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Egocentrism and the Cognitive Psychotherapy of Personality Disorders

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The concept of cognitive egocentrism provides useful guidelines for the cognitive psychotherapy of personality disorders. The patient's imaginary audience- and "personal fable" (aspects of egocentrism that are normally overcome in late adolescence, according to developmental psychologists, and that unhealthily permeate the thinking of adult personality disorders) may be effectively selected as targets for the therapist's assessment and intervention. This paper illustrates the hypothesis that therapy should involve criticism of the imaginary audience first, and that this should be followed by exercises of interpersonal perspective-taking. These first steps allow for deliberate, responsible self-disclosure in interpersonal relationships that the patient may wish to develop in the direction of growing degrees of intimacy. The experience of healthy relationships seems necessary in order to relinquish the personal fable.

In developmental psychology, "egocentrism" means the inability to deal with multiple perspectives simultaneously, and therefore the lack of the capacity to differentiate between one's point of view and the point of view of others (Elkind, 1967; Flavell, 1963; Rosen, 1985). Egocentrism is obviously a limiting feature in cognitive-emotional development and declines as long as the cognitive growth proceeds. This decline is gradual, but not linear. In periods of life crises and existential changes, as for instance in adolescence, egocentric behavior may increase dramatically after having decreased in frequency because of the preceding cognitive growth (Rosenroll, 1987). If the crisis is overcome successfully, egocentrism is further relinquished with the conquering of a higher level of

cognitive growth. Egocentrism limits the knowledge of both inner and outer realities: The proper understanding of one's emotions and thoughts, not only the understanding of the emotions and thoughts of other people, is hindered by cognitive egocentrism (Baldwin & Holmes, 1987; Elkind, 1967, 1974, 1985; Enright & Deist, 1979; Fenigstein, 1984).

The concept of egocentrism should be taken in its purely cognitive meaning, and be carefully distinguished from that of selfishness, egotism and narcissism, which imply emotional and motivational components. Egocentrism and selfishness or narcissism may or may not go hand in hand during development and in psychopathology. An infant is egocentric but it would be inappropriate to consider it egotistical. A child's normal love for its parents is not necessarily narcissistic—it may be, rather, an instance of cooperative partnership (Bowlby, 1982, pp. 352–356)—although how parents are known by their children is certainly an egocentric kind of knowledge. To give an example pertaining to developmental psychopathology, children forced to assume an inverted protective relationship with their parents (compulsive caregiving) (see Bowlby, 1980, p. 222–224) certainly think in an egocentric way, but their feelings, motivations and actions could hardly be labeled selfish or narcissistic.

In this paper it will be argued that the concept of egocentrism may provide fertile grounds for the understanding of psychopathological phenomena in general, and for the treatment of adult personality disorders in particular.

THE GRADUAL DECLINE OF EGOCENTRISM DURING NORMAL COGNITIVE DEVELOPMENT

At the beginning of cognitive development, egocentrism implies the inability to discriminate one's perceptions of a given object from other people's perceptions of the same object: The child is totally unaware that others may have different viewpoints regarding a given object. The child, during the *sensory-motor stage* of cognitive development construes *all* of reality with the self as the only possible model (see Flavell, 1963, for explanations of this and other Piagetian conceptions of cognitive growth).

Later on in childhood and in adolescence, egocentrism is gradually overcome at the perceptual level, but it still persists at more abstract levels of cognitive operations. During the phase of cognitive functioning that Piaget has termed *concrete operations*, the child interchanges hypothesis and facts, and does not feel any need to offer proof for assertions. In the course of the concrete operations phase, the child's mental life is characterized by a state of fusion, or confusion, between convictions personally held and those held by others.

During the later phase of cognitive development that is usually reached in adolescence and is known as the stage of *formal operations*, it becomes possible to think about one's own thinking. Teenagers become able to work deliberately

on their own thoughts, and thereby to construct complex "theories" about self and the world. They are now able to understand that different people may have different beliefs, and not only different behavior. They are usually eager to discuss their "theories" with others. Egocentrism, however, is not yet completely conquered: Adolescents may still attribute an unlimited power to their own thoughts and may strongly wish to act on others so as to compel them to adapt their "theories," which they regard no more as the only *possible* ones, but still as the only *valid* ones, Furthermore, the teenagers are now able to consider the thoughts of others but have difficulties in differentiating between their main interest in a given moment and what may be of primary concern to others (Elkind, 1974). These are still forms of cognitive egocentrism, although different from those observable during childhood. Indeed, a dramatic *increase* in egocentric behavior may be frequently observed in the transition between childhood and early adolescence: This peak of egocentrism is followed by a gradual decrease through middle and late adolescence if social support and personal development proceed satisfactorily throughout this difficult period of human life (Rosenroll, 1987).

