perceptions, which enhance dysphoria, which encourages self-defeating behaviours, which bring about failure, which justifies depression.

This is a cosy little circle, charmed and emotionally protective because it is unfailingly predictable. Depression is addictive because it is a strong love substitute. Much like drugs, it has its own rituals, language and worldview. It imposes rigid order and behaviour patterns on the depressive. This is learned helplessness: the depressive prefers to avoid even situations which hold the promise of improvement in his harrowing condition.

The depressive patient has been conditioned by repeated aversive stimuli to freeze in his tracks: he doesn't even possess the requisite energy to end his cruel predicament by committing suicide. The depressive is

devoid of the positive reinforcements, which are the building blocks of our self-esteem. He is filled with negative thinking about his self, his (lack of) goals, his (lack of) achievements, his emptiness and loneliness and so on. And because his cognition and perceptions are deformed no cognitive or rational input can alter the situation. Everything is immediately reinterpreted to fit the paradigm.

People often mistake depression for emotion. They say about the narcissist: "but he is sad" and they mean: "but he is human", "but he has emotions". This is wrong. True, depression is a big component in the narcissist's emotional make-up. But it mostly has to do with the absence of Narcissistic Supply. It mostly has to do with nostalgia for more plentiful days, full of adoration and attention and applause. It mostly occurs after the narcissist has depleted his secondary Sources of Narcissistic Supply (spouse, mate, girlfriend, colleagues) with his constant demands for the "re-enactment" of his days of glory. Some narcissists even cry – but they cry exclusively for themselves and for their lost paradise. And they do so conspicuously, ostentatiously, and publicly in order to attract attention.

The narcissist is a human pendulum hanging by the thread of the void that is his False Self. He swings from brutal and vicious abrasiveness to mellifluous, maudlin, and saccharine sentimentality. It is all a simulacrum, a verisimilitude, and a facsimile: enough to fool the casual observer, enough to extract the narcissist's drug: other people's attention, the reflection that somehow sustains his house of cards.

But the stronger and more rigid the defences – and nothing is more resilient than pathological narcissism – the greater and deeper the hurt the narcissist aims to compensate for. One's narcissism stands in direct relation to the seething abyss and the devouring vacuum that one harbours in one's True Self.

Perhaps narcissism is, indeed, as many say, a reversible choice. But it is also a rational choice, guaranteeing self-preservation and survival. The paradox is that being a self-loathing narcissist may be the only act of true self-love the narcissist ever commits.

## Biography

Sam Vaknin is the author of "Malignant Self-love: Narcissism Revisited" and other books about personality disorders. His work is cited in hundreds of books and dozens of academic papers

<http://www.narcissistic-abuse.com/mediakit.html>

He spent the past 6 years developing a treatment modality for Narcissistic Personality Disorder (NPD). Over the years, with volunteers, it was found to be effective with clients suffering from a major depressive episode as well.

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