Egocentrism during adolescence is expressed by two important phenomena that have been identified by Elkind (1974, 1985) with the terms "personal fable" and "imaginary audience." The *personal fable* is an untrue story that is accepted as an important part of a person's identity. For instance, a male adolescent engaged in dangerous kinds of motorcycle riding may believe that he will never die, or a female teenager involved in an affair may believe that she will never become pregnant. In normal adolescents, "stories" such as these are very transient, but they may persist for many years in the case of personality disorders, even in the face of strong contrary evidence. For instance, a 29-year-old female patient of mine remarked (while she was describing how she became pregnant for the second time in her life) that she had decided to have intercourse with her boyfriend because she "felt" that it was impossible for her to get pregnant. Her first pregnancy was terminated by an induced abortion. On that occasion she had been cautioned by her gynecologist against her habit of "forgetting" contraceptives.

One of the "personal fables" that more often persists in the adult life of patients suffering from personality disorders concerns the tacit denial that the flow of time is inexorable in bringing about changes both in the self and in the world. As in the tale of Sleeping Beauty, these patients *behave* as if they believe that the world and the self will not change while they postpone decisions.

It is important to note here that the personal fable is more often a tacitly held belief system than an explicitly verbalized conviction. Its nature and theme are to be inferred by the patient's behavioral style (e.g., procrastination) and by specific discrepancies between explicit self-descriptions and the accompanying emotional experiences. For instance, a patient who *systematically* procrastinates constructive decisions may describe feelings of being doomed to failure. When not *stably* sad or depressed, the patient may utter such a self-description as a sort of lip homage paid to current opinion, a mere repetition of what others have said

(e.g., "You will never have such an opportunity again; you'll be a failure in life if you go on missing good opportunities such as this one . . ."). At the same time he may tacitly expect that his chances for success will remain equally good when he eventually decides to "awaken" from his procrastinating "sleep."

The *imaginary audience* refers to the observation that the adolescent seems to live on the stage, with everybody else considering him a great success (or a failure). While adolescents are now able to consider what others are *thinking* and *feeling*, they believe it is with their *appearance* and *behavior* that others are concerned. They anticipate the reactions of others to them and expect these to be the same as their own attitudes (either positive or negative) toward themselves. Again, this belief and anticipation should be understood more as tacit attitudes than as explicit, verbalizable thoughts in adolescents' mind.

An important sign that adolescent egocentrism is on the way to being conquered and relinquished is the appearance of the ability to put oneself in the place of another in order to understand how that person is thinking and feeling. This, of course, is a particularly difficult endeavor when the other's ideas and emotions are utterly discordant with one's own. This ability, so vital for both personal development and interpersonal adjustment, is known in developmental and social psychology as *perspective-taking* (see, e.g., Elkind, 1985; Enright & Deist, 1979; Falk & Wagner, 1985; Johnson, 1975; Selman, 1971, 1980).

The major factor contributing to the decline of egocentrism through the various stages of cognitive growth is social interaction (see, e.g., Rosen, 1985, pp. 61–63). As Piaget asserted, it is

> . . . the shock of our thought coming into contact with that of others, which produces doubt and the desire to prove . . . We are constantly hatching an enormous number of false ideas, conceits, utopias, mystical explanations, suspicions and megalomaniacal fantasies, which disappear when brought into contact with other people. The social need to share the thought of others and to communicate our own with success is at the root of our need for verification." (Piaget, 1969, p. 204).

When one tries to communicate and be understood, one has to adapt to the informational capacity of the listener. Rather than limiting oneself to assimilating what the other says to one's own schemata, one has also to accommodate one's own schemata to the information provided by the other. Accommodation to another's points of view fosters the ability to entertain multiple perspectives about a given object of thought. The decline of egocentrism and the establishment of positive interpersonal relationships are, therefore, like two sides of the same coin. It follows that, if others are unavailable or unwilling to communicate or unable to respond properly to the child's or adolescent's social needs, egocentrism will not easily be overcome. Disturbances in social interaction (particularly in family communication) during cognitive-emotional development may therefore reflect themselves in a persistence of egocentrism beyond the age at which it is regarded as normal.

UNHEALTHY RELATIONSHIPS, NEGATIVE COGNITIONS AND EGOCENTRISM

It is a truism that unhappy relationships with parents produce long-lasting emotional suffering in the child. The systematic study of this obvious truth by developmental psychologists has yielded observations and theories that have shed light on the relationships between interpersonal exchanges, emotional experience, cognitive structures and such qualities of cognitive processing as egocentrism.

The various patterns of insecure attachment (anxious-resistant attachment, systematic avoidance of the attachment figure, disorganized-disoriented attachment: see Ainsworth, 1982; Bowlby, 1982; Bretherton, 1985; Main & Solomon, 1988) may be regarded as instances of early *organized* emotional suffering, related to abnormal patterns of parental behavior in otherwise normal children. Insecure attachment correlates highly with abnormal styles of communication between parent and child. It is likely (unless family communication changes for the better while the child grows older) that early patterns of insecure attachment will become the developmental roots, as cognitive growth proceeds, of a distorted or limited capacity to communicate about one's emotions. There is now suggestive evidence concerning the importance of the ability to talk about emotions both in the conduct of interpersonal interaction and in the development of self-knowledge (see, e.g., Bretherton, Fritz, Zahn-Waxler, & Ridgeway, 1986). This evidence is related to the construction of new integrated theories of cognitive and emotional development in the tradition of Piaget's developmental psychology (Lane & Schwartz, 1987; Rosen, 1985). Thanks to this evidence and these theories, we may safely accept the hypothesis that untoward early social relationships, through the mediation of painful emotions, hamper the process of overcoming egocentrism.

Patterns of abnormal parenting, besides being the interpersonal context of the child's emotional suffering, prepare the ground for the construction of different kinds of negative cognitions about self and others (see, e.g., Guidano & Liotti, 1983; Liotti, 1984, 1988). Therefore, we should expect that, if emotional and family problems are related to the persistence of egocentrism, egocentrism should also be related to negative cognitions about self and others. Evidence supporting this expectation is beginning to accumulate. For instance, it has been shown that adolescents with a high degree of egocentrism have more negative views of self and others than peers with a low degree of egocentrism. Furthermore, neither egocentrism nor dysfunctional attitudes declined with age when they were linked, while egocentrism did decline with age if associated with positive views of self and others (Baron, 1986).

It is not difficult to understand the main reason why egocentrism, if coupled with dysfunctional attitudes, tends to persist beyond the age and maturational stages in which it may be expected that perspective-taking will ensue. The

explanation is related to the effect of self-disclosure and perspective-taking on a developing interpersonal relationship. Negative cognitions hinder self-disclosure, and egocentrism—by definition—runs contrary to perspective-taking. Now, it has been proved that reciprocal perspective-taking and self-disclosure facilitate the development of a healthy relationship, while egocentrism, as a response to another's self-disclosure, has negative effects on the relationship (Falk & Wagner, 1985). The less egocentric partner of a relationship feels that the more egocentric one is unwilling to share experiences, and unable to understand or appreciate the effort made to reach a higher degree of intimacy through progressive reciprocal self-disclosure. There is a tendency for the less egocentric partner to discontinue attempts at achieving friendship and intimacy. On the other side, precisely because of greater egocentrism, the more egocentric partner will be unable to understand the reasons for the deterioration of the relationship, and will be likely to feel either global guilt about it ("I am an unlovable person") or to attribute equally global malevolent attitudes to the other ("One cannot trust anybody"). In any case, the negative views of self and the other will be reinforced and confirmed. Egocentric youngsters run, therefore, the risk (a) of feeling rejected by their less egocentric peers with whom they may begin to establish friendly intercourse; (b) of being automatically squeezed into the limited area of communication permitted by relationships with peers who share their negative views of themselves and others; and (c) of being trapped in a self-confirmatory cycle of dysfunctional attitudes, egocentric cognition and unhealthy relationships.

EGOCENTRISM IN THE PERSONALITY DISORDERS

The degree and type of egocentrism differ depending upon the styles, structures, and contents of cognitive processing that characterize, respectively, the neuroses, the psychoses, and the personality disorders. It is likely, for instance, that a young person who is in the process of developing schizophrenia is not only blocked, by psychogenic and/or biochemical mechanisms, from going beyond adolescent egocentrism, but also cognitively *regresses* to *preoperational* forms of egocentrism (Lidz, 1973). Preoperational forms of egocentrism will, then, accompany the complex conceptual deficits and distortions of schizophrenic thought.

In the neurotic reactions (the relatively minor emotional disorders starting in adult life as a reaction to precipitating factors), on the other hand, egocentrism seems to be more of the adolescent type, that is, of the type characteristic of the stage of *formal operations*. Moreover, while egocentrism seems to permeate wide areas or even all of schizophrenic thinking, in the neuroses it seems limited to those meaning domains in which the specific type of cognitive dysfunction that characterizes each neurotic syndrome operates. Thus people who are depressed will fail to differentiate between their view of themselves as a total failure and the more positive view their spouses, for instance, may have of their character and

doings. However, they will be able to decentrate and entertain multiple points of view when issues other than their personal worth are the focus of interpersonal exchanges. An obsessive-compulsive patient with hand-washing rituals may find it difficult to comprehend the fact that other people do not believe that a given object is contaminated, or that there is a risk of becoming ill for having touched it. The same patient, however, will be able to deal simultaneously with the different views other people may have whenever the focus of attention is on aspects of his character outside the domain of the patient's compulsive attitudes. An agoraphobic patient will be likely to think in an egocentric way whenever issues related to physical isolation and lack of freedom are raised, but not in other circumstances.

Egocentrism in personality disorders seems of a degree and type somewhere in between the poles of schizophrenia and neurotic reactions. The cognitive style in personality disorders does not entail, as in schizophrenia, the regression to preoperational forms of egocentrism, with the consequent major cognitive deficits and distortions. On the other hand, based on this author's clinical experience, egocentrism is much more pervasive in the thinking of people suffering from personality disorders than in the cognitions of reactive neurotics. Almost every aspect of the patient's self-knowledge is egocentric in the personality disorders. Different cognitive structures are characteristic of the different kinds of personality disorders (and they stem, most likely, from different abnormal patterns of attachment and early family interactions), but the pervasive, egocentric form of cognitive processing that characterizes adolescent thought is similar across the various syndromes of borderline personality, histrionic personality, schizoid personality, etc.

Because of the central role of egocentrism in personality disorders, it is essential to devise therapeutic strategies that may help the patient to decenter as often as possible. Interventions aimed at overcoming pervasive egocentrism should precede, or at least accompany, any attempt to revise and change specific cognitive structures (e.g., irrational beliefs) and specific cognitive distortions (e.g., dichotomous thinking, overgeneralizations, etc.). Clinicians treating personality disorders with a cognitive-behavioral approach will observe that these patients have a *proteiform* way of presenting their problems. Typically, they tend to change the focus of attention as soon as the therapist tries to concentrate on any problem they have just described, with the apparent intention of asking for help. Patients with personality disorders seem to respond to the therapist's *attention* rather than to the content of his/her suggestions. Perhaps in order to get more of this attention, they quickly produce a new complaint to dwell on—only to go back to the first problem, or to puzzle over a third one, if the therapist begins to concentrate on the second. Single irrational beliefs and specific distorted cognitions constantly seem to slip through the therapist's fingers.

Another reason for the primacy of egocentrism in the list of problems to be dealt with during the treatment of a personality disorder concerns the structure of the

patient's interpersonal life. The self-perpetuating, reciprocal relationships between pervasive egocentrism and unhealthy interpersonal transactions are so powerful that limited attempts to change individual cognitive structures are very unlikely to help the patient break the vicious circle. Since it is usually difficult to change directly the patient's interpersonal milieu, the therapist treating personality disorders must address the issue of egocentrism straightforwardly in the therapy relationship.

EGOCENTRISM AND THE THERAPEUTIC STRATEGY IN THE TREATMENT OF PERSONALITY DISORDERS

Knowledge about egocentrism in adolescence is helpful in devising therapeutic interventions aimed at breaking the vicious circle between egocentrism and faulty relationships in personality disorders. The concepts of imaginary audience, personal fable, perspective-taking, and self-disclosure may all be used as part of the therapeutic strategy. In the course of the therapeutic process, it is usually advisable to begin dealing with the patient's imaginary audience; then help the patient to assume another's point of view as often as possible (perspective-taking); and third, guide the patient to engage in appropriate self-disclosure.

Only when the patient is able, through the effects of perspective-taking and deliberate self-disclosure, to figure out and begin experiencing a better interpersonal reality, is it advisable to criticize the patient's personal fable in a radical way. Any critical confrontation with the absurdities and the irrational beliefs that are implicit in the tacitly held personal fable during the first phases of the treatment is unlikely to be successful. The patient's cognition is marked by the memories of very unhappy relationships and before more satisfying relationships than the personal fable are experienced, it is unlikely that the patient will be able to relinquish them or even be willing to subject them to rational criticism.

Imaginary Audience

First of all, then, the patients should be confronted with the fact that they tend, frequently, to look at people as if they were a uniform *imaginary audience*, whose reactions are expected to be the same as their own reactions (either positive or negative) to personal appearance and behavior—or at least whose concern they are sure will be the same as their own main focus of interest. If this confrontation is successful, the therapist may proceed to help patients substitute their imaginary audience with a more appropriate representation of the likely thoughts and concerns of the people they are going to meet. An example of this is presented in the following vignette.

> Carlo, 31 years old, diagnosed as borderline personality disorder, complains during the fourth therapeutic session that he is afraid of accepting an invitation to a party. He

expects that people in the party will be critical, reject him, or be straightforwardly hostile in the face of his best efforts to make himself accepted. The therapist inquires whether or not Carlo expects everybody to focus their attention on his behavior.

Having obtained confirmation that this is exactly what Carlo expects to happen, the therapist proceeds to ask Carlo to entertain for a moment a fanciful idea: namely, that one of the male guests is so involved in the courtship of a girl at the party that he cannot possibly notice what Carlo is doing and saying for most of the party. Then the therapist asks Carlo to imagine what the girl, who is being so insistently courted, may be focused on during the party. He asks Carlo to dwell on some other fanciful ideas of this sort about other guests. May for instance, some of them be secretly immersed, for the duration of the party, in worried thoughts concerning a big financial crisis they are having to deal with? May someone else be thinking all the time how to get rid of an unhappy relationship? What other kinds of important life events could distract people from focusing on Carlo?

This vignette illustrates how, at the beginning of the treatment of personality disorders, the therapist is not *primarily* engaged in assessing the patient's irrational beliefs (à la Ellis) or the more widely known types of cognitive distortions (e.g., dichotomous thinking, arbitrary inference, selective abstraction, overgeneralization, etc.) and is wary of disputing them. For instance, in Carlo's case, the therapist avoids criticizing directly his idea that it is awful and absolutely unbearable not to be appreciated and loved by almost everybody. Rather, the therapist's main concern is to help the patient acknowledge that he is operating—both in his thinking and in his overt behavior with other people—on the tacit assumption that everybody will share his main focus of interest at any given moment. In the example, Carlo's main focus of interest was the kind of social behavior that he regarded as acceptable and worthy of praise. The therapist, therefore, begins intervening by showing Carlo that people's attention may be concentrated on topics different from his social behavior during a party. It is not relevant whether the characters in the imaginary audience are represented as valuing what the patient values or despising what the patient prizes. The main point to be made is that the patient wrongly assumes that everybody will share his main focus of attention.

Once patients are aware of the existence and the nature of their imaginary audience, it is possible to help them conceive less uniform "audiences" that may be more akin to what is likely to take place in the minds of an actual group of people. As the above clinical vignette illustrates, it is important to help patients acknowledge the great variety of people's cognitions, leaving to the patient the conclusion that people's thoughts are more likely to be centered on something else. To reach this conclusion as the result of one's own reasoning (even if the chain of reasoning has been set in motion by others) is usually more productive, less painful, and less likely to evoke resistance than to hear it from another person.

Perspective-Taking

Once the patient is aware that other people's mental life is more like an unknown universe that is worth being explored than like a replica of one's own view of self and reality, this awareness may be used to foster the patient's willingness to reconstruct, or try to figure out, the "inner life" of significant others (perspective-taking). An example of this process follows.

> Paola (28 years old, diagnosed as a mixed histrionic/dependent personality disorder) was very prone, when anxious, to uttering her hypochondriacal complaints dramatically, in order, apparently, to obtain the attention of parents, friends, and mainly of her husband. Paola became furious when her husband did not pay her what she regarded as the due attention any decent person should pay to a relative suffering from an illness or discomfort. She was unable to understand why her husband sometimes responded in a caring and affectionate way to her sufferings, and at other times—unpredictably, according to her reconstruction of various episodes of their conjugal interaction—was careless or annoyed.

Each time he did not react to her sufferings in the "appropriate way," she could not help thinking that he was (a) not loving her any more and (b) behaving in such an awful way as to deserve severe punishment. Rather than attack the various irrationalities implied in the patient's cognition, the therapist chose to begin dealing with Paola's limited skills of perspective-taking. He asked Paola to try to take her husband's point of view over a given event related to her sufferings, and made this request while she was angrily reporting one episode of his "unforgivable carelessness." To figure out what her husband felt and thought, the therapist stated, could afford useful information for a better understanding of the conjugal problem that was afflicting Paola.

In order to facilitate the execution of such a difficult task of perspective-taking, the therapist used a modified version of a Gestalt technique: the dialogue with an empty chair. Paola was asked to sit on a chair and talk about her sufferings to her (imagined) husband sitting on the empty chair in front of her. Immediately thereafter, Paola was asked to sit an the other (the "husband's") chair, to imagine being her husband, and to tell an imaginary Paola sitting on the now empty (the "wife's") chair how he felt while listening to her talk. With a little help from the therapist, Paola (role-playing her husband) said: "Oh, I had such a difficult time today at work . . . To see you in such a state when I was just back home hoping to relax... It is too much for me to bear today . . . I tried to listen, but could not be supportive. . . ." After this exercise, Paola's rage was considerably reduced. The therapist prescribed the repetition of the dialogue with the empty chair at home, as often as possible, each time spending a little more time on the "husband's" than on the "wife's" chair. After these exercises, Paola was supposed to inquire about the husband's thoughts and feelings by asking him directly, and to notice how accurate her role-playing had been.

Interpersonal Relationships and Developmental History

Now able to take another person's viewpoint, the patient is also in a position to reflect on how to phrase thoughts, and on when or how to express feelings and wishes in order to make them understandable or accepted by that particular person. The degree and type of self-disclosure in the relationship with that person may then be the fruit of a conscious and rational decision, Timely and conscious acts of self-disclosure, based on relinquishing egocentrism, lead to more satisfactory and intimate relationships (Falk & Wagner, 1985). Once engaged in more positive interpersonal relationships, the patient will have an easier time noticing, by contrast, the untoward aspects of former interactions with significant others.

It is important, in this regard, to consider that the therapeutic relationship may be the first healthy interpersonal experience in the patient's life. The accurate consideration of what exactly was wrong in one's past interpersonal experiences, in turn, helps a patient to acknowledge the origins of his actual beliefs about people, personal worth, and lovableness (Liotti, 1987, 1988, 1989). To acknowledge that one's incorrect appraisals of various interpersonal situations have been learned in the context of past unhealthy relationships facilitates the rational criticism and change of one's beliefs and cognitive distortions. It prevents patients from blaming themselves for their irrationalities. By reflecting on their developmental history, patients can see that many distortions in their present thoughts stem from originally plausible appraisals of aberrations in their interpersonal reality (Bowlby, 1988, pp. 39ff., 99ff.; Miller, 1985; Schatzman, 1973). Trust in the basic reliability of their own cognitive processes is thus preserved in the patients, even while they acknowledge that they are nurturing inaccurate patterns of thought and behavior (Liotti, 1987, 1988, 1989).

To preserve and enhance self-esteem during the process of cognitive reorganization is obviously important for every patient engaged in a psychotherapeutic process. This is particularly true in the treatment of personality disorders, given the vicious circle of negative views of self and others, egocentrism and distorted interpersonal communication in which these patients (much more than reactive neurotics) are trapped. For example:

> Paola was very defensive whenever somebody accused her of being selfish and greedy for people's attention. She seemed to misconstrue the therapist's first attempts to assess her irrational beliefs regulating her behavior with her husband as an accusation of selfishness. Once her relationship with the therapist and (thanks to the beginning relinquishment of egocentrism) with her husband became more satisfactory, Paola began to reflect on memories of the interaction with her parents that could explain how she came to relate her "dire need to be loved" (Ellis, 1962) to the idea that it was necessary for her to compel another person to sacrifice every personal interest in order to assist her in every moment of discomfort. Once she recognized how she learned from her parents—or developed as a "solution" to problems created by family relationships—many of the habits and beliefs related to her inordinate wish for attention, it became possible for her to relinquish her resistances, i.e., to question these beliefs and to understand fully the adverse consequences of self-centeredness.

Personal Fable

During the psychotherapy of a patient with a personality disorder, the therapist often observes some aspects of the patient's thinking and behavior that seem regulated, at a tacit level of cognitive processing, by that aspect of egocentrism that Elkind (1974) has christened *personal fable*. In this author's experience treating personality disorders, personal fables centering on the themes of time and risk are particularly common. Some patients are, in their own self-representation, like characters in a story who run the frightening risk of losing valuable things or beloved persons, yet real losses never happen. In such a story, old age and death are like dreamed images that never really concern the protagonist. These patients seem not to be fully aware that time is passing by, and that by postponing decisions they are losing perhaps irretrievable opportunities in work, love relationships, or friendship. Other patients seem unaware that obviously unsafe habits may be harmful to their physical and mental health or to their most significant relationships. It is almost as though they believed that they, or their affectional bonds, are invulnerable.

These types of personal fables are similar to what psychoanalysts call unconscious fantasies of omnipotence and immortality. They do not produce feelings of self-reliance nor are they accompanied by a positive mood. On the contrary, they are usually accompanied by labile, negative emotions: anger, fear, shame, and sadness. In fact, personal fables such as those above, when persisting after adolescence, probably originated in unhappy early interpersonal experiences (mainly, abnormal attachment relationships). They are, therefore, related to deep-seated schemata portraying a negative view of self and others and facilitating the experience of unpleasant emotions (see section on Unhealthy Relationships, Negative Cognitions and Egocentrism).

The personal fable may prove especially difficult to conquer during psychotherapy, if the vignette above described therapeutic operations (reflecting on the imaginary audience; taking other people's perspective; building up better interpersonal relationships; reflecting on past negative experiences; revising the beliefs constructed on the basis of those experiences) have not been successfully performed. This process is illustrated in the following vignette:

> Carlo seemed incapable of any commitment and perseverance in his life plans. He procrastinated for years before completing his university studies, changed jobs, dropped out from psychotherapies, and forgot or avoided cultivating friendly connections. Carlo was seemingly unable to comprehend that his procrastination and inconstancy amounted to a waste of time and energy and that one's time is limited. Every time during the first months of treatment that the therapist tried to confront him with this idea in order to foster his willingness to commit himself to constructive life-plans, Carlo reacted with self-despising statements such as: "You are right, I'm wasting my life, I'm a failure, I'll never change." Afterwards, he experienced a short-lived depressive mood. Then his depression vanished, and he kept on procrastinating any serious decision about his life. He resisted not only cognitive antiprocrastination arguments, but also behavioral prescriptions aimed at attaining the same antiprocrastination goal.

Carlo neither rationally dwelled on the idea that time is passing, nor did he seem aware that, since we have a limited supply of time, we would do better to actively reflect on how to make use of it. Instead, he had a kind of concrete (i.e., not yet pertaining to the stage of formal operations) way of thinking about this issue: Carlo often reported episodes in which he saw his body in the mirror as the body of an old man and thereupon was afraid of being rejected by people. Although this was the result of an arbitrary selection and amplification of perceptual features rather than a hallucination, Carlo described his experience almost as if he was re-enacting the drama of Dorian Gray in the famous novel by Oscar Wilde. The image in the mirror seemed the concrete (perceptual) antecedent of a line of thinking, not yet developed in a formal (propositional) way, that could eventually lead to the relinquishment of procrastination and the related personal fable.

This line of thinking, if formally developed, could be expressed as follows: "They will look at me, see how old or (if they are women) how ugly I am, and judge me because I am so old and yet have not made anything useful out of my life." In other words, if transformed into a mature form of thought and an explicit self-description, the "Dorian Gray phenomenon" could have become a powerful determinant of depression. For Carlo, relinquishing the personal fable underpinning both procrastination and the resistance to antiprocrastination arguments would have implied the risk of viewing himself as a total failure and may have developed into a full-blown long-lasting depression. This conceptualization led the therapist to focus on the imaginary audience, fostering perspective-taking, and reconstructing Carlo's developmental history before attacking his irrational beliefs, his arbitrary inferences, or his overgeneralizations.

While the therapeutic sequence aimed at overcoming egocentrism was in progress, Carlo became able to persevere both in his relationship with his girlfriend and in his work. It seemed implausible to consider this stability in love and work as the result of the early aborted efforts to dispute the procrastination theme in Carlo's personal fable. After over a year of stable gains, the therapist asked Carlo to what he attributed his newly developed perseverance and decisional skills. According to Carlo, he had learned how to persist in a difficult job from his girlfriend: He admired her way of facing difficulties and coping with them in her work, and tried to imitate her attitude. She came from a poor family plagued by the psychosis of her brother, and was strongly motivated since early adolescence to earn a living and become autonomous, goals that she had just achieved when she met Carlo. On the other hand, Carlo acknowledged that he had learned how to persevere in a relationship through therapeutic work on egocentrism. He did not even remember that the therapist had tried to attack the irrational ideas related to his indecisiveness at the beginning of the treatment. Interestingly, as Carlo experienced stability in his work and in his love life, the Dorian Gray phenomenon spontaneously disappeared. At this stage of the treatment, Carlo was able to listen attentively to the therapist's seemingly casual observation that we humans have a limited amount of time to use, and would do better to make explicit

decisions on how to use it. Carlo agreed with this idea and even elaborated on it a little bit, thereby showing that a formal-operational, and not egocentric, way of looking at the problem of how to live a meaningful life before becoming old was now within his reach. In other words, he seemed well an the way to giving up his personal fable.

The above example shows how therapeutic work on egocentrism and on interpersonal realities may lead to the spontaneous disappearance of both the personal fable and of concrete forms of thought related to it (the Dorian Gray phenomenon, in Carlo's case). As the result of therapeutic interventions aimed at overcoming egocentrism, more formal kinds of thought may develop within the meaning domains formerly permeated by the personal fable, while the risk of these formal (propositional) thoughts, assuming the character of stable depressive cognitions, is kept at a minimum. This whole process of cognitive growth and cognitive-emotional-behavioral change is always set in motion within a relationship that allows for a sufficient degree of intimacy. For Carlo, the relationship with his girlfriend provided this. In Rosen's words: "The personal fable, which may never be entirely overcome, yields to some extent to the relationship of intimacy. It is through the sharing of mutual feelings, fantasies and goals . . . that each participant comes to realize the illusion of his being unique in experiencing life's emotions so intensely" (Rosen, 1985, p. 63).

CONCLUDING REMARKS

It is hardly necessary to state explicitly that these strategies for dealing with egocentrism in personality disorders do not exempt patient and therapist from working on other aspects of cognitive psychotherapy. The shaping of a good therapeutic alliance, and the accurate self-monitoring by the patient of thoughts, feelings and behaviors, are necessary steps in the treatment of personality disorders as they are in the treatment of any emotional disorder. Techniques facilitating cognitive change should be selected and implemented according to the patient's needs and the therapist's preferences. Resistances should be recognized and addressed. When working on all these aspects of cognitive psychotherapy, however, the therapist treating a patient with a personality disorder would do well to remember that patients' egocentrism will likely hinder their understanding of the meaning of the various therapeutic maneuvers. The patient will likely be less able than the ordinary neurotic to take the therapist's perspective and to figure out at what the therapist's suggestions, prescriptions, or even questions are aimed at. To take this feature of personality disorders into constant account—even if the strategy of the treatment is not primarily focused on the overcoming of cognitive egocentrism as suggested in this paper—may therefore help to put many of the problems of the therapeutic relationship with these patients into the proper light.

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